Agenda Item 3.4

NHS Highland

Meeting:	**Highland Health & Social Care Committee**
Meeting date:	**01 July 2026**
Title:	**Learning Disability Services Assurance Report**
Responsible Executive/Non-Executive:	**Arlene Johnstone, Chief Officer**
Report Author:	**Andy Grant, Service Manager LD**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- 5 year Strategy, Together We Care, with you, for you
- Emerging issue
- Government policy/directive
- Local policy
- NHS Board/Integration Joint Board Strategy or Direction

This report will align to the following NHS Scotland quality ambition(s):

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

Start Well		Thrive Well		Stay Well	x	Anchor Well	
Grow Well		Listen Well		Nurture Well		Plan Well	x
Care Well	x	Live Well	x	Respond Well	x	Treat Well	
Journey Well		Age Well		End Well		Value Well	x
Perform well		Progress well	x				

2 Report summary

2.1 Situation

This paper provides an update following the previous report presented in July 2025, outlining progress in the provision of care, support, and treatment for individuals with a learning disability across North Highland.

It highlights developments against key national performance measures, with a particular focus on the delivery of Annual Health Checks and the ongoing implementation of the Dynamic Support Register. These remain critical components in improving health outcomes, strengthening early intervention, and ensuring coordinated support for individuals with complex needs.

While demonstrable progress has been made, the report also reflects the continued scale and complexity of this agenda, emphasising the sustained effort required to fully realise equitable, high-quality care for this population.

The committee is asked to:

- Note the continued progress in delivery of Annual Health Checks for people with a Learning disability across North Highland, while recognising the significant scale of work still required towards achieving comprehensive coverage for this important population health initiative.
- Support the ongoing programme of improvement enabling individuals with learning disability to live fulfilling and active lives within their own communities, with meaningful opportunities for social participation, contribution and progression towards employment where appropriate.
- Acknowledge both the risks and achievements associated with supporting individuals with complex and enduring needs, noting the continued commitment to delivering safe, effective and person centred care, treatment and support.

2.2 BACKGROUND

2.2.1 PREVELENCE

An estimated 1,800 adults with a learning disability live within the Highland area. Of these, NHS Highland has formally identified 1,034 individuals who are currently receiving health and social care support. Work is ongoing to improve the accuracy and completeness of these figures by comparing data held by the Highland HSCP Adult Learning Disability Service with newly obtained information from GP practices. This process aims to strengthen oversight, ensure records are up to date, and provide a more reliable understanding of the population's needs.

2.2.2 **HEALTH CHECKS**:

The Scottish Government allocates £92,000 per annum to Highland HSCP to support the implementation and rollout of this programme. An Advanced Nurse Practitioner has been appointed to deliver the health checks and embed the nurse led model across North Highland.

Since the previous update in July 2025, the Learning Disability Service has utilised a portion of this recurring funding to strengthen administrative capacity and to procure essential clinical equipment, ensuring the delivery of high-quality, comprehensive health checks in line with Scottish Government standards and recommendations

2.2.3 **SUPPORT PROVISION**:

Highland HSCP continues to commission a range of independent sector providers to deliver support for adults with a learning disability in their own homes, ensuring needs and outcomes are met and enabling people to lead ordinary, fulfilling lives.

The Assessment and Treatment Unit at New Craigs (Willows) provides specialist inpatient care for six individuals with learning disabilities and complex needs. Five of these individuals remain in hospital while awaiting suitable adult social care placements to support safe discharge.

Day opportunities continue to be delivered across Highland through building-based services, including the Isobel Rhind Centre, Corbett Centre, Montrose Centre and Thor House. NHS Highland also provides 24/7 registered housing support in Portree and Inverness for eight individuals.

These services operate alongside partner organisations such as Nansen, Cantraybridge and L’Arche, offering a broad range of activity-based, learning-focused and employability programmes. A key priority within the Learning Disability Service’s three-year delivery plan is to strengthen and expand pathways from these opportunities into paid employment.

2.2.4 **COMPLEX NEEDS**:

Work is continuing towards meeting the recommendations set out in the Scottish Government’s Coming Home implementation plan, which seeks to eliminate inappropriate out-of-area placements and delayed discharges for people with learning disabilities and complex needs. Previous reports have outlined the specific recommendations and their relevance to local service planning and delivery, in this report we are pleased to be able to provide further data and examples detailing that this work is making progress for this cohort of individuals.

2.3 Assessment

2.3.1 **HEALTH CHECKS:**

In Highland HSCP, a nurse-led model continues to deliver the Annual Health Checks. The Learning Disability Service hosts and manages a 1.0 WTE Advanced Nurse Practitioner (ANP), supported by administrative resource to deliver the programme. The ANP is embedded within the wider learning disability and multidisciplinary team and also provides additional support, guidance and interventions beyond the structured programme, contributing to the service's broader aim of keeping people safe and well in their communities.

The table below provides a breakdown of the total numbers between July 2025 and end of May 2026.

Measure	Number	Percentage
Health checks offered	454	100%
Health checks completed	273	60.1%
Not completed (DNA / cancelled / pending)	181	39.9%

Non-attendance reflects a range of factors, including changes in circumstances on the day, challenges for families or carers in supporting attendance, and limitations in care provider staffing to facilitate transport and support. In some cases, families or guardians have advised that health needs are being monitored through alternative clinical contacts. The team continues to make reasonable adjustments and offer flexible options to maximise uptake. Appointments may take place in day centres, hospital settings, or through home visits, ensuring that care is tailored to meet individual patient needs and supports a patient centred approach.

The core function of the Annual Health Check programme is early identification and intervention, which is demonstrating a positive impact. Through proactive engagement, the team is identifying previously unmet or emerging health needs at an earlier stage and enabling timely, coordinated access to appropriate medical and specialist services. This includes onward referrals to General Practice, Community Learning Disability Nursing, Dietetics, Speech and Language Therapy, and Audiology. This approach supports a more preventative model of care, reducing the risk of deterioration, avoiding crisis interventions, and providing reassurance to individuals, families and carers.

The programme has also identified safeguarding concerns, with Adult Support and Protection procedures initiated following a recent community visit, further evidencing its role in promoting safety and wellbeing.

In parallel with service delivery, the team continues to contribute to the Scottish Government's policy work on the implementation and national expansion of Annual Health Checks. This engagement enables collaboration with colleagues across

Scotland to address shared challenges, identify best practice, and inform future learning—supporting the consistent rollout of this important public health initiative for people with learning disabilities.

Since commencing in post in April 2024, the Advanced Nurse Practitioner (ANP) has worked closely with the Scottish Government data lead and local primary care partners to obtain Learning Disability registers across Highland. This work is now complete. It enables comparison between the 1,083 individuals known to the Learning Disability Service and the 1,500+ individuals recorded on primary care registers.

It is recognised that data quality and coding remain national challenges, with some individuals on primary care registers incorrectly or historically coded as having a learning disability. Work is therefore ongoing to reconcile and validate these datasets. The overarching aim is to ensure that all eligible individuals in North Highland are accurately identified and offered an Annual Health Check.

Furthermore, the Health checks team have been working alongside the national group to develop a unified Health Check for use across the country via the Morse system. The ANP is also a Morse super user here in Highland and provides support, guidance and training to colleagues across the Learning Disability Service in the continued roll out and use of Morse. Our ANP also attended an advanced practice conference here in NHS Highland and is collaborating with colleagues in Argyll and Bute to design a poster summarising the aims of the annual health check – the future plan would be to incorporate the views of people with lived experience and work with People First (our collective advocacy partner) is planned for later this year.

2.3.2 **SUPPORT PROVISION:**

Providers continue to manage the financial and workforce pressures associated with increased National Insurance contributions, which continue to impact recruitment and retention. Some providers have reported improved recruitment outcomes through Home Office overseas worker schemes.

The service can report a reduction in urgent multi-disciplinary responses to placement instability. Red Person meetings have decreased from 24 to 16 over the same reporting period, reflecting strengthened processes and earlier intervention. The Learning Disability Service reviewed the revised Red Person meeting framework in June 2026 and confirmed that meetings are now well-structured, well-attended and supported by timely, high-quality information. Chairs are consistently able to agree clear actions aimed at stabilising situations and progressing care, treatment and support planning. These meetings continue to be an example of high quality multi-disciplinary, multi-agency working which include input from families and other key partners. The continued aim is to maximise person centred discussion and action planning.

Workforce pressures remain a significant challenge across the sector, as highlighted in last year's report, where staffing shortages limited providers' ability to maintain or accept new support packages. The Learning Disability, Mental Health and Highland HSCP Commissioning teams have reinstated the bi-monthly support provider forum which aims to increase collective oversight of emerging issues, consider together possible measures which can achieve a more sustainable approach to challenges. The forum is also a platform for improving communication across the sector on strategic intentions and will be particularly important in relation to the soon to be agreed Highland HSCP Commissioning strategy.

NHS Highland Day and housing support services

- Over the past year, The Montrose Centre has strengthened community inclusion through projects such as the donation-based Vintage Café, which provides vocational experience for supported individuals while funding local charities, community events, and internal wellbeing initiatives. The café's *"pay what you can"* approach ensured full accessibility for the wider community.

- The service delivered a wide range of health, fitness, creative, and educational activities, including swimming, gym sessions, Music and Movement groups, drama workshops, and customised first aid training. When the Nevis Centre closed unexpectedly, staff quickly relocated activities to the Kilmallie Community Centre, ensuring continuity for all participants.

- Looking ahead, the centre is developing an eight-week educational partnership with the West Highland Museum, offering hands-on historical workshops shaped by service-user interests. With strong community partnerships and donation-funded projects, the service continues to demonstrate resilience, creativity, and a commitment to high-quality, person-centred support.

- Over the past 12 months, the Isobel Rhind Centre has continued to strengthen and expand its service, with a clear focus on improving opportunities, accessibility and outcomes for supported individuals. Key developments include enhanced leadership capacity through the appointment of a Team Leader, improved facilities such as refurbished polytunnels and a fully accessible kitchen, and strengthened partnership working with third sector organisations and local employers to support employability pathways. The service currently supports 27 individuals through a range of structured activities—including gardening, retail, woodworking and volunteering—designed to build independence, confidence and work-based skills.

- The Care Inspectorate inspected the Isobel Rhind Centre in March 2026 and this indicated consistently high-quality care, with ‘Very Good’ evaluations across staffing, environment and care planning, and ‘Good’ for wellbeing. The service demonstrates a proactive approach to continuous improvement, including strengthened compliance with Care Inspectorate requirements and improvements in medication management practices. Feedback from individuals and stakeholders highlights a caring, safe environment with positive staff interactions and a strong focus on achieving personal outcomes. Overall, the service is characterised by strong leadership, a commitment to learning, and the delivery of person-centred, outcome-focused support.

- The Corbett Centre has seen a marked increase in activity and engagement over the past year, with more individuals participating in a diverse range of opportunities, including art-based, sensory, and social sessions. Monthly social events now regularly attract in excess of 50 attendees, reflecting growing interest and sustained involvement. The Centre is increasingly established as a vibrant and welcoming environment, providing meaningful opportunities for connection, participation, and community inclusion.

- Importantly, the Corbett Centre is playing a bigger role in helping people move on from hospital, offering a more relaxed environment to build confidence, keep up daily living skills like cooking, and support smoother transitions back into community life. Work is also underway to review the current and future role which the Centre can play in relation to enhancing better transitions for young people leaving school and entering into adult services.

- Over the past year, SILC Portree has continued to demonstrate strong, person-centred care that keeps people connected to their communities and supported in ways that reflect their own choices and needs. This was recognised through the recent Care Inspectorate inspection, which highlighted good performance in how people’s wellbeing is supported and how care is planned, reflecting the positive outcomes being achieved day to day.

- A structured Improvement Plan has been developed for SILC Portree to build on the feedback from the Care Inspectorate and includes introducing regular quality assurance processes, reviewing training needs, and improving governance around care planning and medication.

- Alongside this, SILC Portree has continued to build strong links within the local community, strengthening partnerships and creating more opportunities for people and families to be involved, with events such as the upcoming summer fayre helping to bring people together.

2.3.3 COMPLEX NEEDS

Inpatient service

The Mental Welfare Commission's most recent unannounced visit to the Assessment and Treatment Unit at New Craigs took place in May 2025, and a further visit is anticipated this year. During the previous inspection, the Commission highlighted strong compliance with Mental Health Act and Adults with Incapacity documentation requirements, alongside effective use of seclusion guidance and a clear commitment to maintaining the least restrictive care options.

The Commission has consistently noted that the current ward environment is not optimal for recovery. This remains a recognised priority within the New Craigs Hospital Masterplan, which is progressing following the end of the PFI contract in July 2025. The Learning Disability Service has identified ward reconfiguration planning as a key theme within its three-year delivery plan.

A Short-Life Working Group is developing recommendations for interim and longer-term ward moves to ensure continuity of safe, high-quality care for this highly complex inpatient population. Engagement is ongoing with estates and hospital management colleagues as this work progresses and will form a significant area of development in the year ahead.

The Dynamic Support Register (DSR)

The Coming Home Action Plan 2026 has renewed focus on improving outcomes for people with learning disabilities and complex needs, and the Dynamic Support Register (DSR) has become an important mechanism for identifying and monitoring people at greatest risk across these areas. It has improved visibility of individuals with the most complex needs and supports quarterly reporting to the Scottish Government.

Progress to date in Highland includes the establishment of a consistent local DSR process, maintained through a multi-disciplinary group, which has strengthened oversight of people in hospital, those at risk of placement breakdown, and individuals requiring enhanced monitoring. The DSR has been particularly valuable in providing a focus on people in out-of-area hospital placements.

Summary of current Highland HSCP DSR numbers

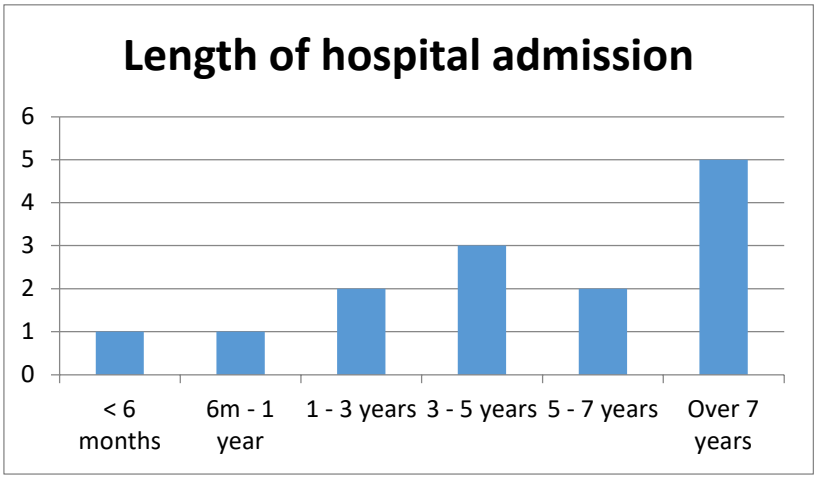
Category	Number of people April 2026
RED: In hospital	14
RED: At risk of placement breakdown	13
RED: Inappropriate out-of-area social care placement	0
AMBER: Enhanced monitoring.	6

This month, one individual who had been in a specialist hospital in England for over nine years moved into his own tenancy in Highland. This was a significant achievement requiring extensive bespoke planning and has resulted in a very positive outcome for him and his family.

Overall, while good progress has been made in establishing oversight through the DSR, there remains a need for coordinated planning across health, social care, housing and commissioning to reduce crisis-driven responses and improve outcomes.

About the people in hospital

People on the DSR spend a disproportionately long time in hospital because of a lack of appropriate community options. Ten out of the fourteen people in hospital have been there for more than three years, and five of those have been in hospital for more than seven years.



Housing challenges

Securing suitable housing remains a significant challenge. In addition to the wider housing shortage across Highland, many individuals on the DSR require highly specialised environments that are seldom available within the existing housing stock, such as detached bungalows, properties with circular layouts, or homes with access

to substantial outdoor space. These requirements are often critical to ensuring safe and sustainable support, helping to reduce the risk of distress, placement breakdown, and potential hospital admission.

The service has engaged proactively with the Highland Council Strategic Housing Needs Assessment process to ensure that this level and type of demand for specialist housing is appropriately recognised and reflected in future planning.

Transitions

Transitions from children's to adult services are an increasingly prominent area of need, despite young people under the age of 18 not yet being formally recorded on the DSR. A growing cohort of young people with highly complex needs—particularly those who are Looked After and placed outwith the area due to limited local provision—will require sustainable, community-based housing and support as they approach adulthood. The principles set out in the Coming Home Action Plan are likely to further increase expectations and pressure to develop appropriate, localised options within Highland.

Current data provides an indication of both the scale and complexity of anticipated demand. A review of young people aged 14–18 with highly complex needs identified existing care and accommodation arrangements with an estimated annual value of £3.5 million. While children's and adult service models are not directly comparable, this figure offers a useful proxy for the level of specialist provision, infrastructure, and workforce capacity that is likely to be required as this cohort transitions into adult services.

In recognition of these emerging challenges, the Partnership's Chief Officer and Chief Social Work Officer have engaged with Learning Disability leadership and management to consider the implications. A strategic review has subsequently been commissioned to ensure the Partnership is appropriately positioned to respond to the needs of those young people expected to transition to adult services in the coming years.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	X
Limited		None	

While there has been progress in developing care and support for individuals with complex needs, challenges remain in securing timely and appropriate discharge pathways for some.

Recognising these pressures, a range of actions are underway to strengthen future capacity and planning. The Partnership has commissioned a strategic review focused on improving pathways, accommodation options, and models of care for people with highly complex needs, including those requiring repatriation or step-down from hospital settings. This review is intended to support a more proactive, whole-system approach to anticipating demand and aligning commissioning, workforce, and infrastructure.

In parallel, the service is actively contributing to the Highland Council Strategic Housing Needs Assessment to ensure that the requirement for specialist and adapted housing is fully reflected in future housing plans. This includes articulating the scale and type of provision required to support safe, sustainable community placements. Together, these actions provide increased assurance that the Partnership is taking a structured and forward-looking approach to addressing current delays while building the capacity needed to meet future demand.

It is important to note that the two most complex discharges reported at last year's assurance report remain stable and are living active, independent lives within The Moorings cluster. This demonstrates that when the right care models and coordinated multidisciplinary approaches are in place, complex discharges can be achieved and sustained effectively.

Delivery of health checks continues to operate at the maximum capacity currently resourced within the service. Further development work is required to expand this national priority in Highland so that annual health checks can be offered consistently to all adults with a learning disability. While the number of completed checks remains relatively small compared with the total eligible population, the quality of the checks undertaken is high and is already enabling earlier identification of co-morbid health conditions that can be addressed proactively. To fully realise the ambition of annual health checks for every eligible individual in Highland, continued investment and service development will be essential, and the Partnership are engaged with Scottish Government to explore options and opportunities to strengthen this programme.

3 Impact Analysis

3.1 Quality/ Patient Care

Highland HSCP Learning Disability services remain committed to supporting people to live purposeful, meaningful lives in their own homes and communities. This continues to underpin all service development and commissioning activity in 2026.

Work with housing and support providers is progressing, with a focus on creating sustainable local housing options that align with effective care models and provide long-term stability. This remains a core priority as demand and complexity increase.

The quality of support provision across the sector continues to be strong. Highland HSCP and the Care Inspectorate maintain a responsive, collaborative approach to addressing any concerns, ensuring that standards are upheld and improved where required.

The majority of the Learning Disability multidisciplinary team has now transitioned to the Morse Electronic Patient Record (EPR) system, a move that has been positively received by clinicians. The adoption of Morse has significantly improved the accessibility and visibility of clinical information, particularly for staff that provide joint or complementary input for individuals with complex needs. This enhanced access supports more coordinated, person-centred practice by ensuring that all relevant professionals can view up-to-date assessments, care plans and interventions in real time.

The transition to a shared electronic record has also strengthened communication across the MDT, reduced duplication, and improved the quality and consistency of documentation. Clinicians report that the system enables more efficient decision-making, clearer handovers and a more integrated approach to care planning.

3.2 Workforce

Highland HSCP Learning Disability Service continues to prioritise staff development as a core component of workforce sustainability. This year, three existing adult social care staff have commenced higher-education pathways through Glasgow Caledonian University and the Open University, working towards Learning Disability Nursing qualifications. One of these staff members has already begun a local clinical placement. This cohort forms an important part of the service's strategic commitment to "grow our own" in response to the well-recognised national challenges in recruiting Learning Disability nurses and consultant-grade medical staff.

It is encouraging to note that investment in professional development is beginning to yield tangible progress. The service continues to engage actively with national programmes such as '*Sustaining the Commitment'* and the Learning Disability Nurses Forum to expand opportunities for skills development and career progression. These initiatives are supporting a more robust pipeline of future LD nursing staff.

Longer-term workforce planning within medical staffing is also being strengthened. Following three years of unsuccessful recruitment rounds for the vacant consultant post, the service is now exploring alternative development pathways and support models to ensure continuity of clinical leadership and specialist expertise.

3.3 Financial

The service's priority is to reduce costs associated with an out of area hospital placement by continuing to make the repatriation of individuals placed in such settings to more appropriate settings in Highland. NHS Highland learning disability services continue to operate within establishment funding.

3.4 Risk Assessment/Management

The Dynamic Support Register (DSR) is providing an important framework for the proactive identification, oversight and management of risk for individuals with learning disabilities and complex needs who are vulnerable to delayed hospital discharge, placement breakdown or out-of-area admission. By bringing together information on individuals who are at risk of admission, delayed discharge or whose current placement may be unstable, the DSR supports a more coordinated and anticipatory approach across health, social care and housing partners.

In relation to delayed hospital discharge, the DSR helps ensure that individuals with the most complex needs remain visible within system-wide planning and escalation processes, supporting earlier discussion of barriers to discharge, including accommodation, workforce and provider capacity. For those placed out of area, the DSR assists in identifying people for whom repatriation should be considered and enables strategic oversight of the clinical, social and financial risks associated with prolonged external placements. It also strengthens the Partnership's ability to monitor individuals whose current community arrangements may be fragile, allowing earlier multi-agency intervention to reduce the likelihood of placement breakdown and avoid unnecessary hospital admission.

Overall, the DSR is strengthening risk management by improving shared oversight, informing strategic commissioning and supporting a more preventative approach to care planning for people with the most complex and vulnerable needs.

3.6 Equality and Diversity, including health inequalities

People with a learning disability continue to experience some of the most significant health inequalities of any population group, with life expectancy estimated to be 10–20 years lower than the general population. Those with severe learning disabilities and multiple co-morbidities face the poorest outcomes. Research from the University of Glasgow identifies respiratory and circulatory disease as the leading underlying causes of death and highlights that many of these deaths are from conditions that are *amenable to treatment*. This reinforces the critical importance of early identification and need to invite people with a learning disability to an annual health check.

3.7 Other impacts

Work is underway to streamline transition pathways and align them more closely with the Dynamic Support Register (DSR), ensuring earlier identification of need, improved planning and clearer accountability across agencies. Strengthening this interface is essential to preventing avoidable crises, reducing future delayed discharges and ensuring that young people with complex needs move into adulthood with appropriate, timely and sustainable support.

3.8 Communication, involvement, engagement and consultation

Highland HSCP Learning Disability Service is working in partnership with Spirit Advocacy and People First Highland to better understand the collective voice of people with learning disabilities across Highland. This work seeks to move beyond service provision alone, to explore what a “good life” looks and feels like for individuals—what matters most to them, and what enables them to live well in their communities. Through this shared approach, we aim to strengthen our collective advocacy and ensure that services and wider systems are shaped by, and responsive to, the aspirations of the people we support.

3 Recommendation

The Committee are requested to review the content of this assurance report and take moderate assurance for the delivery of the Learning Disability services in Highland HSCP.