Agenda Item 3.6

NHS Highland

Meeting:	**Health and Social Care Committee**
Meeting date:	**14th January 2026**
Title:	**Draft Adult Social Care Commissioning Strategy and Intentions**
Responsible Executive/Non-Executive:	**Arlene Johnstone, Chief Officer**
Report Author:	**Rhiannon Boydell, Head of Service Integration, Strategy and Transformation**

Report Recommendation:
The report is presented in draft for final comment and discussion before being presented to the Joint Monitoring Committee for approval.

1 Purpose

This is presented to the Board for:

- Discussion and comment

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

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

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

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

2 Report summary

2.1 Situation

The Highland and Social Care Partnership draft Commissioning Strategy and Intentions is brought to the Health and Social Care Committee for discussion and comment. The final draft will go to the Joint Monitoring Committee for approval.

2.2 Background

The Joint Strategic Plan (JSP) was published in 2024 and Joint Strategic Needs Assessment (JSNA) published in March 2025 and updated in June 2025.

The Commissioning Strategy and Intentions supports the vision of the JSP. It has been developed by an Internal Reference Group representing the commissioning activity areas, finance, and professional social care and commissioning leadership, building on the extensive engagement on which the Joint Strategic Plan was developed.

It is informed by our JSNA and outlines the Highland Health and Social Care Partnership's approach to the commissioning of adult social care services over the next 3 year period.

2.3 Assessment

The document outlines the vision, context, challenges, and planned actions for commissioning adult social care services across Highland, with a focus on person-centred, integrated, and locality-led care models.

The strategy follows the JSP and JSNA, aiming to provide strategic direction to the commissioning challenges, with detailed supporting plans for service activity areas.

The document sets out the policy and vision context, demographic and demand pressures, workforce challenges, market dynamics, financial and performance context, the commissioning approach and our commissioning priorities.

It also describes the governance for the delivery of the strategy and next steps for implementation.

Appendix 1 provides details service plans.
Appendix 2 provides a commissioning summary and 3 year plan

2.4 Proposed level of Assurance

Please describe what your report is providing assurance against and what level(s) is/are being proposed:

Substantial		Moderate	x
Limited		None	

The draft Commissioning Strategy and Intentions has been produced within the required timescale of the end of December 2025 and is presented here for final comment. However further detailed procurement and market facilitation plans are required to enable implementation.

3 Impact Analysis

3.1 Quality/ Patient Care

Quality and patient experience are expected to improve with implementation of the strategy

3.2 Workforce

The strategy aims to address challenges in the workforce including recruitment and retention. The strategy will be supported by a workforce plan.

3.3 Financial

The strategy acknowledges financial pressures and the need for transformative alternative approaches as well as efficient resource use.

3.4 Risk Assessment/Management

Implementation plans will include the identification of risks and mitigating actions.

3.5 Data Protection

The strategy doe s not involve personally identifiable

3.6 Equality and Diversity, including health inequalities

An EQIA was completed for the Joint Strategic Plan (JSP). In addition, the Commissioning Strategy and Intentions is informed by the Joint Strategic Needs Assessment and future demographic requirements identified within it.

3.7 Other impacts

None

3.8 Communication, involvement, engagement and consultation

The document has been developed in line with the Joint Strategic Plan 2024-2027 and the extensive engagement process conducted in it's development. It has been further informed by an internal reference group and is presented in draft form for wide comment

3.9 Route to the Meeting

At the time of writing, the draft document will be presented to:

- HHSCP Senior Leadership Team on 7th January 2026
- Joint Officer Group on 9th January 2026
- NHS Highland Executive Directors Group on 9th January 2026

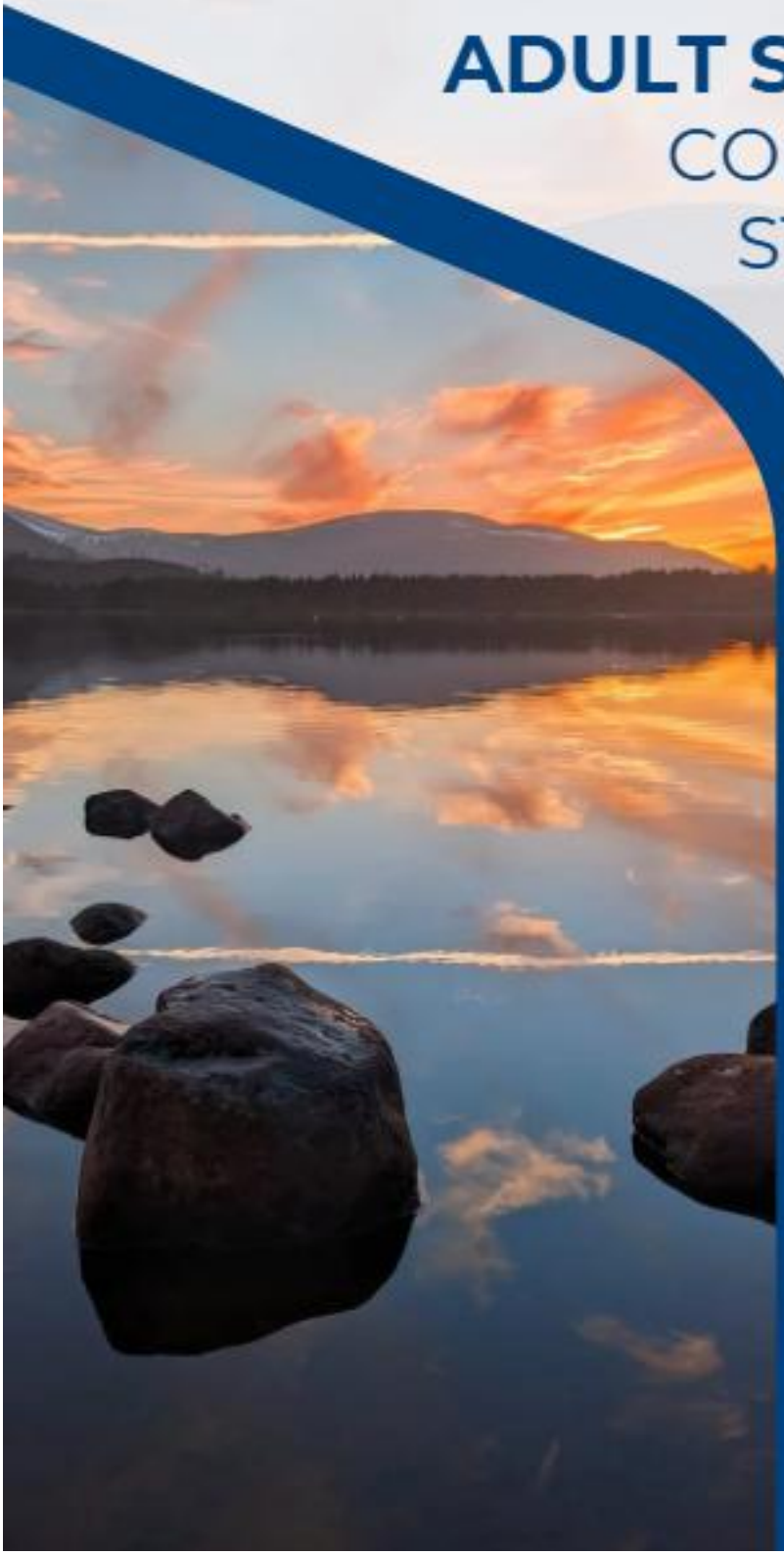
- Strategic Planning Group on 13th January 2026

4.1 List of appendices

The following appendices are included with this report:

- Appendix No. 1 Highland Health and Social Care Partnership Adult Social Care Commissioning Strategy and Intentions 2026-2029.

HIGHLAND HEALTH AND SOCIAL CARE PARTNERSHIP



ADULT SOCIAL CARE COMMISSIONING STRATEGY AND INTENTIONS

DRAFT

2026 - 2029

Document Control

Version	Date	Changes	Initial
V0.1-V0.5	14/11/25	Initial drafting.	GG
V0.6 Clean	21/11/25	Comments included from Carolyn Hunter-Rowe, Ian Thomson, James Bain, Rhiannon Boydell.	GG
V0.7 Clean	05/12/25	Comments from Reference Group members.	GG
V0.8 Clean	12/12/25	Comments from Reference Group members.	GG
V0.9 Clean	17/12/25	Appendix / infographic editing and refinement.	GG
V0.10 Tracked	05/01/26	Further refinements	GG
V0.11 Clean	05/01/26	Further refinements	GG

Executive Summary

Our **Adult Social Care Commissioning Strategy and Intentions 2026-2029** follows on from the Joint Strategic Plan (JSP) published in 2024 and Joint Strategic Needs Assessment (JSNA) published in March 2025 and updated in June 2025.

This document supports the vision of the JSP, is informed by our JSNA and now outlines the Highland Health and Social Care Partnership's approach to address the many contextual challenges in the commissioning of adult social care services over the next 3 year period.

The document outlines the vision, context, challenges, and planned actions for commissioning adult social care services across Highland, with a focus on person-centred, integrated, and locality-led care models.

Strategy foundation and purpose: The strategy follows the JSP and JSNA, aiming to provide strategic direction to the commissioning challenges, with detailed supporting plans for service activity areas.

Policy and vision context: The strategy aligns with national and local policies, including the Scottish Government's frameworks and legislation, and supports the vision of seamless, compassionate, coordinated support close to home through the Highland Care Model, which is person-centred, locality-led, integrated, preventative, digitally enabled, affordable and co-produced with communities.

Demographic and demand pressures: Highland's population is aging with increasing complexity of needs, including a rise in older adults and chronic conditions, leading to higher demand for social care services amidst rural deprivation and access challenges.

Workforce challenges: The recruitment and retention of paid carers is difficult due to geographic, economic, and societal factors, with reliance on overseas recruitment complicated by policy changes. Outward migration and these workforce shortages impact service stability and delivery.

Market dynamics: The adult social care market in Highland is a mixed economy, with independent (including third sector) providers and NHS Highland (in house) delivering services and an intentional move to support a wider more individualised market place and opportunities needs to be developed. Financial viability challenges and staffing shortages have caused service closures, emphasising the need for innovative, flexible care options and ethical commissioning approaches.

Commissioning approach: The strategy emphasises strategic commissioning as a cyclical, equitable, and transparent process involving needs assessment, priority setting, planning, procurement, and quality monitoring. It commits to ethical commissioning aligned with Scottish Government policy and the Independent Review of Adult Social Care's recommendations for collaborative, person-led care. These aspects are to be more fully detailed in an accompanying market facilitation plan.

Commissioning priorities: Key priorities include promoting wellbeing through prevention and early intervention, empowering self-care and unpaid carers, supporting diverse care options including local care models and personal assistance, enhancing workforce skills and conditions, and leveraging technology to improve care delivery.

Financial and performance context: Adult Social Care expenditure is projected at over £203m for 2025-26, with a significant overspend presenting considerable challenges. The strategy acknowledges cost pressures and the need for transformative alternative approaches as well as efficient resource use in the context of significant and increasing demand pressures.

Our forward approach is therefore underpinned by person-centred, locality-led, and integrated care models with priorities on prevention, community-led support, workforce development, and ethical commissioning to deliver high-quality, affordable services informed by the JSP, JSNA and aligned with national and local policies.

This strategy, and our intentions described within it, will be supported by more detailed work to take forward the more granular detail required to move towards action and implementation.

1 - Introduction

This **Adult Social Care Commissioning and Intentions** document follows on from the **Highland Adult Services Joint Strategic Plan 2024-2027 (Joint Strategic Plan)**, which was agreed in December 2023 following extensive consultation.

The previously prepared Joint Strategic Plan (JSP) is a requirement of the Public Bodies (Joint Working) (Scotland) Act 2014 and requires to achieve:

(a) setting out the arrangements for the carrying out of the integration functions for the area of the local authority over the period of the plan,
(b) setting out how those arrangements are intended to achieve, or contribute to achieving, the national health and wellbeing outcomes, and
(c) including such other material as the integration authority thinks fit.

The provision required to be included in a strategic plan by virtue of subsection (2)(a) is to include provision—

(a) dividing the area of the local authority into two or more localities, and
(b) setting out separately arrangements for the carrying out of the integration functions in relation to each such locality.

The JSP therefore is to describe the arrangements for carrying out integrated functions and to outline how these will achieve, or contribute to achieving, the national health and wellbeing outcomes, including how the Partnership will commission and deliver services for its area over the medium term. The term "Strategic Plan" was previously referred to as "Strategic Commissioning Plan" in earlier Scottish Government statutory guidance.

Alongside the Strategic Plan, there is a legislative requirement to:

- Publish the **strategic plan**, consultation actions, financial statement, equality impact assessment (and any other relevant impact assessments)

- Produce an **implementation plan**, (or set of implementation plans), outlining how the strategic plan will be delivered. This is to include a **procurement plan** providing specific detail to direct those responsible for contracting services.

- Prepare a **market facilitation plan** to complement the strategic plan and support its delivery.

- Consider how workforce planning will enable delivery of the strategic plan (**workforce plan**).

- Publish an **annual financial statement** to set out in relation to the strategic plan to which it relates, the amount that the integration authority intends to spend in implementation of the plan.

- Produce an **annual performance report** that sets out an assessment of performance in planning and carrying out integration functions for the reporting year.

- Review and prepare a **replacement plan** prior to expiry

The JSP was prepared in 2023 in the absence of a Joint Strategic Needs Assessment (JSNA), which was unavailable at the time. The content of the prepared document set out a high level vision and future direction of travel for the provision of adult social care services in Highland but did not draw from a JSNA nor include commissioning intentions.

The JSNA is now available (March 2025, revised June 2025) and there is now an opportunity to reflect on this document and prepare this more specific Commissioning Strategy and Intentions document, of what services we need across all client groups and geographies, in order to deliver on the requirements of the JSP within the budget set for Adult Social Care.

This Commissioning Strategy and Intentions document will therefore support the high level vision and direction set out within the JSP and will support the development of a number of enabling supporting plans, which describe the detailed actions for supporting delivery of the JSP and this Commissioning Strategy and Intentions:

- **Market facilitation plan**
  Actions and timescales for how we intend to stimulate a diverse, vibrant and sustainable market, so there are different types of support and provider organisations for supported people to choose from

- **Procurement plan**
  Actions and timescales for how we intend to progress the identified procurement activity and delivery.

- **Workforce plan**
  Actions and timescales for how we intend to create and support the future workforce needed to deliver the required services in Highland.

This Commissioning Strategy and Intentions document is prepared for the purpose of directing the Partnership's activity in delivering on its Joint Strategic Plan and also for other stakeholders, particularly those who use the services and also those who currently or may deliver services in the future, for awareness of these intentions.

It's scope, as articulated within this document, relates only to the following priority service areas of:

- Mental health and learning disability support
- Care home (older people)
- Care at home (older people)
- Housing with care (older people)
- Day care (older people)
- Personal assistance
- Local care model
- Unpaid carers
- Technology

It is intended that the Commissioning Strategy and intentions will be a collaborative working document, reviewed on an annual basis and aligned to the periods of the overarching JSP.

2 - Context

Policy Landscape

The Highland Health and Social Care Partnership operates within an extensive national and local policy landscape in delivering adult social care services.

The national policies set the direction which the Partnership requires to follow and the local strategies describe how the Partnership intends to translate and implement these across the Highland area.

National Context Legislation and Policy	National Strategies and Guidance	Local Strategies and Guidance
Scottish Government National Performance Framework	Health and Social Care Standards	Together We Care
National Health and Wellbeing Outcomes	A Fairer Scotland for Older People	Joint Strategic Plan
Social Work (Scotland) Act 1968	Digital Health and Social Care	Mental Health and Learning Disability Strategy Stronger Together
Community Care and Health (Scotland) Act 2002	SDS Framework and Standards	Highland SDS Strategy: Making the Change Together
Social Care (Self-directed Support) (Scotland) Act 2013	Independent Review of Adult Social Care	Highland Unpaid Carers Strategy
Public Bodies (Joint Working)(Scotland) Act 2014	National Care Service and National Social Care Agency	Director of Public Health Report 2022 – Prevention – Moving Upstream
Community Empowerment (Scotland) Act 2015	Keys to Life Strategy 2019-2021	
Carers (Scotland) Act 2016	Mental Health Strategy 2017-2027	
Social Security (Scotland) Act 2018	Learning / Intellectual Disability and Autism Plan 2021	
Housing to 2040	Mental Health Transition and Recovery Plan 2020	
	Coming Home Implementation Plan	

The national and local policy landscape underpin the JSP and in turn, this Commissioning Strategic and Intentions.

Highland Local Care Model

The vision contained within the JSP is to "*work together to support our communities in Highland to live healthy lives and to achieve their potential and choice to live independently where possible*".

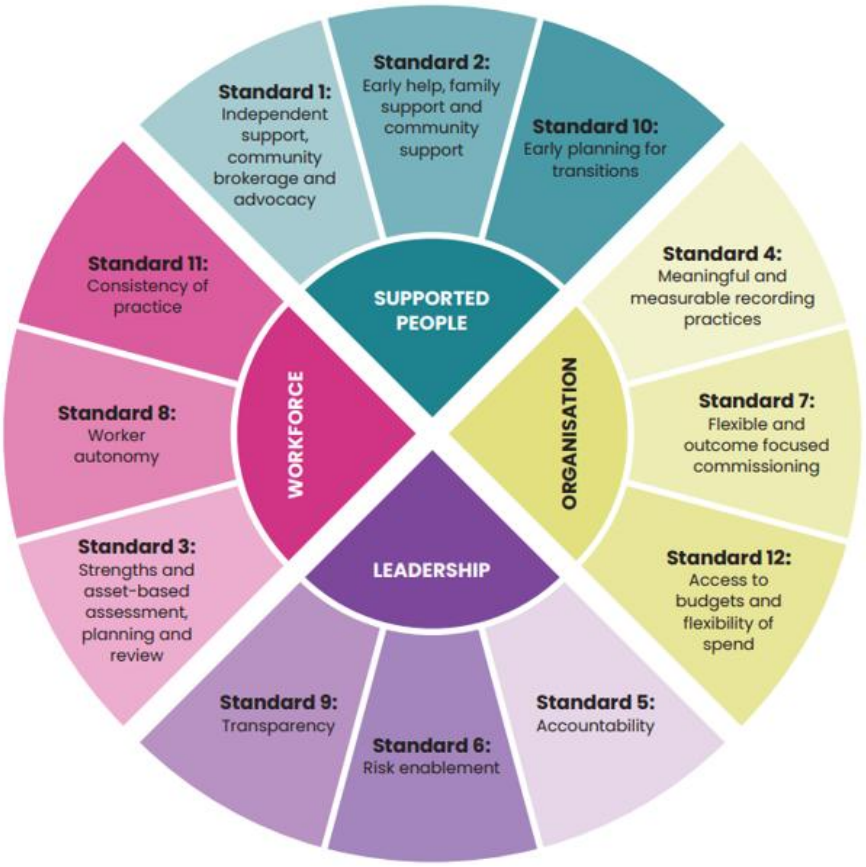
We have confirmed that we want people in Highland to experience seamless, compassionate and coordinated support, close to home, delivered by teams who know and work with their communities and that as part of this, we wish to renegotiate the social contract with the people of Highland to create the Highland Local Care Model.

This Highland Local Care Model is:

- Person-centred and rights based
- Locality led and place-based
- Integrated and multidisciplinary
- Preventative and proactive
- Digitally enabled and data informed
- Co-produced with communities

Using All Our Options

As part of setting out our relevant context, it is relevant to reference the Self-Directed Support Framework of Standards was published in 2024 to support the implementation of Self-directed Support in Scotland. The framework is summarised in the standards wheel as follows. We have been seeking to ensure these standards underpin out activity and our ongoing adoption of these standards will support our realisation of SDS in Highland:

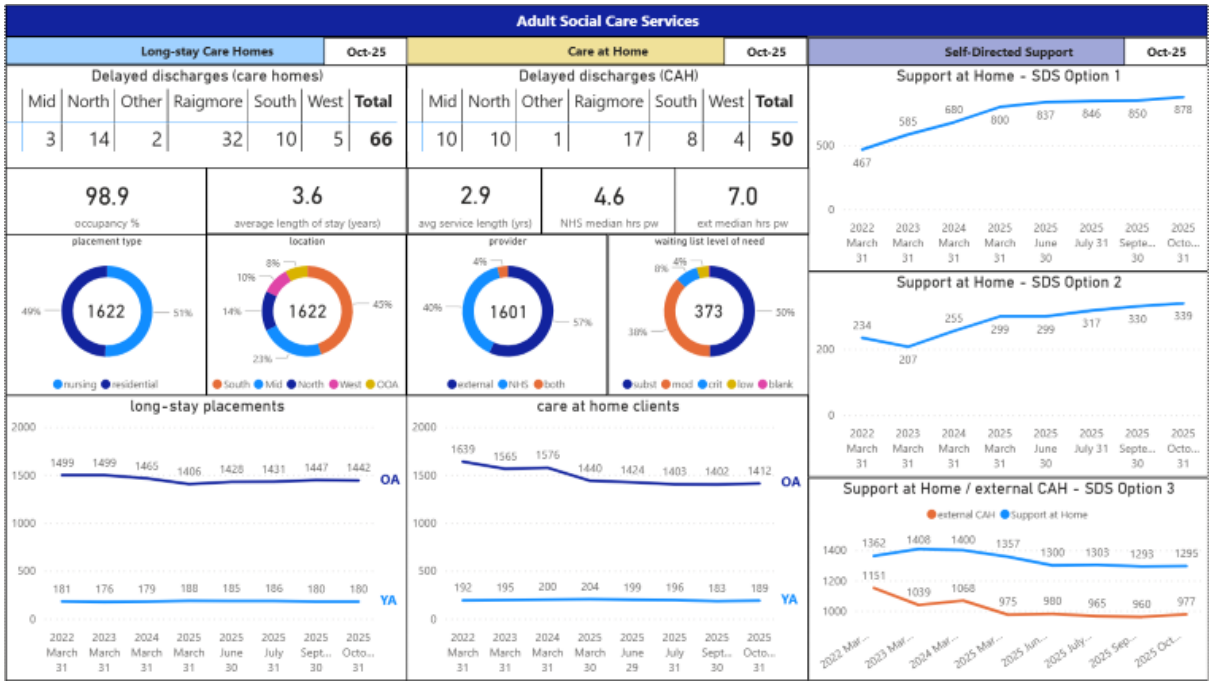


Activity

Currently across Highland there are:

- 1,643 people in care homes. 129 of these people are being cared for and supported in care home placements outwith Highland, due to either choice to be closer to family or due to no alterative provision being available in Highland.
- 2,896 people in receipt of care or support at home
- 878 people in receipt of a direct payment (SDS Option 1)
- 339 people with an individual service fund (SDS Option 2).

The following summarises current activity levels and trends:



- All services are operating to a high level of occupancy and capacity and where this is not the case, this is due to challenges in securing staffing.

- Overall, we are supporting more people, but we are seeing a reduction in the number of people receiving care at home with 6 care providers exiting this market.

- Option 1s are increasing and projected to support in excess of 900 people by the end of this financial year, with growth seen every year since 2022.

- Option 1s and Option 2s are likely to continue to increase.

- There is an increasing number of younger adults with high levels of need supported through the commissioning of high complexity packages.

<u>Demand</u>

Adult Social Care faces sustained pressure from rising demand and increasing numbers of people with complex needs. There is more demand than services available, across most activity areas. This has been an ongoing and increasing trend, which is expected to continue.

As at 8 December 2025, there were:

- At least **229** people delayed in hospital awaiting an appropriate placement which is currently not available.

- **74** people delayed in hospital awaiting a care home placement

- **45** people delayed in hospital awaiting a care at home placement

- **528** people in the community waiting on a social work assessment.

Population projections from National Records Scotland indicate that the population of Highland is expected to increase slightly in the next 5 years, but will become older with an increase of approximately 2.5% each year in the over 75 years age population.

The change in the demographics in Highland is coupled with increasing ill-health in the population (see JSNA below) and therefore demand for social care is expected to increase.

Finance

- The level of funding expended on commissioned and delivered adult social care services is significant at **£182.4m per annum.** However, this is currently insufficient in the current configuration of commissioned and delivered services, in securing services to meet the level of required need, due to the current **£20.7m overspend.**

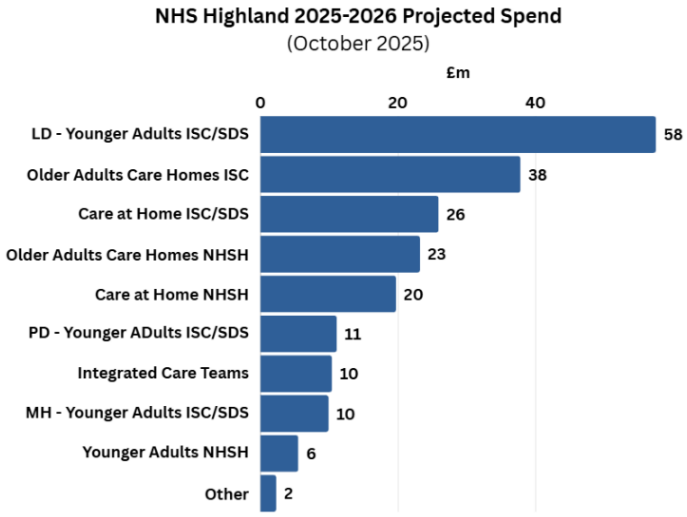
- The ASC projected out-turn for 2025-26 as at the end of October 2025, is expected to be **£203.2m**.

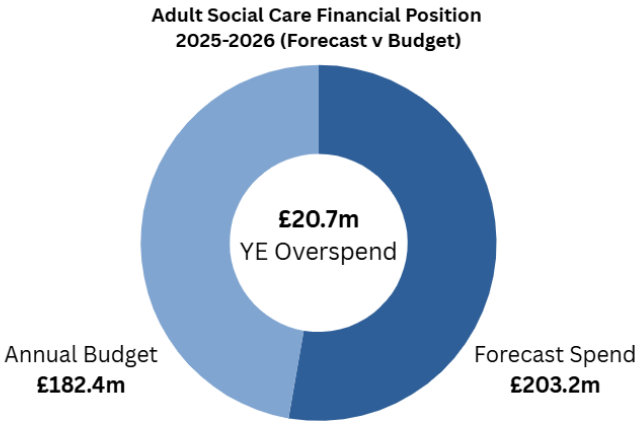
- This expenditure reflects the following composition:

  - In-house spend = **£58.1m**, 28.5% of overall spend

  - Commissioned spend = **£145.1m**, 71.5% of overall spend

- Expenditure is directed into the following activity areas as noted:





- The current projected full year overspend is **£20.7m**, as at the last reported period.

- In order to meet the increasing future needs the approach to the type of services commissioned and the way these are delivered and secured, needs to fundamentally change.

- The opening financial envelope for 2026-2027, before any agreed uplifts, is £182m, with the financial gap of £26m carried over from 2025-2026. The financial model will be confirmed after the Scottish Government budget announcement in January 2026.

- In terms of the financial future for the period of this Commissioning Strategy and Intentions, the Partnership is planning on the basis of continued annual uplifts aligned to previous allocations.

- To deliver within the available financial envelope, significant change and transformation is required. This will be delivered through identified efficiency programmes as set out in the separate Adult Social Care cost containment programme.

- This Commissioning Strategy and Intentions support a number of these programme areas, as described in the investment shift within the accompanying service areas templates.

Recruitment and Retention

The adult social care sector in Highland is challenged to recruit and retain a sufficient number of paid carers to meet demand. This is a picture common across the country but is exacerbated in Highland's context.

Workforce availability is impacted by a combination of factors: geography, demographics, low unemployment, competition from other employment sectors, particularly hospitality and tourism across parts of Highland and other growing sectors (eg Greenport). Availability is also significantly impacted by pay and conditions, lack of recognition, the value that society places on these roles, ongoing negative media coverage.

There has been an increasing reliance on overseas recruitment, which is a slow and expensive process, time consuming and requires available accommodation and additional support for international staff to settle, learn cultural differences in delivering care and integrate into a foreign country. The government policy changes around this area have made this workforce route more challenging.

This is a challenging context in which to attract and retain a workforce to develop and flourish in this demanding and immensely rewarding role.

Market

Social care in Scotland should be characterised by adults choosing and directing the support they need from a wide range of flexible options and the Highland Partnership seeks to offer a choice of care solutions to adults who it recognises are in need of support.

That support has most likely to be chosen from independent sector providers (in care homes, care at home, support and day services) but there is also still a sizeable element of support delivered by NHS Highland itself as a distinct registered provider.

These in house delivered services are provided across Highland, mainly in areas where independent sector providers find it most challenging to deliver a viable and sustainable services.

Independent sector commissioned services include mainstream provision as well as more specialist delivery for people with more complex requirements, delivered either in residential care facilities or directly within a person's home environment.

This is reflected in the current mixed market of provision within the Partnership's area.

NHS Highland in house services have a much higher unit cost than those secured externally, but those externally commissioned services have been experiencing financial viability challenges. This has led to a number of service closures and exits, which in the main have required substantial support and input from Partnership.

There has been instability across both sectors – care home and care at home closures and exits within the independent sector as well as the closure of some in house care homes (some permanently closed, some temporarily) also due to acute staffing shortages.

Across all services, regardless of sector, the challenges presented by an insufficient volume of trained and experienced staff have a destabilising impact on service delivery and sustainability.

Ultimately, high quality care and support is delivered by regulated, trained, experienced and valued staff; and we need to find new and innovative ways to turn around the reduction in this most valuable of our resources.

Given the above, the Partnership has been keen for people to explore what other options exist to find the care and support they need. People have successfully been offered budgets to identify support and care themselves (this is often via employing a Personal Assistant where they can be found), and resources are increasingly being used flexibly to create more individualised arrangements with a broader range of services and products which meet their needs.

3 - Joint Strategic Needs Assessment

In June 2025, a Highland Joint Strategic Needs Assessment - Highland Health and Social Care Partnership (JSNA) was published by the Directorate of Public Health and Policy of NHS Highland.

This JSNA provides an overview of population health and wellbeing needs of the adult population of the Highland council area and looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, well-being and social care services.

The key headlines from this published JSNA, relevant to this forward looking commissioning strategy and intentions, are as follows:

- As of 2024, Highland had a population of 237,920 people. Of these, 15% were children aged 0-15 years, 60% were people aged 16-64 years and 25% were people aged 65 and over.

- The population of Highland has continued to age, with increasing numbers of people in older ages, decreasing numbers of working-age individuals, and smaller cohorts of children and young people. There are now more people aged 65 and over than people under 15.

- 2022-based population projections estimate the population of Highland will increase by 1.8% between 2022 and 2045. Maintaining or growing population numbers in Highland depends on inward migration, offsetting natural population change and outward migration.

- The general demographic picture informing the commissioning of health and care services in Highland is one of smaller populations of children and young people, further reductions in the working-age population, and a continued increase in the proportion of older people.

- Highland has a significant remote and rural geography. Almost four in ten of the population of Highland live in remote rural areas and almost one in four of the population lives in areas that are classified as very remote rural. Older age dependency ratios are higher in these areas.

- Rural deprivation is an important concern. In Highland, most income deprived people live in places not identified among the most deprived areas by the SIMD. This distribution is a significant consideration for policy, strategy and the spatial targeting of resources, particularly in rural areas.

- Around half of the population of Highland live in the twenty percent most access deprived areas in Scotland, with people experiencing longer travel times to local services and poorer digital access.

- Equality, or lack of, directly affects people's chances of being and staying in good health. As an Anchor Institution, the role of the Partnership is pivotal to designing and delivering health and care that has the population and local communities as the focus, particularly in the context of the wider determinants of health.

- Life expectancy is a key indicator of a population's health. Recent evidence has highlighted life expectancy improvements in Highland have stalled over the last decade.

- The general epidemiological picture in Highland is one in which chronic conditions related to ageing are prevalent; multimorbidity is common as age increases, and preventable illnesses exacerbate health inequalities.

- National evidence suggests a substantial increase in prevalence of common health conditions over the next 20 years, due to projected demographic changes. The anticipated rise in a range of diseases including cancer, cardiovascular disease, diabetes and dementia will inevitably place additional pressure on health and care services.

- The harmful use of substances (tobacco, alcohol and drugs), unhealthy diet and physical inactivity are major causes of preventable ill-health and early death. Reducing these risk factors presents a sizeable opportunity to improve health and wellbeing and reduce health inequalities.

- The number of people providing unpaid care increased over the last decade. In the context of increasing demand and growing levels on unmet need, more unpaid care is being relied upon to support people to live at home.

- Current needs and future requirements for housing should be aligned to the Partnership's strategic commissioning and planning to support people at all stages of life and support the shift in the balance of care closer to people's homes.

- Care home capacity has reduced during a period of growth in the older population. Pressure on the care home market is recognised to be associated with challenges of rural operation, smaller size of operation and workforce availability.

- Combined, the data for delayed discharges, care at home and care home capacity reflects the challenge of providing services across the Highland geography and high levels of unmet need.

- People at end of life have relatively high use of health and social care services and demands are forecast to increase. Experience of end of life care should be good, irrespective of where people live or what they die from.

- The evidence on forecast burden of disease, rising service demand and financial sustainability is clear that better prevention of poor health and the creation of good health is essential.

- Improving the health of our population requires a fundamental shift towards prevention and mitigating the underlying issues that can impact on health, such as poverty and deprivation.

- To shift the balance of care closer to people's homes, change is needed in how we approach the delivery of health and care, driving investment in prevention and early intervention.

In summary, we are experiencing the following trends in the provision of Adult Social Care:

From the JSNA the **key drivers for future planning** of Adult Social Care are therefore noted as follows:

- There is an aging population with increasingly large cohorts living into older age, with an overall static or decreasing total population.
- Pressure on all care providers resulting from the challenges of workforce availability and dependence on international workers.
- Epidemiological trends forecast an increase in annual disease burden over the next 20 years.
- People at end of life have relatively high use of health and social care services and demands are forecast to increase.
- To shift the balance of care closer to people's homes, change is needed in how we approach the delivery of health and care, driving investment in prevention and early intervention.
- The Partnership, along with its partners and key stakeholders, play a pivotal role in designing and delivering health and care that has the population and local communities as the focus.

4 - Changes

There are a number of changes that need to take place in the context of the vision that the Joint Strategic Plan is seeking to achieve and in the context of the evidenced challenges we face:

- Focus attention on **wellbeing** through prevention and early interventions to support people to maintain independence at home for as long as possible.

- Empower people to exercise **choice and independence** and include unpaid carers as partners in the planning and provision of care and support.

- Commission services in a way that **respects and values all partners**, and supports a diverse market for all types of providers of care with reduced administrative burden.

- Make it **easy to access services** when they are needed and ensure that health and social care professionals are easily able to direct people to the right organisation and service for their needs.

- Ensure supported people have access to the **independent support and community brokerage** which will allow them to create (commission) the types of services and supports which are best for them.

- Maximise the use of **technology** in supporting people to transform and expand the capacity of current provision (eg care technologists).

- Support the creation of **person-centred services which can respond quickly** to support people who are in urgent need.

- Build **strong partnerships** between community teams, hospitals, third sector and independent providers of care.

- Support **different models of care delivery**, as locally as possible, of services traditionally delivered in acute hospitals, through new and emerging professional roles and making use of technological advances.

- Implement immediate care options that **prevent admission to hospital** and avoid a stay in hospital for longer than is necessary.

- Develop and **maximise our workforce** to be more adaptive and flexible.

- Support the development of **local models of care** which are:

  - Person-centred and rights based
  - Locality led and place-based
  - Integrated and multidisciplinary
  - Preventative and proactive
  - Digitally enabled and data informed
  - Co-produced with communities

5 - Commissioning Steps + Approach

The Joint Strategic Plan referenced in the introduction is underpinned by a number of national and local policies, strategies and action plans. It provides the strategic direction for how health and social care services will be shaped in this area in the coming years and describes the transformation that will be required to achieve this vision. The plan explains what our priorities are, why and how we decided upon them and how we intend to make a difference by working closely with partners.

Strategic commissioning is the process of taking this high level vision to a practical reality and is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services, and working in partnership to put these in place.

It involves the assessment and forecast of current and future needs and the linking of investment to services to meet these needs. However, the way we want to live our lives is influenced by national and local policies, changing demographics and societies changing expectations.

These changing expectations supports the need to create the opportunities for people to also broker their own care solutions and there will be a need to put the mechanisms in place to allow people to plan for themselves. Within this wider market, this shift in emphasis will move to people not planners being in charge.

For instance, many of us now want to live in our own homes, wherever possible, or we want choice around the type of care and support for our own needs and to fit with our own personal outcomes. Some of those shifts will involve a shift in services from hospital care to community based care, to technology enabled health and care and to primary care and care at home services. There will also be a focus on the remodelling of care homes and homely environments where possible to providing models of living which support independence.

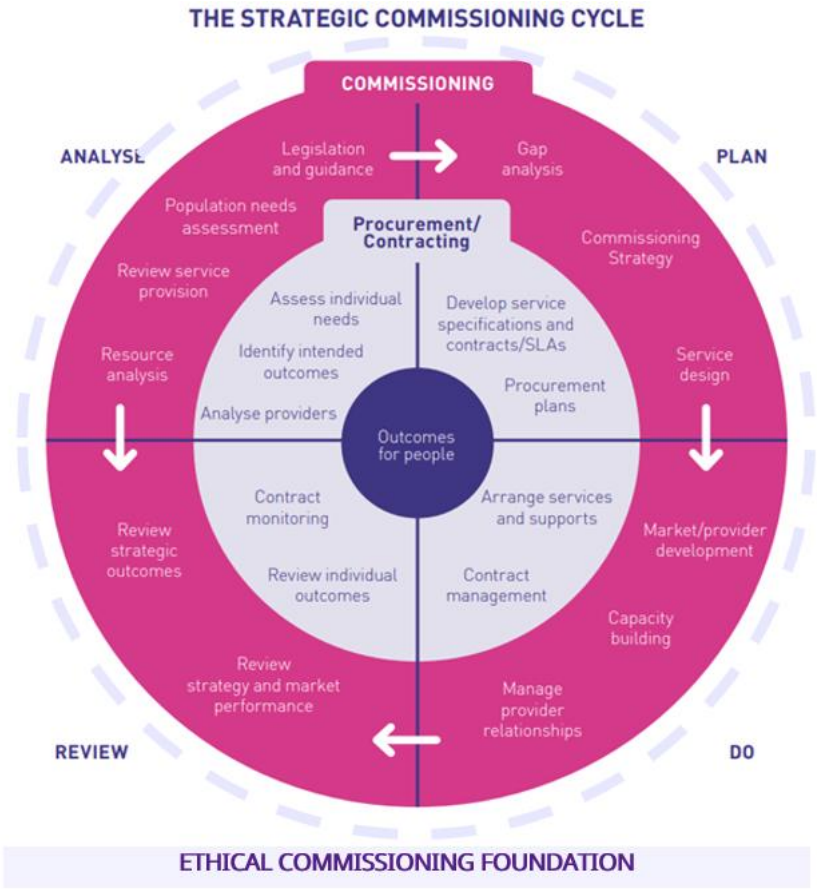
The commissioning process comprises a range of activities, including:

- Assessing needs
- Setting priorities
- Planning services
- Procuring services
- Monitoring quality

The commissioning stages are cyclical and the process is often depicted as the cycle noted below. The cycle is sequential and each part is of equal importance. A key principle of the commissioning process is that it should be equitable and transparent, and therefore open to influence from all stakeholders via an ongoing dialogue with people who use services, unpaid carers and providers.

This is the foundational framework for our commissioning activity[1]:

[1] Source: Independent Review of Adult Care in Scotland, adapted to reflect ethical commissioning foundation.



The Highland Partnership's commissioning approach to date has been a focus on collaboration and engagement and this is intended to continue and to further develop.

We will therefore build on our current approaches to actively engage with our current providers, potential providers and community representatives in the assessment of needs and identification of gaps; we will look at innovative solutions through options appraisal, evidence based interventions and support collaboration and partnership working across sectors with and between providers, to support the needed service redesign and transformation.

We acknowledge that the provision and provider landscape across our geography is challenged by rurality and that we need to actively challenge and extend our definition of provider through recognising and encouraging a wider market place of potential options to meeting people's needs.

In our actions to date, we have instinctively been operating from a premise of ethical commissioning in our sector interactions and procurement activity – working alongside some sectors in co-producing commissioning principles and strategic action plans.

We recognise we need to build on, formalise and consistently apply an ethical commissioning foundational approach across all areas of activity and intend to do so.

The Scottish Government's ethical commissioning policy aims to embed ethical standards into public sector procurement, particularly for social care, by prioritising principles like person-led care, fair work and human rights. It encourages a move from traditional price based competition towards collaborative outcomes-focussed approaches that involve people with lived experience and consider environmental and social impacts.

Our intent aligns with the Scottish Government's ethical commissioning and procurement direction and policy advice[2] and requirement that social care procurements should be based on ethical commissioning and procurement principles and that ethical commissioning and procurement approaches should ensure full engagement with those who access social care support, those who support people to access social care support, families and friends, unpaid carers, the workforce and providers.

Our intent also aligns with the Independent Review of Adult Social Care recommendations[3] and its call for

"*An end to this emphasis on price and competition and to see the establishment of a more collaborative, participative and ethical commissioning framework for adult social care services and supports, squarely focused on achieving better outcomes for people using these services and improving the experience of the staff delivering them".*

This independent review helpfully summarises a suite of new ways of thinking, to focus a preferred direction of travel.

Old Thinking	New Thinking
Social care support is a burden on society	Social care support is an investment
Managing need	Enabling rights and capabilities
Available in a crisis	Preventative and anticipatory
Competition and markets	Collaboration
Transactions	Relationships
A place for services (e.g. a care home)	A vehicle for supporting independent living
Variable	Consistent and fair

The Highland Partnership fully endorses the "new thinking" and has sought to underpin this approach within this commissioning strategy and intentions document in how we will analyse, plan, deliver and review services in Highland. This approach will be more explicitly articulated with the Market Facilitation Plan which will be developed to complement this strategy.

[2] Procurement+Policy+Manual+-+June+2025.pdf
[3] Adult Social Care: independent review - gov.scot

6 - Commissioning Priorities

We will deliver the aims and vision of the JSP in accordance with the SDS Framework of Standards, through actions which will achieve:

- Renegotiating the social care contract with the people of Highland to create the Highland Care Model
- Service rebalancing
- Care pathway redesign
- Community-led local care models and preventative approaches
- Technology and workforce transformation

Our priority focus areas are:

1. Enabling people and communities to take the actions which **support their own wellbeing**, through:

    a) **Self-care and early intervention** – we will work with communities and organisations to enable the co-creation and development of local options that help people to look after themselves and live in their home for as long as possible. We will use digital technology and equipment to support self-care.

    b) **Supporting self-access and management** - we will provide accessible high-quality services that give advice and help people to find local sources of the help that they need. We will make it easy for people to find out what options are available in their locality and how to access them.

    c) **Access/Eligibility criteria** - people will have access to commissioned regulated care (either from NHS Highland or partners) (i.e that there are major risks to independent living or health and well-being which are likely to call for immediate or imminent provision of social care services) and they are unable to look after themselves or get that support from their natural supports in the community.

    d) **Managing expectations** - ensuring that there is a clear understanding and definition of what is included in Free Personal Care and what is expected of people looking after themselves, using their 'natural supports', resources and the local community resources.

2. Developing a wide **range of care options**:

    a) Supporting and creating **new care options** for Adult Social Care and providing the information necessary to allow caring relationships to form freely across our communities.

    b) Supporting communities and third sector organisations to **develop innovative solutions to supporting people in their communities**, promoting Option 2 Brokerage and Community Brokerage.

    c) **Investing in the most efficient and effective services** and **disinvesting in traditional and less efficient and effective Adult Social Care services** and transitioning to provision being delivered by other options or providers where those options are available.

d) **Enhancing care through technology**, including digital skills training for workers and better data management.

3. Supporting and **enabling workers** to use their skills, knowledge and values to put people at the centre of care planning and decision making:

   a) **Separating roles**, eg the services that provide assistance from those that provide advice and those that commission services.

   b) Undertaking a **full holistic assessment** of a person's needs, risks and outcomes is led by the most appropriate registered professional. Determining any social care 'prescription' (or allocation) including when this needs to vary will be completed by a registered adult social care professional who either delivers or plans adult social care.

   c) Allowing workers **increased autonomy** to work within the scope of their registration, qualifications and experience.

4. Developing and structuring the care system so that all those willing to care for others are **valued, recognised equally and supported**:

   a) Commissioning services on the basis that employed carers terms and conditions meet a consistent minimum standard, which **recognises the value of their role** supported by following 'Fair Work First' principles

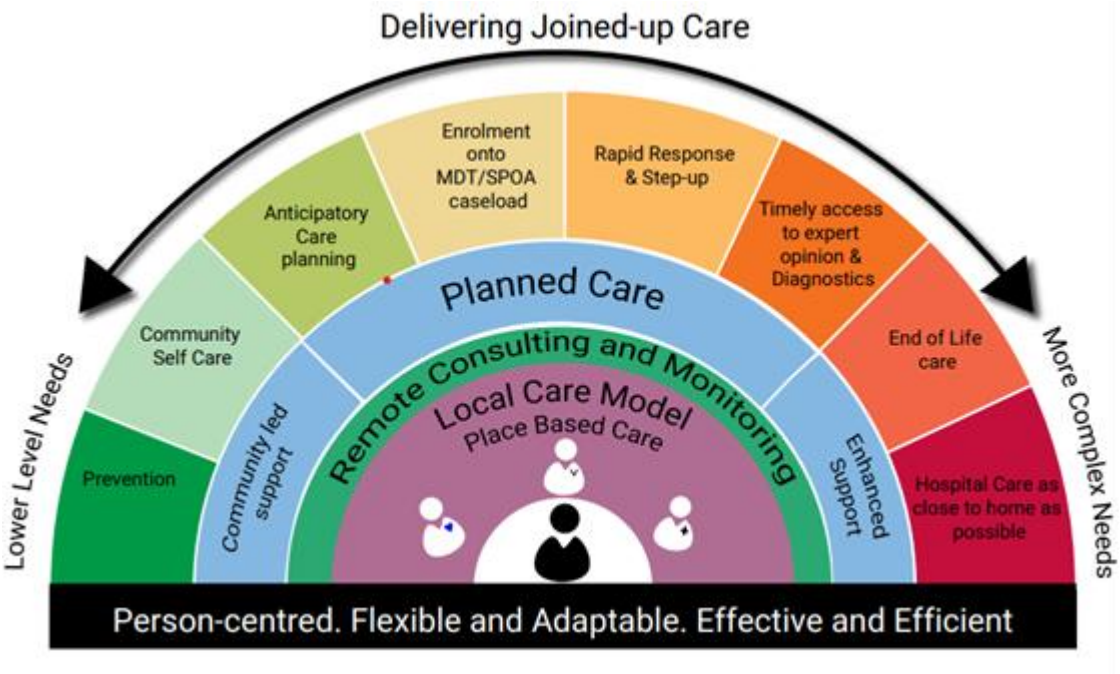
   b) Investing in domestic talent and **creating career progression pathways** and professional supports for people in caring roles

Our **commissioning intentions** describe how we as a Partnership intend to shape local services to meet the needs of individuals within our area.

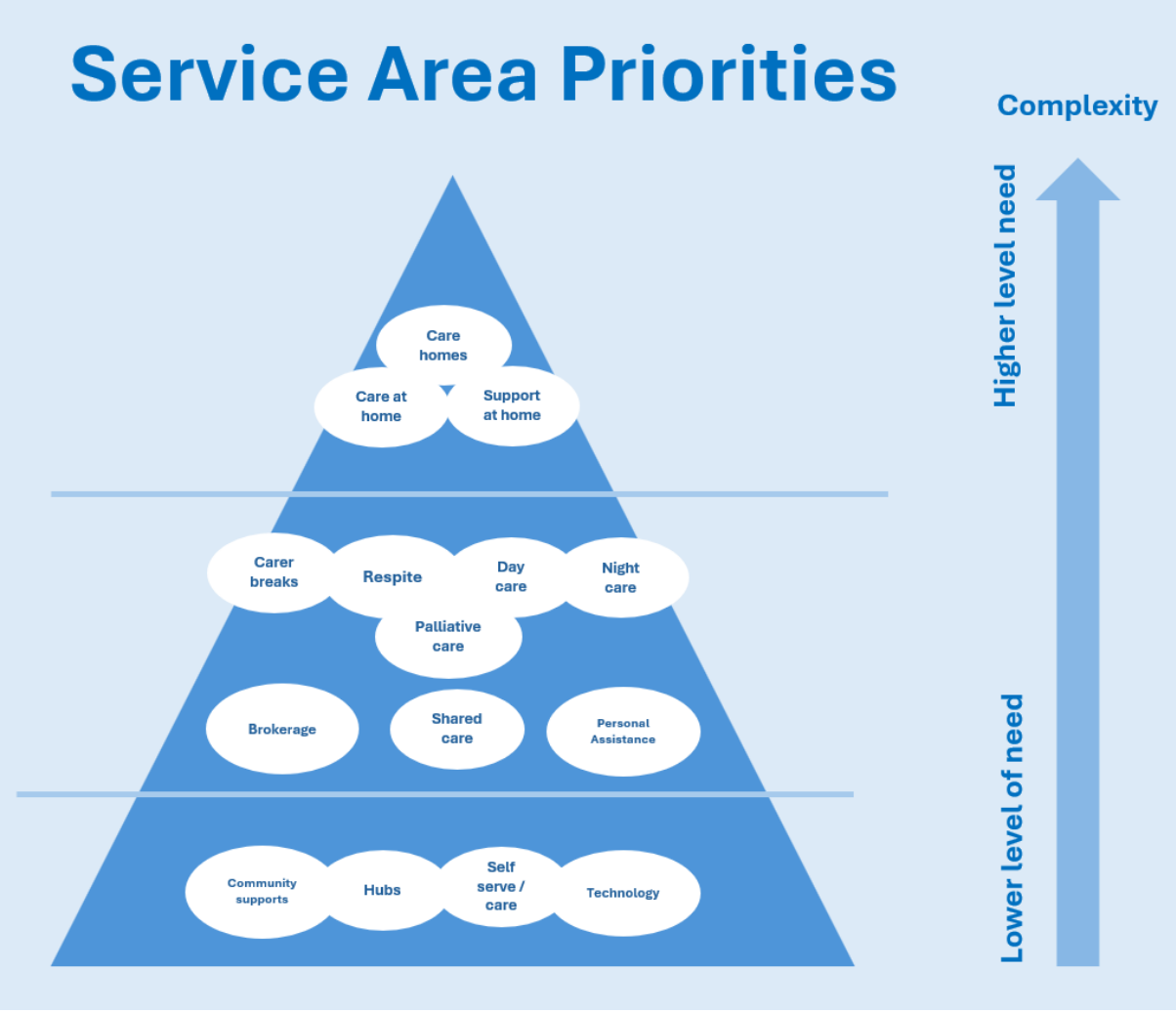
They also describe the services we wish to buy and the outcomes we seek to achieve for our local population.

Our JSP acknowledged that "one size does not fit all" and that there are core social care services that people in every community should have access to. As a consequence of our geography and population distribution, this does not mean everyone within every community will be equally close to these services.

The JSP described the need for a range of supporting services as illustrated below:



These supporting services referenced above, are simplified into the following broad tiers of activity which relate to the prioritised areas to be commissioned.



The Partnership has identified the following underpinning **commissioning aims** across health and social care and these are described below.

1. Appropriate supports are in place to sustain placements and to provide for those with the most complex needs.

2. In house and independent sector provision is refocussed to optimise efficiency and availability, with an increase in commissioned services and other flexible options.

3. There continues to be a mixed economy, which supports a breadth of provision and which minimises market risk.

4. There are a range of available service models and options.

5. Quality and improvement support is available to sustain current placements and packages.

6. Systems and processes maximise the potential for service capacity, availability and growth.

7. Services are of good quality, can be sustainably delivered and are affordable to the Partnership.

8. There are coordinated and prioritised actions to support workforce attraction, retention and development, including specifically for managers, across all sectors.

9. Succession and transition arrangements are understood and in place to support small scale provision.

10. Services are provided in facilities fit for the future.

7 - Commissioning Actions + Intentions

The breadth and scope of adult social care is significant, as are the challenges and changes needed.

A clear and simplified approach with clearly defined actions has been developed for each priority service area, covering:

- Profile / analysis
- What we have done
- Strategy and intentions: what we plan to do
- Investment and shifting of resources.
- Year 1, 2, 3 priorities and longer term horizon.

These are provided at **Appendix 1** for each of the prioritised activity areas as noted:

The **Appendix 2** provides a consolidated summary of these actions.

This information (intentionally not replicated here) provides the framework and structure for the focussed actions required.

8 - Governance

This Commissioning Strategy and Intentions document with defined commissioning actions, describes our focus and actions and as referenced above, will be supported by a number of implementation plans which articulate the greater granular detail of our delivery steps.

It is intended that this strategic document and its supporting plans, will be live documents, with governance for this delivery via the following routes:

Group	Role
Commissioning Delivery Group	Development and operational progress
Strategic Planning Group	Collaboration and engagement
Joint Officer Group	Oversight
Joint Monitoring Committee	Assurance

9 - Communication + Engagement

As legislatively required by the Public Bodies (Joint Working) (Scotland) Act 2014, there was full consultation and engagement in the development of the JSP, aligned with the prescribed steps of the Act.

This commissioning strategy does not require such a process, however the Partnership wish to ensure that there is a fully collaborative and co-productive approach to its development.

An initial draft of this document was prepared internally, to bring together a solid foundation from existing documents and policy direction.

It is intended that input will be invited via the Strategic Planning Group and wider relevant networks

10 - Conclusion + Next Steps

This Commissioning Strategy and Intentions document has described what services we need to commission to respond to the current and expected policy, operating and financial context, and has provided a road map for these intentions over the next 3 years.

The summary **Appendix 2** provides a clear, consolidated and prioritised overview of these actions across all areas of commissioning activity.

There are wider actions and environmental conditions which are are necessary in order to support the success of this Commissioning Strategy and Intentions and having described the strategic commissioning approach and intent, the following now therefore needs to progress:

- develop the granular detail required to describe what we need, where, and how much we can afford within the available financial envelope, using our developed Planning Support Tool.

- resource and implement the actions, within a clear governance framework and linked to the Adult Social Care cost containment plan arrangements;

- develop the following enabling plans:

- **Market facilitation plan**
  Actions and timescales for how we intend to stimulate a diverse, vibrant and sustainable market, so there are different types of support and provider organisations for supported people to choose from

- **Procurement plan**
  Actions and timescales for how we intend to progress the identified procurement activity and delivery.

- **Workforce plan**
  Actions and timescales for how we intend to create and support the future workforce needed to deliver the required services in Highland.

Appendix 1

Service Area Commissioning Actions

Commissioning Activity Area – Mental Health and Learning Disability Support

Profile / Analysis	What We Have Done
• Total spend: £47.3m (£4.7m in house and £42.6m independent sector) • 1165+ people supported Care home – Independent sector: £9.5m, 131 beds, 11 providers (plus 9 OOA providers) Support – Independent sector: £33.1m, 1034 people, 25 providers / 54 registered services – In house: £6.2m, 6 registered support / day care services Day care – Independent sector: £5.5m • 16 people placed out of area in care homes • 9 out of area in care homes placement >£100k pa each • 154 support at home packages >£100k pa • Relatively stable IS service delivery • Significant spend and reliance on providers who deliver MH and LD services and who meet complex needs. • Increasing demands for services including those with complex support needs • Ongoing recruitment issues - a number of providers are dependent on overseas recruitment. Changes to eligibility criteria for Home Office licencing is impacting the ability of some providers to recruit.	• Implementation of Dynamic Support Register to optimise resource • Scrutiny of 2:1 support and overnight support • Moving away from isolated individual packages • High tariff cases brought back into area • Steps towards growing existing market, through PCS framework • Finance authorisation framework (awaiting implementation) • Explored opportunities for Technology-Enabled Care e.g. Vocala

What We Plan To Do

Strategy

From the Financial Plan:

Shared Lives: Expansion of family-based alternatives to residential care for adults with learning disabilities and mental health needs, supported through the Transformation Fund.

Learning Disabilities: Services will re-oriented towards independence, skills development, and employment, with greater use of Self-Directed Support (SDS) and local micro-enterprises.

Specialist Support: Use of the Dynamic Support Register and targeted housing solutions to return individuals from high-cost out-of-area placements, reducing spend and improving outcomes.

Housing-with-Support & Reablement: Transformation Fund investment would support expansion of housing-with-support models and reablement pathways, reducing future reliance on long-term care

Supported Living is a housing and care model that enables adults with mental health needs or learning disabilities to live as independently as possible in their own home (or shared accommodation) while receiving tailored support.

Community Support refers to services delivered within local communities to help people maintain well-being and independence without moving into specialist housing.

Our commissioning approach will **prioritise independence, inclusion, and sustainability**, ensuring that mental health and learning disability services are person centred and outcome focussed as well as equitable and financially stable. Our priorities are to:

- Expand family-based alternatives to residential care for adults with learning disabilities and mental health needs. We will Leverage the Transformation Fund to scale Shared Lives schemes, promoting community inclusion and reducing reliance on residential care
- Re-orient services towards independence, skills development, and employment through increasing the uptake of Self-Directed Support (SDS) and foster local micro-enterprises to diversify provision and empower choice.

- Embed proactive planning for Out-of-Area placements by leveraging the Dynamic Support Register and targeted housing solutions to enable timely access to supported living and community-based support, improving outcomes and ensuring financial sustainability
- Support seamless transitions from inpatient settings to person centred specialist residential care for hospital based complex care patients.
- Align with The Highland Council's strategic housing plan to ensure timely development of housing with support models reducing reliance on long-term care.
- Explore care villages as integrated communities of blended supported living and community-based support to promote sustainability and resilience.
- Implement a comprehensive governance and financial authorisation framework for all MHLD commissioning activity, establishing a clear framework for 1:1 and 2:1 support and overnight care to ensure consistency and financial efficiency.
- Conduct a comprehensive review of community-based support models and expand access to community-based support to reduce reliance on high-cost care-at-home packages, enhancing social inclusion and outcomes.

Investment	Shifting of Resources (Disinvestment)
• Independent provider cluster housing models with co-located community-based support services • Shared care for people in supported living • Expanded access to community-based support services	• Individual / isolated tenancies with 2:1 / individual overnights • Out of area placements for people with complex needs

What, Where and How Much

To be developed post strategy.

Year 1, 2, 3 Priorities	Longer Term
Year 1 (2026-2027) • Extend DSR to adult mental health and hospital based complex care • Review of high-cost supported living and community support packages – seek better solutions for complex needs • Comprehensive review of community support provision	• To lead the development of integrated care villages that supported living and community-based support services—creating inclusive, sustainable communities that enhance resilience, improve population health, and deliver cost-effective care across the system.
Year 2 (2027-2028) • Begin repatriation planning for returning out-of-area placements • Standardise community support provision	
Year 3 (2028-2029) • Implement new commissioning and funding models • Enable timely transitions from hospital-based complex care and out-of-area placements into local supported living solutions that deliver person-centred outcomes and financial sustainability.	

Commissioning Activity Area - Care Homes (Older People)

Profile / Analysis

- 1844 care home beds (84% independent sector and 16% in house).
- 62 care homes (17 in house and 45 independent sector).
- £79m spend (£19.2m in house and £59.9m IS).
- 711 nursing / 738 residential beds commissioned. 29% of these beds self funding.
- High in house unit costs. NCHC insufficient for small scale delivery.
- 6 IS care home closures since 2022. 3 NHSH acquisitions since 2020.
- Ongoing significant recruitment issues impacting delivery and viability.
- Various in house care homes temporarily closed due to staffing – pressure ongoing.
- Ongoing high level of DHDs (74 as at 8 December 2025)
- 203 beds lost since 2022. 58 new beds on stream. 26 further new beds anticipated in next 2 years. Current net loss of 119 beds.
- Ageing stock in house and internal.
- High level of small providers with succession planning risk to NHSH.

What We Have Done

- Responded to arising provider viability issues.
- Acquired 3 care homes to avert closure, at significant ongoing cost.
- Raised political profile of need for an alternative funded NCHC in Highland.
- Taken steps to maximise internal occupancy.
- Ongoing supportive provider engagement.
- Progressing dialogue on wider system and interface issues.
- Created Care Home Career and Attraction post hosted by Scottish Care to support sector recruitment. Ongoing Independent Sector Liaison role to support sector relationship and partnership.

What We Plan To Do

Strategy

- Restructure the delivery landscape to maximise efficiency and ensure in house and independent sector provision are used to their strengths.
- Reprofile **in house** provision to focus on people with the most complex needs (older adults).
- **Independent sector** continue to deliver the majority of care home provision but within a stronger commissioning framework that links fee uplifts to sustainability, quality, and dependency management.
- Quantify locality commissioning volumes of care home provision.

Investment

- Ongoing commissioning from sustainable IS care homes – sustain and maintain.
- Continue to secure complex service from IS provision.
- Reprofile in house delivery from mainstream to also complex care, as opportunities arise.

Shifting of Resources (Disinvestment)

- Disinvest from in house mainstream provision / flexible use of buildings.
- Reduce level of overall residential beds (and increase c@h capacity / personal care capacity and personal assistance).
- Unviable services (in house and independent sector).

What, Where and How Much

To be developed post strategy.

Year 1, 2, 3 Priorities

Year 1 (2026-2027)

- Initiate longevity profile assessment of in house + commissioned facilities.
- Define preferred models, locations and volumes of residential care.
- Consider complex needs transitional plan (in house).
- Develop new commissioning framework (sustainability, quality, dependency)
- Third party top up analysis and impact assessment.
- Define locality commissioning volumes in place.

Year 2 (2027-2028)

- Implement new commissioning framework.
- Longevity assessment to inform longer term replacement plan within a long term care home strategy.
- Implement complex needs transitional plan.
- Shift commissioning focus to nursing provision.

Year 3 (2028-2029)

- Prioritise replacement locations and initiate.

Longer Term

- Facilities fit for the future - replacement / commissioning programme over next 5-10 years.
- Sustained provider base - provider succession plan for next 5-10 years.

Commissioning Activity Area – Care at Home (Older People)

Profile / Analysis

- 9,200 hours pw mainstream c@h (4,000 in house / 5,200 independent sector).
- 383 hours pw of reablement / enablement delivered to 57 people.
- Emergency Responder Service in place in the Inverness area
- 16 providers (in house and 15 independent sector) – total of 24 registered services
- £32.5m pa spend (£14.5m in house and £18m IS).
- High (double) in house unit costs (£73 v £30 ph). C@H tariff does not sustain provision or enable growth.
- Highest level of commissioned service tariff in Scotland – but insufficient to ensure stability or growth.
- Ongoing significant recruitment issues impacting delivery and viability.
- Reliance on international workforce and pay parity issues (£12.82 v £12.60)
- Ongoing high level of DHDs (currently 45 as at 8 December 2025).
- Loss of 1,100 IS hours pw since December 2023.
- Commissioning reliance on a range of providers – 4 providers have over 50% of activity. Some very small provision.
- 6 c@h provider exits since 2023. Significant volume to NHSH.
- Ongoing sector fragility at current tariff.
- NHSH currently has a dual role – as a provider and also commissioner of services from the independent sector.

What We Have Done

In House

- Supported exits and picked up exit activity where IS unable to deliver.
- Building and maintaining effective commissioning relationships.
- Ongoing delivery of mainstream, enablement and reablement.
- Overall delivered hours activity levels reasonable flat.
- Work to focus on clarifying c@h pathway.
- Delivery of "last aid care" to care homes and c@h providers.
- Internal provider delivery actions, focussing on:
  - Standardisation, improvement, consistency of approach and QA.
  - Localised in house model established with registered C@H teams
  - Standardised use of CM2000 to support consistency of C@H systems
  - Better visibility regarding travel time, care planning and visit durations etc
  - Increased recruitment visibility and strengthened career pathways.
  - More proactive outreach to potential candidates.
  - Robust induction process for care staff and managers and L&D plan

Commissioner / Independent Sector

- Sector agreed commissioning principles and proposals (January 2024)
- Tariff review (option 3b)
- Internal case made for further tariff increase for sector stabilisation
- Ongoing dialogue regarding interface issues which remain unresolved
- Independent Sector Liaison role to support sector relationship and partnership.
- Some work on clarifying commissioning processes, further progress needed

WHAT WE PLAN TO DO

Strategy

- Restructure and rebalance the delivery landscape to maximise efficiency and ensure that in-house and independent provision are used to their strengths
- Expand independent sector c@h through outcome-based contracts, reflecting lower (than in house) unit costs and supporting sector sustainability.
- Retain in house c@h as a strategic rebalancing mechanism, ensuring resilience in fragile rural areas and acting as provider of last resort.
- Clarify commissioner and service provider roles to improve relationships and effectiveness.
- Increase and grow capacity by improving the efficiency processes and increasing provider autonomy.
- Manage demand by reviewing eligibility criteria for accessing c@h activity.
- Set locality activity and budget thresholds for c@h activity for commissioned and delivered provision.
- Provide user-friendly, straightforward, equitable access to SDS options 1 and 2 to increase confidence and uptake.
- Work with partners to grow and sustain the available workforce.

Investment

- Independent sector delivery footprint, tariff levels / unit costs.
- In house delivery in remaining defined, geographic areas.
- Early intervention, prevention and enablement.
- Technology to support processes and grow c@h capacity.
- End of life c@h focus and training
- Attract, retain and develop the workforce.
- Relationship management and commissioning process and culture change.

Shifting of Resources (Disinvestment)

- In house delivery to move away from areas where the IS can deliver.

What, Where and How Much

To be developed post strategy.

Year 1, 2, 3 Priorities	Longer Term
Year 1 • Establish required resources to support the required programme of activity. • Identify and confirm geographic delivery focus and develop a transition plan, (including consideration of NHSH staff resource) coproduced with sector. • Develop an appropriate independent sector rate and outcome based contract - agree and implement. • Identify and implement improved supporting processes. • Identify and operate locality activity thresholds. • Co-produce and implement a plan for growing and sustaining the workforce. • Identify, scope and pilot supporting digital solutions to improve processes and enable increased service capacity eg (electronic commissioning, Care Technologists, Alexa-style digital technology etc) • C@h commissioning role delineation and training. • Develop provider of last resort response. • Increase availability of end of life training.	• Further digital commissioning solutions. • Market profile and single operator delivery risk / succession planning. • Continue to proactively develop technological supports to meet demand and optimise the available workforce.
Year 2 • Progress transition plan for agreed geographic areas; initiate procurement if required. • Continue to work towards an equal partnership in care provision. • c@h commissioning arrangements implemented to sustain and maintain. • Continue to implement workforce actions (recruitment and attraction). • Progress supporting digital solutions. • Services operating to thresholds.	
Year 3 • Continue to support transition plan to embed. • Implement outcome of procurement if needed. • Continue to support workforce development.	

Commissioning Activity Area – Housing with Care / Support (Older People)

Profile / Analysis

- 530 sheltered housing units all occupied.
- All older stock some with limited suitability for adaptations or equipment.
- 49 purpose built fit homes with monitoring systems.
- Howard Doris Centre – older adult housing with care facility.

What We Have Done

- Converted Howard Doris Centre accommodation into a housing with care model.

What We Plan To Do

Strategy

From the Financial Plan:

- **Housing-with-Support & Reablement:** Transformation Fund investment would support expansion of housing-with-support models and reablement pathways, reducing future reliance on long-term care

From the ASC Strategy:

- Self-care and early intervention – we will work with communities and organisations to enable the co-creation and development of local options that help people to look after themselves and live in their home for as long as possible.
- We will use digital technology and equipment to support self-care.
- Supporting communities and third sector organisations to develop innovative solutions to supporting people in their communities.

- We will use alternative housing with care models and reduce use care home placements. Our preferred approach is clusters of 1 or 2 bedroomed units for mixed client groups in proximity to complementary services for support and operational efficiency and in sustainable locations.

Investment

- Housing (new and existing) in clusters near other facilities such as care homes and day care that will enable and sustain this model by providing access to a (flexible) workforce.
- Technology and data that supports this model and enables a flexible provision of support and care that can adapt to the person's needs, including consideration of overnight care.

Shifting of Resources (Disinvestment)

- Replace lower complexity packages using 1:1 support
- Smaller and high-cost residential care homes replaced by clusters.
- Moving resources from individual locations with overnight support, to clusters.

What, Where and How Much

To be developed post strategy.

Year 1, 2, 3 Priorities

Year 1 (2026-2027)

- Produce service descriptors for "housing with care" options to enable planning
- Work with THC to input into Strategic Housing Plan for new housing units.
- Work with THC to establish tenancy arrangements for "housing with care' models.
- Identify technology options and initiate plan for use of technology in homes.
- Contractual arrangements allowing care to be flexible to meet the persons changing needs and for staff to work across mixed clients and settings.
- Identify and make use of existing homes as they become available, also adding technology to the buildings as they become available.
- Develop plans for new buildings with services including care pathways.

Year 2 (2027-2028)

- Planning for appropriate housing/facilities built where needed.
- Arrangements in place to commission/procure appropriate support services.

Year 3 (2028-2029)

- Continue development of new housing/facilities and commissioning services.

Longer Term

- Continue to understand need and to develop, commission and expand housing with care options as an alternative to residential based provision.

Commissioning Activity Area – Day Care (Older People)

Profile / Analysis

- 15 providers (5 in house and 10 independent sector)
- 289 total capacity of places (134 in house and 155 independent sector)
- £3.7m pa spend (£1.9m in house and £1.6m IS).
- High in house unit costs v £8.63 per hour (average) for independent sector.
- Ongoing significant recruitment issues impacting delivery and viability.
- Issues with eligibility criteria and alignment with demand.
- In house provision:
  - Occupancy: attendance varies between 38% and 89%.
  - Geography: 80% delivered in Highland's smaller communities.
  - Challenges: staffing fragility, transport to support utilisation of the service.
- Independent sector provision:
  - Varying size of provider from small local charitable organisation to national charities.
  - Occupancy: attendance varies from 50% to 91% occupancy.
  - Geography: 50% of provision is delivered in Highland's more remote areas - and all by charitable organisations.
  - Challenges: sustainable delivery of services.

What We Have Done

- Maintained existing provision and commissioned activity.
- Identified the need for consistency of approach within delivered services.
- Acknowledged the need to review this area of activity and develop a consensus forward direction.

What We Plan To Do

Strategy

Older Adults: Day services will be increasingly delivered by third sector and independent providers, with in-house resource focused on statutory and complex needs.
To continue to promote and support day services alongside other prevention focussed services to support people to live independently at home within their community.

Investment

- Increase in mainstream day care delivered by independent (and third) sector providers.

Shifting of Resources (Disinvestment)

- Delivery of in house mainstream day care to move to a more complex needs focus.

What, Where and How Much

To be developed post strategy.

Year 1, 2, 3 Priorities

Year 1 (2026-2027)

- Review current provision, future needs and develop a forward direction.

Year 2 (2027-2028)

- Transition to the identified direction.

Year 3 (2028-2029)

- Reprofiled services in place.

Longer Term

- Longer term approach and actions to be informed by the planned review.

Commissioning Activity Area – Local Care Model (All)

Profile / Analysis

- Reductions in Option 3 services mean locality need (including eligible need) is no longer able to be met by traditional statutory provision.
- This gap is most acute in remote and rural geographies.
- Increasing demand and complexity are exacerbating the issue.
- Infrastructure is not in place to fully support all SDS Options therefore flexibility, choice and control is attenuated.
- Professional practice is characterised as supporting the operation of the traditional Community Care system (purchaser/provider split)
- Local place-based supports and, with that, community-based commissioning is required to develop relevant/appropriate/sustainable support solutions in localities.
- Preventative supports also need to be fully utilised to help manage demand.
- Support for Community Hubs and Community Organisations is recognised as important in that they offer the potential to:
  - Provide a range of activities to promote well-being and prevent the need for provision of formal SDS budgets;
  - Act as a site of multi-agency help and advice to signpost across whole system of support;
  - Act as a site for integrating community and statutory effort (complementary and collaborative locality care planning)
  - Develop into a range of locally based formal provision (i.e. Hubs+; Social Enterprises; Brokerage);
  - Realise the Community Brokerage and Independent Support roles locally
- Development work will be required to ensure statutory partners can adapt successfully to working in different ways.
- Promotion of worker autonomy will be required to move away from traditional patterns of working

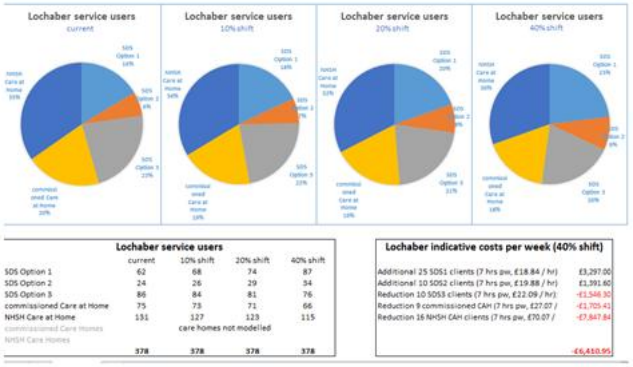
What We Have Done

- Engaged with the community sector across specific geographies to explore their roles in respect of formal SDS and the promotion of wellbeing:
  - Ullapool
  - Skye and Lochalsh
  - West Lochaber
  - Sutherland (Hubs)
- Supported Urram to develop new approaches and initiatives alongside statutory partners in Strontian/Acharacle.
- Undertaken supported self-evaluation exercise with staff and formal partners to explore the need for system improvements
- Secured transformational resource aimed at developing a new Highland Care Model, including:
  - Increased levels of Independent Support and Community Brokerage to support locality change efforts;
  - A purchased CLS initiative to support change in identified areas
  - A transformational resource to trial new approaches/initiatives
  - Financial support to existing Community Hubs to ensure their ability to participate in change.

What We Plan To Do

Strategy

- **Development of community hubs and neighbourhood models** (aligned with NDTi Community Led Support), creating local spaces where health, care, and third-sector organisations collaborate to provide early help and support and reduce demand on statutory services.
- **Small grant schemes and innovation funds** for carers and community groups to deliver localised support, respite, and preventative activities
- **Local innovation funds, backed by the Transformation Fund**, will support community micro-providers, carers' networks, and third-sector partners to scale community-led support and develop local care models.
- The development of community led local care models and preventative approaches will require:
  - Support for Community Hubs and Community Organisations
  - Appropriate levels of locally available Independent Support and Community Brokerage
  - Developing relationships across the system and collaborative working across the range of Highland geographies
  - Exploring/Trialling new and innovative ways of place-based, community-led working
  - Commissioning local, placed-based initiatives and services
  - Resourcing small scale transformational projects to understand what might work at a local level
  - Providing developmental support to ensure partners can work in new and flexible patterns reflecting the need for co-production across the system of social care and beyond.
  - Resourcing successful initiatives and approaches which can evidence positive impact in terms of increased wellbeing and a reduction in the demand for formal SDS
  - Facilitating supported people to have full choice, flexibility and control to deploy their resources (including but not limited to SDS Budgets) in local care markets (see separate template on Personal Assistance)

Investment	Shifting of Resources (Disinvestment)
• Learning and development input to help develop new practice approaches across system • Support for co-working and co-production at a local level, including the space to develop new working relationships. • Support the infrastructure necessary for the formation of new public-facing networks offering information, advice and assistance • Support to Community Hubs and Organisations to continue with impactful initiatives and services which: – Complement (or provide) care at home / day service capacity – Support SDS implementation across localities – Promote wellbeing and act preventatively – Allow local citizens more routes to self –management and independence – Increases social enterprise and community fabric	• Traditional Option 3 service provision is shrinking at current rates. • Rates cannot be increased without further compromising our financial position and/or acting outside agreed arrangements (NCHC etc.) • In-house provision is delivered at particularly high cost • Opportunities to rebalance the system of ASC to lower-cost alternatives need to be taken as they arise • The development of lower-cost alternatives needs to be explored as we co-produce Local Care Models. • Rebalancing our dependence on Option 3 provision may be realised by: – Supporting the creation of more Personal Assistant Relationships – Brokering more SEPA Relationships – Investing in complementary community effort to reduce overall reliance on Option 3 provision (Hubs+ etc.) – Replacing personal care provision with other, ancillary supports to unpaid carers etc – Supporting the creation of Social Enterprise in the field of ASC • This rebalancing has been modelled: 

What, Where and How Much
To be developed post strategy.

Year 1, 2, 3 Priorities	Longer Term

Year 1 (2026-2027)
• Develop a consolidated approach to developing a Community Led Support ethos to work across the system.
• Define a stepwise, locality-led implementation programme for the development of Highland Care Model
• Clarify the model and investment available for Option 2 brokerage service.
• Understand the resource available to support the mainstreaming of community-led activities which have evidenced they can:
  – Complement/substitute statutory provision
  – Increase wellbeing in community members
	• Co-produce the establishment of ASC Social Enterprises in defined geographies which meet locality need and Registration and Regulation requirements
	• Build on the combined operation of both Community and Option 2 Brokerage to develop a distinct route to commissioning of individualised support arrangements.
	• Reduce the levels of centralised bureaucracy by ensuring autonomous social work practitioners can interact flexibly in community settings

Year 2 (2027-2028) • Procure Option 2 Brokerage. • Agree on Highland model for Independent Support and Community Brokerage based on experience of CLS initiative. • Implement Highland Care Models across agreed geographies; including investing in impactful Community initiatives.	
Year 3 (2028-2029) • Procure Independent Support and Community Brokerage. • Move toward full implementation of Highland Care Model across all geographies.	

Commissioning Activity Area – Personal Assistance (All)

Profile / Analysis

- Reductions in Option 3 traditional services, related to:
  - Unit Costs and Rates
  - Staffing and staff dissatisfaction (particularly at C@H model)
- Increased offers of Option 1 (n = 850) and Option 2 (n = 319).
- Good level of PA recruitment given lack of investment to date.
- Increasing demand for Personal Assistance ongoing.
- Difficulty of translating individual budgets into Personal Assistance now being widely reported.
- Independent Support capacity fully utilised.
- Potential to recycle lost supply: workers transferring from C@H report significant satisfaction/benefits of PA role.
- Some SEPAs / potential SEPAs report desire to collectivise.
- Many Supported People are not keen to take on PAE role.
- Currently significant organisational inflexibility around Option 2.
- Limited organisational support for responding to demand for training/confidence building etc.

What We Have Done

- Increased rates payable to Option 1 PAEs.
- Sought to raise the profile of PA role:
  - Pop up events in a handful of localities
  - Online sessions
  - Links to Corporate and ASC recruitment efforts.
- Engaged Contracts in relation to commissioning Option 2 brokerage.
- Identified increased resource for Independent Support to support a three-year Local Care Model initiative.
- Promoted the role of Independent Support to District Professionals via the Highland SDS Strategy.
- Gathered information in respect of the training accessible to (and accessed by) Pas.
- Undertaking a review of NHSH SDS Policies and Procedures to ensure they are congruent with SDS Framework of Standards.

What We Plan To Do

Strategy

- Promote the PA role across Highland
- Promote the role of Independent Support to District Professional (see also Local Care Model Template)
- Increase available levels of Independent Support and Community Brokerage to facilitate the development of PA relationships at local level (across Options 1 & 2)
- Commission a model of Option 2 Brokerage to ensure routes for supported people to access SEPAs are maximised at local levels.
- Facilitate a training plan to ensure confidence and competence can be developed across the PA workforce.
- Explore mechanisms to expand markets for the provision of Personal Assistance (websites, events, regular Hub activity).
- Explore local care models and preventative approaches including:
  - Development of community hubs and neighbourhood models;
  - Greater levels of Independent Support and Community Brokerage
  - Local innovation funds.
- Ensure SDS budgets can be used flexibly to create supply in personal assistance (incl. SEPAs)

Investment

- Commission an Option 2 Brokerage Service.
- Invest in higher levels of Independent Support and Community Brokerage.
- Provide PA development and support.
- Support and develop CLS approaches to practice across the system.

Shifting of Resources (Disinvestment)

- Rebalance expenditure from reduced option 3 market to be realised by:
  - Supporting the creation of more Personal Assistant Relationships
  - Brokering more SEPA Relationships
  - Investing in complementary community effort to reduce overall reliance on Option 3 provision (Hubs+ etc.)
  - Replacing personal care provision with other, ancillary supports to unpaid carers etc
  - Supporting the creation of Social Enterprise in the field of ASC

What, Where and How Much

To be developed post strategy.

Year 1, 2, 3 Priorities	Longer Term
Year 1 (2026-2027) • Clarify the model and investment available for Option 2 brokerage service. • Link developments into the CLS approach to practice. • Facilitate new marketplaces. • Provide dedicated input to recruit, support and develop PAs. • Delegate greater levels of autonomy to statutory workforce.	• Establish clear developmental/support routes for Personal Assistants • Monitor (research) the experience of Personal Assistants
Year 2 (2027-2028) • Procure Option 2 Brokerage Service. • Agree on Highland model for Independent Support and Community Brokerage. based on experience of CLS initiative.	
Year 3 (2028-2029) • Procure Independent Support and Community Brokerage capacity.	

Commissioning Activity Area – Unpaid Carers

Profile /Analysis

- This commissioning activity includes all unpaid adult carers including those who care for children in the North Highland area and includes the following:
  - One singular Carers Centre servicing the whole of North Highland.
  - 4 x under £50k Third Sector Funded projects.
  - 1 x Advocacy Service.
  - 1 x SDS Support Service (1-year funded 2025/26).
  - 1 x Localised Carer Support Service – Lochaber.
  - 1 x Digital Partner.
  - Carers Wellbeing Fund - £600k per annum.

What We Have Done

- One year funding for increased SDS information.
- Tender for under £50k projects for a 3 year period ending 31/03/28.
- Commenced work on Service Specification for a Carers Centre.
- Developed a contract for both the Carers Centre and Digital Partner – both due to end 31/03/26, but option available to extend for 1 year.

What We Plan To Do

Strategy

- Align with the Scottish Government's Carers Strategy and local priorities.
- Focus on preventative support to reduce crisis interventions.
- Integrate carer support across health and social care pathways.
- Restructure the delivery of Carer Support, ensuring support is meaningful and locally available
- Restructure of the current delivery model for those carers who are categorised as having a Substantial or Critical need.
- Ensure equitable access across Highland, including rural and remote areas.
- Support the four strategic pillars of the NHS Highland Carers Strategy: Identify, Inform, Involve, Support.

Investment

- Expansion of localised carer support services in under served areas (e.g. Caithness, Sutherland, Skye)
- Investment in community-based respite and wellbeing initiatives aligned with the Carers Wellbeing Fund.
- Increase available replacement care options (eg residential and home-based respite).
- Increased investment in meaningful carer support.

Shifting of Resources (Disinvestment)

- Reduction in investment to centralised support models delivered remotely – moving to a digital option would achieve in the region of £260k pa.
- Review and reallocate funding from underutilised duplicated services: approx. £150k pa in smaller projects that are reaching < 50 unpaid carers pa.
- Reduction or withdrawal from smaller initiatives that have not demonstrated measurable impact in relation to financial input. approx. £150k pa. in smaller projects that are supporting < 50 unpaid carers pa.

What, Where and How Much

The financial envelope for commissioning services for unpaid carers is £1.8m pa.

Year 1, 2, 3 Priorities

Year 1 (2025/26)

- Commence design of a service specification for a carers centre.
- Continue to co-design with stakeholders to ensure commissioned services are appropriately available in local areas.
- Develop a commissioning framework for Home Based Respite providers.

Year 2 (2026/27)

- Implement the commissioning framework for Home Based Respite providers and attract provision in rural and remote areas
- Undertake tender process for a carers centre and digital partner.

Year 3 (2027/28)

- Ascertain impact of smaller initiatives to ascertain continued / future funding
- Assurance of service provision in all areas of Highland, with sustainable access to short break provision.

Longer Term

- Widen the framework to include more respite options.
- Framework design and implementation for Shared Lives as a viable short break option.

Commissioning Activity Area – Technology

Profile / Analysis	What We Have Done
• Promotion of and provision of technology to support independence at home.	• Temporary funding secured for tests of change in 3 sites to support the development of a TEC First Framework to optimise utilisation throughout the persons pathway – at first point of contact, while at home and waiting for full assessment, while receiving care and to support discharge • ASC Transformation Programme is conducting a Minimum 6 months proof-of-concept of Vocala Alexa-style technology with up to 50 adults with learning disabilities.

What We Plan To Do

Strategy

Technology-Enabled Care (TEC): Scaled up across Highland — falls prevention, digital monitoring, medication management, and scheduling — reducing double-up care and improving efficiency. (Currently supported by the Transformation Fund)

Increase use of TEC at all points of the persons care pathway, maintaining independence as close to home as possible and reducing reliance on provided care.

Investment	Shifting of Resources (Disinvestment)
• Unknown at present. To be informed by tests of change	• Expected to come from reduced care hours required, care at home budget.

What, Where and How Much

To be developed post strategy

Year 1, 2, 3 Priorities	Longer Term
Year 1 (2026-2027) Complete tests of change, analyse and plan roll out of successful areas.	
Year 2 (2027-2028) Continued roll out and embedding of change.	
Year 3 (2028-2029) Ongoing review of use of TEC and new technologies developing.	

Appendix 2

Commissioning Intentions Summary and Plan

Commissioning Area	Strategy	Year 1 (2026–27)	Year 2 (2027–28)	Year 3 (2028–29)
Mental Health & Learning Disability Support	Prioritise independence, inclusion, sustainability Introduce and expand Shared Lives Re-orient to skills/employment Reduce out-of-area placements Embed governance	Extend DSR Review high-cost packages Develop integrated care villages.	Repatriation planning Standardise community support.	Implement new commissioning /funding models; Enable transitions from out-of-area to local supported living.
Care Homes (Older People)	Restructure for efficiency Complex needs to be provided in house where possible utilising strengths of integrated district teams Independent sector for majority Link fees to sustainability/quality	Longevity assessment Define models/locations Develop new commissioning framework Succession planning	Implement new framework Longevity assessment for replacement plan Shift focus to nursing provision.	Prioritise and initiate replacement locations
Care at Home (Older People)	Restructure/rebalance delivery Expand independent sector via outcome-based contracts Retain in-house for resilience Clarify roles Manage demand.	Resource programme Confirm geographic focus Develop independent sector rate Pilot digital solutions Workforce plan.	Progress transition plan Implement commissioning arrangements Continue workforce actions Operate to thresholds.	Embed transition plan Implement procurement outcomes Support workforce development.
Housing with Care/Support (Older People)	Expand housing-with-support & reablement Promote self-care/early intervention Use technology Cluster models for efficiency.	Service descriptors Input to housing plan Tenancy arrangements Tech options Flexible contracts Use existing/new homes.	Plan/procure new housing/facilities Commission support services.	Continue development and commissioning of new housing/facilities.
Day Care (Older People)	Shift to third sector/independent delivery Complex need to be provided in house where possible, drawing on the strengths of the integrated district teams Support prevention and independence.	Review provision and needs Develop forward direction.	Transition to new model.	Reprofiled services in place.
Local Care Model (All)	Develop community hubs Support local innovation Invest in micro-providers Promote autonomy and co-production.	Develop Local Care Model ethos and define implementation Clarify brokerage model Co-produce social enterprises Reduce bureaucracy.	Procure Option 2 Brokerage Implement Highland Care Models Invest in impactful initiatives	Procure Independent Support Move to full Highland Care Model implementation.
Personal Assistance (All)	Promote PA role Increase Independent Support Commission Option 2 Brokerage Expand markets Ensure flexible SDS budgets.	Clarify brokerage model /investment Recruit/support PAs Delegate autonomy Monitor PA experience.	Procure Option 2 Brokerage Agree Highland model for support/brokerage.	Procure Independent Support capacity.
Unpaid Carers	Align with Scottish/Highland strategies Focus on prevention Integrate support Restructure for equity and impact.	Design carers centre specification Co-design services Develop respite commissioning framework Expand Shared Lives.	Implement respite framework Tender carers centre/digital partner.	Assess impact of initiatives Ensure sustainable access to short breaks.
Technology	Scale Technology-Enabled Care (TEC) Support independence Reduce care hours Embed digital solutions.	Complete tests of change Plan rollout of successful technology	Continue rollout and embed change.	Ongoing review and adoption of new technologies.

Appendix 3

Key Terms

Annual Financial Statement The integration authority should draw links between its strategic plan and medium term financial plan, demonstrating how the financial resources available to it will be applied to achieve the outcomes set out in the strategic plan. Further detail on the content of medium term financial plans is available in the finance guidance. The integration authority must publish an annual financial statement upon publication of its first strategic plan and each year after that. The financial statement must set out the total resources that the integration authority intends to allocate under the provisions of the strategic plan.

Complexity Adults with complex needs are defined as people needing a high level of support with many aspects of their daily life and relying on a range of health and social care services. This may be because of illness, disability, broader life circumstances or a combination of these[4]. The level of complexity does not relate to the care intervention per se but to the extent and range of response needed to support an individual safely and appropriately.

Joint Strategic Needs Assessment (JSNA) The process of identifying the future health, care and wellbeing needs of the population in a particular area, and planning services to help meet those needs.

Market The range of current and potential types of support, wider community opportunities and provider organisations, for supported people and commissioners to choose from.

Market Facilitation The process by which strategic commissioners ensure there is sufficient, appropriate range of provision, available at the right price to meet needs and deliver effective outcomes.[5] Market facilitation is how public authorities stimulate a diverse, vibrant and sustainable market, so there are different types of support and provider organisations for supported people to choose from. Successful market facilitation and shaping relies on collaboration, commissioners need to work with people and providers to understand what's needed, so they can offer the services people need and want, now and in the future[6].

Market Facilitation Plan A Market Facilitation Plan should be prepared to complement the strategic plan and support its delivery. A Market Facilitation Plan outlines the approach and provides detail on how integration authorities will engage with the existing and prospective market in order to work together with agencies to put the right services and support in place. Based on a shared understanding of need and demand, market facilitation is the process by which all partners ensure there is sufficient, appropriate range of provision to meet needs and deliver effective outcomes.[7]

[4] https://www.nice.org.uk/guidance/ng216/documents/final-scope
[5] Public Bodies (Scotland) Act Strategic Commissioning Plans Guidance, Scottish Government, 2015
[6] CCPS Market Facilitation Guide CCPS Collaborative Commissioning-Reading and Resources.pdf
[7] Health and Social Care Integration: Strategic plans: statutory guidance 2024

Market Shaping Collaboration with other relevant partners to facilitate the whole market in the area for care, support and related services. This includes services arranged and paid for by the Partnership itself, those services paid by through direct payments, and those services arranged and paid for by individuals from whatever sources (sometimes called 'self-funders'), and services paid for by a combination of these sources. Market shaping activity should stimulate a diverse range of appropriate high quality services (both in terms of the types, volumes and quality of services and the types of provider organisation), and ensure the market as a whole remains vibrant and sustainable.

Option 1 – Direct Payment The supported person receives a direct payment. NHS Highland will decide how much money they will give to the supported person towards their support. The supported person receives this money and uses it to arrange their own support, which can include employing staff and/or buying goods and services. The supported person has full choice and control and also has the most responsibility for arranging support, which may include employer responsibilities

Option 2 – Individual Service Fund The supported person decides on the support they want, and support is arranged on their behalf. NHS Highland will decide how much money they will give to the supported person towards their support. The supported person can use the money to choose goods and services, for example from a registered support or other approved provider, and then the support is arranged on their behalf. This can be arranged by NHS Highland or a third party (such as a support provider) managing the money on behalf of the supported person. This way, the supported person has full choice and control over how their support is arranged but does not have to manage the money.

Option 3 – Directly Provided Service After discussion with the supported person, NHS Highland decides and arranges support. The local authority will decide how much money can be spent. The supported person asks the local authority to choose and arrange the support that it thinks is right for them. With this choice the supported person is not responsible for arranging support, and has less direct choice and control over how support is arranged.

Option 4 – Mix of Option 1, 2 and 3 The supported person uses a mixture of ways to arrange their care and support. Some people will want to have direct control of how some parts of their support is arranged but not other parts. Option 4 lets the supported person pick the parts they want to have direct control over and what parts they want to leave to the local authority.

Procurement The process of buying goods, works and services from external suppliers. Commissioning provides the context for procurement and contracting to take place.

Procurement Plan The document setting out how the strategic plan will be delivered, as it relates to procurement, with sufficient detail to direct those responsible for contracting services.

Strategic Commissioning All the activities involved in assessing and forecasting needs, linking investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place as, articulated in a **Commissioning Strategy.**[8]

Strategic Plan A document required of the 2014 Act, which sets out arrangements for carrying out integrated functions and outline how these will achieve, or contribute to achieving, the national health and wellbeing outcomes. Through determining needs and developing services to meet these needs, commissioning is a key process in achieving this objective and therefore strategic plans should draw upon output from the commissioning process. The strategic plan is to set out how the Partnership will commission and deliver services for its area over the medium term.[9] Previously referred to as "Strategic Commissioning Plan" in earlier Scottish Government statutory guidance.

Workforce Plan Workforce planning is a key element in delivering the ambitions set out in strategic plans. Therefore, integration authorities should also consider how workforce planning will enable delivery of its strategic plan. The workforce plan is therefore a document which sets out the actions and timescales required to support the future workforce in order to deliver the required services in Highland, and should also support a workforce strategy.

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[8] Learning_Development_Framework.pdf
[9] Health and Social Care Integration: Strategic plans: statutory guidance 2024