THIS PAPER RELATES TO ITEM 7

ON THE AGENDA

CLACKMANNANSHIRE COUNCIL

Report to: Audit & Scrutiny Committee

Date of Meeting: 6 February 2025

Subject: Clackmannanshire and Stirling Integration Joint Board Annual Performance Report 2023-2024

Report by: Wendy Forrest, Head of Strategic Planning and Health Improvement

1. Purpose

1.1. This report offers assurance that the Integration Joint Board continues to fulfil its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services, and relevant targets and measures included in the delegated functions, and as set out in the current Strategic Commissioning Plan.

1.2. The Integration Joint Board has a statutory responsibility to ensure effective performance monitoring and reporting of all services delegated in the Health and Social Care Partnership. The Health and Social Care Partnership is the delivery vehicle for the community health and social work/care services delegated by NHS Forth Valley, Clackmannanshire Council and Stirling Council.

1.3. Under the Public Bodies (Joint Working) (Scotland) Act 2014 Section 42 the Integration Authority must produce an Annual Performance Report (APR) for the reporting period, in this case 1 April 2023 to 31 March 2024. The report must be published by 31 July.

1.4. As set out in The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014 No. 326 the Annual Performance Report must cover a range of areas, these include:

- An assessment of performance in relation to national health and wellbeing outcomes, integration delivery principles, strategic planning.
- Financial planning and performance
- Best value in planning and carrying out integration functions
- Performance in respect to Localities
- Inspection of services
- Review of the Strategic Plan
- Any other information related to assessing performance during the reporting year in planning and carrying out integration functions as the integration authority thinks fit.

1.5. The Annual Performance Report Executive summary (Appendix 1) and Annual Performance Report 2023/2024 (Appendix 2) reflects on our progress together as a Health and Social Care Partnership from 1 April 2023 to 31 March 2024.

1.6. Within the Annual Performance Report we have illustrated the linkages between the Strategic Commissioning Plan priorities, National Health and Wellbeing Outcomes and the National Health and Care Standards.

1.7. Within the guidance, we are required to publish the Core Indicator set published by Public Health Scotland. This data is standardised and allows us to compare our performance to national trends and with other Partnership areas. This data is published annually in July and we have included analysis within the Annual Performance Report.

2. Recommendations

2.1. Note the Annual Performance Report 2023-24 and note that this has been published on the Partnership website as required.

3. Considerations

3.1. Highlights, Progress and Achievements

3.1.1. Most MSG (Ministerial Steering Group) and National Core indicators follow the desired trend direction with MSG 3a A&E attendances (18+) showing a 9% decrease since 2021/22 and is now below the target baseline of 26,585 set in 2015/16.

3.1.2. We have identified the challenges, such as the continued recovery from the pandemic, continued budget pressures, staffing challenges due to national shortages and the impact of the cost of living crisis for supported people and their carers.

3.1.3. We also identified the opportunities and the transformation delivered despite the challenging environment in which we operate. Establishing the Commissioning Consortium and the significant engagement and planning work completed, including the Alcohol and Drug Partnership Commissioning Plan, Integrated Workforce Plan and the Locality Planning Networks.

3.2. Challenges

3.2.1. Although the number of A&E attendances has decreased MSG1a shows the number of emergency admissions, especially in the 18+ age group, has been increasing since 2021/22.

3.2.2. The latest National Core Outcome Indicators (NI1-9) are based on the 2023/24 Health and Care Experience Survey. This online and postal survey is sent to a random sample of people registered with a general practice in Scotland every two years.

3.2.3. The level of support required for people in the Clackmannanshire & Stirling communities is changing due to an increasing proportion of older adults and increasing numbers of people with more than one long term condition (also known as comorbidities).

3.2.4. The ongoing financial and workforce challenges continue to be reflected in our recruitment and retention of staff.

3.2.5. The two social work client recording systems are in urgent need of modernisation and both Clackmannanshire Council and Stirling Council are looking to replace these systems.

3.3. Local and National Data Availability

3.3.1. The report uses a range of data to describe and illustrate performance within the HSCP, and when data is used the source will be noted. Local data is gathered within the HSCP and Forth Valley NHS.

3.3.2. We are required to publish the National Core Suite of Integration Indicators. This is published by Public Heath Scotland. These indicators are a standard national set of data and allow us to compare our performance with other HSCP s and to the national average. National data covers all residents within the HSCP area and all services that have been used. This means that if a resident attended a hospital out with Forth Valley the data will be included.

3.3.3. Public Health Scotland publish their most up to date indicators annually in July. Where full information to March 2024 is not available guidance from PHS is to use the 2023 calendar year as a proxy for 2023/24. Where this has occurred it has been noted.

3.3.4. The Core Indicators are reported throughout the main body of the report, within the context of our strategic policies and we have provided comparisons against other HSCP areas in our LGBF family group (comparators) and the national average.

3.3.5. The Core Suite of Integration Indicators are based on Standardised Mortality Ratio (SMR01) returns from the Health Board. Where not all 100% of records have been submitted/published/validated, this affects the data and will be the main reason figures change retrospectively from year to year and month to month. Where completeness is an issue, it has been noted and mainly affects national data only.

3.3.6. Some methodology has also changed within the Health Care and Experience Survey which makes comparison with previous year's data difficult. Again, this has been noted where appropriate.

3.3.7. Public Health Scotland also publish a suite of MSG (Ministerial Steering Group) Indicators which HSCP areas can use to monitor local progress without the expectation of benchmarking or comparison within Scotland or other HSCP areas.

3.3.8. The MSG Indicators are reported throughout the body of this report, within the context of our strategic direction.

3.3.9. As an HSCP, we have a wealth of data collected by our systems within the NHS Forth Valley services, Clackmannanshire Council and Stirling Council. This data provides local information on the people supported by our services within Forth Valley, it is not always possible to compare this local data to other partnership or national figures.

3.3.10. The Annual Performance Report is a part of public performance reporting. It is aimed at providing the public with a simple and effective overview of the progress made towards the priorities and how we are performing. It is written in Plain English and efforts to increase accessibility will be made. For example, publication of a Reader friendly plain text version, use of videos.

4. Sustainability Implications

N/A

5. Resource Implications

5.1. Financial Details

5.1.1. The full financial implications of the recommendations are set out in the report. This includes a reference to full life cycle costs where appropriate. Yes X

5.1.2. Finance have been consulted and have agreed the financial implications as set out in the report. Yes X

5.2. Staffing

5.2.1. Workforce is considered in the report.

6. Exempt Reports

Is this report exempt? Yes ☐ (please detail the reasons for exemption below)
No X

7. Declarations

The recommendations contained within this report support or implement our Corporate Priorities and Council Policies.

(1) **Our Priorities** (Please double click on the check box ☑)

Clackmannanshire will be attractive to businesses & people and ensure fair opportunities for all	☐
Our families; children and young people will have the best possible start in life	☐
Women and girls will be confident and aspirational, and achieve their full potential	☐
Our communities will be resilient and empowered so that they can thrive and flourish	X

(2) **Council Policies** (Please detail)

8. Equalities Impact

8.1. Have you undertaken the required equalities impact assessment to ensure that no groups are adversely affected by the recommendations? Yes ¨ No X

9. Legality

9.1. It has been confirmed that in adopting the recommendations contained in this report, the Council is acting within its legal powers. Yes X

10. Appendices

10.1. Appendix 1 – Clackmannanshire and Stirling IJB - HSCP Annual Performance Report 2023-2024 - Executive Summary.

10.2. Appendix 2 – Clackmannanshire and Stirling IJB - HSCP Annual Performance Report 2023-2024

11. Background Papers

Have you used other documents to compile your report? (All documents must be kept available by the author for public inspection for four years from the date of meeting at which the report is considered)

Yes X (please list the documents below) No ☐

Author(s)

NAME	DESIGNATION	TEL NO / EXTENSION
Wendy Forrest	Head of Strategic Planning and Health Improvement	07385 031941
Ann Farrell	Principal Information Analyst	hscpperformance@stirling.gov.uk

Approved by

NAME	DESIGNATION	SIGNATURE
Joanna MacDonald	Interim Chief Officer	[redacted]

Annual Performance Report 2023-2024

Executive Summary

Clackmannanshire & Stirling Health & Social Care Partnership

Key Achievements in 2023/2024

- Developing and approving Locality Plans
- Developing and approving Alcohol and Drug Partnership Commissioning Plans
- Developing and agreeing a Workforce Plan including an improvement action plan
- Approved, along with Falkirk IJB, the development of a Forth Valley Strategic Commissioning Plan for Palliative and End of Life Care
- Agreeing significant and ambitious transformation and savings plans to support a 'Needs Led, Resource Bound' approach and demonstrate clear alignment to strategic priorities.

£272.6m total IJB Strategic Plan Budget 2023/24

£2.616m overspend met from Reserves

Performance Summary

Performance (MSG and NCI) 25 indicators	**12** Improving performance	**6** Static	**7** Declining performance
Strategic Theme 1 - Prevention, early intervention, and harm	7	1	2
Strategic Theme 2 - Independent living through choice and control	1	1	2
Strategic Theme 3 - Achieving care closer to home	3	4	3
Strategic Theme 4 - Supporting empowered people and communities	1	0	0

Benchmarking (NCI only) 18 indicators					
Scotland	**9**	Better than average	**3**	Within 5%	**6** Worse than average
Comparators	**6**	Better than average	**8**	Within 5%	**4** Worse than average

Ministerial Strategic Group (MSG) Performance Summary

Desired Trend ↑ increase ↓decrease

Strategic Theme	Performance	The MSG information covers a range of activities under the umbrella of 'unscheduled care'. These activities support people to remain in their own homes, return to their own homes as quickly as possible when hospital treatment is required, prevent related re-admission to hospital and include end of life care. Unscheduled care is a core element of the health and social care system and as such, our services need to be responsive to need whilst being transformative in that contact with patients is shifted from reactive to proactive planned engagement, and from hospital settings to the community where appropriate.
ST1	↓	MSG1a - Number of emergency admissions (aged 18+) has increased for the last 3 years to 14,582 and is above the target of 10,584 set in 2015/16.
ST1	↓	MSG2a - Although the Number of unscheduled hospital bed days (aged 18+); acute specialties has decreased by 5.2% from 106,732 in 2022/23 to 101,143 in 2023/24. This is still above the target of 88,804 set in 2015/16.
ST1	↓	MSG2c - Although the available data for is for 2023 as a proxy for 2023/24 current information shows that the number of unscheduled hospital bed days (aged 18+); mental health specialties has reduced to 17,001 which is below the 2015/16 baseline of 20,378.
ST1	↓	MSG3a - A&E attendances (aged 18+) for Patients from all areas has reduced from 28,398 in 2022/23 to 26,053 in 2023/24 which is now below the 2015/16 base line of 26,585.
ST1	↓	MSG4a - Delayed discharge bed days (aged 18+) - All Reasons has increased from 14786 in 2022/23 to 15,624 in 2023/24 and is above the 2015/16 baseline of 10,069.
ST3	↓	MSG5a - Percentage of last 6 months of life spent in community (all ages) decreased to 89.2% in 2023/24 and has remained slightly under the target of 90% for the last 3 years.
ST3	↓	MSG6 -The latest information for is from 2022/23 and shows Proportion of 65+ population living in Community or institutional settings - Home (Supported and unsupported) is 96.8%. Although this is a reduction from 97.3% in 2021/22 it is still above the 2015/16 baseline target of 96.6%.

Desired Trend ↑ increase ↓decrease

Strategic Theme	Performance	Outcome Indicators - Information published by PHS is sourced from the latest Scottish Health and Care Experience Survey 2023/24. This online and postal survey is sent to a random sample of people registered with a general practice in Scotland every 2 years.	Scotland average	Comparator HSCP average
ST2	↑	**NI 1** - Percentage of adults able to look after their health very well or quite well has shown a small decrease from 91.7% to **90.8%**.	90.7%	91.8%
ST2	↑	**NI 2** - Percentage of adults supported at home who agreed that they are supported to live as independently as possible has decreased from 72.5% to **67.2%**.	72.4%	71.9%
ST2	↑	**NI 3** - Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided has decreased from 64.3% to **57.9%.**	59.6%	63.7%
ST3	↑	**NI 4** - Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated has decreased from 61.7% to **56%**.	61.4%	59.8%
ST3	↑	**NI 5** - Total percentage of adults receiving any care or support who rated it as excellent or good has decreased from 67.8% to **64.8%**.	70%	70.5%
ST3	↑	**NI 6** - Percentage of people with positive experience of the care provided by their GP practice has increased from 67.3% to **72.3%.**	71.3%	68.5%
ST3	↑	**NI 7** - Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life has decreased from 79.2% to **66.1%.**	69.8%	69.5%
ST4	↑	**NI 8** - Total combined % carers who feel supported to continue in their caring role has increased from 26.6% to **32.8%.**	31.2%	31.9%
ST3	↑	**NI 9** - Percentage of adults supported at home who agreed they felt safe has reduced from 75.3% to **66.8%**.	72.7%	71.4%

Desired Trend ↑ increase ↓decrease

Core Suite of Integration Indicators Performance Summary

Strategic Theme	Performance	Data Indicators - Information published by PHS. Data for indicators 12, 13, 14, 15, 16 and 18 are reported for the calendar year 2023 as a proxy for 2023/24 as data for the full financial year is incomplete at this time. Data for indicator 11 to calendar year 2023 is not currently available. Data is derived from various organisational/system datasets.	Scotland average	Comparator HSCP average
ST1	↓	**NI 11** - The latest information for Premature mortality rate per 100,000 persons by Calendar Year is from 2022. This shows a decrease 440 in 2021 to **407** in 2022.	442	394
ST1	↓	**NI 12** - Emergency admission rate (per 100,000 population) has increased from 13,036 in 2022/23 to **13,127** for calendar year 2023.	11,707	12,327
ST1	↓	**NI 13** - Rate of emergency bed day per 100,000 population for adults (18+) decreased from 115,181 in 2022/23 to **110,213** for calendar year 2023.	112,883	114,651
ST1	↓	**NI 14** - Emergency readmissions to hospital for adults (18+) within 28 days of discharge (rate per 1,000 discharges) has decreased from 126 in 2022/233 to **122** for calendar year 2023.	104	113
ST3	↑	**NI 15** - Proportion of last 6 months of life spent at home or in a community setting reduced slightly from 89.3% in 2022/23 to **89.2%** for calendar year 2023.	89.1%	89.4%.
ST1	↓	**NI 16** - Falls rate per 1,000 population aged 65+ has decreased from 23.8 in 2022/23 to **23.6** for calendar year 2023.	22.7	23
ST3	↑	**NI17** - Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections has increased from 80.8% in 2022/23 to **84.6%**.	77%	78.7%.
ST2	↑	**NI18** - Percentage of adults with intensive care needs receiving care at home has increased from 69.3% in 2022/23 to **70.4%** for calendar year 2023.	64.5%	64.8%.
ST3	↓	**NI19** - Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population has increased from 804 in 2022/23 to **814**.	902	870

Clackmannanshire & Stirling
Health & Social Care Partnership






Clackmannanshire and Stirling Integration Joint Board Annual Performance Report 2023-2024

Contents

Message from the Chair

2023-2024 saw the cost-of-living crisis and increasing demand for services create the 'perfect storm' for health and social care across the country.

Our vision remains the same – to enable people to live full and positive lives in supported communities. We see progress on our four key strategies: prevention and early intervention; independent living; care closer to home and empowering people.

But we still face the challenge of meeting the increasing needs of an ageing population against the backdrop of limited resources. In Clackmannanshire and Stirling, one in five of us is over the age of 65 - by 2038 that will be one in four.

We need to ensure money is spent where it will most positively impact on people's health and wellbeing. That involves transforming our model of care.

For instance, £100 invested in prevention and early intervention near someone's home could save £1000s in a costly hospital stay down the line. Last year we invested in a falls prevention leader with the goal of reducing the number of emergency admissions to hospital.

And we need to make sure everyone has a say in how health and care is seamlessly delivered in their communities.

This year we strengthened our three Locality Planning Networks - Clackmannanshire, Urban Stirling and Rural Stirling. A great opportunity for you to make your voice heard, so I would welcome you to come along to one of their roadshows.

Finally would like to acknowledge the hard work and dedication of our staff, GP practices, third sector and independent providers in making a positive difference to thousands of lives. And a special shout out to our unsung heroes - the 21,000 unpaid carers who look after their loved ones in Clackmannanshire and Stirling.

Thank you

Allan Rennie

Vice Chair
Integration Joint Board

Message from the Interim Chief Officer

I want to express my sincere thanks to HSCP staff alongside colleagues in our Third and Independent sectors who have continued worked tirelessly to ensure the safe and effective provision of community health and social care and support across our communities.

This report reflects progress made in delivering against the priorities within our 2023-2033 Strategic Commissioning Plan which was approved by the Integration Joint Board in March 2023 follow an extension period of engagement with our communities and partners.

This report reflects some of the significant work and efforts of all people who worked alongside the communities of Clackmannanshire and Stirling throughout the last year. We have seen improvements in progressing key pieces of transformational work which will continue into 2024-25.

This eighth Annual Performance Report evidences that there is much to be proud of, however, it also shows that the HSCP continues to seek to meet the challenge of the growing population and increasing levels of complex needs in our population, against a backdrop of significant financial challenges now and going into the future.

Addressing these pressures will require significant further transformation in how we deliver services across the partnership area in the coming years and we will continue to provide engage with citizens to co-produce solutions to these challenges.

I hope you enjoy reading about our progress, in partnership with our communities.

David Williams

Interim Chief Officer

Introduction and background

The Public Bodies (Joint Working) (Scotland) Act 2014 requires the Integration Joint Board to publish an Annual Performance Report. This is the eighth Annual Performance Report for Clackmannanshire and Stirling Integration Joint Board (IJB) where we reflect on the 2023/24 and review the progress made in delivering the priorities set out in our Strategic Commissioning Plan 2023 - 2033 which was approved by the IJB in March 2023. The Clackmannanshire and Stirling Health and Social Care Partnership (HSCP) is the delivery vehicle of the Integration Joint Board, services are delivered in line with the Strategic Commissioning Plan 2023 - 2033. See Appendix 1 for a list of the functions delegated to the IJB.

The Strategic Commissioning Plan is a ten year plan based on the principles of human rights, equality and ecology. Five strategic themes reflect our aims setting out the vision and future of health and social care services in Clackmannanshire and Stirling.

- Prevention, early intervention & harm reduction
- Independent living through choice and control
- Care Closer to Home
- Supporting empowered people & communities
- Loneliness & isolation

In our Strategic Commissioning Plan, we set out our key strategic themes and priorities based on what our citizen's, staff and partners have told us; where they wish for us to focus our activity and resources based on local demographics, population and need. The participation and engagement work carried out with communities, partners and stakeholders and how this feedback alongside current data informed our priorities with in the strategic themes. We have also linked our priorities to the national and local environment and how our Enabling activities support our delivery. On page 5 we have detailed links across our strategic themes to the National Health and Wellbeing Outcomes set by the Scottish Government.

This report is a review of service delivery across Clackmannanshire and Stirling Health and Social Care Partnership including outcomes for citizens, key achievements, effective partnership working and challenges as well as reporting on the significant programme which has been delivered to modernise and transform services in recovery from the impact of COVID-19 and the challenging financial position we currently face.

Engagement

The Public Bodies (Joint Working) (Scotland) Act 2014 requires full consultation and engagement with stakeholders in the development of all plans and policies that impact people. Stakeholders include the public, people with lived and living experience, people who access services, unpaid carers, staff, providers, third sector and independent sector. Clackmannanshire and Stirling Health and Social Care Partnership are committed to the co-design and coproduction of community health and social care in the area. Engagement with people helps us all understand need, demand and work out how to deliver this in partnership with a wide range of people and organisations.

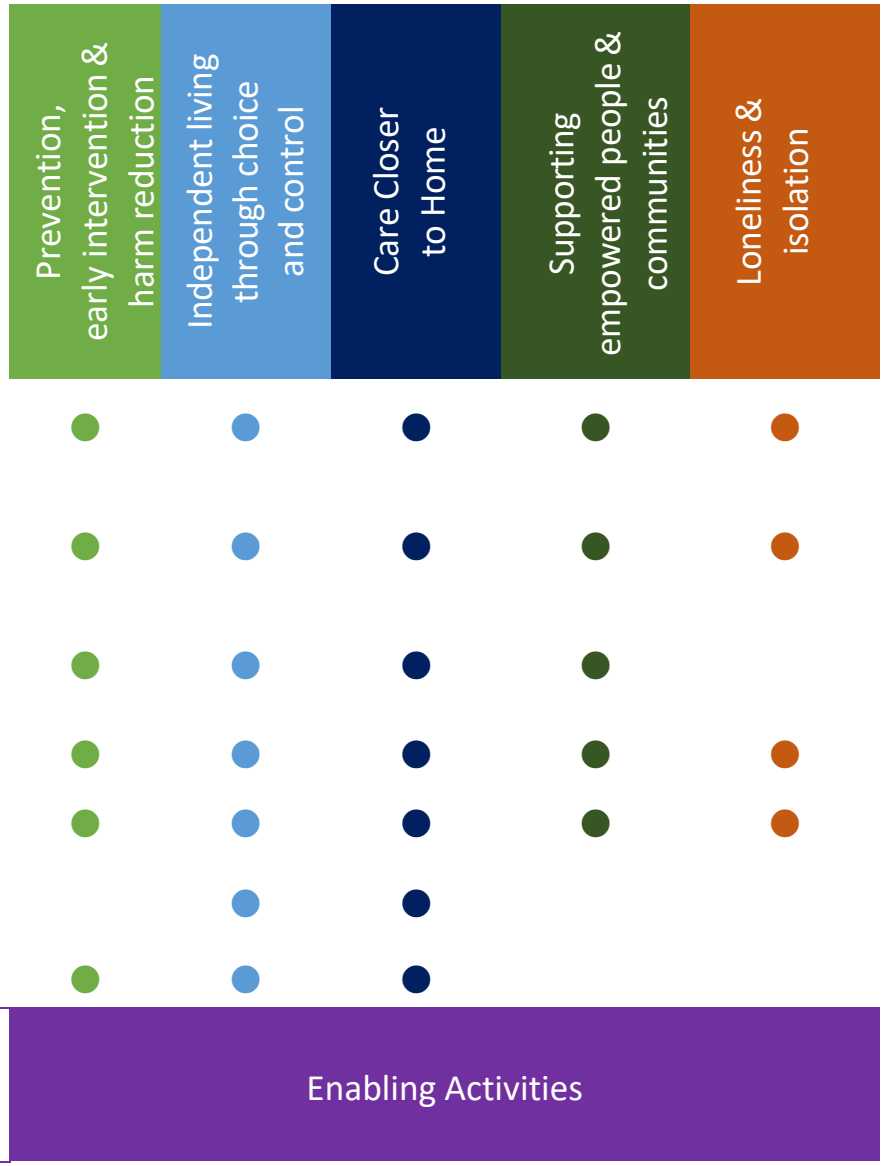
Have your say and get involved in shaping community health and social care. You can find out more here: Get involved

Our Strategic Commissioning Plan 2023-2033 - plan on a page

National Health & Wellbeing Outcomes

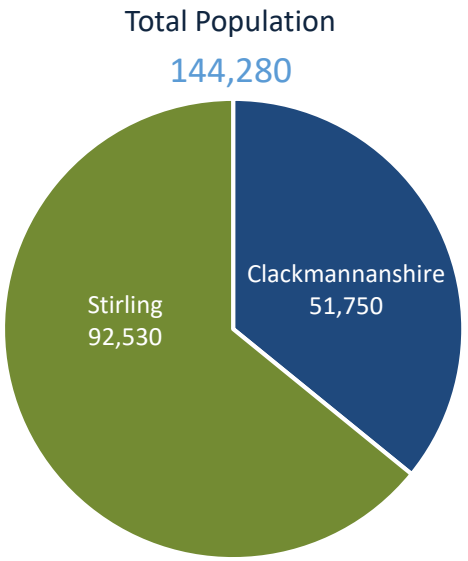
All themes and priorities of the Strategic Commissioning Plan are linked to the National Health and Wellbeing Outcomes. Each theme will demonstrate improvement for people and communities, how we are embedding a human rights based approach, consideration for equalities and evidencing improvement across the services we deliver.

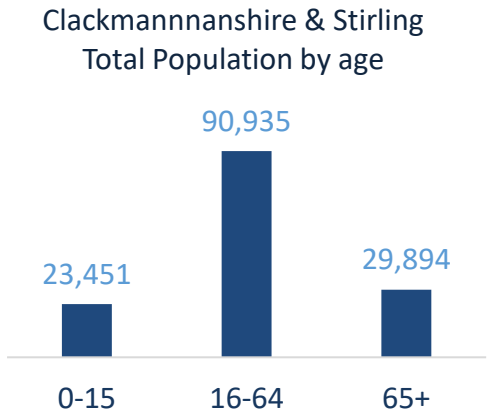
Health and Wellbeing Outcomes



Overview of Clackmannanshire and Stirling

Our Population (NRS 2022 mid-year)





Currently 20.7%, over a fifth of the population, is aged 65+. This is expected to increase to 25% by 2038 (NRS 2018 projections).

Life Expectancy (NRS 2020-22)

Females	2021	2022	Direction
Clackmannanshire	80.6	79.9	↓
Stirling	81.9	81.6	↓
Scotland	81.0	80.7	↓
Males	**2021**	**2022**	**Direction**
Clackmannanshire	76.2	75.7	↓
Stirling	77.6	77.7	↑
Scotland	76.8	76.5	↓

Female life expectancy is generally higher than male life expectancy.

When compared to Scotland, Stirling has higher life expectancy for both females and males while Clackmannanshire has lower life expectancy.

In 2022, there was a slight decrease in life expectancy, with the exception of Stirling males.

Health and Social Care Needs

- 68% of people living in Clackmannanshire and 72% of people living in Stirling consider their health to be good or very good. This compares to 70% in Scotland (Scottish Household Survey).
- In Clackmannanshire 39% of people are living with a limiting long term illness or condition. In Stirling, 38% of people are living with a limiting long term illness or condition. This compares to 37% in Scotland. (Scottish Household Survey).
- In March 2024, 638 adults with learning disabilities (288 in Clackmannanshire and 335 in Stirling) were known to HSCP (Adult Social Services).
- There are approximately 21,250 unpaid carers in Clackmannanshire and Stirling area. 12,958 people identify themselves as unpaid carers and it is estimated that there are 8,000 unknown unpaid carers.
- In Clackmannanshire 22.0% and in Stirling 17.8% of the population were prescribed medication for anxiety, depression and psychosis. This compares to 20.1% in Scotland. (ScotPHO)
- 18% of adults in Clackmannanshire and 17% in Stirling are current smokers, compared to 15% in Scotland. (Scottish Health Survey)
- In Clackmannanshire 13,426 people (26.1% of the population) live in the 20% most deprived areas of Scotland. In Stirling, 11,110 people (11.8% of the population live in the 20% most deprived areas of Scotland (SIMD 2020).

How we measure our performance

The Integration Joint Board has a responsibility to ensure effective performance monitoring and reporting. The IJB needs to be able to monitor performance and measure impact for our communities against our Strategic Commissioning Plan priorities and be able to share with communities and stakeholders.

Our Integrated Performance Framework relies on an integrated approach to managing, using, and understanding our data. This is because driving performance is most efficiently achieved based on a sound understanding of the systems and processes involved. Analysing our data alongside listening to our supported people and other stakeholders provides the best way to do that and provides advantage in planning change, deploying preventative approaches, evidencing our functions under legislation and driving process and cost efficiency.

Due to the nature of the delegated services (Appendix 1) within the Health and Social Care Partnership, the data we require to report and analyse is held across systems in NHS Forth Valley, Clackmannanshire Council and Stirling Council, national datasets and a collection of smaller datasets across a range of wider partners. The complexity of multiple organisations is further complicated by the fact that each organisation works with multiple systems. This leads to challenges in pulling information together and making the reporting processes as efficient as possible. Local data is reported throughout the relevant Strategic Themes and priorities in this report.

Appendix 2 shows our performance for the Ministerial Strategic Group (MSG) indicators which support the delivery of the National Priorities Partnerships. The MSG information covers a range of activities under the umbrella of 'unscheduled care'. These activities support people to remain in their own homes, return to their own homes as quickly as possible when hospital treatment is required, prevent related re-admission to hospital and include end of life care.

In Appendix 3 we have provided an assessment of our performance against the National Core Indicators (NCI) and includes comparisons with the Scottish average and with our comparator HSCP's. The 'Outcome' indicators above are reported every 2 years from the Scottish Health and Care Experience Survey commissioned by the Scottish Government with the latest information being published in 2023/24. The 'Data' Indicators measure mainly health activity, community and deaths information.

Performance Summary

Performance (MSG and NCI) 25 indicators	12 Improving performance	6 Static	7 Declining performance
Strategic Theme 1 - Prevention, early intervention, and harm	7	1	2
Strategic Theme 2 - Independent living through choice and control	1	1	2
Strategic Theme 3 - Achieving care closer to home	3	4	3
Strategic Theme 4 - Supporting empowered people and communities	1	0	0

Benchmarking (NCI only) 18 indicators						
Scotland	9	Better than average	3	Within 5%	6	Worse than average
Comparators	6	Better than average	8	Within 5%	4	Worse than average

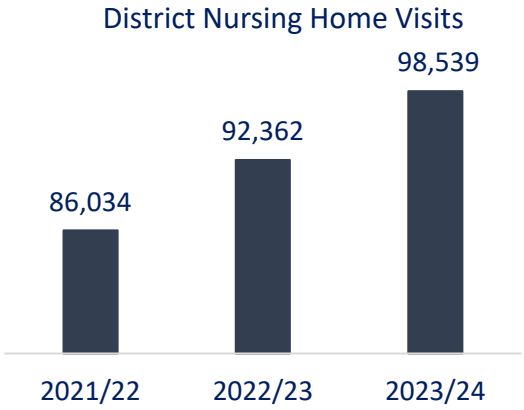
Strategic Theme 1 - Prevention, early intervention & harm reduction

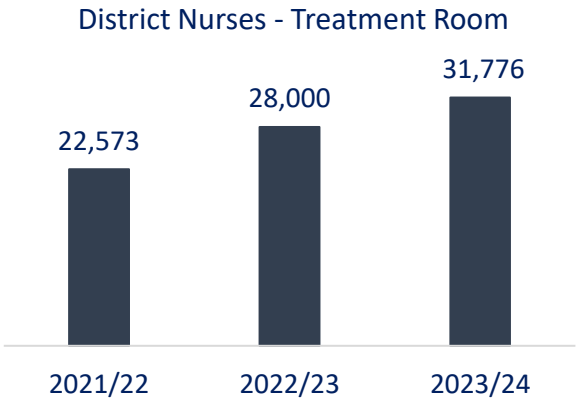
Prevention, early intervention, and harm reduction is focused on working with partners and communities to improve overall health & wellbeing and preventing ill health. By promoting positive health and wellbeing, physical activity and reducing exposure to adverse behaviours we can prevent pressures on people's health and in turn health and social care services. Early intervention and harm reduction is about getting the right levels of support and advice at the right time, maintaining independence, and improving access to services at times of crisis.

There has been a small increase in the rate of emergency admissions per 100,000 population for adults (18+)(NI12) from 13,036 in 2022/23 to 13,127. This is above the Scottish average and the average for our comparator HSCP's.

District Nursing

Many adults and older people can be supported at home, even when unwell, because it is well documented that staying unnecessarily in hospital can be detrimental to a person's ability to be re-abled or rehabilitated which may lead to a loss of function. The community nursing team is available 24 hours a day, 365 days a year, and provides planned and unplanned care and support. From 2022/23 there has been a 6% increase in the number of home visits and a 13.5% increase in the number of treatment room visits.





The rate of emergency bed days per 100,000 population for adults (18+)(NI13) has reduced, by 4%, from 115,181 in 2022/23 to 110,293 in 2023. This is below the Scottish average of 112,883 and is considerably lower than the average of our comparator HSCP's

Delayed discharge bed days (aged 18+) - All Reasons (MSG4a) has increased from 14786 in 2022/23 to 15,624 in 2023/24 and is above the 2015/16 baseline of 10,069.

A delayed discharge is when someone is assessed as ready to go home after being admitted to hospital, however, they are unable to leave because where they are going is not ready. For example, sometimes a person needs social care, or adaptations to their home or they are moving into a care home. How long someone stays in hospital can have a big impact on them, from how they move, their confidence and how they are recovering from or living with a condition. We aim to reduced delayed discharges. Delays in hospital can not only lead to poor outcomes for the person who is delayed, but this can cause hospital beds to be unavailable for someone who needs acute treatment.

The falls rate per 1,000 population (aged 65+)(NI16) has reduced from 23.8 in 2023/24 to 23.6 in 2023/24. This is higher than the Scottish average of 22.7 and the HSCP comparator average of 23.

Preventing Falls

In Scotland, falls are the most common cause of emergency hospital admission for unintentional injuries in adults and can have a major impact on people's health and well-being. From an organisational perspective we know the significant pressures that falls puts on hospital beds, requests for packages of care and community rehabilitation services. In light of these pressures a key objective of Allied Health Professional (AHP) Falls Prevention Lead, who commenced their role in February 2023, was to both improve the accessibility of our services and increase awareness about falls and the many components involved that increase a person's risk of falling. The Community Falls webpage has been redeveloped and Local Falls Awareness Events have been held to help support self-management strategies within the community and encourage people to act earlier to seek the right support at the right time and a Falls Local Community Support leaflet has been developed to provide information on what local support is available to the community in relation to falls prevention Through collaboration with the Scottish Ambulance Service (SAS), we aim to develop a pathway to encourage the use of community support services to reduce the conveyance of uninjured and well fallers to hospital. We will also explore using MECS (Telecare) to attend uninjured fallers and help return them to their feet to improve capacity within the SAS.

Stop Smoking Services

Stop Smoking Advisors provide free treatment and local support in Clackmannanshire and Stirling to stop smoking, usually over a 12 week programme to help you reduce your nicotine dependency.

In 2023/24 161 people achieved a 12 week quit success. This is a reduction from the 233 reported 12 week quits in 2022/23.

Quote from client accessing the Stop Smoking Service
on Care Opinion April 2024

"I was beginning to smoke heavy and I could tell it was harming me when taking my dog a walk. I also have to climb stairs every day and I knew I wasn't fit and put it down to smoking. I picked up a smoking cessation card from a health centre and decided to give it a try. I struggled at first and reduced my smoking to about 5 per day which was brilliant for me but with the encouragement and support from Laura, I managed to stop altogether. Laura was excellent and she kept giving me goals to achieve. I cannot thank her enough".

Priority 1 Mental Health and Wellbeing

Mental health and wellbeing is as important as physical health and wellbeing. There has been significant change as to how we deliver mental health services, there has been a redesign of existing services and developing additional resources to meet increasing demand, and in response to the impact of the COVID-19 pandemic.

Primary care is the first point of contact with the NHS. This includes contact with community based services such as general practitioners (GPs), community nurses, and Allied Health Professionals (AHPs).

The mental health nurse team are now embedded in the majority of GP practices offering weekly appointments across the area. Patients who require the medical opinion of a specialist clinician may be referred to an outpatient clinic for treatment or investigation. Outpatients are not admitted to a hospital and do not use a hospital bed.

Community Mental Health Teams (CMHTs) support people with severe and enduring mental health in the community. The Mental Health Acute Assessment and Treatment Service (MHAATS) receive urgent referrals from the Emergency Department at Forth Valley Royal Hospital and General Practitioners across Forth Valley.

The total number of unplanned bed days (mental health) 18+ financial year (MSG 2c) has continued its downward trend from its baseline of 24,851 in 2015/16 to 17,001 (2023 calendar year). The December 2023 snapshot rate of unplanned bed days (mental health) 18+ per 1,000 was 17.3.

7.8% of mental health emergency readmissions within 28 days (financial year 2023). This is higher than the Scottish average of 6.7%. (NHS FV)

In 2023/24 there were 355 admissions to the Mental Health Unit at Forth Valley Royal Hospital. This is a small increase from 334 in 2022/23 (NHS FV).

In 2023/24 there were 232 referrals to Adult Social Care services for Mental Health Clients. This is a 21% increase from 183 in 22/23.
(Adult Social Services)

In March 2024 the percentage of people who commenced treatment within 18 weeks of referral to Psychological Therapies in Forth Valley was 73.6%. This is below the Target of 90% (PHS) and below the Scottish average of 80.7%.

What is the Mental Health Act?

The Mental Health (Care and Treatment) (Scotland) Act 2003 applies to people who have a "mental disorder" - this is defined under the Act and includes any mental illness, personality disorder or learning disability. This includes Emergency Detention Certificates and Compulsory Treatment orders.

Clackmannanshire & Stirling	2018/19	2022/23	2023/24
Number of Emergency Detention Certificates (Mental Health) Section 36	67	62	66
Number of Short Term Detention Certificates (Mental Health) Section 44	124	139	134
Number of Compulsory Treatment Orders (existing)	41	31	45
Number of Compulsory Treatment Orders (new applications)	46	107	90

(Adult Social Services)

What is a Guardianship?

This is a court appointment which authorises a person to act and make decisions on behalf of an adult with incapacity.

Clackmannanshire & Stirling	2018/19	2022/23	2023/24
Total number of Existing Guardianships (private and local authority)	375	473	561

(Adult Social Services)

Anyone with an interest can make an application for a guardianship order. When we refer to an adult, this is someone who is aged over 16 who is not able to look after their own affairs.

The NHS and Local Authorities have a statutory responsibility to provide access to independent advocacy for specific groups of people. These include people with a learning disability, mental health disorder (including young people under 16) an acquired brain injury, physical disability or life-limiting illnessfrail and elderly, young people in transition to Adult Social Care services, offenders within the Forth Valley prison estate who are subject to the Mental Health Act.

Independent advocacy aims to help people by supporting them to express their own needs and make their own informed decisions. Forth Valley Advocacy (FVA) is the current provider of independent advocacy across Forth Valley (including the Clackmannanshire and Stirling & Falkirk Health and Social Care Partnership, and NHS Forth Valley). In 2023-2024, FVA provided advocacy support to approximately 760 individuals, with the majority eligible under the Mental Health Act.

Mental Health Money and Benefits Advice Project facilitated by Citizens Advice Bureau ran throughout 2023-24 for people experiencing poor mental health. This is a collaborative project with Mental Health services, Citizens Advice Bureau and The Robertson Trust. The project has gathered positive feedback and people feel more positive about the future.

Key actions for 2024-25

- A Joint Inspection of Adult Services in the Clackmannanshire and Stirling Health and Social Care Partnership is currently in progress and is due for completion in November 2024.
- A consultation and engagement programme to inform the development of the Mental Health and Wellbeing Strategic Commissioning Plan.

Priority 2 Drug and alcohol care and support

The Clackmannanshire and Stirling Alcohol and Drug Partnership (ADP) is responsible for the planning of local support services in partnership with Clackmannanshire and Stirling Councils, NHS Forth Valley, Police, Fire, and Third Sector colleagues.

Commissioning

The ADP Commissioning Consortium has considered lived and living experience and performance data to develop recommendations for the modernisation of our system of treatment and care. In November 2023 the IJB agreed proposals for future third sector contracted delivery of specialist substance use treatment aligned to MAT Standards*. We have also agreed the recontracting of family support aligned to the Whole Family Approach Framework and whole system strategic drivers including The Promise and Children's Services Plans.

Lived Experience and Human Rights

We have established our ADP Lived Experience Advisory Panel (LEAP) to facilitate lived and living experience input to ADP Strategic Planning. The group has already contributed critical feedback to ADP planning. We have also worked with REACH Advocacy to deliver Human Rights training and workshops to people connected to our system of care and at HSCP strategic planning level. Our involvement of lived and living experience continues through our work to implement the MAT Standards*.

MAT Standards and Harm Reduction

MAT Standards* implementation has been key to ADP work, supported by Public Health Scotland. Progress continues to be made to implementing these new standards for drug and alcohol treatment systems, through collaborative working across the whole system. Work continues to gather and share performance data to reflect progress, and collaborative discussion continues to ensure progress can be sustainably maintained. Our Primary Care Facilitation Team has been meeting to develop sustainable approaches within Primary Care and low intensity settings. ADP has also supported the development of a Clackmannanshire Council Naloxone policy and wider learning from drug and alcohol harms in partnership with Public Health.

The Scottish Government set a Standard that 90% of people referred for help with problematic drug or alcohol use will wait no longer than three weeks for specialist treatment that supports their recovery.

As of 31st March 2024 82.5% NHS Forth Valley referrals waited no longer than three weeks whilst the Scottish average is 91.9%. *Public Health Scotland*

Waiting times data is currently available from two sources. DAISy, local data which is gathered and reported to Public Health Scotland who use this data to form their online dashboard. The Public Health Scotland published data shows different levels of compliance than our own local data. Generally, data for Clackmannanshire and Stirling shows higher rates of compliance than the Forth Valley wide figures that are published nationally.

There has been no national publication of Alcohol Brief Intervention delivery data since 2020, and local recording is still being examined for validity. This is not being reporting on locally or nationally but it remains a national target.

*MAT Standards are Evidence based standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland. These are relevant to people and families accessing or in need of services, and health and social care staff responsible for delivery of recovery oriented systems of care. For more detailed information about MAT Standards please see the Scottish Government web page Medication Assisted Treatment (MAT) standards: access, choice, support - gov.scot (www.gov.scot)

Forth Valley Recovery Community

Recovery cafés and Recovery Drop-ins (mini cafés) provide support seven days per week.

Locations in Clackmannanshire and Stirling

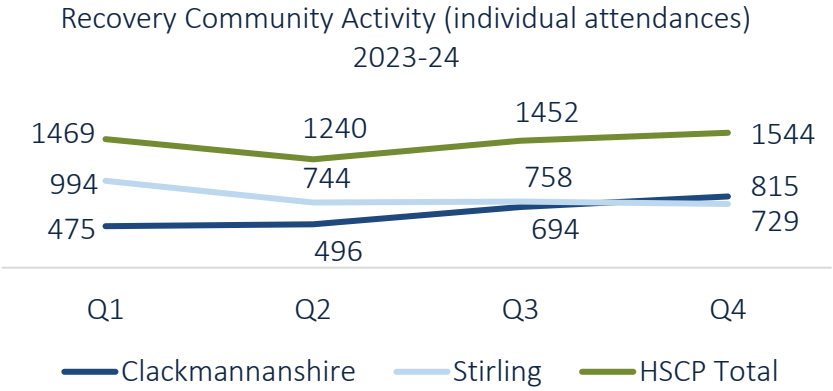
- Recovery café in The Gate at Alloa.
- Recovery drop-in, in Alva at The Baptist Church.
- Recovery café in Stirling at The Mayfield Centre.
- Women's mini -cafe in Stirling at Kildean Business and Enterprise Hub.
- Recovery drop-in, Stirling at Kildean Business and Enterprise Hub.

Peer Support sessions run at the following locations:

- The FV Royal Hospital in Larbert
- The SMS clinics

Recovery Ramble walks and Recovery in the Wild events continued to be popular activities which contributed to improving the physical and mental wellbeing of community members. Employment, training and education and self development along with various other activities and events were are also held.

Find out more information at Forth Valley Recovery Community website.



The Recovery Community Activity data is gathered from commissioning and contract review processes and reflects the number of individual attendances in each area. The average weekly number of attendances has increased from 104 in 2022/23 to 112 in 2023/24.

Key actions for 2024-25

- Continue work with national and local partners to develop proposals for tier two recovery support aligned to relevant strategic drivers and lived experience requirements.
- Commission Harm Reduction Outreach approach drawing on local knowledge and experience.
- Continue support for Lived Experience Advisory Panel (LEAP)
- Refine planning and consider sustainability arrangements for lived and living experience reflection on service delivery
- Align ADP support for prevention messaging to Health Improvement planning and delivery.
- Facilitate whole system coordination for substance use harm reduction activity

Strategic Theme 2 - Independent living through choice and control

This Strategic Theme focuses on how the HSCP supports people and carers to actively participate in making informed decisions about how they live their lives and meet agreed outcomes. Services are focussed around helping people identify what is important to them to live full and positive lives and make decisions that are right for them.

Percentage of adults with intensive care needs receiving care at home (NI18)(has increased from 69.3% in 2022/23 to 70.4% for calendar year 2023 which is above the Scottish average of 64.5% and our comparators average of 64.8%.

Percentage of adults supported at home who agreed that they are supported to live as independently as possible (NI2) has decreased from 72.5% to 67.2%. This is below the Scottish average of 72.4% and below our comparators average of 71.9%

Priority 3 Self-Directed Support information and advice promoted across all communities

Self-Directed Support that supports people's rights to provide choice, dignity and being able to take part in the life of their communities. As part of our response to the Self Directed Support Act, we are developing, in partnership with staff and supported people, a new Self Directed Support Policy which is outcomes focused and will be rolled to all staff working across Clackmannanshire and Stirling.

As at 31st March	2019/20	2020/21	2021/22	2022/23	2023/24
Option 1	56	59	67	89	94
Option 2	56	60	69	92	93
Option 3	4273	4389	4152	3888	4579
Option 4	133	95	109	130	169
All SDS options	4518	4603	4397	4199	4935
Change year on year		2%	-4%	-5%	18%

(Adult Social Services)

The total number of people eligible for support has increased by 18% from 4199 in 2022/23 to 4935 in 2023/24. The majority of people (92.8%) continue to choose support arranged by their local council (Option 3).

With the development of the new SDS approach, we will develop indicators around the new process. Key areas we are keen to develop will allow analysis of the asset based approach, recording to what extent people feel their outcomes have been met. It is also a priority to gather service delivery information on the number of people receiving the right advice and support at the right time, with robust recording of the number of people being signposted successfully, number of people with budget and support plans, reviews and understanding the experiences of people to improve and develop our process. We also aim to understand what is important for people and understand any barriers to accessing chosen SDS options to continue to modernise our local service delivery.

When a person has been assessed as eligible for support there is a duty to offer four choices in relation to how support will be facilitated. There should be no default option under Self-directed Support.

All of the four options are equally valid. What is important is that each supported person is informed of the four Self-directed Support options and are able to select the option that is right for them. The four options as follows:

Option 1 – Direct Payments This is the option that gives you the most control, flexibility and responsibility when it comes to your social care support.

Option 2 – Individual Budgets This is the option where you choose how you want to be supported and then the support is arranged on your behalf. You direct the support, but you do not have to manage the money.

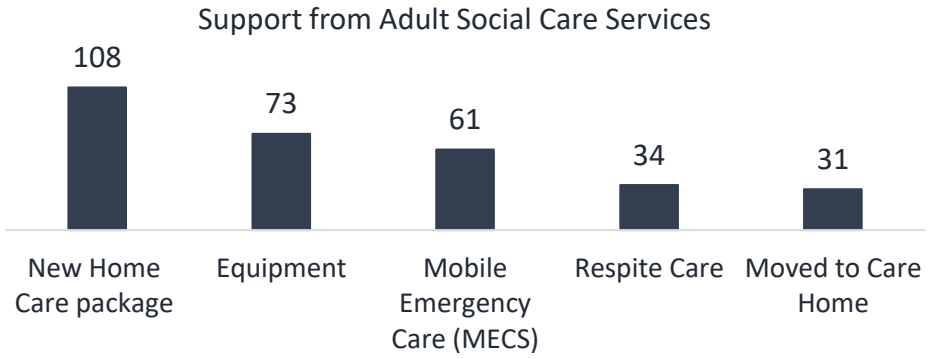
Option 3 – Arranged Support This is the option where you ask your local council to choose and arrange the support that it thinks is right for you. You are not responsible for arranging the support, and you have less direct choice and control over how the support is arranged.

Option 4 (mixture of options 1, 2 and 3) This is where you choose the parts of your support you want to have direct control over, and what you want to leave to your council to sort out for you.

Priority 4 Support those affected by dementia at all stages of their journey

We aim to support people living with dementia to live well within their own communities following their diagnosis as well as reducing the amount of time people with dementia spend unnecessarily in a hospital environment. Good quality post diagnostic support is a priority of the HSCP in order to achieve good outcomes for people diagnosed with dementia, their family, carers and wider support networks.

In 2023/24 there were 192 new referrals to Health and Social Care Partnership adult social work for people with a Dementia diagnosis. Some individuals go on to receive one or more services from adult social work services. There a number of third sector organisations commissioned to support people with dementia and their carers in relation to post-diagnostic support with 456 people being supported at the end of March 2024.



(Adult Social Services)

Data from all services delivering post-diagnostic support is a current area for improvement. Qualitative data would also allow for more of a focus on the outcomes of people accessing these support, which would help highlight any development work which could be beneficial in this area.

Commissioning

The Commissioning Consortium model is grounded in the fundamental principles of ensuring a comprehensive partnership approach across all sectors providing health and social care services; a commitment to provide enhanced delivery of service to individuals and communities and a need to create diversity within the marketplace based on population needs. The Dementia Commissioning Consortium was convened in February 2024, with the aim of coming together to review commissioned services for dementia, and if the right supports were in place.

Engagement

Engagement to date has taken place through the Commissioning Consortium. Membership includes representation from the third sector, service providers, staff within NHS community mental health, and researchers. While members of the public can be invited, work needs to progress to ensure representation from those with lived and living experience in future. Engagement with lived and living experience will be developed for 2024-2025.

Strategic Theme 3 - Achieving care closer to home

Achieving care closer to home shifts the delivery of care and support from institutional, hospital-led services towards services that support people in their community and promote recovery and greater independence where possible. Investing in and working in partnership with people, their carers and communities to deliver services. Improving access to care, the way services and agencies work together, working efficiently, improving the supported person's journey, ensuring people are not delayed in hospital unnecessarily, co-design of services, primary care transformation and care closer to home. It is also about providing people with good information and supporting our workforce.

In 2023/24 there was small increase in the number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population (NI19) to 814 from 804 in 2022/23. This is under the Scottish average of 902 and lower than our comparators average of 870.

Percentage of people with positive experience of the care provided by their GP practice (NI6) has increased from 67.3% to 72.3% in 2023/24 which is above the Scottish average of 71.3% and our comparators average of 68.5%.

The total percentage of adults receiving any care or support who rated it as excellent or good (NI5) has decreased from 67.8% to 64.8%. This is below the Scottish average of 70% and below our comparators average of 70.5%

Reablement

Reablement is an approach within health and social care that helps individuals to learn or re-learn skills necessary to be able to engage in activities that are important to them. It is goal focussed and involves intensive therapeutic work. There is a focus on a person's strengths and abilities and what they can do safely, rather than focus on what they cannot do anymore. Reablement can support people recovering from an illness or accident and may prevent acute hospital admission, delay an admission to long-term care, supports timely discharge from hospital and maximises independent living and can reduce the need for ongoing care.

Reablement	2022/23	2023/24
Number of people receiving reablement support (at 31st March)	222	198
Number of people left reablement in year	363	591
% of people who required reduced or no care after reablement	61%	57%

Planned Care in Place in People's own Homes

At 12th March 2023/24 2,069 people received care and support in their own homes . At the same time 35122 hours of care and support were commissioned from providers.

An average of 66.9 placements start each month and 64.8 end so there has been a slow but steady increase in placements over the last 3 years.

Waiting list for Care and Support

Unfortunately, system pressures can cause delays or waiting lists. We work hard to avoid this, however there are challenges such as high demand and staff shortages, as seen nationally. This is an important area for the Partnership as we know that behind each of these numbers there is a person and family struggling.

In March 2024, 46 people without care already in place were waiting for care and support . This time last year 77 people were waiting.

Palliative and end of life care

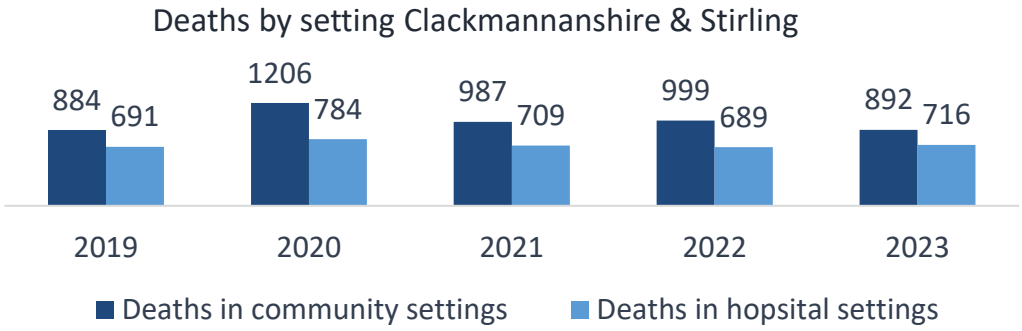
Palliative and end of life care helps improve the quality of life for someone who has a life-limiting illness, by offering services, advice, information, referrals and support. While this can be a challenging time, there are important conversations involved.

Clackmannanshire and Stirling Integration Joint Board, Falkirk Integration Joint Board and NHS Forth Valley have have agreed a joint approach to develop and produce a Strategic Commissioning Plan to commission community palliative and end of life care across Forth Valley. This is a whole system partnership approach to identify need in particular areas of health and care provision, and agreeing how to provide services to meet that need.

A programme of in-person engagement meetings hosted by the Interim Chief Officer and online surveys have been held and will inform the strategic commissioning plan which will be presented to the IJB in 2024-25. One of the key areas of focus is ensuring equality of access to a good death for everyone, including those with issues of substance use.

Engagement meeting hosted by the Interim Chief Officer

Stakeholders involved with the consultation included, people with lived and living experiences, palliative and End of Life care providers and staff, NHS staff working within palliative and end of life care, Locality Planning Group members, Community Councils, Care Homes, Third Sector partners, GP surgeries, Libraries, Service user reps, Health Improvement colleagues. The engagement in Stirling and Clackmannanshire complements the engagement in Falkirk to capture experiences covering the whole of Forth Valley.



Deaths across a range of settings has remained consistent with the majority of people dying in a community setting for the past five years. This is consistent with the national trend. From 2019 to 2023, the percentage of people dying in hospital has ranged from 39% in 2020, to 44.5% in 2023. (NHS FV)

Average number of days spent in hospital in last six months of life			
	Clackmannanshire	Stirling	Scotland
2019/20	22	21	21
2020/21	19	15	18
2021/22	19	19	19
2022/23	20	19	20
Average	20	18.5	19.5

The amount of time spent in the community in the last six months of life has increased slightly in both Clackmannanshire and Stirling residents, reflecting the national trend.

However, people are spending on average 20 days in Clackmannanshire and 18.5 days in Stirling in hospital in the last six months of life, compared to 19.5 in Scotland. (NHS FV)

Priority 5 Good public information across all care and support working

Digital Information

Locality Planning Network - Clackmannanshire

How we access information is quicker and easier, for most people, than ever before. A quick search on the internet and we can order food, supplies, book events and trips, learn something new, and diagnose ourselves.

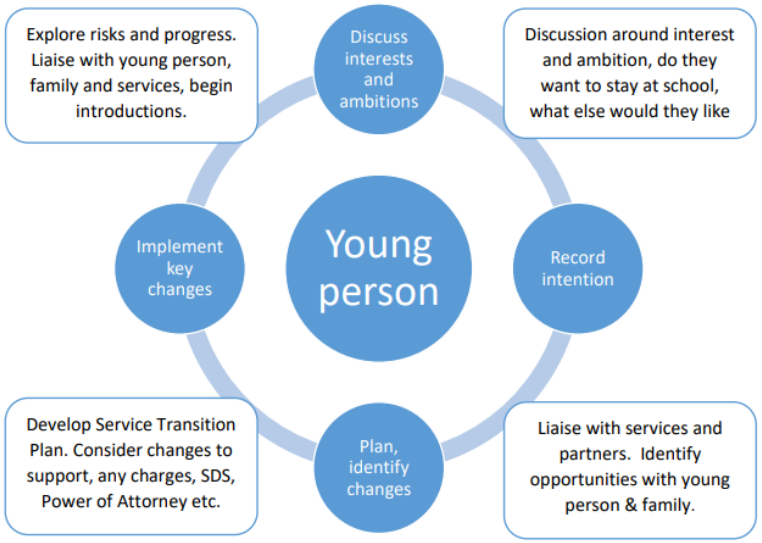
We know that digital information and support helps a lot of people navigate their conditions, disabilities and illness and can also be a place of support though social media groups for example. But how do people find relevant information for Clackmannanshire and Stirling? This year, we have been planning how we can improve the information out there for people in Clackmannanshire and Stirling, with our third sector interfaces and partners. Over the next year, what we have learned will be developed into better digital support and communication with people.

Transitions for young people with disability into adulthood Policy

The Transitions for young people with disability into adulthood policy was agreed in January 2024. Young people with additional support needs hope for the same things as other young people; to be independent, to have a voice and a social life. It is important that the transition from children's services to adulthood is as seamless as possible.

A young person with additional support needs (ASN) may receive support for their needs throughout their time at school. When a young person is due to leave school and children's Social Work Services, it is essential that the transition is well planned and directed around the wishes of the young person. Engagement with young people, their families and staff found that this is an immensely stressful time. As well as planning and multidisciplinary working, access to good information at their fingertips was key to helping young people and families navigate the transition and life change. A need for a website with details of the process, but also around the changing relationship parents have with their child as they become adults is needed, with guidance on guardianship and changes to benefits to options for education, work and socialising as examples of the information asked for. We are working to develop webpages specifically for young people, their families and carers to support this life stage.

Transition Review and Planning



Priority 6 Workforce capacity and recruitment

Workforce data is important to the planning and delivery of services. The Integrated Performance Framework sets out the requirement to develop data in order to plan and monitor service delivery. This is a key focus on the Strategic Workforce Plan Implementation Group over 2024 - 25. To this end, our employing organisations are building on our collation and analysis of workforce data to better understand the future needs of our workforce. Human Resource leads are working to harmonise and share data across Health and Social Care Partnership. For example, we now receive monthly reports from each of the employing bodies with an opportunity to look at how we report in an integrated way. This work is underway and it is hoped that we will be in position to begin reporting harmoised data in the near future.

This year we have:

In the last year we have achieved all the actions set out in Year 2 of Integrated Workforce Plan 2022-25. Workforce planning and development is now a standing agenda item at all leadership and management operational meetings across Health and Social Care Partnership. We have worked to better understand gaps in our recruitment and the challenges of recruitment and retention in health and social care. We have worked closely with HR leads in all three employers to understand trends and analysis linked to recruitment and retention of our health and social care workforce.

All partners have been working collaboratively to review and re-design job roles with staff involved; looking at skills, knowledge and competence to deliver roles confidently and safely, while building on the Fair Work Principles. For example, the senior role within Assessment and Locality teams has been approved and evaluated, this has provided career development for staff.

Our employing organisations are also building on our collation and analysis of workforce data to better understand the future needs of our workforce. Human Resource leads are working to harmonise and share data across Health and Social Care Partnership. For example, we now receive monthly reports from each of the employing bodies with an opportunity to look at how we report in an integrated way.

Recruitment

We have recognised the recruitment challenges in mental health clinical and nursing posts and have been actively seeking to recruit and offer peer to peer conversations to encourage applications.

Training

Key workforce planning leads have been undertaking learning around the Health and Care (Staffing) (Scotland) Act 2019. Managers have attended integrated sessions with Care Inspectorate in relation to Health and Care (Staffing) (Scotland) Act 2019 and have been supported to review staffing requirements as part of vacancy management. We have also worked closely with our third and independent sector providers and Care Inspectorate to support providers readiness for implementation.

As well as learning and development opportunities being shared across Health and Social Care Partnership, e-modules are also now routinely shared across the lead agency learning platforms. Work has also taken place to develop learning platform access that third sector services can make use of as well. All Public Protection learning and training is now trauma informed and trauma responsive in its content and delivery.

Engagement

The HSCP Learning and Development Group, supported by Workforce Leads and employing organisations have been overseeing the delivery of the Integrated Workforce Plan; meeting bi-monthly and reporting back to the Extended Senior Leadership Team of Health and Social Care Partnership.

In relation to addressing the continued challenge of recruiting care staff in our rural areas, we have delivered a campaign of local community career fairs which are helping us engage our communities even further as well as working directly with local community activists.

Work with staff around the implementation and operationalisation of policy and programmes such as Self-Directed Support Policy, Right Care Right Time and Transitions to Adult Health and Social Care Services Policy.

Key actions for 2024 - 2025

Planning for the coming year involves looking at career pathways, talent development and succession planning, with design already under way in relation to new Senior Practitioner roles within our Assessment and Partnership teams which will provide clearer routes of progression and development into more senior roles.

We are establishing baseline data in relation to internal mobility rates to monitor the impact of talent development and succession planning although it is too early to evaluate.

- Recruitment Challenges across professions and geographical areas
- Budget limitations given current financial situation – impacts upon resources available
- Balancing meeting the different needs of individuals/teams/areas to provide person-centred support whilst also trying to attain equity and cost and time effective interventions
- Workload and time-constraints of the staff responsible for delivering upon these objectives.

NI17 - Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections has increased from 80.8% in 2022/23 to 84.6% in 2023/24 which is above the Scottish average of 77% and our comparators average of 78.7%.

NI4 - Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated has decreased from 61.7% to 56%. This is below the Scottish average of 61.4% and below our comparators average of 59.8%

Strategic Theme 4 - Supporting empowered people and communities

Working with communities to support and empower people to continue to live healthy, meaningful, and satisfying lives as active members of their community. Being innovative and creative in how care and support is provided. Support for unpaid carers; helping people live in their local communities, access to local support, dealing with isolation and loneliness. Planning community supports with third sector, independent sector and housing providers. Neighbourhood care, unpaid carers, third sector supports. It is also about providing people with good information and supporting our workforce.

Priority 7 Support for Carers

32.8% of carers feel supported to continue their caring role (NI8). This is above the average for Scotland of 31.2% and above the average of 31.9% in our LGBF family. This is an increase from 25.6% in the 2021/22 survey.

Carers' support continues to be a priority for Clackmannanshire and Stirling HSCP, the Carers' Lead and Short Breaks Co-ordinator are progressing work to widen the scope of support and compliment the support already provided by both Carers Centres.

Following a period of consultation and engagement including in person and an online survey we developed a Carer Support Framework (in line with Carers Act requirement for Eligibility Criteria for carers).

Partnership working has strengthened with the establishment of the Carers Planning Group with lived and living experience and partners supporting good health and wellbeing outcomes for carers by working together. By listening to carers across the area, digital approaches to compliment the support provided by the Carers Centres were explored and resulted in the introduction of Mobilise digital supports for Carers. This provides access to virtual meetings, telephone support and a wide range of advice and guidance to support them in their caring role and improve their health and wellbeing.

We have two Carers centres Stirling Carers Centre and Central Carers (who cover Clackmannanshire and Falkirk). They are funded by the Partnership to support carers in their caring roles and also carry out Adult Carer Assessments. The Carers Centre's also offer information and advice for carers aswell as training workers across the Partnership. They also represent the interests of carers in a number of forums.

Whilst the aspiration is to provide every carer with an Adult Carer Support Plan (ACSP), not every carer wishes to complete a plan.

530 new Adult Carers were registered with both Carer's Centres and offered an ACSP with 496 completing a plan. This is a reduction from 540 in 2022/23. As at 31st March 2024 there were 2686 Adult Carers registered with 2365 one to one appointments carried out throughout the year.

In collaboration with the HSCP, Carers Centres and CAB a Welfare Rights Project for Carers facilitated by Citizens Advice Bureau provides support for carers to provide immediate holistic person centered advice, information and representation to Unpaid carers & support to colleagues working with unpaid carers and where necessary, refer and support clients to access appropriate advice agencies.

496 Adult Carer Support Plans for carers were completed in 2023/24

Key actions for 2024-25

- Providing good information and support to carers around Self-Directed Support with Forth Valley SDS.
- Celebration of Carers event to be held showcasing services supporting carers within the HSCP area.
- Launch and publication of Carers Support Pack, providing current information on community groups and organisations supporting carers and supported people throughout Clackmannanshire and Stirling. In response to requests for a local support pack and developed in collaboration.
- The Short Breaks Bureau will be a hub for information and support to carers for access to short breaks and respite.

Priority 8 Early intervention linking people with third sector and community supports

Community Connectors & Social Prescribing

The main aim of the Community Link Worker Project is to support activities that provide a person-centred and human rights approach utilising social prescribing, an important self-management tool, enabling people to continue to live in their community, independently, safely and well. It widens choice and control through signposting to third sector organisations and statutory agencies. The CLWs promote the understanding of and access to self-directed support. It has been recognised that CLWs are more than social prescribers, providing one-to-one support to enable people to gain confidence to access local activities. The CLW programme was developed through partnership collaboration. CTSI and SVE, the Third Sector Interfaces (TSIs) in each of their respective local authority areas, are the employing organisations and the lead partners in the project, providing the necessary resources, training, and supervision to ensure effective service delivery and professional development for the CLWs.

New Referrals	Reason for referral to CLW	Onward referrals
248 Stirling 142 Clacks 106	Social prescribing 94 Financial problems 60 Social isolation 50 Housing 38 Physical disability 27 Carer support 26 Stress 18	Financial support 74 Mental health support 50 Housing 30 Community groups 29 Self-help 19
Total Encounters	**Duration of encounter/ appointment**	**Onward referrals to other services**
1238 Stirling 727 Clacks 511	0 – 30 minutes 455 30 – 60 minutes 233 60 – 90 minutes 105 90 – 120 minutes 57 120 + minutes 46	CAB Stirling Council on Disability Wellness exercises HSTAR Mental Health Nurse Scottish Autism Reachout with Arts in Mind Stirling Council Inspiring Communities

Priority 9 Develop locally based multiagency working across communities

Localities

The Public Bodies (Joint Working) (Scotland) Act 2014 requires the IJB to identify Localities for the planning and delivery of services at a local level. Working in Localities supports collaborative working across primary and secondary health care, social care and with third and independent sector provision. Communities are empowered to co-design service provision within their local areas within the Locality Planning Networks and their Locality Action Plans. There are three localities with the Health and Social Care Partnership area Clackmannanshire, Rural Stirling and Urban Stirling.

Locality Planning Networks (LPNs)

The three LPNs have set priorities and actions establishing community priorities for each Locality area, these have been aligned with the Strategic Commissioning Plan. The Locality Planning Networks work collaboratively to co-design and co-deliver services, oversee delivery of the priorities and activities within these communities to meet the outcomes of individuals.

Locality Planning Network Priorities

Clackmannanshire	Rural Stirling	Urban Stirling
Issues of alcohol and drug use across Clackmannanshire.	Better understanding of services and increased knowledge linked to access to services across rural Stirling.	Clear shared communication on the clarity of roles across community health and care services.
Supporting and promoting Mental Health and Wellbeing.	Access to care closer to home.	Supporting Mental Health and Wellbeing.
Addressing Health Inequalities.	Scope support available to develop caring and connected communities and supporting recruitment opportunities in health and social care.	Identifying Social Enterprise opportunities based around our communities.
Clear shared communication on roles across community health and care services to be shared across communities.	Supporting people with dementia within our communities supporting capacity and need.	Supporting people with dementia within our communities supporting capacity and need.

Over 2023-24 we have moved to in-person event held in communities and have focussed on themes specific to the area. The events are useful forums for learning more about developments within the HSCP, linking with community organisations and groups and for collaborative problem solving. The Locality Planning Networks are an opportunity to engage with communities and is open to members of the public, people working in our localities, health and social care professionals and people managing services within the area. Each LPN has an independent Chair responsible for engaging with communities and discussion and providing leadership for local planning of informal service provision.

2024 Programme of Locality Planning Networks

Clackmannanshire	Rural Stirling	Urban Stirling
Health Improvement Alloa	Health Improvement Gartmore	Health Improvement Raploch
Caring in Clackmannanshire Alloa	Caring in rural Stirling Balfron	Caring in urban Stirling Bridge of Allan
Accessing Service - Bowmar Centre Alloa	Accessing Services Crianlarich	Accessing Services Cambusbarron
Mental Health Tillicoultry	Caring, Connected Communities Doune	Mental Health Braehead
Alcohol & Drugs Sauchie	Dementia Callander	Dementia Bannockburn

Localities continue to be an integral part of the engagement around developing and delivering the Strategic Commissioning Plan, contributing to the response to system pressures and desired outcomes of communities. They feed directly into the Strategic Planning Group and have clear influence. The priorities identified and agreed by the communities highlight the level of engagement and commitment to the Locality Planning Networks and the communities they represent.

In 2024-25, the Locality Planning Networks are working closely with operational Locality Working Groups, involving GP locality coordinators, community health and social care locality managers, health improvement locality leads and third sector interfaces to shape service delivery within the localities. There has also been a commitment in 2024 - 2025 to allocate a budget for each locality to support local organisations and groups to support building capacity and resilience within our communities.

Priority 10 Ethical Commissioning

Clackmannanshire and Stirling Health and Social Care Partnership has developed a collaborative approach to understand, plan and commission local services and care & support. The Commissioning Consortium is the basis for co-production form of service design with meetings involving supported people and their representatives, current third & independent sector providers, future providers and internal services. The aim is to create, develop, maintain and grow high quality service delivery. In the past year, there has been a focus on carers' support (Strategic theme 4), alcohol & drug partnership funding priorities (Strategic theme 1) , dementia support (Strategic theme 2) and palliative & end of life care support (Strategic theme 3) with a new programme focused on mental health and well-being underway.

This approach relies on a partnership with the third and independent sector, people with lived experience, carers and their representatives as well as Health and Social Care Partnership delivered services. There is a focus on ethical commissioning, of choice & control and the principles of Human Rights-Based, to ensure we are future proofing the commissioning model to comply with current and future policy direction. The approach creates the conditions for open discussions around the right care at the right time whilst ensuring the budgets are managed effectively i.e. services are needs led but resource bound - creating a discussion with partners and supported people focused on best use of available financial spend, rather than cost pressures within the system.

The health and social care marketplace in Clackmannanshire and Stirling represents a mixed economy approach to service delivery, bringing together differing elements of service delivery and agreed shared outcomes for people. Within this landscape, the Health and Social Care Partnership and Third Sector Interfaces provide leadership and support both in service planning and mapping; and in ensuring service quality compliance within an agreed standard of quality assurance of services.

The Commissioning Consortiums have agreed shared principles of partnership working:

- To have an interest in, support, and promote the Consortium approach and its development across the whole system.
- Provide high quality, innovative services in collaboration with others and towards the delivery of the National Health and Social Care Outcomes.
- Have clear health and social care objectives whether delivering universal or specialist services.
- Be involved in delivering health and social care services, or aspiring to be involved in delivering services within Clackmannanshire and Stirling; with existing providers being asked to demonstrate their track record of providing high quality and robust care and support in the area.

For the Health and Social Care Partnership and Third Sector Interface there is a commitment to:

- Encourage all sector representatives to participate in the Consortium.
- Offer access to commissioning opportunities across all sectors and networking opportunities and shared learning with stakeholders across all sectors.
- Collective approaches to service planning, inspection preparation, performance management and demonstrating outcomes for people and communities.
- Support to facilitate the development of skills and capacity of organisations to operate in a complex commissioning and tendering environment.

Therefore the principles of the consortia approach ensure, in equal measure, a commitment to involvement and participation for those in receipt of care and support as well as a commitment to Best Value and resource efficiency across the whole system.

Impact of the Commissioning Consortium approach

A key success factor for the Commissioning Consortium has been the ability to communicate the principles across the sector by targeting the right partners

and stakeholders; explaining the ethical commissioning model approach; what it will mean for providers and people with lived experience; and finally how each can play a part in planning and commissioning the right care and support.

We have recognised that the approach is resource and time intensive to deliver, with officers offering safe spaces for discussions with all external stakeholders and internal providers, with the models of care which have been developed are more robust, person centred and economically viable. As well as more focused on outcomes for people and their carers.

The process of the commissioning consortium meetings has ensured all partners and stakeholders to be at same place when making commissioning recommendations to the Integration Joint Board, the IJB is committed to the approach as it provides detailed and robust feedback from supported people, providers, Health and Social Care Partnership staff and communities about the type and level of service required. There have been more positive and mature relationships created with internal and external commissioned services as well as a clarity of the role of the Third Sector Interfaces as key delivery partners of Consortium.

Feedback from providers has been mostly positive around openness of commissioning conversations and the opportunities to be flexible in their offering; feeling more able to participate meaningfully in planning and commissioning conversations.

Feedback from supported people and their carers has been really positive, individuals feeling that can influence the model of care, create flexibility in system, ensure they have choice & control as well as an ongoing commitment to the delivery of Human Rights-Based Approach across all services.

There has already been interest from Scottish Government colleagues as this approach aligns to current policy directives linked to human rights legislation as well as from IJB Chief Officers Network nationally.

The Commissioning Consortium across Clackmannanshire and Stirling is demonstrating the strength in relationships between Health and Social Care Partnership, third sector and independent sector providers to ensure care and support can continue to be delivered with those receiving care and their carers as key influencers and partners in the planning and commissioning of services.

Financial, Best Value Governance and Risk

Annual Financial Statement

The Integration Joint Board will continue to use the funding available to the partnership to improve services for people and pursue our Strategic Commissioning Plan priorities. Over time our alignment of use of resources (both financial and non-financial) to Strategic Commissioning Plan priorities and key performance indicators will continue to improve and evolve.

Financial Performance

The funding available to support delivery of the Strategic Commissioning Plan comes from Clackmannanshire and Stirling Councils and NHS Forth Valley and funding from Scottish Government.

This forms the Integrated Budget and the Set Aside budget for LargeHospital Services. The IJB then directs partners to deliver and/or commission services on its behalf.

For the financial year ended 31 March 2024 the IJB had an overspend on the Integrated Budget of £2.616m. This was met from the IJBs reserves reducing the financial flexibility to meet unexpected costs in future years.

£272.6m total IJB Strategic Plan Budget 2023/24

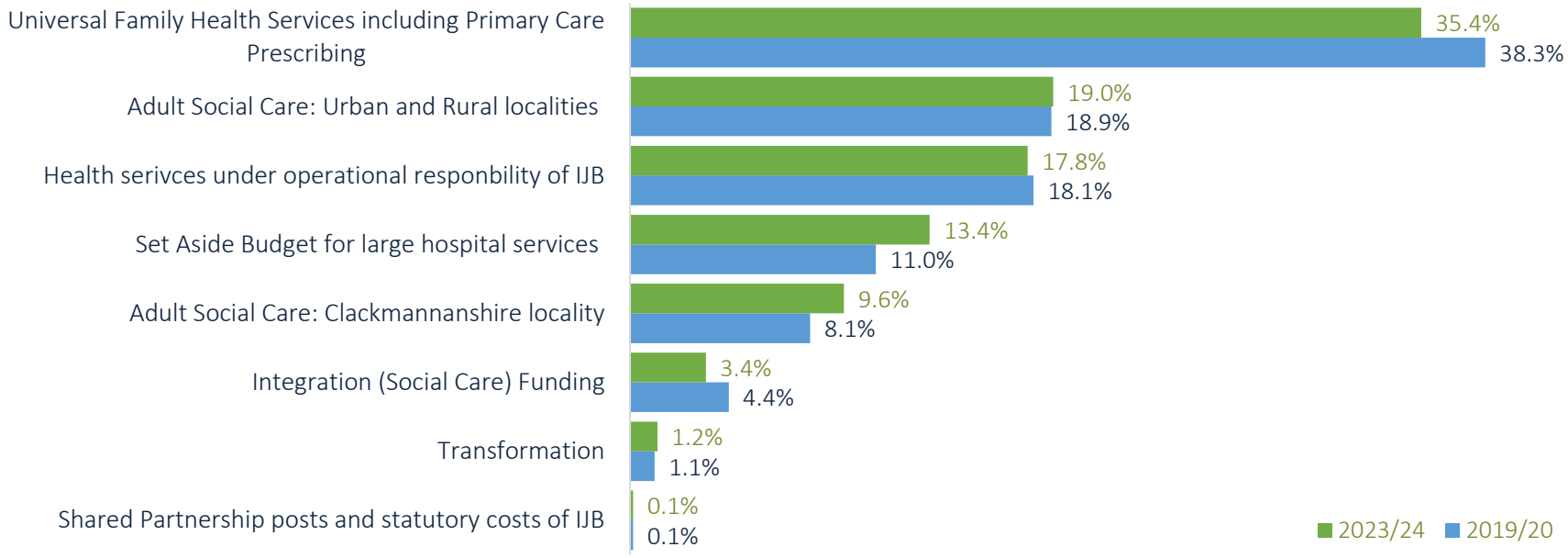
£2.616m overspend met from Reserves

The expenditure of the IJB for 2023/24 and the previous 5 years is summarised in the table and graph below. As the IJBs spend profile changes over a number of years we will continue to illustrate the effect of this graphically to provide evidence of alignment with strategic priorities and outcomes – this will be an evolutionary process over time. These figures are subject to statutory audit, and it may be useful to read the content of the IJBs Annual Accounts alongside this report. The IJBs Annual Accounts are published here: Clackmannanshire and Stirling HSCP – Finance (clacksandstirlinghscp.org)

Clackmannanshire & Stirling Health and Social Care Partnership budget by Service Area

	2019/20	2020/21	2021/22	2022/23	2023/24
Service area	£000	£000	£000	£000	£000
Set Aside Budget for large hospital services	22,007	23,588	24,736	31,513	36,595
Adult Social Care: Clackmannanshire locality	16,129	17,266	21,583	25,092	26,131
Adult Social Care: Urban and Rural localities	37,736	36,804	42,447	48,652	51,678
Health services under operational responsibility of IJB	36,129	37,774	39,774	43,685	48,544
Universal Family Health Services including Primary Care Prescribing	76,594	82,090	83,691	90,720	96,632
Integration (Social Care) Funding	8,838	23,072	13,168	10,148	9,287
Shared Partnership posts and statutory costs of IJB	284	300	317	375	391
Transformation	2,202	2,454	2,521	2,728	3,359
Total expenditure	199,919	223,349	228,237	252,914	272,618

Clackmannanshire & Stirling Health and Social Care Partnership budget by service area as % of total spend



Best Value, Governance & Risk

Clackmannanshire Council, Stirling Council and NHS Forth Valley (the partnership authorities) delegate budgets to the Integration Joint Board (IJB). The IJB decides how to use the budget to achieve the priorities of the Strategic Commissioning Plan and to progress towards the National Health and Wellbeing Outcomes set by the Scottish Government. Put in a more simple way, the Board identify our priorities and plan how we will deliver our services, improve outcomes for people and support people to live independent lives with the care and support they need.
The governance framework are the rules, policies and procedures that ensure the IJB is accountable, transparent and carried out with integrity. The IJB had legal responsibilities and obligations to its stakeholders, staff and residents of Clackmannanshire and Stirling.

The Partnership monitors performance to measure progress in delivering the priorities of the Strategic Plan with financial performance a key element of demonstrating Best Value.

We monitor Best Value through:

- The Performance Management Framework and performance reports
- Development and approval of the Annual Revenue Budget
- Development of and reporting on the Transforming Care Programme
- Regular Financial reports
- Regular reporting on Strategic Improvement Plan
- Topic specific progress reporting e.g. Primary Care Improvement Plan
- Reporting on Strategic Plan Priorities to the IJB and topic specific reports.
- Best Value Statement

The IJB accounts contain an Annual Governance Statement which reports progress on the review and improvement of governance arrangements identifies any weaknesses apparent during the year and sets out a governance action plan for the coming year to continually improve governance arrangements.

The IJB is supported by two committees – Audit and Risk Committee and Finance and Performance Committee which report to the IJB through committee chairs who are voting members of the IJB. The terms of reference of the committees are reviewed periodically.

Appendix 1 - Functions delegated to Clackmannanshire and Stirling IJB

Clackmannanshire and Stirling Health and Social Care Partnership is responsible for planning and commissioning integrated services and overseeing their delivery. These services cover adult social care, adult primary and community health care services and elements of adult hospital care. We have strong relationships with acute health services and wider Community Planning Partnerships, the third sector and independent sector to jointly deliver flexible locality based services. Planning and designing outcome focused care and support in collaboration with communities and people with lived and living experience.

Last year significant progress in our integration was made with the delegation of Primary Care, Mental Health and Health Improvement Services into the Health and Social Care Partnership. Here are the services that fall under the management of the Health and Social Care Partnership.

NHS services delegated to HSCP

- Primary Care (as of April 2023)
- Mental Health (as of April 2023)
- Health Improvement (as of April 2023)
- District Nursing
- Substance use services
- Allied Health Professional services in outpatient clinics/out of hospital
- Public dental services/Primary medical services including out of hours, general dental, Ophthalmic & Pharmaceutical services
- Geriatric medicine and palliative care outwith hospital settings
- Community Mental Health & Learning Disability services
- Continence and kidney dialysis outwith hospital

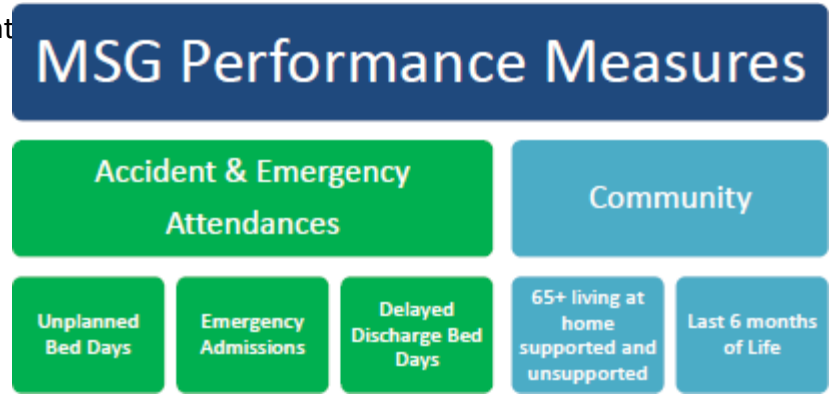
Clackmannanshire and Stirling Council services delegated to HSCP

- Social work services for adults aged 16+
- Services and support for adults with physical disabilities
- Services and support for adults with learning disabilities
- Mental health services
- Drug and alcohol services
- Adult Protection
- Carers support services
- Community Care Assessment Teams
- Support services
- Care home services
- Adult Placement services
- Aspects of housing support and assistance including aids and adaptations
- Day services
- Respite provision
- Occupational therapy, equipment and telecare

Appendix 2 – Ministerial Strategic Group (MSG) Indicators

To support the delivery of the National Priorities Partnerships we completed a self-assessment and improvement action plan as well as agreeing local targets for key areas. Nationally this is monitored by the Ministerial Strategic Group for Health and Community Care (MSG).

The MSG information covers a range of activities under the umbrella of 'unscheduled care'. These activities support people to remain in their own homes, return to their own homes as quickly as possible when hospital treatment is required, prevent related re-admission to hospital and include end of life care. Unscheduled care is a core element of the health and social care system and as such, our services need to be responsive to need whilst being transformative in that contact with patients is shifted from reactive to proactive planned engagement, and from hospital settings to the community where appropriate.



Ref	Indicator	Strategic Theme	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Desired trend or target
MSG1a	Number of emergency admissions (all ages)	For Info only	13,688	16,704	14,247	16,385	16,447	16,674	↓
	% change from previous year			22.0%	-14.7%	15.0%	0.4%	1.4%	
	Number of emergency admissions (aged 18+)	ST1	11,700	14,573	12,638	13,941	14,205	14,582	↓ 5% decrease from 2015/16 to 10,584
	% change from previous year		-0.5%	24.6%	-13.3%	10.3%	1.9%	2.7%	
MSG2a	Number of unscheduled hospital bed days (all ages); acute specialties	For Info only	96,213	103,004	85,703	98,922	109,497	104,253	↓
	% change from previous year		-	7.1%	-16.8%	15.4%	10.7%	-4.8%	
	Number of unscheduled hospital bed days (aged 18+); acute specialties	ST1	93,050	100,090	83,743	96,412	106,732	101,143	↓ 5% decrease from 2015/16 to 88,804
	% change from previous year		3.3%	7.6%	-16.3%	15.1%	10.7%	-5.2%	
MSG2c	Number of unscheduled hospital bed days (all ages); mental health specialties	For Info only	27,582	24,177	23,648	22,286	22,198	*17,463**	↓
	% change from previous year		-	-12.3%	-2.2%	-5.8%	-0.4%	-21.3%	
	Number of unscheduled hospital bed days (aged 18+); mental health specialties	ST1	26,750	23,637	23,059	22,055	21,950	*17,001**	↓ 18% decrease from 2015/16 to 20,378
	% change from previous year		**3.7%**	**-11.6%**	**-2.4%**	**-4.4%**	**-0.5%**	**-23.4%**	

Ref	Indicator	Strategic Theme	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Desired trend or target
MSG3a	A&E attendances (all ages) - patients from all areas	For Info only	38,557	40,552	28,388	36,805	36,430	32,769	↓
	% change from previous year		-	5.2%	-30.0%	29.6%	-1.0%	-10.0%	
	A&E attendances (aged 18+) - Patients from all areas	ST1	30,284	32,040	23,092	28,512	28,398	26,053	↓ Maintain 2015/16 baseline of 26,585
	% change from previous year		7.1%	5.8%	-27.9%	23.5%	-0.4%	-8.3%	
MSG4a	Delayed discharge bed days (aged 18+) - All Reasons	ST1	11,016	12,630	9,355	13,518	14,786	*15,624*	↓ Maintain 2015/16 baseline of 10,069
	% change from previous year		36.8%	14.7%	-25.9%	44.5%	9.4%	5.7%	
MSG4b	Delayed discharge bed days (aged 18+) - Code 9	For Info only	2,942	2,540	3,482	2,608	5,446	*6,963*	↓
	% change from previous year			-13.7%	37.1%	-25.1%	108.8%	27.9%	
MSG5a	Percentage of last 6 months of life spent in community (all ages)	ST3	87.8%	88.2%	91.0%	89.6%	89.3%	89.2%	↑ 4.1% increase from 2015/16 baseline to 90%
	% change from previous year		0.9%	0.4%	2.8%	-1.4%	-0.3%	-0.1%	
MSG6	Balance of care: Proportion of 65+ population living in Community or institutional settings - Home (supported)	For Info only	5.2%	4.9%	4.9%	4.4%	4.7%	Not available	↑
	Scotland		4.7%	4.5%	4.5%	4.2%	4.3%		
	Balance of care: Proportion of 65+ population living in Community or institutional settings - Home (unsupported)	For Info only	91.7%	92.0%	92.5%	92.9%	92.1%	Not available	↑
	Scotland		91.3%	91.6%	91.9%	92.3%	92.0%		
	Balance of care: Proportion of 65+ population living in Community or institutional settings - Home (Supported and unsupported)	ST3	96.9%	96.9%	97.4%	97.3%	96.8%	Not available	↑ 0.1% increase from 2015/16 baseline to 96.6

MSG1, 2a, 3a, 3b, 4a, 4b, 4c 4d Updated to Mar 24 on 28-6-24 from v1.67 (SMR01a)
*MSG2c 2023 Calendar year used as a proxy for 23/24
MSG5a Death records, NRS; SMR01 & SMR04, Public Health Scotland from v1.67
MSG6 SMR01, SMR04, Care Home Census, Source Social Care data - Public Health Scotland; Social Care Census, SG; Population estimates, NRS From v1.67
Completeness issues: SMR01 records submitted by NHS Forth valley are 99% for 2023/24. Data SMR4 is 75% which means that some figures are likely to change. Where there are completeness issues this has been noted and the figure is highlighted in red italics.
MSG report advises this data should not be published for peer partnership/Scotland comparison.

Appendix 3 - National Core Indicators

The national core indicators are a requirement of the Annual Performance Report. Sourced from the latest release of the Core Suite of Integration Indicators published on 2nd July 2024.

Desired Trend ↑ increase ↓decrease						
Performance		Improving performance		Static		Declining performance
Benchmarking		Better than average		Within 5%		Worse than average

	Ref	Indicator	Strategic Theme	2015/16	2017/18	2019/20	2021/22	2023/24	Desired trend	Scottish average	Comparator Average
Outcome Indicators	NI1	Percentage of adults able to look after their health very well or quite well.	ST2	94.60%	93.60%	93.60%	91.70%	90.80%	↑	90.70%	91.80%
	NI2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible.	ST2	81.70%	81.90%	76.10%	72.50%	67.20%	↑	72.40%	71.90%
	NI3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided.	ST2	76.40%	73.50%	74.40%	64.30%	57.90%	↑	59.60%	63.70%
	NI4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated.	ST3	72.90%	76.50%	68.80%	61.70%	56%	↑	61.40%	59.80%
	NI5	Total % of adults receiving any care or support who rated it as excellent or good.	ST3	77.60%	77.60%	75.20%	67.80%	64.80%	↑	70%	70.50%
	NI6	Percentage of people with positive experience of the care provided by their GP practice.	ST3	86.70%	86.60%	78.80%	67.30%	72.30%	↑	68.50%	71.30%
	NI7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life.	ST3	77.10%	79.40%	79.10%	79.20%	66.10%	↑	69.80%	69.50%
	NI8	Total combined % carers who feel supported to continue in their caring role.	ST4	32.40%	38.30%	29.70%	25.60%	32.80%	↑	31.20%	31.90%
	NI9	Percentage of adults supported at home who agreed they felt safe.	ST3	81.60%	86.00%	83.50%	75.30%	66.80%	↑	72.70%	71.40%

The 'Outcome' indicators above are reported every 2 years from the Scottish Health and Care Experience Survey commissioned by the Scottish Government (latest 2023/24). Please also note that 2021/22 results for some indicators are only comparable to 2019/20 and not to results in earlier years. This data is also available on the Public Health Scotland Website, you can access this here: publichealthscotland.scot

	Ref	Indicator	Strategic Theme	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Desired trend	Scottish average	Comparator Average
Data Indicators	NI11	Premature mortality rate per 100,000 persons by Calendar Year	ST1	379	371	429	459	440	407	Not available	↓	442	394
	NI12	Emergency admission rate (per 100,000 population)	ST1	10,323	10,451	13,206	11,772	12,827	13,036	13,127	↓	11,707	12,327
	NI13	Rate of emergency bed day per 100,000 population for adults (18+).	ST1	113,000	113,435	109,221	96,473	106,781	115,181	110,293	↓	112,883	114,651
	NI14	Emergency readmissions to hospital for adults (18+) within 28 days of discharge (rate per 1,000 discharges)	ST1	104	105	130	153	130	126	122	↓	104	113
	NI15	Proportion of last 6 months of life spent at home or in a community setting	ST3	87.0%	87.8%	88.2%	91.0%	89.6%	89.3%	89.2%	↑	89.1%	89.4%
	NI16	Falls rate per 1,000 population aged 65+	ST1	19.7	20.8	23.5	20.2	23.6	23.8	23.6	↓	22.7	23.0
	NI17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	ST3	96.2%	93.4%	91.0%	91.1%	87.0%	80.8%	84.6%	↑	77.0%	78.7%
	NI18	Percentage of adults with intensive care needs receiving care at home	ST2	66.7%	66.7%	69.8%	69.2%	71.2%	69.3%	70.4%	↑	64.8%	64.5%
	NI19	Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population	ST3	503	579	665	448	743	804	814	↓	902	870
	NI20	% of health and care resource spent on hospital stays where the patient was admitted in an emergency.	NA	22.7%	23.7%	23.0%							

Data for indicators 12, 13, 14, 15, 16 and 18 are reported for the calendar year 2023 as a proxy for 2023/24 as data for the full financial year is incomplete at this time. Data for indicator 11 to calendar year 2023 is not currently available. Data is derived from various organisational/system datasets.

Appendix 4 - Inspection of Services

Registered services owned by the Partnership are inspected annually by the Care Inspectorate. There were four registered service inspections during 2023/24. Additional information and full details on inspections can be found at the Care Inspectorate website. Since 1 April 2018, the new Health and Social Care Standards have been used across Scotland. In response to these new standards, the Care Inspectorate introduced a new framework for inspections of care homes for older people. Where we have areas for improvement we are required to publish our action plans.

Inspection Summary

Registered Service	Date Inspection Completed	How well do we support people's wellbeing?	How good is our leadership?	How good isour staff team?	How good is our setting?	How well is our care and support planned?	Recommend ations	Requirements	Areas for improvement
Menstrie House	25/05/2023	Good	Very good	Very good	Good	Good	0	0	0
Bellfield Centre Care Home Service	05/10/2023	Very good	Good	Very good	Very good	Good	0	0	1
Stirling Council Reablement and Tec Services Housing Support Service	02/11/2023	N/A	N/A	N/A	N/A	N/A	0	0	0
Clackmannanshire Reablement and Technology Enabled Care Service Housing Support Service	11/01/2024	Very good	Good	N/A	N/A	N/A	0	0	0
Care Inspectorate									