Clackmannanshire & Stirling
Health & Social Care
Partnership

Annual Performance Report 2022-2023

Message from the Chair, Allan Rennie

Welcome to our seventh Annual Performance Report, which reflects the progress and delivery responsibilities of Clackmannanshire and Stirling Health and Social Care partnership over another challenging year.

Pandemic recovery continues including challenges with workforce recruitment, including social care and key professions in mental health. We have also faced the biggest cost of living crisis and financial sustainability risks in a generation which continues into 2023-24. However, the vision remains - to enable people in Clackmannanshire and Stirling to lead full and positive lives within supportive communities.

Our key focus remains on prevention and public protection and the delivery of sustainable services. We strive to support people to remain independent and safe in their own homes, so they can keep their connections with friends and family and maintain optimal quality of life and have maximum choice and control.

The report illustrates that, despite the challenges, we made a difference to thousands of people's lives in 2022-2023 and that is a result of the resilience and dedication of health and social care staff, Third Sector colleagues and a range of partners. I would also acknowledge the debt we all owe to the army of unpaid carers in Clackmannanshire and Stirling who look after loved ones every day.

Going forward, we will face difficult choices as public finances are under pressure and people's needs are becoming more complex. That is why it is important that we keep listening and engaging with the communities we serve to ensure that we prioritise what is important to you within our available resources.

Message from the Chief Officer, Annemargaret Black

I want to express my sincere thanks to HSCP staff alongside colleagues in our Third and Independent sectors who have worked tirelessly to ensure the safe and effective provision of community health and social care and support across our communities. I also want to acknowledge the pressures you have been under while trying to recover from the Pandemic and I am keen to have ongoing engagement with you about the way we can sustain our services for the future while supporting your wellbeing.

This report reflects some of the significant work and efforts of all people who worked alongside the communities of Clackmannanshire & Stirling throughout the last year. We have seen improvements in progressing key pieces of transformational work which will continue into 2023-24 and we will be providing opportunities to engage with you on this going forward.

This seventh Annual Performance Report evidences that there is much to be proud of, however, it also shows that the HSCP continues 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.

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

Allan Rennie
Chair Clackmannanshire & Stirling

Annemargaret Black
Chief Officer

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Section 1: Introduction and background

The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Boards to publish an Annual Performance Report, to review what we have achieved against the priorities set out in the Strategic Commissioning Plan.

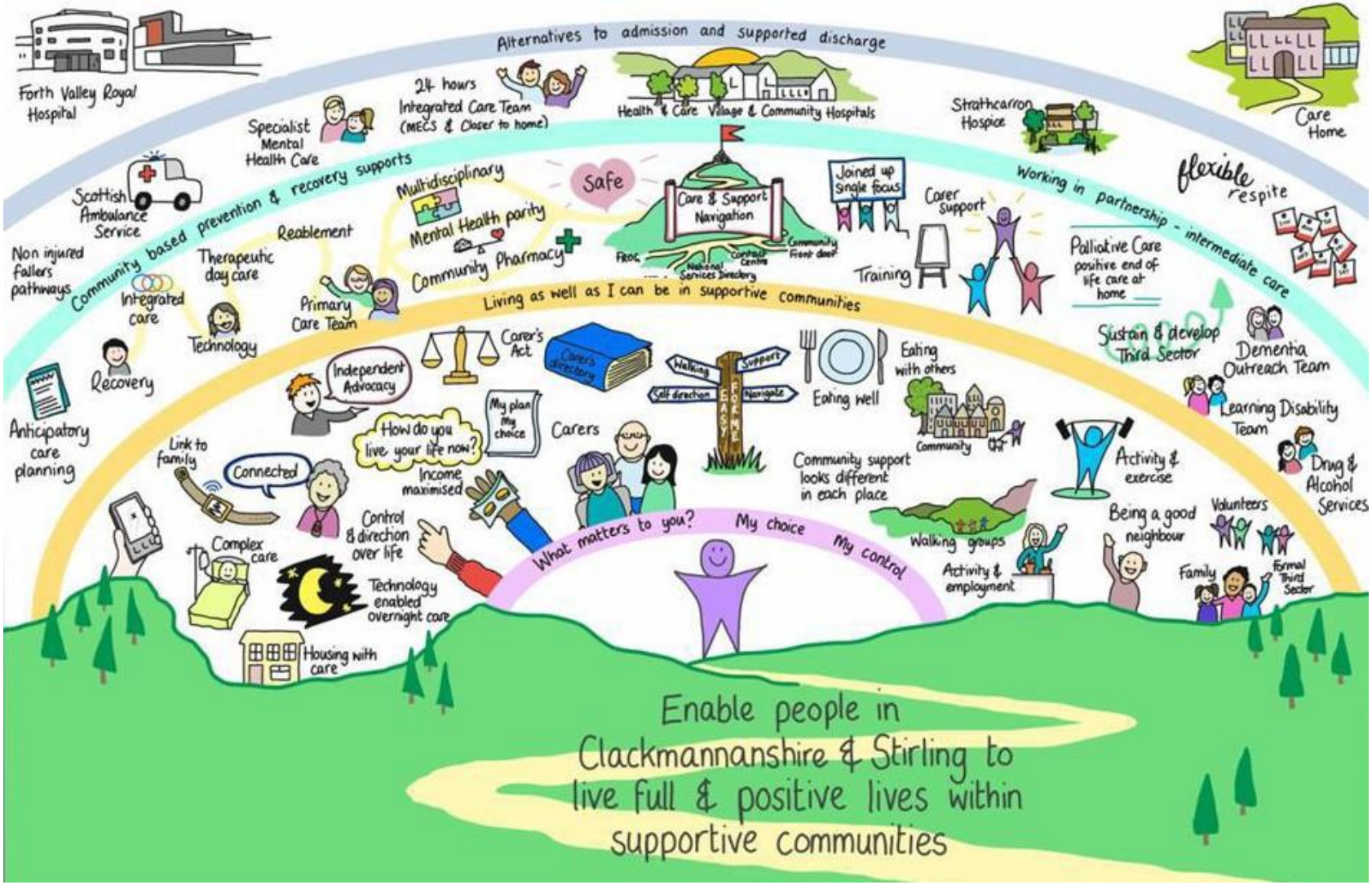
The purpose of the Strategic Commissioning Plan is to set out the vision and future of health and social care services in Clackmannanshire and Stirling; how this links with the priorities set out by engagement with communities; create clear priorities for the area; and link to the national Health and Wellbeing Outcomes set by the Scottish Government.

This is the seventh Annual Performance Report for Clackmannanshire & Stirling Integration Joint Board (IJB) where we reflect on the last year 2022/2023 and look at the progress made in delivering the priorities set out in the Strategic Commissioning Plan 2019-2022. This document is a review of service delivery across the HSCP 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 light of the impact of COVID-19 and the challenging financial position over the past year.

Vision	Priorities	Enabling Activities				Strategies and Initiatives to deliver change
...to enable people in the Clackmannanshire and Stirling Health & Social Care Partnership area to live full and positive lives within supportive communities	Care Closer to Home	Technology Enabled Care	Workforce Planning and Development	Housing / Adaptations	Infrastructure	Intermediate Care Strategy
	Primary Care Transformation					Primary Care Improvement Plan
	Caring, Connected Communities					Carers (Scotland) Act 2016 Community Empowerment (Scotland) Act 2015 Free Personal Care for under 65's 'A Connected Scotland: our strategy for tackling isolation and loneliness and building stronger social connections' Public Health Priorities for Scotland
	Mental Health					Mental Health Strategy
	Supporting people living with Dementia					Dementia Strategy
	Alcohol and drugs					Forth Valley ADP Strategy

Section 1: Partnership Vision

To consider the meaning of this vision, a collaborative exercise was carried out with members of our Strategic Planning Group and wider citizens. The output was then recorded by a graphic artist. The diagram below illustrates what the vision means for delivery of care and support for communities across Clackmannanshire and Stirling. This Rich Picture was used in the development of the Strategic Plan, guiding discussions, setting priorities and agreeing next steps with our communities.



Section 1: Strategic Commissioning Plan and Priorities

The Strategic Plan 2019-2022 was extended until 31st March 2023 due to the COVID- 19 pandemic. As such, this Annual Performance Report focusses on reporting againstthe extended Strategic Plan and agreed priorities. However, throughout 2022, work was underway to develop the new Strategic Commissioning Plan 2023-2033.

This report looks at our progress towards the priorities of 2019-2022 shown in the figure to the right.

In this report, we will look at what we have achieved over the past year.

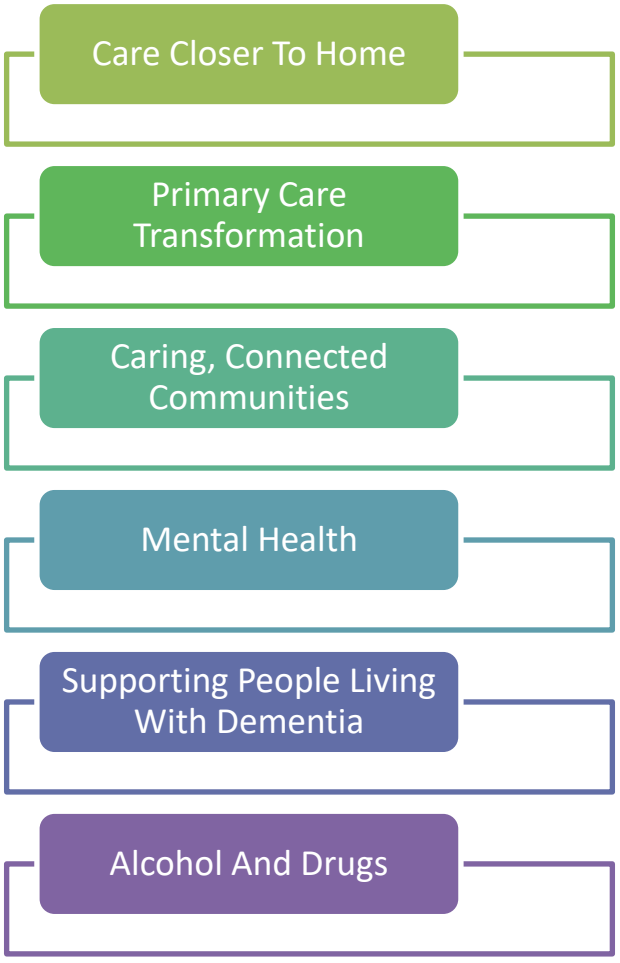
Setting our Priorities

The Public Bodies (Joint Working) (Scotland) Act 2014 requires full consultation andengagement with stakeholders in the development of Strategic Plans. Stakeholdersinclude the public, service users, supported people, unpaid carers, staff, providers, third sector and independent sector.

This creates the opportunity for continuous engagement and conversation around community health and social care across Clackmannanshire and Stirling, focused on co-production, co-design and co-delivery of community health and social care in thearea.

Have your say, get involved. To be part of this continuous process, you can findout more here: Get involved

The Strategic Plan Priorities

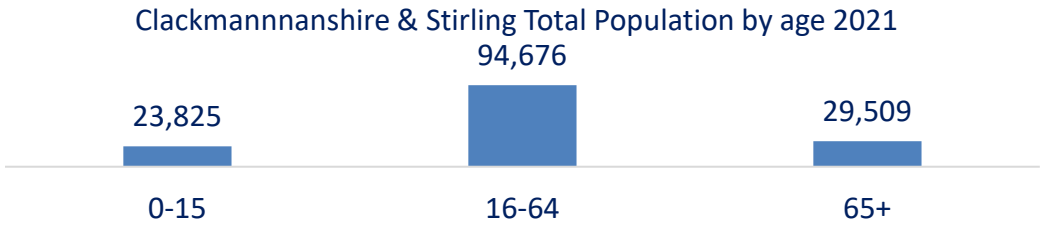


Section 1: Overview of Clackmannanshire & Stirling

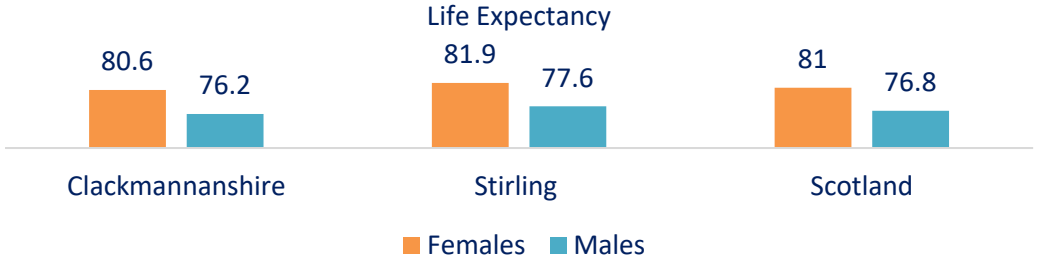
Our Population

145,010 people live in Clackmannanshire & Stirling

51,540 Clackmannanshire
93,740 Stirling



Currently, 20.4%, over a fifth of the population is aged 65+. This is expected to increase significantly by 2038.



Female life expectancy is higher than male life expectancy.

Stirling has higher life expectancy for both females and males compared to Scotland.

Clackmannanshire has lower life expectancy for both females and males compared to Scotland.

Health and Social Care Needs

- 73% of people living in Clackmannanshire and 72% of people living in Stirling consider their health to be good or very good.
- In Clackmannanshire 32% of people are living with a limiting long term illness or condition. In Stirling, 40% of people are living with a limiting long term illness or condition. This compares to 34% in Scotland.
- In 2019, 668 adults with learning disabilities (272 in Clackmannanshire and 396 in Stirling) were known to the local authorities.
- In 2019, 144 adults on the Autistic Spectrum were known to councils (60 in Clackmannanshire & 84 in Stirling).
- There are approximately 21,250 unpaid carers in Clackmannanshire and Stirling area. 12,958 people identify as unpaid carers and it is estimated that there are 8,000 unknown unpaid carers.
- In Clackmannanshire 20.93% and in Stirling 16.75% of the population were prescribed medication for anxiety, depression and psychosis. This compares to 19.29% in Scotland.
- The Scottish Health Survey found that 20% in Clackmannanshire and 17% of people in Stirling are current smokers, compared to 16% in Scotland.
- In Clackmannanshire & Stirling, 25,884 people (17.8% of the population) live in 20% most deprived areas of Scotland (SIMD 2020).

Section 1: How we measure our performance

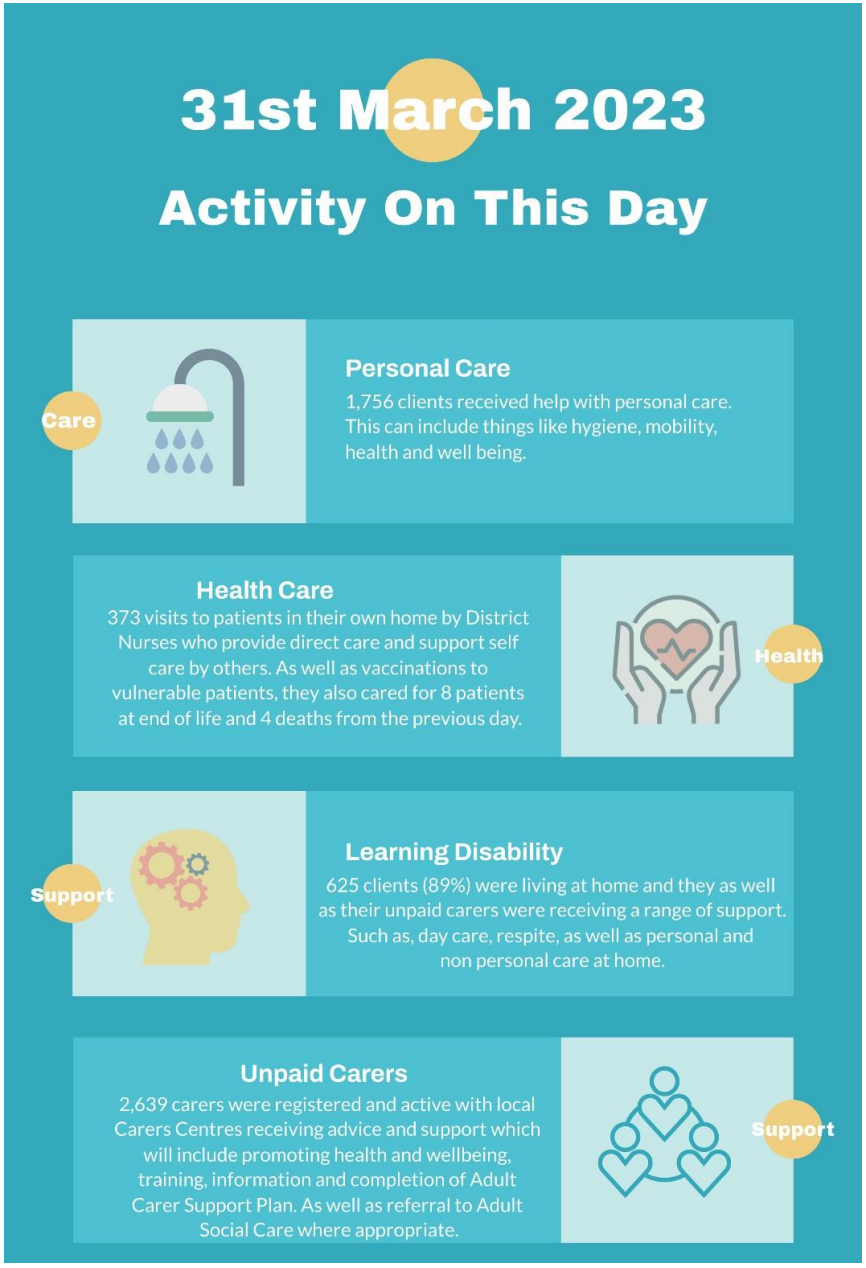
To compile this report, data and local intelligence has been accessed from a range of published national and local data sources.

The Annual Performance Report sets out how well local people's outcomes have been met; laying out and measuring the impact of the changing model of care, and support being delivered for the people of Clackmannanshire and Stirling.

The Strategic Priorities form the focus of this Annual Performance Report, drawing attention to day-to-day performance as well as to areas of good practice and areas where there has been improvement.

To provide a wider context, Appendix 1 lays out how the current Strategic Plan 2019-2022 priorities link with the National Health and Wellbeing Outcomes and the National Health and Care Standards.

In Appendix 2 we also map our progress against these outcomes using the national core indicators.



Section 1: Challenges

The delivery of care and support across all sectors including HSCP, independent and third sectors is influenced by many factors as well as challenges within the current operating environment. The task is to work together to resolve this and continue to provide high quality care and support.

Some of the challenges and opportunities through 2022-2023:

- Continued recovery, re-mobilisation and learning from COVID-19
- Continued budget pressures;
- Continued staffing challenges due to national shortages within particular staff groups and professions;
- The impact of the cost of living crisis for supported people and their carers, and staff;
- Flexibility of the delivery of care and support;
- Service modernisation and transforming care;
- Predicted demographic changes and burden of disease;
- Resilience of communities and workforce;
- Place based activity, environmental impacts and early intervention and prevention;
- Engagement, participation and empowerment of communities;
- Supporting and delivering change with partners and stakeholders;
- Tackling the impact of COVID-19 on health inequalities and well-being

We continually review our environment and how it may impact on the services we deliver and the people within our communities and plan to reduce the impact where possible.

COVID-19 Pandemic

In March 2020, the COVID-19 pandemic started to significantly impact our communities and services. Very quickly, we had to change the way we delivered our services. People who receive care and support at home, who live in care homes, those in hospital and those with complex needs were most vulnerable to COVID-19.

Those vulnerable had to 'shield', with reduced or no contact to people from outwith their household. We ensured that prescriptions were delivered safely to their homes. We worked with partners and community organisations to ensure food and household supplies were delivered.

We had to use face masks, test regularly and if we had any symptoms, we couldn't go to work, even if we felt ok, such was the risk to the people we care for. This meant there were high levels of absence and this placed even more pressure on the staff.

There were reduced hospital appointments and if someone needed treatment, they had to go alone and there were no visitors for people who had to stay in hospital. We utilised all available resources to deliver the vaccination programme.

We are still feeling the impact of COVID-19 to this day, and realise this is likely to continue well into the future. Our workforce showed immense resilience throughout the pandemic, we recognise the strain and pressure of the pandemic and the increase in demand over the past year while services resumed on our staff and resources.

We learned a lot, and despite the pandemic, we continued to develop our service provision through investment and transformation.

Section 1: Winter Planning

During winter there is an increase in demand for health and social care services with the associated colds and flus, vomiting bugs and respiratory (breathing) conditions affecting patients and staff. This places a significant strain on health and social care services. Hospitals get fuller and more people want to see their GP, this can mean people wait longer for care. Planning for the winter is important to reduce the impact of this anticipated increase in demand.

On 27 July and 7 October 2022 the HSCP senior managers and clinical leaders devised proposals for the HSCP to implement to support the health and social care services during winter.

There are some of the actions detailed in the Winter Plan.

Support for Carers

We recognise and rely on Carers and the important work Carers do. We know we need to support carers in order to prevent crisis through breakdown. A Carers' Investment Plan has been developed and agreed by the Carers Planning Group. We also have a new Carers Lead and a Short Breaks Co-ordinator. Recovery funding has been approved by Senior Leadership Team to be given to the Carers Centres to support them in their recovery.

Interim Care home placements

We have an agreement with Care Home providers who support us with short terms stays. This is for people ready to leave acute hospital, but in need of some level of health or social care before they go home or homely setting. This is used if there is no space in a Community Hospital or where the package of care is being set up.

This has supported the discharge profile and supported more people to be discharged from hospital, while also helping Care Home providers utilise their vacant beds.

Care at home

The Commissioning Team continue to secure an average of 75 new packages of care each month across the partnership. This includes hospital discharges, Intermediate Care Discharges, Re-ablement discharges and supporting those at greatest need in the community to prevent them from becoming discharges. We have implemented meetings with our external providers to develop geographical patch-based working, which provides some efficiency gains and releases capacity back into the system.

Development of Rural Care at home Team and RAPID response team

The HSCP has had significant challenges commissioning care at home in the rural areas of Stirling. The IJB commissioned investment to develop an in-house rural team to work beside our existing independent providers.

Throughout 2022/23 we have delivered a huge recruitment campaign with videos, posters, social media, job fairs and events. People in the rural communities were encouraged to apply. The teams includes managers, care coordinators, resource planners, care support workers, Occupational Therapists and Physiotherapists.

Hospital at home

The Hospital to Home team support frail, elderly patients, and those with complex health problems in the community. District Nursing and care support workers provide the care that someone would receive in hospital with oversight by doctors.

We have increased the number of hospital at home beds from 25 to 50. This helps prevent admissions to acute hospital, which reduces the burden on acute hospital and is also better for the people receiving hospital at home, as they are likely to do better at home than in a hospital setting.

Section 1: Opportunities and Transformation

Throughout 2022/23 we have pushed through an ambitious programme of transformation. The Transforming Care Board has a developing agenda and range of work. From May 2022 to May 2023 a total of nine projects were completed. These are listed below;

- We established the HSCP Commissioning Consortium.
- We transformed Carer Support through the Carers Investment Plan.
- We developed and recruited the new RAPID Response Service team.
- We created and recruited a new Rural Care at Home team.
- Health Improvement Service was delegated to the HSCP from NHS Forth Valley.
- We commissioned a service for all wheelchair services.
- Locality Planning Networks were developed and are now flourishing.
- We redesigned our Hospital Discharge process, significantly reducing delayed discharges and length of stay on acute hospital wards.
- We developed and published our Strategic Commissioning Plan and Integrated Workforce Plan.

Further to this we have developed a better and more transparent relationship with providers. Particular success has been achieved by working closely with Care Home providers and the HSCP CHART Team and this has led to general improvement to Care Home grades across Clackmannanshire and Stirling.

Despite the national recruitment shortage and crisis within Health and Social Care services, we have improved recruitment, this is a focus within the Integrated Workforce Plan and is demonstrated in the success to recruiting to both Rural and RAPID teams. We have also improved Trade Union engagement by developing open lines of communication with management.

We have carried out more staff engagement sessions, asking about how we can help and support them and showing how we value their work and continued effort. Staff feel more engaged and informed as aresult.

We have also improved services for people, we are reducing our waiting lists for people after assessment and for those awaiting care. We have also seen a significant reduction in the number of complaints we have received in the past and are seeing more compliments. This is a huge boost to staff morale.

Section 2: Care closer to home

Closer to home means our services support people to live full and independent lives in their home or homely setting, by enabling people to live how they want to live confidently. Where someone needs more support, we help recovery and reablement, and reduce or avoid hospital stays where appropriate. This includes finding alternatives to admission to hospital and discharging people from hospital efficiently when they are ready to leave.

Jordan's Story with ReACH Team

Jordan had a brain haemorrhage and stroke on his 24th birthday, only five weeks after the birth of his girl. At first, he couldn't sit in a chair or dress himself. The hospital team helped him get to a point where he was ready to go home, but there were some things he still needed help with.

The ReACH Team helped him to recover further at home and achieve the things that were important to him. Fiona assessed him to see what he could do in his home environment. Together they devised a plan, including going to the gym twice a week.

Jordan really wanted to be able to hold his little girl, to be a dad and care for her. He wanted to pick her up and get strength in his arms. He also used a stick to walk, and really wanted to take her a walk in her pram, and Fiona and the ReACH team helped him achieve this.

"Most people think the NHS is like all the doctors and the surgeons saving lives, not at all, the people in ReACH Team saved my life. They didn't keep the heart pumping, but they kept me alive. Kept me living, not just surviving. I can be a dad now".

"My destiny is in my hands, it wasn't, but people helped put it back in my hands"
"I didn't know what the future's gonna hold, but now I do".

"I reached my goals with the ReACH Team, they've given me my life back"

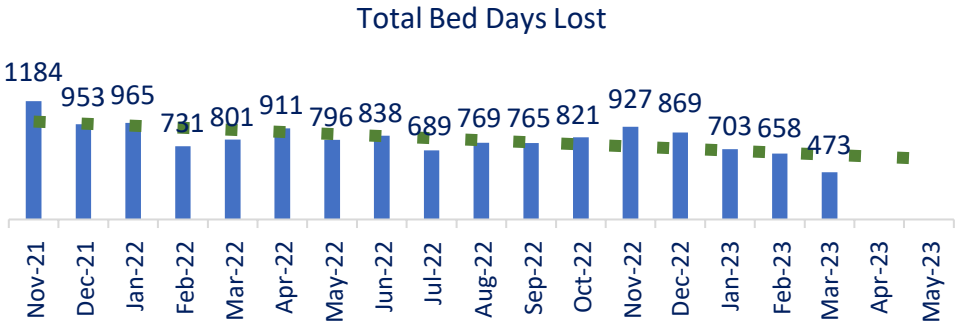
Watch Jordan tell his story by clicking HERE

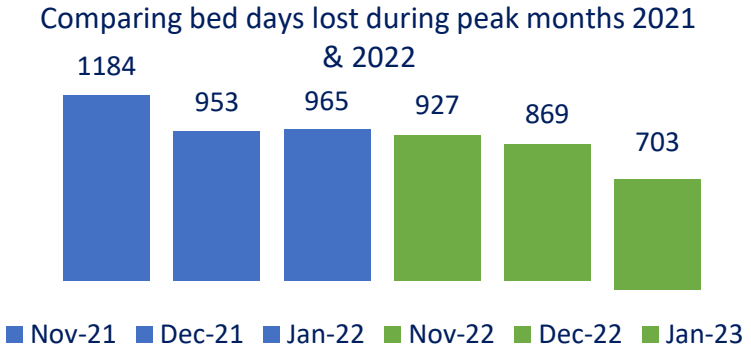
Section 2: Care closer to home

Reducing Delayed Discharges by changing Hospital Discharge

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, and have 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 HSCP reviewed the process of supporting people home or to a homely setting, as part of the national Discharge without Delay programme. This review started to identify ways we could increase the 'flow' of people using a collaborative approach bringing all the different teams and resources to plan the discharge of people. This work started in November 2021, however, throughout 2022/23 we have been working to further improve the way we work to reduce delayed discharges even further.





'Daily Flow' meetings were established, where staff from a range of teams come together to look at the people who are due for discharge and they work together to ensure the services are in place for that person when they are ready. Better use of Intermediate Care (a step down from Acute Hospital), with focus on reablement, including Occupational Therapy and Physiotherapy, helps people make that step back home where needed.

The impact of the Hospital Discharge Redesign is further demonstrated in the reduction of bed days lost during the winter of 2022/23 compared to 2021/22. A total of 603 less bed days were lost in the winter of 2022/23 compared to the previous winter 2021/22. In March 2023, the lowest level of bed days lost was reached and this is predicted to continue to reduce.

Section 2: Care closer to home

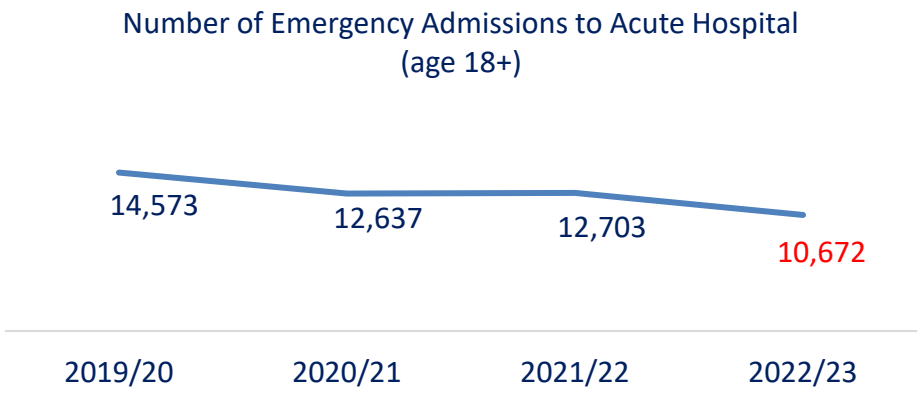
Hospital Admissions

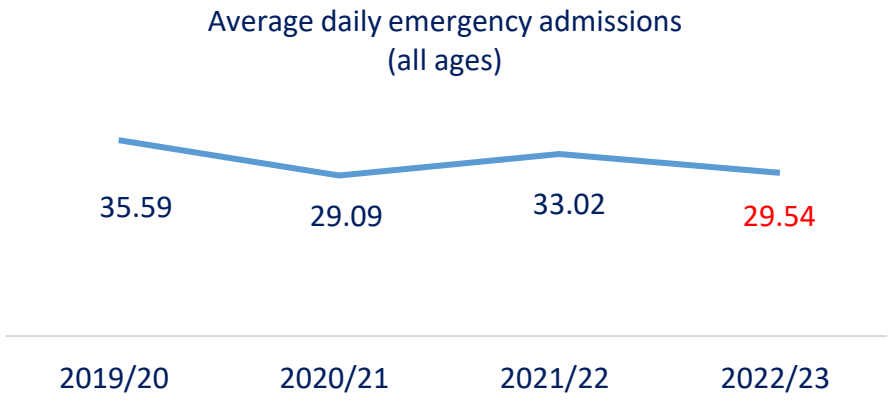
We aim to avoid hospital admissions to Acute Hospital services where we can, this allows theAcute Hospital to deal with people who need specialist health care and treatment.

The average daily emergency admissions has also decreased this year. This figure allows us tosee approximately how many emergencies colleagues in acute hospital are dealing with, and helps us plan the person's pathway when they have been treated.

The number of emergency hospital admissions have reduced since 2019/20 from 14,573 perfinancial year to 10,672 in 2022/23.

In 2022/23, Clackmannanshire and Stirling had a rate of 12,935 emergency admissions to hospital, this is higher than the Scottish rate of 11,120 per 100,000 population. So while we are working to reduce emergency admissions, we have more to do.





Note: Figures in red are provisional as Public Health Scotland will report the full year in July 2023

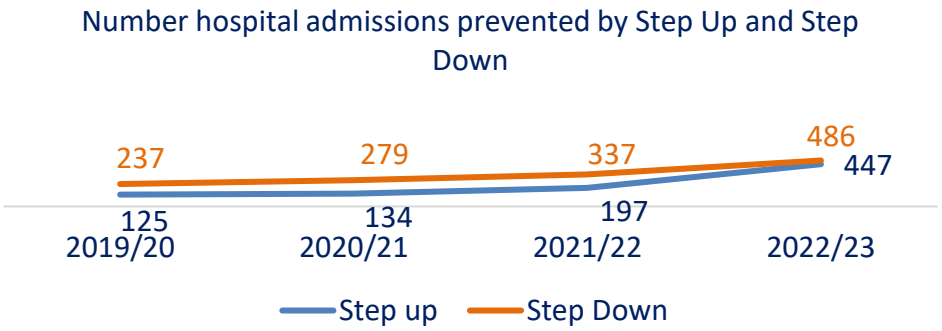
Section 2: Care closer to home

Preventing Hospital Admissions

We have two ways we can prevent hospital admissions:

Step up is where we provide people with care when they are stillliving at home. This helps to stabilise people, give care needed and maintain their confidence and independence.

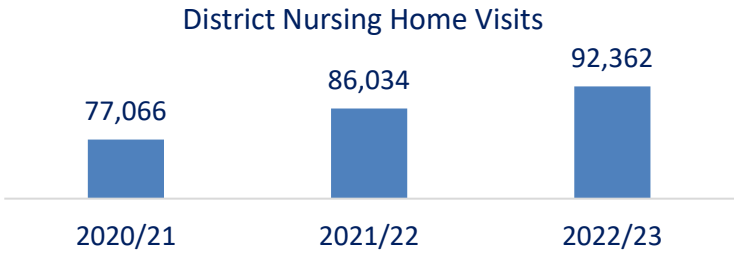
Step Down helps people who have recently been in hospital. They are moved out of the Acute hospital setting into a more homely setting, for example the Bellfield Centre, where there is more focus on rehabilitation, and getting them ready to go home.Strength, movement, confidence and independence building is key here.

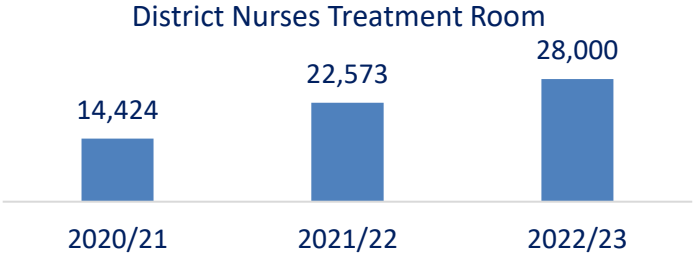


Long hospital stays can lead to reduced mental wellbeing and physical weakness and reduced confidence, particularly in older or frail people. It is important that people get the treatment they need, using Step Up and Step Down options helps improve the outcomes for people. The chart above shows that from 2019/20 to 2021/22 we have gradually increased the number of hospital admissions avoided through Step up and Step Down options. In 2022/23 we really worked hard and increased this is a faster rate.

District Nursing

District nurses provide support to people and their families in the patient's own home. District nurses support people who need some level of health care to stay at home. The charts below show that over the past three years, we have increased the number of home visits from our district nurses by over 15,000. Patients have presented for double the number of visits to treatment rooms within the community. Supporting an early intervention and community treatment model of care. Therefore helping people to stay out of hospital and in their own homes or a homely setting.





Section 2: Care closer to home

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.

There are a large range and variety of reablement activities; such as washing, dressing, preparing drinks and snacks, as well as mobility exercises linked to moving around the home or outdoors, resulting in building confidence to function independently and socialise.

	2021/22	2022/23
Number of people receiving reablement support (31st March)	165	224
Number of people left reablement	104	136
% of people who required no care after reablement	34%	29%
% of people who required reduced care after reablement	26%	24%

The number of people receiving reablement support has increased by 35% from 2021/22 to 2022/23.

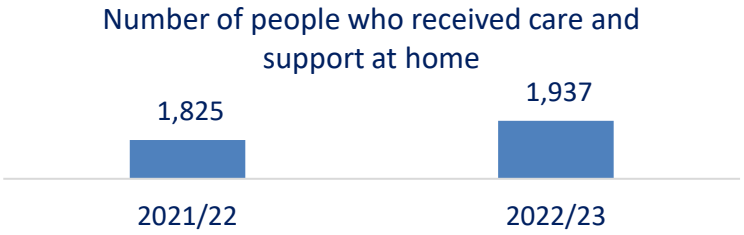
The table above shows that 53% of people leaving Reablement services in 2022/23 either required no support care or reduced care.

Section 2: Care closer to home

Planning Care and Support/Packages of Care

Care and support plans are for anyone who needs care or cares for someone else. Following an assessment where you outline what is important to you a care and support plan details the type of support you need, how much support is needed and how this will be provided (Self-Directed Support options). The aim of the plan is to help you stay as independent as possible, have as much control over your life as possible and help you to do the thingsyou enjoy.

Planned Care in Place in People's own Homes across the Partnership



During 2022/23 the number of people who received care and support in their own homes increased by 6% from 2021/22.

At the same time the number of hours of care and support commissioned from providers increased by 7% from 2021/22.

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 June 2022, 168 people without care already in place were waiting for 1,414 hours of care and support per week. To tackle this, we recruited staff to increase the size of the internal provision in Stirling. This allowed more people to be discharged from hospital and to be assessed at home.

The waiting list was at its lowest on 7 March 2023 when 80 people were waiting for 551.25 hours of care and support per week. Since then, the waiting list continues to improve (as of June 2023).

142 people on average without care in place waiting for a package of care and support across the Partnership. The waiting list was almost all older adults.

In 2022/23 the waiting list for care and support fell around November 2022 from 160 people to 80 people in March 2023.

In 2021/22 the NHS opened two new care homes and recruited many people.

Section 3: Primary Care Transformation

Primary Care can be the first point of contact for many people in the health and social care system. It includes GPs, community pharmacy, community nurses, dentists and opticians. Transforming Primary Care in Clackmannanshire and Stirling is an ambitious programme. It is focussed with transforming how primary care is delivered, bringing the different disciplines and teams together to ensure the right service is available at the right time for people and to reduce wider systems' pressures on services.

How GP services are changing.

Often a patient needs to see a GP to access health and social care, however, this is changing, over the past few years, there have been changes to the way patients can access services.

More and more people with complex needs are managing their conditions with support in their own homes and away from hospital. The role of GP surgeries is changing to meet this new change in community health and social care. This continuing transformation of primary care helps us provide a better service for people.

Multi-disciplinary teams include health professionals into GP practice teams to help get the right care at the right time. This expanded team includes physiotherapists, mental health nurses, advanced nurse practitioners, primary care pharmacy and community pharmacy. This means that reception services can direct and signpost people to the most appropriate service. These services can organise blood tests, x-rays and make referrals to secondary care (hospital services).

There continues to be work required to ensure multi-disciplinary teams are embedded across communities and integrated teams of social work, social care and community health practitioners are delivering within locality areas for the people of Clackmannanshire and Stirling.

Kathleen tell us more about the changes to GP Practices HERE

Section 3: Caring, Connected Communities

Caring is natural to humans and connects us to each other. Anyone can become a carer at any time in their lives. Supporting carers in their roles is key to the health and social care partnership and we recognise the role they play in supporting people with health and social care needs. Support within our communities is important to people's sense of wellbeing and belonging. People want to stay in their communities and we know that loneliness and isolation can have a detrimental impact on people's health and wellbeing. We work with the Third Sector to develop and provide community supports.

Kate's Story

Kate is 29, she enjoys drama and swimming and has Cerebral Palsy. In the last year, she had three carers who help her with things like getting out of bed, getting showered and dressed. They help her with food and getting out and about.

Prior to the pandemic, Kate had four carers and personal assistants (PAs) who supported her to be independent. Kate can't get all the care she needs, and agencies are struggling to recruit care staff.

Kate tells us what is important to her, she shares 'what makes a good day', and lists the things she misses most. If Kate had a PA she could get her life back and Jacqueline could be her Mum, she misses her Mum just being a Mum.

With a personal assistant, Kate would have some things in common with someone her own age, have someone to talk to and do the things she enjoys doing like going to the cinema and shopping. She would love to find a carer that wants to go nightclubbing with her.

Kate lives with her mum. She doesn't want her mum helping her to go to the toilet and feeding her. She wants her mum to be her mum and not her carer.

"I want to keep my mum as my mum, I don't want to see her as my carer as well"

Watch Kate tell her story HERE

Section 3: Caring, Connected Communities

Rapid Team

Over the past year, we have created the new Rapid Team, transforming how we support people to avoid being admitted into hospital and in making the move from hospital to a homely setting quicker and more efficient.

The Rapid Team brings together the existing Reablement Team and Crisis Care Team into one multi-disciplinary team. The Rapid Team also includes the Hospital to Home team who support earlier discharges from hospital while people wait for their packageof care support to be implemented.

We know that hospital admissions can be stressful and we know you are much better to be in your own home. Reablement services help people regain or retain their skills and confidence so they can learn to manage again after a period of illness.

Referrals come into the Rapid Team who can quickly identify the best pathway for that individual, for example, if someone needs care support at home, physiotherapy or adaptations made to their home. Our assessments are carried out with the person in their own home or homely setting, where they are more relaxed and familiar, so the assessment is more accurate.

We have recruited approximately 50 people to the team, ranging from care support workers, occupational therapists and physiotherapists. The staff all work close together to support and facilitate both discharges from hospital and preventing admissions to hospital.

It allows us to work more flexibly to meet the needs of people as we can adapt to the different multiple needs of people (we are working together) multi-disciplinary teams.

The team is dynamic and love what they are doing, they embrace every day and cansee the difference they are make on day to day life for both the individuals and their families.

"This team is making a real differenceto people's lives".

Locality Manager Judy tells us about the new RapidTeam HERE

Section 4: Caring, Connected Communities

Adult Social Care

Adult social care covers a wide range of activities to help people are older or living with disability or physical or mental illness live independently and stay safe and well. Adult social care covers all forms of personal and practical support for adults who need extra support to stay healthy, play a part in their community and lead as fulfilling a life as possible. It is delivered by the voluntary sector (charities/not for profit), independent providers, through social care and health services and people arranging their own support through Personal Assistants. It includes many types of support and help, from care homes, day services, outreach and crisis support, to an individual's own home.

Clients receiving help with personal care	1,756
Clients receiving help with non-personal care	1,345
Clients with a community alarm	3,013
Clients receiving equipment	4,255

Unpaid Carer's

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 as well as training workers across the Partnership. They also represent the interests of carers in a number of forums.

Clackmannanshire and Stirling Health and Social Care Partnership are committed to supporting Carers who have been significantly impacted by the pandemic. There have been challenges with delivering short breaks and respite as a result of the pandemic. In 2022 we recruited a new Carer's Lead who has started to review the current Carer's Strategy and reviewing the Carers Support Framework in the coming year.

Carer Support Plans helps you think about the support you might need as a carer, now and in the future. It helps determine who can best provide the support you need, whenever you need it, so you don't reach crisis point. In 2022/23, 540 plans were completed by the Carers Centre and Adult Social Care completed 216.

657 Adult Support Plans for carers were completed in 2022/23

Click on the logo for more information from the Carers' Centre

Section 4: Caring, Connected Communities

Morgan's experience with Self-Directed Support

Morgan is a young man with a love of cars and socialising. He has a car with lights and a sound system that he just loves.

Morgan has chosen to receive his budget through SDS Option 1 and employs personal assistants (PA's) to provide the care and support he needs. Morgan and his family recruit the PAs themselves and have built up a team that know Morgan well. The support that is in place is both lifesaving and life maintaining.

Morgan is able to live the life he wants, be responsible for himself, and have control and independence.

Before he used SDS Option 1, his care was provided a company with care support workers. Due to shifts, Morgan had to arrange his life around appointments and visits. Sometimes he would be out with his friends and had to be home for 11.00pm, which wasn't cool, he was 25.

He wanted his independence. With SDS he was able to directly recruit personal assistants. They have built good relationships, they know each other and now Morgan can do what he enjoys.

Together the HSCP SDS Lead Officer and Forth Valley SDS helped Morgan and his family identify what was important to him and what was available. Through the support of his PA's, Morgan has been to weddings, car shows, raves, go out for dinner and enjoy the occasional beer.

The PA's are trained to a very high standard, receiving between 8 and 12 weeks training and are then signed off by a nurse. They deal with Morgan's breathing machine, clean and dress him, look after him when he is ill and manage his medication (there are 45 medications in a week). He's built a relationship with them and he is much happier.

For support, advice and a free downloadable information pack : https://sdsforthvalley.org

"Being able to be responsible for myself and be myself, and aye, I'm chuffed and happy to be able to live my own life and dae as I please, when I please basically."

Hear Morgan tell his story Here

Section 4: Caring, Connected Communities

How we are improving Self-Directed Support

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. The four options as follows:

- Option 1: Direct Payment is made to the individual, who can use it any way they choose as long as it secures the outcomes agreed between the person and their allocated worker as set out in their support plan.
- Option 2: Directing the available support – when an individual chooses their support and provider but the local authority or local organisation maintains the control of the budget. In order to make an informed choice, individuals should be made aware of all the resources that are available to achieve their support plan.
- Option 3: Services arranged for the person by the local authority – budget and support is managed by the local authority with the individual.
- Option 4: A mix of the three above.

Self Directed Support
ILA Forth Valley

Contact SDS Forth Valley for support, training and advice byclicking on the logo.

Over 2022/23 we have delivered the SDS Project Plan with support from the SDS Steering Group. This plan reviewed and refreshed our approach to SDS across Clackmannanshire and Stirling.

We have increased engagement with the development of regular Staff Forums and we have delivered comprehensive training on SDS with HSCP staff with SDS Forth Valley. We also have a dedicated supported persons' forum.

We are in the process of developing an asset based assessment tool and case example have been developed and consulted upon.

169
HSCP staff received SDS refresher training in 2022/23 to improve awareness and knowledge

Section 5: Mental Health

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.

Lyndsey's experience with Mental Health Nurse Service

Lyndsey lives with Bipolar Disorder, she tells us why accessing the support of the mental health nurse (Stacey) at her local GP practice made such a difference.

The person-centred approach allowed early intervention and prevented deterioration in Lyndsey's mental health.

Lyndsey was able to build a relationship with her Mental Health Nurse, Amy, who was able to push her when she needed pushing and to support when she needed supporting. From working with Amy, Lyndsay was able to understand the way she felt, build support networks with family and friends and knew how to manage her mental health.

During the pandemic, Lyndsey had three bereavements in the family, but due to lockdown, the tools Lyndsey previously relied on weren't available. She couldn't go to a family member and take time with them, she wasn't able to be with her support network. She knew she needed help, so she contacted the Mental Health Nurse.

"I knew what I needed, I just didn't know how to access it".

Lyndsey wanted to keep working as this gave her routine and focus which helps her. Lyndsey had an appointment with Stacy who helped her go through some significant changes in her life and offered an impartial perspective, knew her illness and gave her the support she needed in time. Stacy stayed with Lyndsey all the way through, until she was settled.

"I was able to speak to someone and tell them exactly how I felt. They understood my life"

Watch Lyndsey tell her story HERE

Section 5: Mental Health

Primary Care Mental Health Team

The Primary Care Mental Health Nursing Service is based in 52 GP practices across Clackmannanshire and Stirling. With 29 Mental Health Nurses offering short-term interventions for people with stress, anxiety, low mood and suicidal thinking. When a patient phones their GP practice, they can ask for an appointment with a Mental Health Nurse and reception can book you an appointment. Reception may ask you a few questions, to make sure they are directing the caller to the right person.

At the appointment with the Mental Health Nurse, there is an assessment and then a treatment plan is developed and agreed. This may include some education around symptoms and how they are affecting the person. From there, the person and the Mental Health Nurse can look at self-help with support. The Mental Health Nurse can also refer to other mental health services, including secondary care and crisis services.

There is also signposting information within HSCP and third sector services to help identify the right resource; help with goal-setting and providing tools and strategies to help you manage health and wellbeing. Pharmacy practitioners can help with a review of medications and arrange prescriptions for people as required. This service reduces pressure on GPs and helps people access the right care at the right time.

"Our aim is to match the person with the best step for them, we do this in consultation with you"

Learn more about the Mental Health Nurse service by clicking HERE

In 2022/23 there were 334 admissions to hospital for Mental Health Acute Support

In 2022/23 there were 183 mental health referrals to Adult Social Care

8.4% of long term Care Home clients have mental health problems.

Section 6: Supporting People living with dementia

We aim to support people living with dementia to live well within their own communities following diagnosis as well as reducing the amount of time people with dementia spend 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 support

Town Break

Town Break is a local charity that supports people living with dementia and their carers. They have trained, supportive and committed staff and volunteers, and work with other organisations to help support people with dementia.

There are currently 17 services running and they are located within the communities. In a typical year, Town Break support 250 people and their families affected by a form of dementia.

Town Break run social clubs where people meet to have fun, talk to others and get the help that focusses on what they need. Town Break provide warm and friendly expert advice through support groups to provide post diagnostic support. They offer structured support, for example music, art, walking and physical activity. All these things are important to keep the person connected to their community.

The groups give people a chance to meet new people and get peer support and people enjoy the social aspect, especially the home baking.

Learn more about Town Break HERE

"It's very important to get support early for somebody with a diagnosis of dementia and the family, because it affects everyone"

Town Break
Dementia Support Services

Section 6: Supporting People living with dementia

Living with dementia can be challenging and stressful for the person and their family. We provide support to help along with organisations like Town Break and the Carer's Centre within the community.

Adult Social Care can help with providing carers to help with washing and dressing, meals, equipment and adaptations to you home, signpost to local groups and specialist providers.

The main thing to remember is you are not alone, and help and advice is available.

In 2022/23 322 people with dementia were referred to Adult Social Care for support. People with dementia make up 46%, almost half, of referrals to Adult Social Care.

Below, we look at the different ways we support people with Dementia at home.

Home Care

46% of new referrals in 2022/23 for home care, have dementia.

Equipment

10% of people newly referred for equipment like hand rails have dementia.

MECS

13% of people referred in 2022/23 for Mobile Emergency Care Service to help monitor and people remotely have dementia.

Respite Care

14% of people newly referred in 2022/23 for respite care have dementia.

Care Homes

36% of people in Care Homes have dementia.

Section 7: Alcohol & Drugs

We aim to improve outcomes by supporting people with complex social and health issues around alcohol and drug use, with their support network.

Catriona & Scottish Families Affected by Alcohol & Drugs

Catriona had no experience of addiction when she met her husband eight years ago, when he was in recovery. He had always been open about his recovery, the 12 step programme and the support network of friends and contacts. However, when the pandemic hit and they were in lockdown, he relapsed. This was new to Catriona, and through lockdown they were unable to use the normal supports. His relapse was short, but the impact was big. She didn't know how to support him so she started to reach out for groups and organisations that could help her.

Catriona wanted to be a positive influence in his recovery and she found Scottish Families Affected by Alcohol & Drugs. Jillian was able to help Catriona understand what her husband was going through and what she could do to help. They both found it reassuring that Catriona had support to help her, while he focused on his recovery. This also gave Catriona advice and there was always someone to speak to, who understands and without judgement.

"It's such a great asset and we're really fortunate to have it"

Watch Catriona speak about Scottish Families Affected by Alcohol & Drugs HERE

Medication Assisted Treatment (MAT) Standards Implementation

This year, we implemented the MAT Standards. The aim of MAT Standards is to reduce drug related harms and risk of death. This is done by enabling safe, accessible and high-quality treatment and support nationally. The standards aim to directly impact the current drug related death crisis being experienced in Scotland.

The first year of MAT Implementation work has been completed. This has gathered a large amount of data which was submitted to Public Health Scotland. The first year of MAT Implementation has demonstrated the enormous efforts by staff and partners across the substance use cares system to work together to improve services. This data show this work is valued by people who use services, and has highlighted areas for future development.

Planning for Year two of MAT Implementation has already begun, and we await further guidance from Scottish Government and Public Health Scotland on reporting requirements. In many instances people receive a MAT Standard level of care already, or would do with adaptations to the delivery of clinical services. This awareness is informing both the MAT Implementation planning and Commissioning Consortium process.

For more information click here www.gov.scot/publications/mat-standards-scotland-access-choice-support/

Section 8: Adult Support & Protection

Adult Support & Protection (ASP) offers support and protection to adults who may be at risk of harm. It aims to balance people's rights and take action, where necessary, to support and protect adults at risk of harm (this includes adults in community, residential and hospital settings)

The Act, defines 'adults at risk' as individuals, aged 16 years or over, who:

- are unable to safeguard themselves, their property, rights or other interests;
- are at risk of **harm**; and
- because they are affected by disability, mental disorder, illness or physical or mental infirmity, **are more vulnerable to being harmed than others who are not so affected.**

When a concern is reported (called a referral or AP1), we will undertake initial inquiries to agree what action is required. This information helps make the best decision with the involvement of the adult concerned. It may lead to immediate action or a more planned response.

Clackmannanshire and Stirling Adult Support and Protection Committee provides oversight and scrutiny of local policies and procedures and ensures that residents in Clackmannanshire and Stirling are safe.

2,203
Adult Support & Protection referrals were received between 1 April 2022 and 31 March 2023

144
Investigations commenced under the Adult Support & Protection Act

25.7%
Investigations were due to physical harm
14.6 %
Investigations were due to financial harm

75.3%
of people supported at home said they felt safe (National Outcome Indicator)

Section 9 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 HSCP area **Clackmannanshire, Rural Stirling and Urban Stirling**.

Population

	Clackmannanshire	Rural Stirling	Urban Stirling
Population	51,540	25,534	67,936
Aged 65+	10,718	5,979	12,812

There are three Locality Planning Action Plans establishing community priorities for each Locality area, these have been aligned with the Strategic Commissioning Plan.

Each of the Locality areas are distinct in their characteristics, geography and history, they therefore have identified different priorities and activities. 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.

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.

Section 9 Localities

Engaging our localities

We have three Locality Planning Networks for each area, Clackmannanshire, Rural Stirling and Urban Stirling. These were launched in 2021, and throughout 2022/23 they became better established. We have a statutory requirement to have Locality Planning Networks.

In 2022/23 the Locality Planning Networks are a chance to improve local networks and relationships between local services, community supports and the third sector.

The Locality Planning Networks provide a 'grass roots' approach for professionals, communities and individuals to inform service design and improvement for their local area.

The groups meet bi-monthly and over 2022/23 worked to produce Locality Plans to be implemented over the next three years.

The plans were created using data from the Scottish Burden of Disease and the Strategic Needs Assessment as well as community engagement within each of the communities. Engagement included online sessions in the evenings, drop in sessions within the communities and local groups, and online surveys. HSCP Officers also met with groups such as the recovery communities, refugees, Forth Valley Sensory Centre, Clackmannanshire Older Adults Forum and Balfron Lunch Club, as well as community councils.

The Locality Planning Networks have been really good at helping reconnect people with their communities, and to link organisations together following the pandemic. The engagement has helped to understand the value of the community support and groups within each of the local areas.

Working closely with third sector colleagues at Stirling Voluntary Enterprise and Stirling Council's Community Learning and Development Team has been integral to achieving this.

More information on Localities and how to participate can be found here https://clacksandstirlinghscp.org/

Section 10: Finance, 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. Our aim is to improve how our use of resources (both financial and non-financial) is aligned to the Strategic Commissioning Plan priorities and development of key performance indicators.

Financial Performance

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

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

For the financial year ended 31 March 2023 the IJB achieved a net underspend on the Integrated Budget of £1.076m. We are then allowed to transfer this into the IJB reserves. This is like savings to help mitigate any future financial risks.

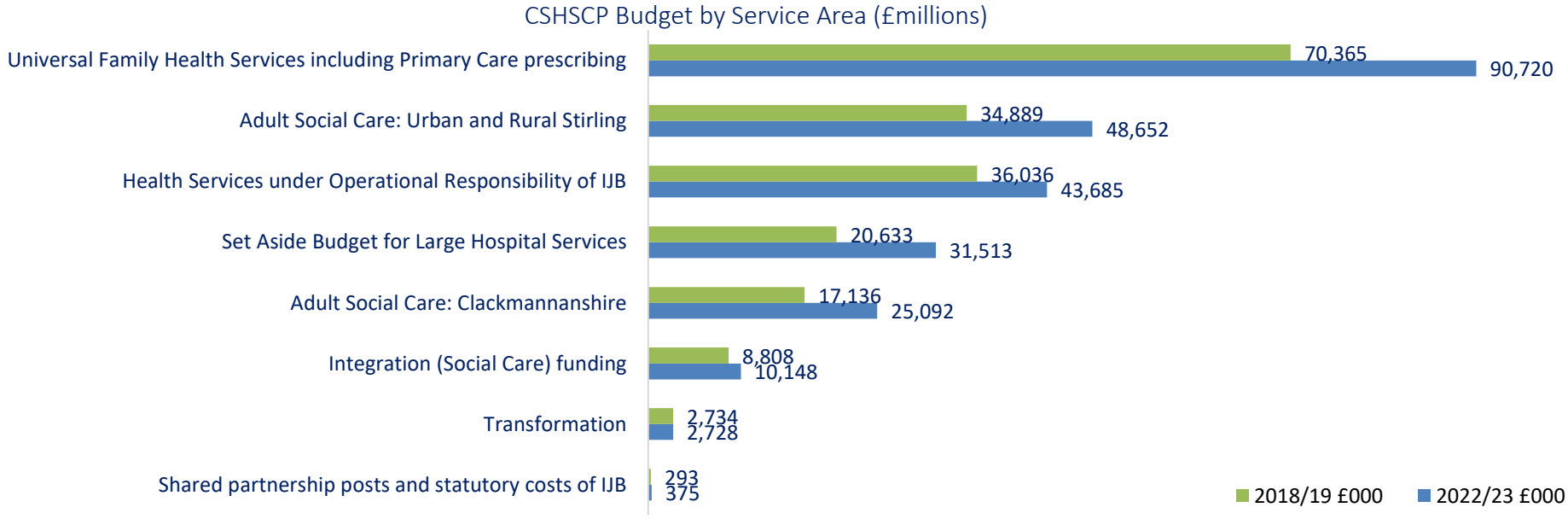
£251m total
IJB Budget 2022/23

£1.076m underspend
transferred into Reserves

The expenditure of the IJB for 2022/23 and the previous five years is summarised in the table and graph below. As the IJBs spend profile changes over a number of years we will attempt to illustrate the effect of this graphically to show how the spend is aligned with strategic priorities and outcomes. This will be an evolutionary process over time. These figures are subject to statutory audit and it might 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

CSHSP Budget by Service Area 2018/19 to 2022/23	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000
Set Aside Budget for Large Hospital Services	20,633	22,007	23,588	24,736	31,513
Adult Social Care: Clackmannanshire Locality	17,136	16,129	17,266	21,583	25,092
Adult Social Care: Urban and Rural Stirling Localities	34,889	37,736	36,804	42,447	48,652
Health Services under Operational Responsibility of IJB	36,036	36,129	37,774	39,774	43,685
Universal Family Health Services including Primary Care Prescribing	70,365	76,594	82,090	83,691	90,720
Integration (Social Care) Funding	8,808	8,838	23,072	13,168	10,148
Shared Partnership Posts & Statutory Costs of IJB	293	284	300	317	375
Transformation	2,734	2,202	2,454	2,521	2,728
Total Expenditure	190,894	199,919	223,349	228,237	252,914



Section 10: Best Value, Governance & Risk

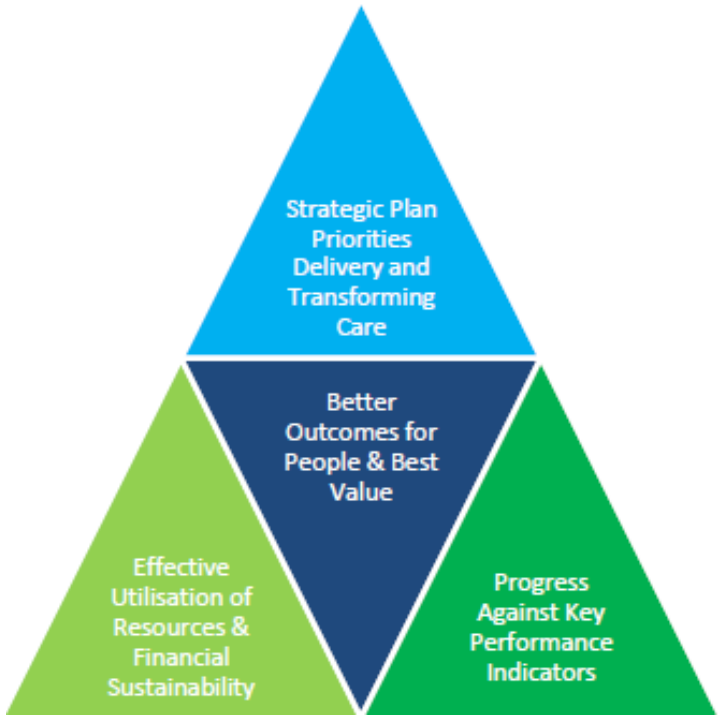
Clackmannanshire Council, Stirling Council and NHS Forth Valley (the partnership authorities) delegate budgets to the Integration Joint Board (IJB). The IJB decides how to use the budget to achieve the priorities of the Strategic Commissioning Plan and to progress towards the National Health and Wellbeing 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 - Strategy Map

Our Strategic Plan on a Page

Vision	Priorities	Enabling Activities				Strategies and Initiatives to deliver change
...to enable people in the Clackmannanshire and Stirling Health & Social Care Partnership area to live full and positive lives within supportive communities	Care Closer to Home	Technology Enabled Care	Workforce Planning and Development	Housing / Adaptations	Infrastructure	Intermediate Care Strategy
	Primary Care Transformation					Primary Care Improvement Plan
	Caring, Connected Communities					Carers (Scotland) Act 2016 Community Empowerment (Scotland) Act 2015 Free Personal Care for under 65's 'A Connected Scotland: our strategy for tackling isolation and loneliness and building stronger social connections' Public Health Priorities for Scotland
	Mental Health					Mental Health Strategy
	Supporting people living with Dementia					Dementia Strategy
	Alcohol and drugs					Forth Valley ADP Strategy

All priorities have the National Health and Care Standards at the centre:

- I experience high quality care and support that is right for me
- I am fully involved in all decisions about my care and support
- I have confidence in the people who support and care for me
- I have confidence in the organisation providing my care and support
- I experience a high quality environment if the organisation provides the premises.

Appendix 1: How our priorities link with the National Health and Wellbeing Outcomes

National Health and Wellbeing Outcome	Care closer to home	Primary Care Transformation	Caring, Connected Communities	Mental Health	Supporting people with Dementia	Alcohol & Drugs
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.					✓	
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	✓					
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	✓	✓	✓	✓	✓	✓
4. Health and social care services are centred on helping tomaintain or improve the quality of life of people who use those services.	✓	✓	✓	✓	✓	✓
5. Health and social care services contribute to reducing health inequalities.	✓	✓	✓	✓	✓	✓
6. People who provide unpaid care are supported to look aftertheir own health and wellbeing, including to reduce any negative impact on their caring role on their own health and wellbeing.	✓	✓	✓	✓	✓	
7. People who use health and social care services are safe from harm.	✓	✓	✓	✓	✓	✓
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.		✓		✓		
9. Resources are used effectively and efficiently in the provisionof health and social care services.	✓	✓	✓	✓	✓	✓

Appendix 2 - National Core Indicators

*Note this data and analysis will be published in July 2023

The national core indicators are a requirement of the Annual Performance Report.

	Ref	Indicator	2013/14	2015/16	2017/18	2019/20	2021/22	2023/24
Outcome Indicators	NI-1	Percentage of adults able to look after their health very well or quite well.	95.5%	94.6%	93.6%	93.6%	91.7%	Bi-annual Data reported 2024.
	NI-2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible.	84.1%	81.7%	81.9%	76.1%	72.5%	
	NI-3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided.	79.1%	76.4%	73.5%	74.4%	64.3%	
	NI-4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated.	71.3%	72.9%	76.5%	68.8%	61.7%	
	NI-5	Total % of adults receiving any care or support who rated it as excellent or good.	80.3%	77.6%	77.6%	75.2%	67.8%	
	NI-6	Percentage of people with positive experience of the care provided by their GP practice.	86.6%	86.7%	86.6%	78.8%	67.3%	
	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.	84.7%	77.1%	79.4%	79.1%	79.2%	
	NI-8	Total combined % carers who feel supported to continue in their caring role.	39.6%	32.4%	38.3%	29.7%	25.6%	
	NI-9	Percentage of adults supported at home who agreed they felt safe.	82.9%	81.6%	86.0%	83.5%	75.3%	
	NI-10	Percentage of staff who say they would recommend their workplace as a good place to work.	No data from Public Health Scotland					

The ‘outcome’ indicators above are normally reported every 2 years from the Scottish Health and Care Experience Survey commissioned by the Scottish Government. 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	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Scotland 2022/23
Data Indicators	NI-11	Premature mortality rate per 100,000 persons aged under 75 years		389	379	371	429	459	440	407 *2022	442 *2022
	NI-12	Emergency admission rate (per 100,000 adult population)		10,012	10,323	10,451	13,206	11,777	12,814	13,036	11,273
	NI-13	Emergency bed day rate (per 100,000 population)		111,864	113,000	113,435	109,221	95,437	105,470	115,181	119,806
	NI-14	Readmission to hospital within 28 days (per 1,000 population)		105	107	105	130	153	130	126	102
	NI-15	Proportion of last 6 months of life spent at home or in a community setting		86.9%	86.9%	87.8%	88.2%	91.0%	89.6%	89.3%	88.9%
	NI-16	Falls rate per 1,000 population aged 65+	14.2	16.0	19.7	20.8	23.5	20.2	23.6	23.8	22.5
	NI-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	82.0%	88.3%	96.2%	93.4%	91.0%	91.1%	87.0%	80.8%	75.2%
	NI-18	% of adults with intensive care needs receiving care at home	69.7%	70.0%	66.7%	66.7%	69.8%	71.2%	68.6%	69.3%	64.6%
	NI-19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	640	723	503	579	665	448	743	804	919
	NI-20	% of health and care resource spent on hospital stays where the patient was admitted in an emergency	-	20.7%	22.7%	23.7%	23.0%	No longer reported by Public Health Scotland			
	NI-21	% of people admitted to hospital from home during the year, who are discharged to a care home	No data published by Public Health Scotland								
	NI - 22	% of people who are discharged from hospital within 72 hours of being ready	No data published by Public Health Scotland								
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	No data published by Public Health Scotland								

Appendix 3 - Inspections

Registered services owned by the Partnership are inspected annually by the Care Inspectorate. There were seven registered service inspections during 2022/2023. 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.

Registered Service	Date Inspection Completed	How well do we support people's wellbeing?	How good is our leadership?	How good is our staff team?	How good is our setting?	How well is our care and support planned?	Recommendations	Requirements	Areas for improvement
Menstrie House	04/05/2022	Adequate	Adequate	Adequate	Good	Adequate	0	2	5
Menstrie House	06/10/2022	-	Weak	-	-	-	0	2	5
Menstrie House	06/12/2022	-	Very good	Very good	-	-	0	1	2
Ludgate House Resource Centre Care Home Service	09/08/2022	Very good	Very good	-	-	-	0	0	1
Bellfield Centre Care Home Service	12/10/2022	Good	Adequate	Good	Very good	Good	0	0	5
Stirling Council Reablement and Tec Services Housing Support Service	24/11/2022	Very good	Very good	-	-	-	0	0	0
Clackmannanshire Reablement and Technology Enabled Care Service Housing Support Service	8/12/2022	Very good	Very good	-	-	-	0	0	0

Source : Care Inspectorate

Appendix 4: Unscheduled Care – MSG Performance Measures (update to follow)

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).

For more information on SMR completeness please see further information here: https://publichealthscotland.scot/publications/scottish-morbidity-records-smr-timeliness-charts/

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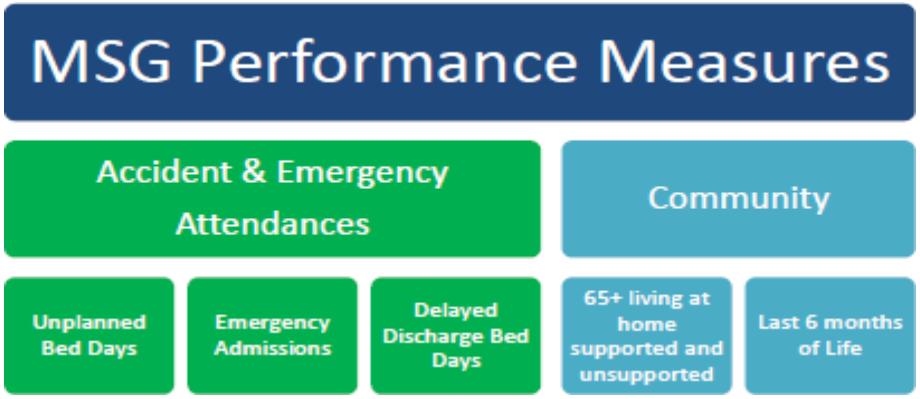

MSG Indicator	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Target change from 2015/16 baseline	% change from 2015/16 baseline
Number of Emergency Admissions (aged 18+)	11,141	11,082	11,755	11,700	14,573	12,638	13,939	14,203	5% decrease	21.6% increase
Number of unscheduled hospital bed days; (Acute) (aged 18+)	94,472	88,996	90,043	93,050	100,170	83,743	96,409	106,696	6% decrease	11.5% increase
Number of unscheduled hospital bed days; Mental Health (aged 18+)	24,851	24,599	25,799	26,750	23,637	23,059	22,055	21,950	18% decrease	13.2% decrease
A&E Attendances (aged 18+)	26,585	26,430	28,264	30,284	32,040	23,091	28,505	28,398	Maintain Baseline	0.1% increase
Delayed discharge bed days All reasons (aged 18+)	10,069	11,851	8,054	11,016	12,630	9,355	13,518	14,786	Maintain Baseline	31.9% increase
% of last 6 months of life spent in community (all ages)	85.9%	86.9%	86.9%	87.8%	88.2%	91.0%	89.6%	89.3%	4.1%increase	3.4% increase
Proportion of 65+ population living at home (supported and unsupported)	96.5%	96.6%	96.8%	96.9%	97.0%	97.4%	97.3%	96.8%p	0.1% increase	0.3% increase