Clackmannanshire & Stirling
Health & Social Care Partnership





Clackmannanshire and Stirling Integration Joint Board Annual Performance Report 2024-2025

Contents

Message from the Chair

Whilst 2024-2025 had brought its own challenges through the continuation of the cost-of-living crisis and increasing demand for health and social care across the country, our vision for Clackmannanshire and Stirling remains the same – to enable people to live full and positive lives in supported communities.

We have seen progress across our five key strategies: prevention and early intervention; independent living; care closer to home; empowering people and reducing social isolation. However, we still face the challenge of meeting the increasing needs of an ageing population against the backdrop of limited resources.

Given the increased demand on resources, 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. In Clackmannanshire and Stirling, one in five of us is over the age of 65, by 2038 this will be one in four.

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

Finally, I 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 reserve a special thank you to our unsung heroes - the 21,000 unpaid carers who look after their loved ones in Clackmannanshire and Stirling.

Thank you.

David Wilson
Chair
Integration Joint Board

Message from the Interim Chief Officer

I want to express my sincere thanks to all staff across the Partnership area, including colleagues across both Councils and the NHS. In addition to colleagues within the third and independent sectors who have continued to work tirelessly to ensure the safe and effective provision of community health and social care and support across our communities. I have seen first-hand the dedication of both staff and our partners in supporting and championing people to achieved their outcomes.

This report reflects some of the significant work and efforts of everyone who worked and continues to work alongside the communities of Clackmannanshire and Stirling. We have seen improvements in progressing key pieces of transformational work, that directly impact our communities and staff, which will continue into 2025-26.

This Annual Performance Report, the Partnership's tenth, evidences that there is much to be proud of, and outlines how we are working to increasingly support people to remain in their communities for as long as they are able to, which is aligned to what people have told us they want. However, whilst there continues to be progress the report also reflects that we continue to seek to meet the challenges of our growing aging population and those living with increasing levels of complex needs. This is all set against a backdrop of significant financial challenges now and going into the future. With that said our focus now, as it continues to be, is on supporting and empowering our communities.

Addressing these pressures requires ongoing transformation focussed on how we deliver a range of supports and services across the partnership area in the coming years. It is important to look at the need for continued engagement with those within our communities to co-produce solutions to allow us to continue to understand what matters to best inform our response.

I would like to thank everyone involved in developing, delivering and those who access the tapestry of supports that we and our partners offer across our communities.

Joanna MacDonald
Interim Chief Officer

Introduction and background

The Public Bodies (Joint Working) (Scotland) Act 2014 requires the Integration Joint Board (IJB) to publish an Annual Performance Report. This is the tenth Annual Performance Report for Clackmannanshire and Stirling IJB. This document outlines and reflects on work and projects carried out in 2024/25 and reviews the progress made in delivering the priorities set out in our Strategic Commissioning Plan 2023 - 2033. The Clackmannanshire and Stirling Health and Social Care Partnership (HSCP) is the delivery vehicle of the IJB, 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 strategic priorities which align our focus to our vision 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 communities, 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 within the strategic themes. We have also linked our priorities to the national and local environment to reflect 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 outlining outcomes for communities, key achievements, effective partnership working and challenges as well as reporting on the significant programme which has been delivered to modernise and transform services post-COVID and the continuing challenging financial position we 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. 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.

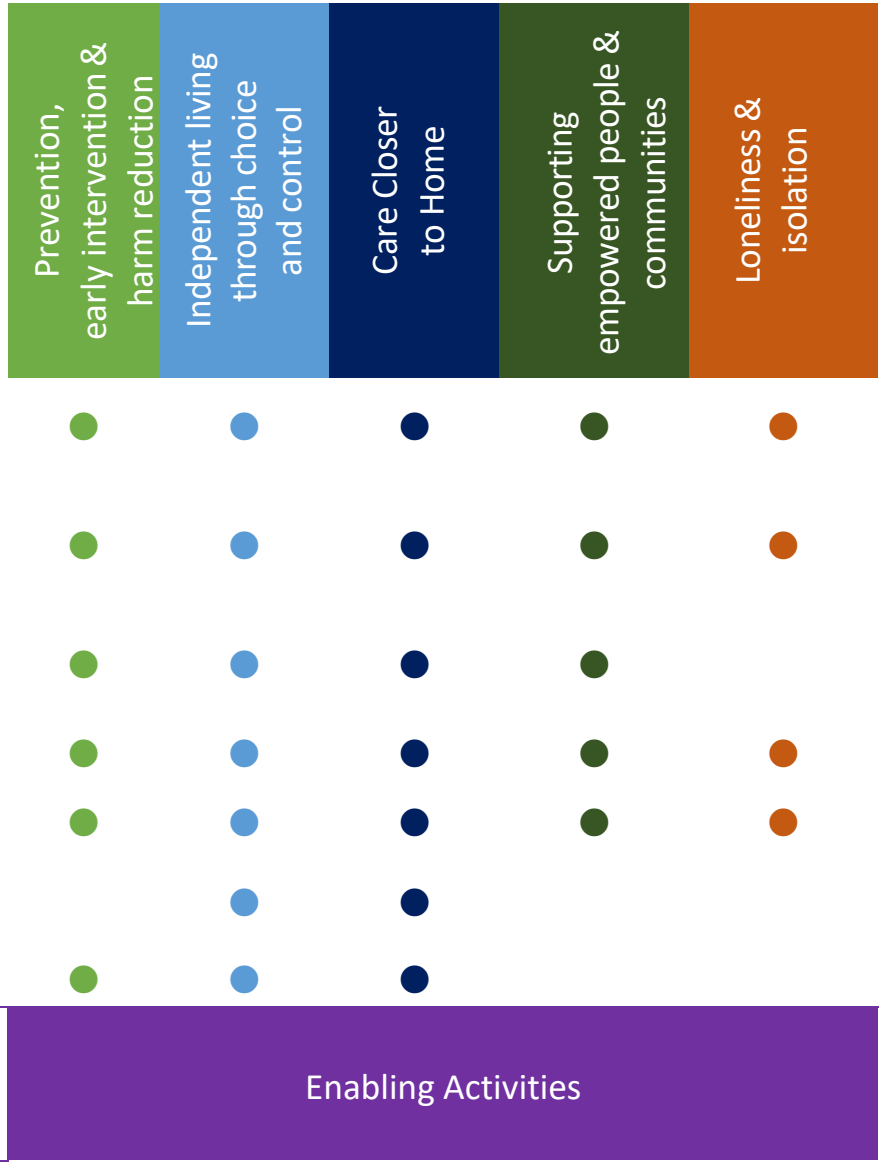
Have your say and get involved in shaping community health and social care. You can find out more here: Get involved.

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

National Health & Wellbeing Outcomes

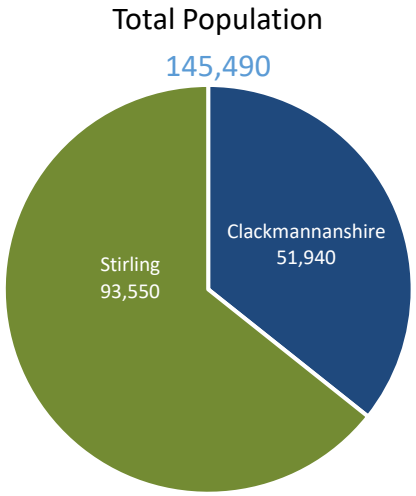
All themes and priorities of the Strategic Commissioning Plan are linked to the National Health and Wellbeing Outcomes. Each theme will demonstrate improvement for people and communities, how we are embedding a human rights based approach, consideration for equalities and evidencing improvement across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

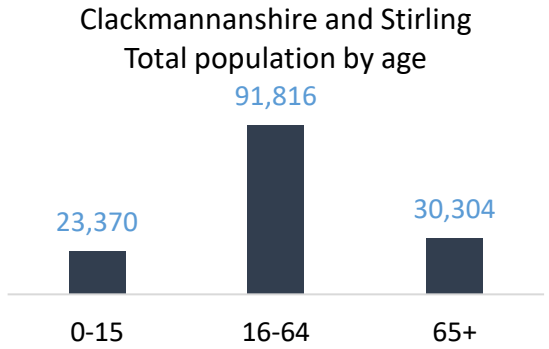
Health and Wellbeing Outcomes



Overview of the demographics within Clackmannanshire and Stirling

Our Population (NRS 2023 mid-year)





Currently 21%, over a fifth of the population, is aged 65+. This is expected to increase to 25% by 2038 (NRS 2018 projections).

Average Life Expectancy (ScotPHO 2021-2023 3 Year aggregates)

Females	2020-22	2021-23	Direction
Clackmannanshire	80.0	80.3	▲
Stirling	81.6	81.2	▼
Scotland	80.7	80.8	▲
Males	**2020-22**	**2021-23**	**Direction**
Clackmannanshire	76.0	75.8	▼
Stirling	77.3	78.3	▲
Scotland	76.5	76.8	▲

Female life expectancy is generally higher than male life expectancy.

When compared to Scotland, our population in Clackmannanshire has a lower life expectancy whereas our population in Stirling has a higher life expectancy.

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 2025, 1001 adults with learning disabilities (410 in Clackmannanshire and 591 in Stirling) were known to the 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 an additional 8,000 unknown unpaid carers.
- In Clackmannanshire 23.3% and in Stirling 19% of the population were prescribed medication for anxiety, depression or psychosis in 2023-24. This compares to 20.9% 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 Partnership wide information together. However we continually work to make our 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, and return to their 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 contain health activity, community related information as well as data associated with deaths.

Performance Summary

Performance (MSG and NCI) 25 indicators	12 Improving performance	3 Static	10 Declining performance
Strategic Theme 1 - Prevention, early intervention, and harm	6	1	3
Strategic Theme 2 - Independent living through choice and control	1	1	2
Strategic Theme 3 - Achieving care closer to home	4	1	5
Strategic Theme 4 - Supporting empowered people and communities	1	0	0

Benchmarking (NCI only) 18 indicators

Scotland	9	Better than average	4	Within 5%	5 Worse than average
Comparators	8	Better than average	4	Within 5%	6 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+)(NI-12) from 13,076 in 2023-24 to 13,424 in calendar year 2024. This is above the Scottish average and the average for our comparator HSCP's.

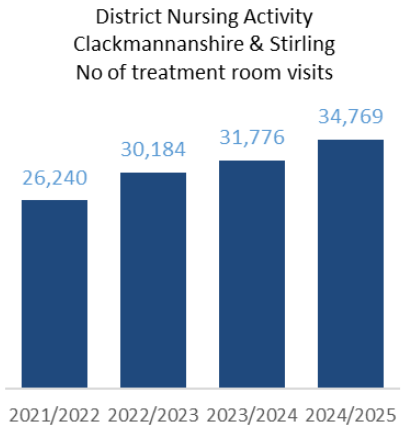
The rate of emergency bed days per 100,000 population for adults (18+)(NI-13) has reduced slightly from 116,414 in 2022/23 to 116,095 in 2023-24. This is below the Scottish average of 112,883 and the average of our comparator HSCP's.

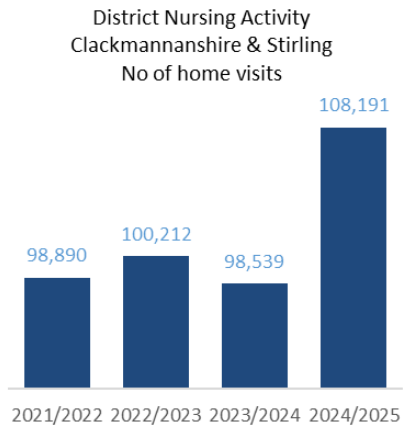
District Nursing

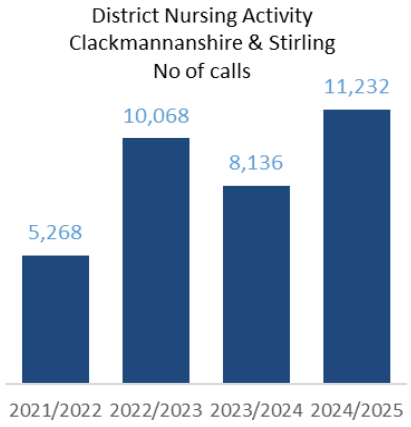
Many adults and older people can be supported at home, even when unwell, as staying in hospital when there is no need to can be detrimental to a person's ability to be reabled or rehabilitated. The community nursing team is available 24 hours a day, 365 days a year, and provides planned and unplanned care and support.

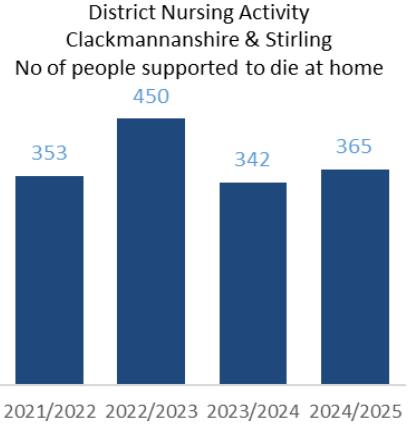
In 2024-25 there has been an increase in District Nursing activity. This is reflected against the context that there have been no extra staffing or increases in resources over the past four years. Instead, the increases in performance over the last few years (see graphs to the right) can be attributed to:

- More care taking place in a community settings.
- Increase in frail elderly patients being nursed and kept in their own homes instead of a hospital setting, which correlates with an increase in age profile in our communities. This also links to more people living with several long-term conditions (comorbidities) at once.
- Proactive discussions around anticipatory care so that those who do go to hospital return to their own homes sooner.
- Increase in palliative and end of life patients being supported to remain in their own homes.
- Earlier discharges from hospital following surgery, due to the support the district nursing team can provide at home.









The falls rate per 1,000 population (aged 65+)(NI-16) has reduced from 23.5 in 2022/23 to 23.2 in 2023/24. This is higher than the Scottish average of 22.7 and the HSCP comparator average of 22.5.

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 wellbeing. 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 the Allied Health Professional (AHP) Falls Prevention Lead is 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. Also, a Falls Local Community Support leaflet is available 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 encourage the use of community support services to reduce the conveyance of uninjured and well fallers to hospital. We also explored using MECS (Telecare) to attend uninjured fallers and help return them to their feet to improve capacity within the SAS.

Provisional Local Data for 2024/25 shows an admission rate of 20.6 per 1,000 population (age65+) with 616 admissions.

Informing and continuing to education both our staff and those within communities is very important.

For our care staff, we held 8 Reablement training sessions which included an innovative Falls Simulation to support the 91 carers who attended to be more confident having conversations with service users regarding falls and identifying risk factors. You can find a link to a You Tube video of our first session here.

We ran 20 community engagements sessions across 2024/25, reaching out to approximately 200 people across Clackmannanshire & Stirling. The central focus of these sessions was to have conversations around falls, frailty and bone health. This has been targeted through various existing groups such as:

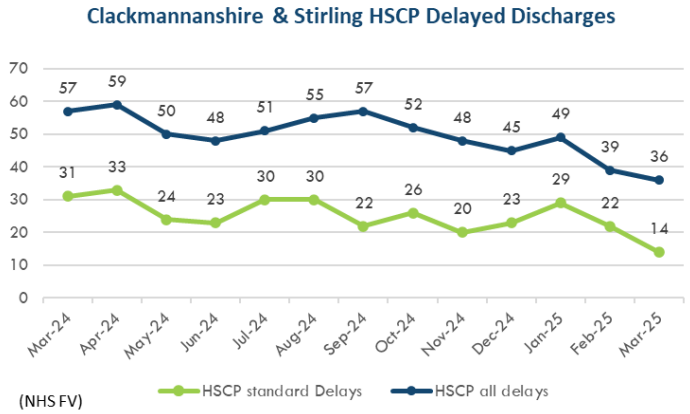
- Dementia friendly Dunblane
- Alzheimer's Scotland (Alloa)
- Inspiring Communities
- OTAGO Exercise Classes
- Stirling Libraries
- Falkirk & Clackmannanshire Carers Centre

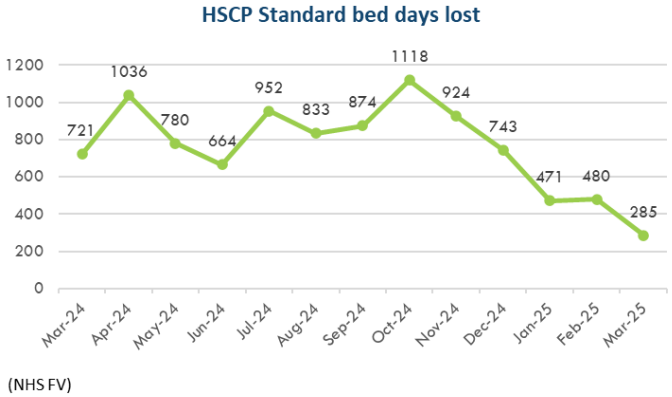
More information from Falls Awareness week 2024 can be found here.

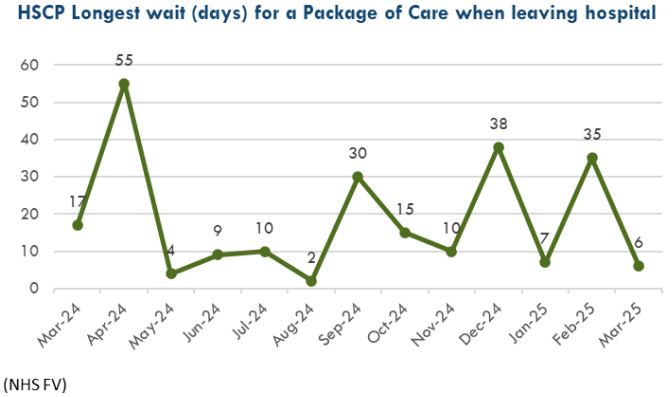
Delayed Discharges

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 of issues relating to them being able to move to a safe environment. For example, sometimes a person needs social care, or adaptations to their home or they are moving into a care home. We aim to reduced delayed discharges, as extended delays without a medical need to be there can lead to poorer outcomes for the individual this delay in throughput also means that people who need medical attention may need to wait longer.

Local data shows a 37% decrease in the total number of delayed discharges From March 2024 to March 2025 with a 55% decrease in the number of standard delays over the same period with a reduction in the number of bed days lost over the year.







These improvements are due to work reducing length of stay, timely admission from acute and discharge home from community sites under the Discharge Without Delay (DWD) programme. This is evidenced by the decrease in waits for those coming out of hospital, which can be attributed to improvements in working across the whole system. The aim of this work is aligned to the understanding that reduced waits in acute settings ensures better outcomes for people around reduced risk of hospital acquired infections and deconditioning. This is coupled with taking an assets-based approach to what people require, as the majority of people wish to return home after hospital. To this end there has been a particular focus on the discharge to assess/ home first approach and the community hospital and step-down rehabilitation unit parts of the DWD programme, and how this can facilitate swifter discharges (see right hand graph), which align people wishes with their abilities to ensure discharges home are safe. This programme of work has been sustained while aligning budgets to deliver our services more effectively and efficiently.

Stop Smoking Services

The service collects client feedback through the Care Opinion Platform. One client said "Great support and advice was offered through my 12-week program. Very beneficial program and I highly recommend."

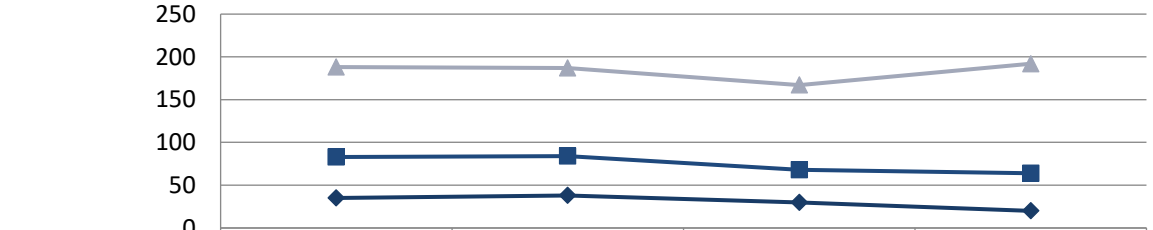
The Specialist Stop Smoking Service, in partnership with Community Pharmacies, provides free behavioural support and pharmacotherapy for individuals who want to stop smoking. Referrals to the Specialist Stop Smoking Service are received through various clinical and community pathways, as well as self-referrals.

Of the 435 individuals referred to Stop Smoking Services in Stirling in 2024-25, 40% (176) reported they had not smoked in the prior four weeks. Moving into the measured quit attempt period, this fell to 28% (123) at the twelve week mark. The definition we use for a 'successful quit' is an indiviudals not smoking for at least 12 weeks.

Data related to those who did not smoke for 4-week and then 12-week is only accurate at the time of reporting, leading to variation in quarterly reporting.

Variation occurs due to differences in follow-up timing and validation of quit attempts. The entire reporting period for any 'quit success' is 16-20 weeks after the date an individual last smoked. Therefore, final reporting for 2024-25 will not be available until late 2025.

PH5-HW2 Smoking Quit Rate



	Q1	Q2	Q3	Q4
Referrals	105	103	99	128
4 Week Quit	48	46	38	44
12 week Quit	35	38	30	20

Priority 1 Mental Health and Wellbeing

Mental health and wellbeing is as important as physical health and wellbeing. There have been significant changes regarding how we deliver mental health services, through redesign of existing services and developing additional resources to meet increasing needs.

A Joint Strategic Inspection of Adult Services in the Clackmannanshire and Stirling Health and Social Care Partnership took place in November 2024. Which specifically focussed on adults living with mental illness (under the age of 65) and their unpaid carers.

Areas for improvements were identified and reported as part of the finalised Report published in November 2024. Staff and partners working with people across the Partnership area were highlighted as providing good care and support to people living with mental illness in Clackmannanshire and Stirling. Their care and compassion was noted as contributing to good outcomes for some people and improved their quality of life. There were specific actions around local systems and the processes linked to working across three employing organisations as well as specific supports for carers of people with issues of mental health.

An Improvement Plan was developed with staff, partners and supported people's representatives in December 2024; the subsequent Plan was approved by Chief Executives from all partner bodies in January 2025, presented to governance bodies of each constituent organisation and approved at Integration Joint Board before submission to the Care Inspectorate. The Plan was focused on the identified key areas for improvement within the published Inspection Report. The need to focus on local systems and processes is being progressed and should create increased consistency across the Partnership area. This will also ensure developing processes for capturing robust data focussed on outcomes which can be used to inform service planning and ongoing improvement. There is work underway to improve integrated processes for assessment, care planning and treatment to support more effective collaboration between staff. As well as developing a more proactive approach to emergency and future care planning.

Work continues to progress in line with the actions outlined within the Improvement Plan, the Plan is monitored by a monthly Inspection Group meeting chaired by Chief Officer.

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 21,605 in 2023-24.

In 2024/25 there were 414 referrals to Adult Social Care services for Mental Health Clients. This is a 43% increase from 232 in 23-24.
(Adult Social Services)

In March 2025 the percentage of people who commenced treatment within 18 weeks of referral to Psychological Therapies in Forth Valley was 79.9% which is an increase from 73.6% at March 2024. This is below the Target of 90% (PHS) but is above the Scottish average of 78.6%.

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	2022-23	2023-24	2024-25
Number of Emergency Detention Certificates (Mental Health) Section 36	62	66	58
Number of Short Term Detention Certificates (Mental Health) Section 44	139	134	104
Number of Compulsory Treatment Orders (existing)	31	45	41
Number of Compulsory Treatment Orders (new applications)	107	90	72

(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	2022-23	2023-24	2024-25
Total number of Existing Guardianships (private and local authority)	473	561	629

(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. Someone would require a guardian if they were not able to look after their own affairs.

Across April 2024 to March 2025, Forth Valley Advocacy supplied 9,500 hours of support to people, which equates to supporting just over 700 people. As this service is based on demand it is important to note that their annual levels of support provided is based purley on referrals and their complexity.

Independent advocacy enables individuals to articulate their needs, make informed choices, and build the confidence to speak up. It is not only a statutory entitlement for many service users, which safeguards people who are vulnerable, but also a vital support in navigating complex systems and service pathways. During summer and autumn 2024, a comprehensive consultation was undertaken with internal and external stakeholders to inform the commissioning strategy for advocacy.

Key finding from that engagement process identified that for those with lived and living experience, independent advocacy is primarily to support individuals to make their own decisions about they want and assist them in expressing their needs to other people and organisations, especially during statutory procedures. However, they widely agreed that advocates should also help people to understand their options and help them gain access to information, particularly in supporting earlier interventions. Individuals also overwhelming expressed the importance of speaking to someone in person about their eligibility and their views, but widely requested that a variety of means of communication be available to support varying needs.

The consultation process culminated in the development of the Clackmannanshire & Stirling HSCP Independent Advocacy Strategic Commissioning Plan 2024–27, which incorporates stakeholder feedback and sets out a corresponding action plan. The strategy received formal approval in October 2024.

The current advocacy service is commissioned until 31 October 2025. In preparation for this contractual milestone, the advocacy commissioning consortium was convened in early 2025, building on the Strategic Commissioning Plan's foundations. The consortium's objective is to co-produce a Model of Care in collaboration with individuals with lived and living experience, as well as practitioners. This model, taking into account what people have told us, will reflect statutory duties around independent advocacy, with a strong emphasis on early intervention, prevention, and community capacity building.

The Mental Health Money and Benefits Advice Project led by Stirling District Citizen's Advice Bureau (CAB) was supported by the Health Improvement Fund from NHS Forth Valley in partnership with The Robertson Trust.

The Mental Health Money and Benefits project delivers an accessible, collocated and holistic person-centred specialist advice service for people in treatment (or recovery) for/ from chronic or episodic mental ill health. The project provides client led advice, information and representation/advocacy services and is fully accessible throughout the existing CAB outreach sites for Stirlingshire residents in the Forth Valley Health Board area. It also collocates twice weekly within Livilands Community Mental Health Hospital and Action in Mind Mental Health support service.

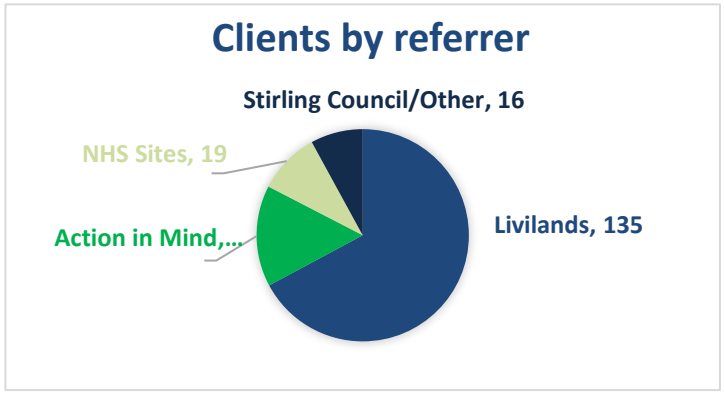
The project encompasses a second-tier consultancy support service to front line mental health professionals on rights, financial inclusion and associated social/ welfare/ legal matters for their clients or patients. This project adopts an early intervention educative element through the delivery of financial capacity building and welfare reform mitigation workshops for service user groups. Bespoke training delivered through the project helps build capacity of front-line mental health professionals.

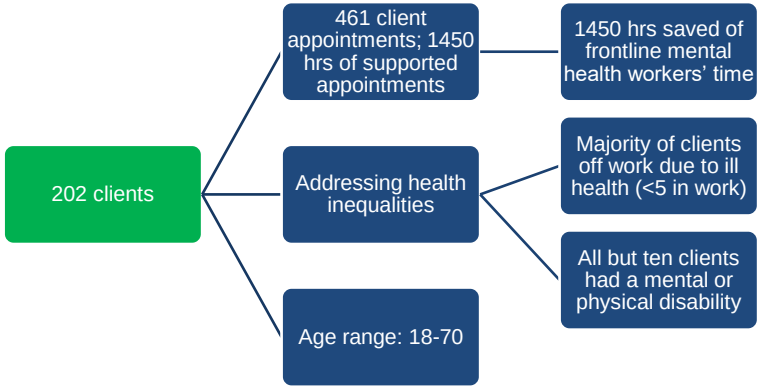
In the period 1st April 23 to 31st January 24 the Mental Health Money & Benefits Outreach advice service:

- Supported 202 clients
- Generated reported client financial gains of £340,123.35

Please note the above figure is likely an underestimation of actual client financial gain as it is based on what clients choose to share.

The last year of operation has seen an unprecedented level of organisational development that has allowed the project to provide a wider variety of services to more people. However, it has also brought forward challenges around ensuring that the team are able to respond to the increased opportunities.





Key actions for 2025/26

- For Independent Advocacy approval from the Intergration Joint Board will be sought for a proposed Model of Care, which is currently being developed through the commissioning consortium. Followed by procurement activity aligned with the strategic aims for delivering independent advocacy.
- Publication of the Mental Health and Wellbeing Strategic Commissioning Plan, and a subsequent workplan which will provide the direction of travel going forward for mental health services.

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 Alcohol and Drug Partnership (ADP) continues to focus on the transformation of the substance use system ahead of the end of the National Drugs Mission in 2026. Work continues to implement a model of mobile prescribing in primary care as agreed by the IJB in August 2024, with funding reinvested in harm reduction outreach and recovery oriented supports. We anticipate that our system will support comprehensive delivery of prescribing MAT Standards* by April 2026.

Lived Experience and Human Rights

We continue to work with our ADP Lived Experience Advisory Panel (LEAP) to facilitate lived and living experience input to ADP Strategic Planning. The group has advised on the expansion of our lived experience data gathering and the strategic commissioning of recovery and harm reduction support. We continue to work also with family and loved ones who are supported through the Scottish Families Affected by Alcohol and Drugs (SFAD) service. Human rights empowerment and accountability activity is now being included in contract monitoring arrangements in line with the IJB Strategic Commissioning Plan 2023-33. Collaboration with the Health Improvement Service is increasing this activity to other areas of HSCP work.

MAT Standards and Harm Reduction

MAT Standards* implementation has been key to ADP work, supported by Public Health Scotland. Harm reduction activity is now being coordinated by ADP support team and has reduced response time to new harms from months to less than 48 hours. People at risk of overdose receive more comprehensive support from partners who are able to share knowledge and wrap around each person's own needs. The rebalancing of ADP investment agreed in 2024-25 will be enacted in 2025-26 and is expected to sustainably resource improvements from the National Drugs Mission period within available resource.

Performance against the Scottish Government LDP Target that 'People seeking Drug and Alcohol treatment are supported within 3 weeks' has been met consistently across the Forth Valley area (most local dataset available) since Q1 2024-25.

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

Workshops with community members and ADP partners in 2024-25 have been supported by Scottish Recovery Consortium and reflected on the delivery of recovery services. We have flourishing recovery communities across Clackmannanshire and Stirling but our collective ambition is to enhance their autonomy and sustainability with additional investment made possible by the ADP Commissioning Consortium. In 2025-26 we will recontract provision for Recovery Communities to make foster the enthusiasm of people in recovery and wide support of stakeholders.

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.

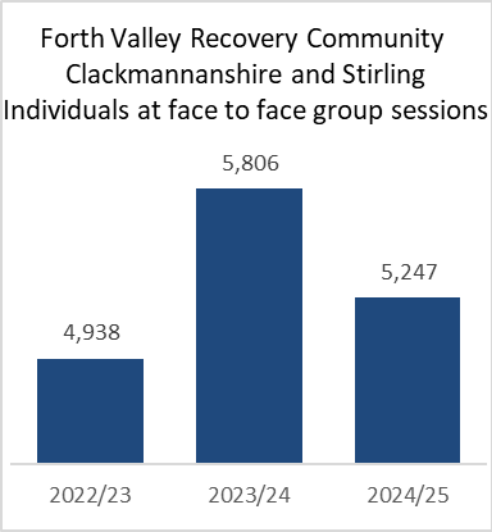
Peer Support sessions run at the following locations:

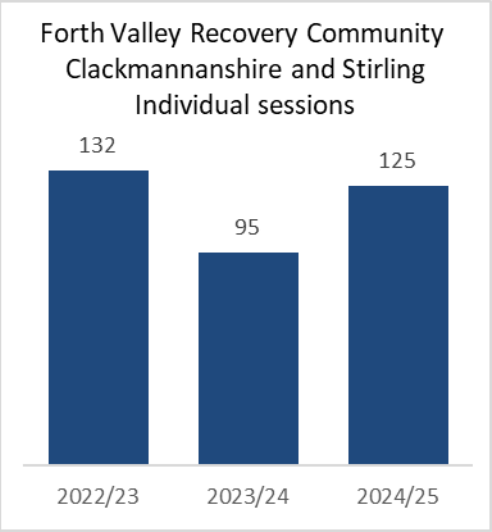
- The FV Royal Hospital in Larbert
- The SMS clinics

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.

Attendance numbers at Recovery Community activity fluctuate throughout the year. Our focus for 2025-26 is to develop a sustainable contract for delivery of autonomous recovery activity, building on the thriving work already done so far.





Key actions for 2025-26

- Continue work to assure delivery of MAT Standard care within available resource from end of National Drugs Mission in April 2026
- Continue transformational redesign of system of care and support through further commissioning activity
- Develop practical Human Rights Based Approach, building on successful development of LEAP and other activity to date.
- Align ADP support for prevention messaging to Health Improvement planning and delivery.
- Continue coordination of harm reduction activity across localities.

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 (NI-18)(has increased from 69.3% in 2022/23 to 74.6% for 2023/24 which is above the Scottish average of 65% and our comparators average of 64.5%.

Percentage of adults supported at home who agreed that they are supported to live as independently as possible (NI-2) 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, 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 have developed, in partnership with staff and supported people, a new Self Directed Support Policy which was published in June 2024. Since the outcomes focused policy was approved the emphasis has been on implementation and operationalisation of the policy in practice.

Self Directed Support (SDS) is the way that social care is delivered across the Partnership. To enable more empowered individuals to make decisions through the adoption of an asset-based approach the Care at Home Review Team was established as a test of change with work commencing in Stirling on 20 May 2024. The financial impact of the changes made by this team are reflected in reporting around the IJB's Delivery Plan.

When considering the team and the agreed measures which would evidence success, each point can clearly be evidenced from their first nine months in post:

- Ensuring that those requiring care are accessing supports they need to, taking into account an asset-based approach and non-statutory supports.
- An aligned performance against wait times in Locality Teams leading to reductions in length of wait and number of people waiting.
- Improved oversight and governance arrangements in relation to unmet need, vulnerability and risk.
- Increase in signposting or referrals to third sector, where appropriate.

The Review Team in Stirling over a short period of time has increased consistency through their application of the SDS principles and practices throughout the HSCP through adopting an asset-based approach. In Clackmannanshire, where there is not a dedicated Care at Home Review Team, data gathered clearly shows that numbers and duration of outstanding reviews continues to grow in the absence of a dedicated review team.

Although a challenging and often lenghty task, there is a growing body of positive testimony from supported people, families and carers relating to their experience of their reviews, and also from providers.

Supported People Testimony (As this has been anonymized, SP = Supported Person, RTW = Review Team Worker)
SP1's Family: The below testimony Paraphrases what the supported person's wife and daughter said of the worker within the Review Team:
"I would like to sincerely thank you for your invaluable efforts in helping reunite our family. After months of conflict and misunderstanding, your support, patience, and guidance have brought us back together. We are truly grateful for the compassion and dedication you showed throughout this journey. Your role in restoring peace and harmony within our family will always be deeply appreciated."

Asset Based Approach

An asset based approach looks at someone's personal strengths, familial supports and community resources, this may include assistance from family or friends or attending activities within the community. For some individuals they can achieve their outcomes and have their needs met through their own assets/community resources and therefore will not require formal supports to achieved their assessed needs.

This approach is being used to ensure that as a Partnership we are able to provide as much care and support to as many people as possible, through ensuring that we are working with individuals to define the right amount of support for them. This process also means that through looking to our partners in the community and third sector we are able to continue providing support, where there is an assessed need in line with available resources and supports that enable that goal. This approach is about enabling individuals to live well in their communities for as long as they are able to.

Lived and Living Experience

Learning from the experiences of those with lived experience is important in influencing and driving how we work and continue to develop through providing insight and understanding from the perspective of those who access service that we provide.

The Lived Experience Panel was formed at the end of 2024. They has an agreed terms of reference and meet regularly. The group wants to ensure their experiences are reflected to help further develop practices and be used as a basis to drive forward meaningful change. The group are also looking at ways to extend the membership of the group, to enable more views and experiences to be reflected, ensuring the voice of lived and living experience remains at the heart of informing developments that affect those within our communities.

Raising Awareness

Self-directed Support Forth Valley have been working, through Support In the Right Direction funding from Scottish Government, to raise public awareness of SDS. They have been delivering 'Know Your Options' presentations across various locations across Stirling and Clackmannanshire to ensure communities, third sector organisations and leaders are aware of what the SDS options are, what they entail and how to access them.

35 Carers reported feeling better supported in their caring role. An average of 42 Carers accessed information or received support regarding their cared for person throughout the year.

Staff Training:

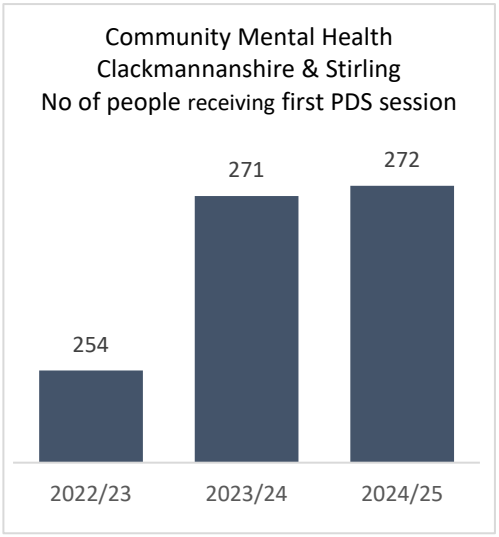
It is important that everyone, including members of staff, are aware of the ethos of SDS. Staff need to understand how to put knowledge into practice to continue to embed a consistent and holistic approach to social care. In light of this, Self-directed Support Forth Valley (SDSFV) have developed and rolled out 'SDS - Putting It Into Practice' training. This is a whole day session which covers the values and principles, legislative and duties and practical application. 10 members of staff across the HSCP attended this training on the 6th May and feedback from both SDSFV and staff who attended was positive. Further sessions have been scheduled with SDSFV to deliver this training throughout the year. These sessions will continue to run throughout the year to enable any new members of staff joining the HSCP to attend as part of their induction.

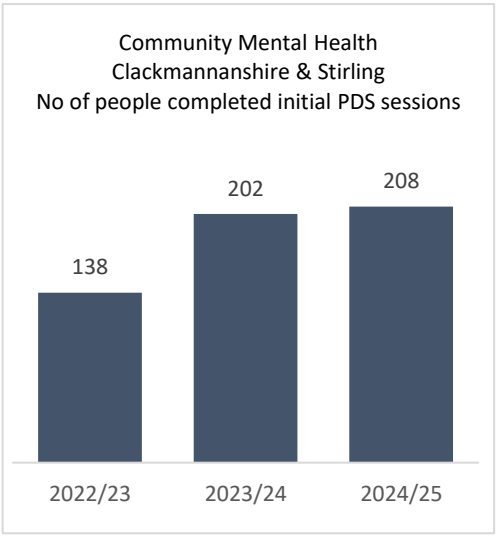
Priority 4 Support those affected by dementia at all stages of their journey.

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.

Delivery of one year's post-diagnostic support to every individual who is diagnosed with dementia is a Local Delivery Plan commitment from the Scottish Government. Below are details of this support from the perspective of the Community Mental Health Teams across both Clackmannanshire and Stirling, who provide initial sessions to those newly diagnosed with dementia.

In 2024-25 269 people received a diagnoss of dementia. 272 people had their first post diagnostic support (PDS) session with a member of the Community Mental Health Team (CMHT), compared to 208 people who completed their initial sessions of PDS with the same teams.





Commissioning

At the March 2025 meeting members of the commissioning consortium agreed to take forward a Hub and Spoke model. A Community Hub Model would allow people to access the information, advice and resources they need, within a collocated space with the Community Mental Health Team and third sector, that would be able to offer a wide range of advice and supports. It should be made clear that this approach would not replace home visits for those who need them. This would complement, not replace, community and peer support out with a fixed location.

The Hub and Spoke model takes into account the supports and interconnections of supports available to those living with dementia. We propose a community hub would be created to be at the centre of this model. The purpose of the hub would be to:

- Provide a space for information, advice and signposting
- Provide activities and respite for those living with dementia
- Be a place where both clinicians and third sector organisations can come together and share knowledge/ information.
- Be a place that has support from clinicians so that people can be supported closer to home until later into their diagnosis, and provide a mechanism for early intervention and prevention, before a crisis.

- Bring together carers supports and those for people living with dementia

The emphasis is on supporting someone's functional impairment, which is wider than solely people wit a diagnosis of dementia, by providing information, advice, signposting and supports that will aid that person in their community.

Key actions for 2025-26

- Develop tools that mean asset based and good conversations can be evidenced on our systems, after assessments, support plans or reviews take place.
- Continue to inform and educate both staff and communties about SDS and their right, and how these can be implemented in a way that meets an invidiuals outcomes.
- Work related to dementia commissioning will focus on developing the Hub and Spoke Model and determining what commissioning activities are required going forward to ensure sustainable service deleivery that can meet increasing demand.

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 (NI-19) to 785 in 2023-24 from 776 in 2022-23. This is under the Scottish average of 867 and lower than our comparators average of 844.

The percentage of people with positive experience of the care provided by their GP practice (NI-6) 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 (NI-5) has decreased from 67.8% to 64.8% in 2023-24. 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	2024-25
Number of people who completed reablement in year	367	587	598
% of people who required reduced or no care after reablement	65%	65%	59%

Planned Care in Place in People's own Homes

At the end of March 2025, 2,186 people received care and support in their own homes . At the same time 38,860 hours of care and support were commissioned from providers. An average of 104.9 placements start each month so there has been a 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.

In March 2025, 26 people without care already in place were waiting for care and support . This time last year 46 people were waiting.

Palliative and end of life care

The World Health Organisation (Palliative care) defines palliative care as encompassing "the care and support which is provided to support someone to live well following diagnosis of a life-threatening illness. This includes the support that is provided to their loved ones and carers." Palliative and end of life care (P&EOLC) remains a national and local priority for change and improvement. In response to this, Clackmannanshire and Stirling Integration Joint Board, Falkirk Integration Joint Board and NHS Forth Valley agreed a joint approach to develop and produce a Strategic Commissioning Plan and to subsequently 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. Clackmannanshire and Stirling have led this pan Forth valley work.

Engagement meeting hosted by our previous Interim Chief Officer. David Williams

To inform the drafting of a Forth Valley Strategic Commsisining Plan for P&EOLC, engagement took place across Stirling, Clackmannanshire as well as Falkirk between April and May 2024. Engagement was sought from those who had views on palliative and end of life care. In Stirling and Clackmannanshire six engagement events took place. The questions asked focussed on what was good, what could be improved, and what should be aspired to. The feedback gathered from this initial engagement contained a good mix between people with professional experiences, both within the NHS and third sector organisations, and those with personal experiences.

In August and September a follow up consultation took place, and in Stirling and Clackmannanshire two engagement events were held, as well as an online survey. Across both rounds of consultation, in person sessions and online surveys, a total of 161 views were contributed from both Stirling and Clackmannanshire.

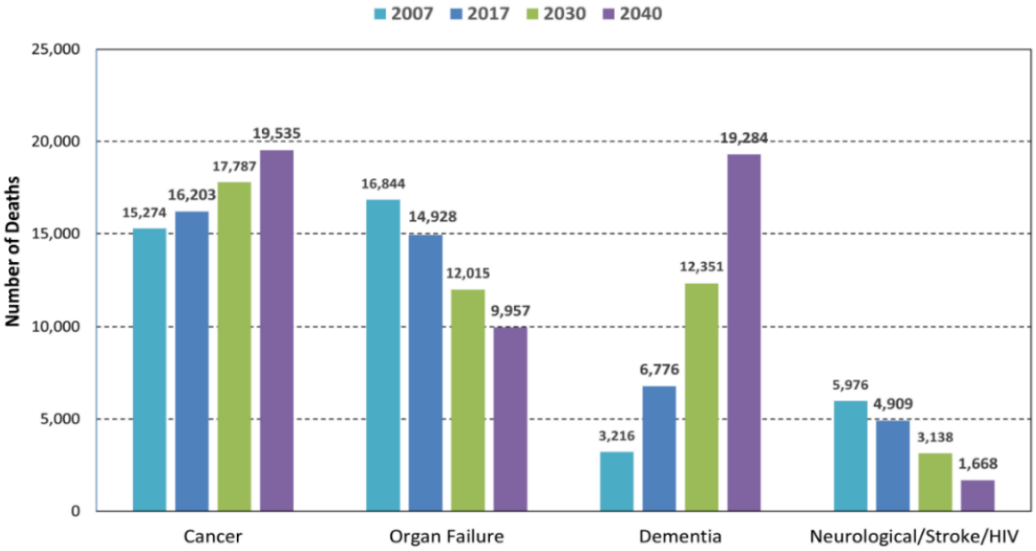
Based on views sought from engagement the following vision was developed, *"Health and wellbeing is important throughout everyone's lives, although some may need additional support to enable them to live well with long term conditions. However, we want all people with palliative and end of life care needs to be able to access compassionate, responsive and coordinated holistic care and support throughout their palliative journey in their preferred location."*

Upon agreement of the P&EOLC Strategic Commissioning Plan in November 2024, by both IJBs in Clackmannanshire and Stirling, and Falkirk, a commissioning consortium was convened.

The Commissioning Consortium had its first meeting in January 2025 and has wide representation from across Clackmannanshire, Stirling and Falkirk. The consortium has a focus on discussing and considering how to better financially resource supports in the community, as this is where people have told us they want to be, that provides consistency and equity to those at the end of their life.

Projected main underlying cause of death associated with palliative care need by disease group up to 2040

Ref: Finucane AM, Bone AE, Etkind S, et al. How many people will need palliative care in Scotland by 2040? A mixed-method study of projected palliative care need and recommendations for service delivery. BMJ Open 2021;11:e041317. doi:10.1136/bmjopen-2020-041317

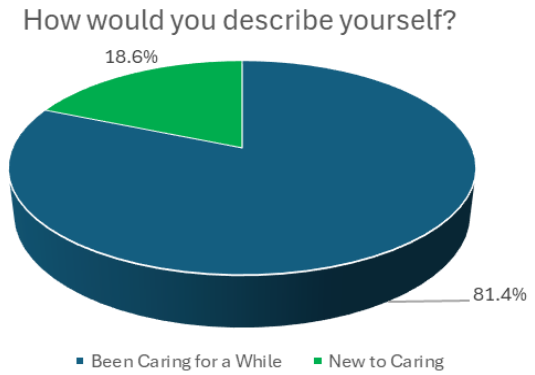


Our health and social care system needs to evolve and transform to keep pace with the changing PEOLC needs of FV residents. An ageing population, increasing multi-morbidities and complexity, rising demand, equity of access, changes in location of care and death, in addition to rising pressures on resources. As well as staff constraints related to recruitment and retention all mean that the status quo in the way that people are currently supported through their palliative care and at end of life is not a viable option moving forward.

It is also important to note that the projected increase in the over 85 population is likely to increase by 42% between 2024 and 2035 and by 68% between 2024 and 2043, which will likely add increasing pressures onto the system of health and care.

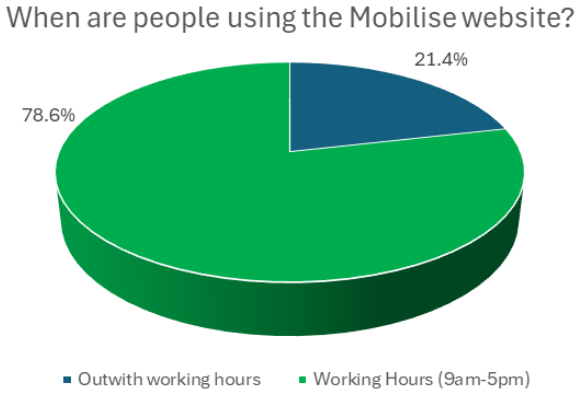
Priority 5 Good public information across all care and support working

Digital Information



How we access information is quicker and easier 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 provision of information to those within 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.



Mobilise provides digital supports for carers and was commissioned in 2024 in response to carers wanting more choice and the ability to have access to more digital supports to complement existing ones. Mobilise provides access to virtual meetings, telephone support and a wide range of advice and guidance to support carers in their caring role and improve their health and wellbeing. This approach enables carers to access light touch support 7 days a week to self-manage and improve their emotional wellbeing.

The top graph outlines the self-identity profile of people accessing Mobilise, over the past year 81% of people identified themselves as having been caring for a while.

The second graph shows that over the past year the majority of people (78.6%) sort information about caring were outside working hours (9am-5pm on weekdays). In addition, 79% of those who accessed Mobilise had not accessed support before. Which reinforces the need for a range of supports to be available for people.

Priority 6 Workforce capacity and recruitment

Workforce data is important to the planning and delivery of services. Work has taken place to better understand gaps in recruitment and the challenges of recruitment and retention in health and social care. This work has was carried out in collaboration with HR leads in all three employing bodies to understand trends and analysis linked to recruitment and retention of our health and social care workforce. The three employing organisations are also building on collation and analysis of workforce data to better understand the future needs of our workforce. In response to issues identified in terms of consistency with regards to data an HR lead has been appointed who will operate across the HSCP, to work towards and ensure there is cohesion across the piste.

This year we have:

Review of Roles

Over the year all partners have been working collaboratively to review and re-design job roles cantered around the staff involvement. This work focusses on considering the 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 was approved and evaluated, which has provided career development for staff. In addition, there has been collaborative working in terms of role design, to reduce dependence on agency staffing in some of our services.

Recruitment and Work with Partners to increase employability

All three employing organisations currently have vacancy controls in place, which mean only essential posts are able to go out to advert. This has an impact on teams where there are vacancies, but the roles are considered non-essential.

Despite challenges there are regular recruitment drives via social media, as well as through partners and community partnerships. Engagement is in place in line with our staffing needs as demand changes across the seasons.

The HSCP continues to work with partners to ensure that the recruitment process is positive, timely, inclusive and supportive. Whist there are a number of programmes that support this, some examples of this approach are outlined below:

- The NHS Forth Valley/ Department of Work and Pensions Sector Based Work Academy Programme for HCSW roles was piloted in Forth Valley Royal Hospital with a view to expanding into community hospitals. This programme provides training, work experience and a guarantee of a job interview upon completion.
- Stirling Council continues to work with local schools, Forth Valley College and Universities which continue to be developed to support young people into health and care careers. Through a multi-agency partnership approach opportunities are widened within health and care for young people. In addition there was a pilot for a new pre-foundation apprenticeship programme in health and care with SQA qualification. This mirrors the work of the Employability Team within Clackmannanshire.

Training

Community development with partners is encouraged, for example, through the continued offer for programmes of recruitment for staff in our rural locations. In addition to the standard health and social care mandatory training. The HSCP, through the Multi- Agency Public Protection Learning and Development Advisor, offers a robust multi-agency public protection training programme that covers child protection, adult support and protection and violence against women and girls. The programme of learning and development opportunities is available across the general, specific and intensive workforces.

The multi-agency public protection training calendar is produced annually. To accompany the calendar, we provide a learning and development framework and guidance document which outlines the learning outcomes for each of the learning and development opportunities available. The learning opportunities help support those we serve; the needs of the service and our practitioners own professional development.

Key actions for 2024 - 2025

Guiding Principles

Work is underway to develop a set of guiding principles across the three employing organisations, this is important as it will outline which organisation's policy should be used in instances such as the grievance process, which means all those involved in these matters are clear about which policy is being used. This is important as staff are sometimes managed by managers who are employed by a different organisation than themselves, having guiding principles will also mean there is consistency and fairness in these matters.

The proportion of care services graded 'good' (4) or better in Care Inspectorate inspections (NI-17) 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%.

Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated (NI-4) 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

In 2023/24 32.8% of carers felt supported to continue their caring role (NI-8). 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.

In March 2025 the IJB agreed the Carers Short Breaks Statement which provides information on what a short break is, how to access one and what it may look like. As well as providing details for seeking further information.

In collaboration with the HSCP, Carers Centres and Citizens Advice Bureau (CAB) a Welfare Rights Project for Carers facilitated by Citizens Advice Bureau provides support for carers to provide immediate holistic person-centred advice and information. They provided representation to unpaid carers and supports colleagues working with unpaid carers and, where necessary, refer individuals to appropriate advice agencies. There were 451 contacts with unpaid carers during 2024/25 with 54 clients reporting a financial gain of £144,435 over the year.

Please note CAB are only permitted to disclose financial gains unless reported by the client as it is their right to decide. CAB are not permitted to report amounts beyond a one year period (i.e. if a £30k award is granted for 3 years they are only permitted to report £10k and the remaining £20k goes unreported). Therefore, such figures are likely to be far greater than those reported and should not be considered comparable to other providers that report on client financial gain.

Key actions for 2025-26

- Provide good information and support to carers around Self-Directed Support.
- Continue to develop and update the 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

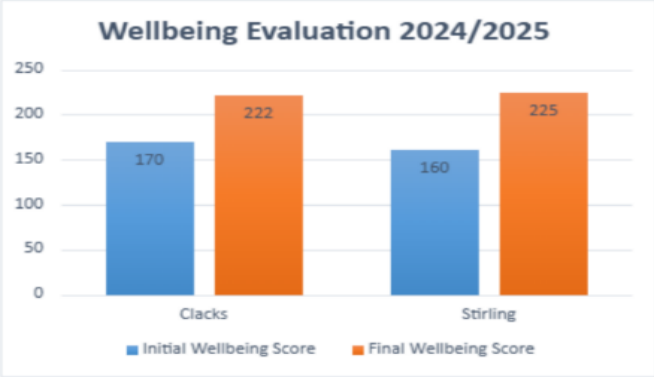
Community Connectors & Social Prescribing

The main aim of the Community Link Worker Project is to support activities that provide a person-centred and human rights approach. This is done by utilising social prescribing, which is 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 Community Link Workers (CLWs) promote the understanding of and access to self-directed support. It has been recognised that CLWs also provide one-to-one support to enable people to gain confidence to access local activities. The CLW programme was developed through partnership collaboration. Clackmannashire Third Sector Interfect and Stirlingshire Voluntary Enterprise, the Third Sector Interfaces in each of their respective local authority areas, are the employing organisations and the lead partners in the project. The interfaces provide the necessary resources, training, and supervision to ensure effective service delivery and professional development for the CLWs.

The CLW project ascertains the impact of their service in terms of the affects it has had on someone wellbeing. Using the ONS4 Wellbeing survey they focus on life satisfaction, meaning and purposefulness and someone's emotions. The impact of CLW supports clearly show a positive impact on those who used the services wellbeing.

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



Priority 10 Ethical Commissioning

Clackmannanshire and Stirling Health and Social Care Partnership have developed a collaborative approach to understand, plan and commission local services and care & support. The Commissioning Consortium is based on co-production regarding assessment and focus on delivery of 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), palliative & end of life care support (Strategic theme 3) and independent advocacy (Strategic Theme 1) with a new programme focused on mental health and well-being currently under deveelopment.

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 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.

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.

In 2024/25 there were commissioning consortium meetings covering the following topics:

- Dementia
- Alcohol and Drugs Partnership
- Carers
- Independant Advocacy
- Palliative and End of Life Care (this covers the whole of the NHS Forth Valley board area)

In 2025/26 there will be commissioning consortiums developed with a focus on learning disablities and mental health (the latter will be pan Forth Valley).

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.

Strategic Theme 5 – Reducing Loneliness and Social Isolation

Connecting people to their communities, reducing loneliness and isolation and the impact on people's health and wellbeing.

Priority 11 Reducing levels of Loneliness and Isolation

In 2024/25 613 Carers were offered Adult Carer Support Plans by the Carers Centres with 389 people choosing to complete one

Reducing lonliness and social isolation is important for everyone, whether someone is being cared for, they require care and support themselves, or whether they are supporting themselves without the use of statutory services. Our communtities provide an important network of supports. There are numerous supports avalible in our communties throughout Stirling and Clackmannashire, that cater to a range of interests and host a number of different activites for different groups of people.

Carers Centres provide support to unpaid carers, there is currently one that covers Clackammanshire and another that supports those living within Stirling. They empower people to understand their rights, and also provide options to develop peer supports. In the past year 642 new Adult Carers were registered with both Carer's Centres with 389 choosing to complete and adult carer support plan. As at 31st March 2025 there were 2926 Adult Carers registered with 1914 one to one appointments carried out throughout the year.

Another way that carers and those they care for can be supported is through our local directory of community supports and services. The Clackmannanshire & Stirling carers support pack has been compiled and is regularly updated, it is aimed toward both carers, and those they support. The resource is split into different catagories, to make it easier to use, and enable someone to see what services avaliable locally that would support specific needs.

Our third sector partners provide a wealth of care and support within our communtities. The Community and Mental Health Wellbeing Fund is now entering its fifth year and distributes around £400k annually between Clackmannanshire and Stirling.

The Community Mental Health and Wellbeing Fund supports grassroots initiatives aimed at improving mental health and wellbeing across Scotland, with a focus on prevention and early intervention. One of the key priorities is to address Social Isolation and Loneliness, specially looking at initiatives aimed at connecting individuals and fostering community support networks.

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 Large Hospital Services. The IJB then directs partners to deliver and/or commission services on its behalf.

The operational financial position on the Integrated Budget (the partnership budget excluding set aside budget for large hospital services) was a net overspend of £6.991 million after taking account of the impact of financial recovery measures.

£286.9m total IJB Strategic Plan Budget 2024/25

£6.991m net overspend after use of reserves

The 2024/25 Revenue Budget was approved by the IJB on 27 March 2024. The plan was predicated on a savings requirement of £14.041 million on the Integrated Budget and £6.469 million in relation to the Set Aside Budget for Large Hospital Services with risk assessed plans in place to deliver these. The budget was also predicated on utilisation of £3.947 million of reserves, fully depleting general reserves balances. Approximately 55.9% of the planned savings and efficiencies programme were achieved in the year in relation to the Integrated Budget with a c£1.5m reduction in costs pressures delivery being observed in relation to the Set Aside Budget for Large Hospital Services.

The overspend on the Integrated Budget was predominantly met by additional payments from the constituent authorities including £1.327m from Clackmannanshire Council which the Council have provided on the basis of this being repayable in 26/27. The unresolved risk share amount totals £0.421m and the dispute resolution process, in line with the requirements of the extant Integration Scheme is ongoing. The IJBs Annual Accounts are published here: Clackmannanshire and Stirling HSCP – Finance (clacksandstirlinghscp.org).

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 simpler 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 the Finance, Audit & Performance Committee which report to the IJB through committee chairs who are voting members of the IJB.

There was a change in the committees in January 2025, where the Finance, Audit & Performance Committee meetings convened its first meeting, both the Audit and Risk Committee and Finance and Performance Committees. The Finance, Audit and Performance Committee's purpose is to provide an effective scrutiny role to support the corporate governance of the IJB and its performance and risk management arrangements.

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.

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

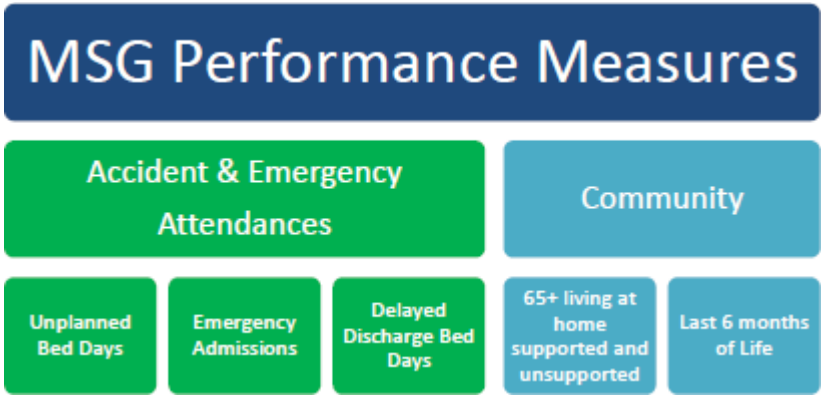
Clackmannanshire and Stirling Council services delegated to HSCP

- 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	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Desired trend or target
MSG1a	Number of emergency admissions (all ages)	For Info only	16,710	14,249	16,385	16,444	16,693	17,694	↓
	% change from previous year		22.08%	-14.73%	14.99%	0.36%	1.51%	6.00%	
	Number of emergency admissions (aged 18+)	ST1	14,579	12,640	13,941	14,202	14,595	15,738	**↓ 5% decrease from 2015/16 to 10,584**
	% change from previous year		24.61%	-13.30%	10.29%	1.87%	2.77%	7.83%	
MSG2a	Number of unscheduled hospital bed days (all ages); acute specialties	For Info only	103,032	85,668	98,920	109,855	109,827	108,888	↓
	% change from previous year		7.09%	-16.85%	15.47%	11.05%	-0.03%	-0.85%	
	Number of unscheduled hospital bed days (aged 18+); acute specialties	ST1	100,118	83,708	96,410	107,090	106,697	106,699	**↓ 5% decrease from 2015/16 to 88,804**
	% change from previous year		7.60%	-16.39%	15.17%	11.08%	-0.37%	0.00%	
MSG2c	Number of unscheduled hospital bed days (all ages); mental health specialties	For Info only	24,177	23,648	21,860	23,292	*23,061*	*Not available*	↓
	% change from previous year		-12.35%	-2.19%	-5.76%	-0.39%	-23.41%		
	Number of unscheduled hospital bed days (aged 18+); mental health specialties		23,640	23,026	21,629	23,044	22,601	*Not available*	**↓ 18% decrease from 2015/16 to 20,378**
	% change from previous year	ST1	-9.61%	-2.34%	-7.43%	6.55%	-0.99%		

Ref	Indicator	Strategic Theme	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Desired trend or target
MSG3a	A&E attendances (all ages) - patients from all areas	For Info only	40,552	28,388	36,805	36,430	32,769	30,727	↓
	% change from previous year		5.17%	-30.00%	29.65%	-1.02%	-10.05%	-6.23%	
	A&E attendances (aged 18+) - Patients from all areas	ST1	32,040	23,092	28,512	28,398	26,053	24,847	↓ Maintain 2015/16 baseline of 26,585
	% change from previous year		5.80%	-27.93%	23.47%	-0.40%	-8.26%	-4.63%	
MSG4a	Delayed discharge bed days (aged 18+) - All Reasons	ST1	12,630	9,355	13,518	14,786	15,624	19,792	↓ Maintain 2015/16 baseline of 10,069
	% change from previous year		14.65%	-25.93%	44.50%	9.38%	5.67%	26.68%	
MSG4b	Delayed discharge bed days (aged 18+) - Code 9	For Info only	2,540	3,482	2,608	5,446	6,963	9,571	↓
	% change from previous year		-13.66%	37.09%	-25.10%	108.82%	27.86%	37.46%	
MSG5a	Percentage of last 6 months of life spent in community (all ages)	ST3	88.19%	90.97%	89.59%	89.25%	89.45%**	*Not available*	↑ 4.1% increase from 2015/16 baseline to 90%
	% change from previous year		0.41%	2.78%	-1.38%	-0.34%	0.20%		
MSG6	Balance of care: Proportion of 65+ population living in Community or institutional settings - Home (supported) C&S HSCP	For Info only	4.95%	4.91%	4.40%	4.63%	4.93%	*Not available*	↑
	Scotland		4.49%	4.51%	4.13%	4.19%	4.35%		
	Balance of care: Proportion of 65+ population living in Community or institutional settings - Home (unsupported) C&S HSCP	For Info only	92.00%	92.00%	92.00%	92.00%	92.00%	*Not available*	↑
	Scotland		91.62%	91.98%	92.29%	92.16%	92.07%		
	Balance of care: Proportion of 65+ population living in Community or institutional settings - Home (Supported and unsupported)	ST3	96.96%	97.41%	97.29%	96.85%	96.53%	*Not available*	↑ 0.1% increase from 2015/16 baseline to 96.6
	Scotland	For Info only	96.11%	96.49%	96.43%	96.35%	96.42%		

** Figures for 2023/24 are provisional (p):- NRS deaths data for 2024 is provisional and may be revised in the future, SMR data in some areas may be affected by data completeness issues.

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 in July 2025.

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	Comparator Average	National average
Outcome Indicators	NI-1	Percentage of adults able to look after their health very well or quite well.	ST2	94.56%	93.64%	93.57%	91.74%	90.80%	↑	91.84%	90.70%
	NI-2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible.	ST2	81.65%	81.87%	76.05%	72.48%	67.20%	↑	71.90%	72.40%
	NI-3	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%	73.54%	74.37%	64.28%	57.90%	↑	63.73%	59.60%
	NI-4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated.	ST3	72.94%	76.47%	68.80%	61.68%	56.00%	↑	59.77%	61.40%
	NI-5	Total % of adults receiving any care or support who rated it as excellent or good.	ST3	77.64%	77.57%	75.20%	67.77%	64.80%	↑	70.51%	70%
	NI-6	Percentage of people with positive experience of the care provided by their GP practice.	ST3	86.72%	86.55%	78.79%	67.28%	72.30%	↑	71.34%	68.50%
	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.	ST3	77.05%	79.43%	79.12%	79.18%	66.10%	↑	69.46%	69.80%
	NI-8	Total combined % carers who feel supported to continue in their caring role.	ST4	32.36%	38.32%	29.65%	25.57%	32.80%	↑	31.87%	31.20%
	NI-9	Percentage of adults supported at home who agreed they felt safe.	ST3	81.60%	85.98%	83.51%	75.26%	66.80%	↑	71.43%	72.70%

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

Our Comparator HSCP's are Angus, East Lothian, Falkirk, Moray and Perth & Kinross

	Ref	Indicator	Strategic Theme	2020	2021	2022	2023	2024	Desired Trend	Comparator Average	National average
Data Indicators	NI-11	Premature mortality rate per 100,000 persons by Calendar Year	ST1	458	439	409	386	**Not available**	↓	396	441
				2019/20	2020/21	2021/22	2022/23	**2023/24**			
	NI-12	Rate of emergency admissions per 100,000 population for adults (18+).	ST1	13,211	11,776	12,835	13,076	**13,424 *2024**	↓	12,659	11,859
	NI-13	Rate of emergency bed day per 100,000 population for adults (18+).	ST1	109,741	96,425	106,686	116,414	**116,095**	↓	119,501	120,407
	NI-14	National Indicator 14 Emergency readmissions to hospital for adults (18+) within 28 days of discharge (rate per 1,000 discharges)	ST1	130	153	130	126	**122**	↓	115	104
	NI-15	Percentage of adults who rated their care or support as excellent or good.	ST3	88.2%	91.0%	89.6%	89.2%	**89.4%**	↑	89.2%	88.9%
	NI-16	Falls rate per 1,000 population aged 65+	ST1	23.5	20.2	23.6	23.5	**23.2**	↓	22.5	22.7
	NI-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	ST3	91.0%	91.1%	87.0%	80.8%	**84.6%**	↑	78.6%	77.0%
	NI-18	Percentage of adults with intensive care needs receiving care at home	ST2	69.8%	69.2%	71.2%	69.3%	**74.6%**	↑	65.0%	64.5%
	NI-19	Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population	ST3	665	448	743	776	**785**	↓	844	867
	NI-20	% of health and care resource spent on hospital stays where the patient was admitted in an emergency.	NA	23.0%	Not reported after 2019/20						

Data for indicators 12 is reported for the calendar year 2024 as a proxy for 2024/25 as data for the full financial year is incomplete at this time. Data for indicator 11 for calendar year 2024 is not currently available. Data is derived from various organisational/system datasets. This data is also available on the Public Health Scotland Website, you can access this here: publichealthscotland.scot

Our Comparator HSCP's are Angus, East Lothian, Falkirk, Moray and Perth & Kinross

Appendix 4 - Inspection of Services

Registered services operated by the Partnership are inspected annually by the Care Inspectorate. There were three registered service inspections during 2024/25. 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.

Inspection Summary

Registered Service	Date Inspection Completed	How well do we support people's wellbeing?	How good is our leadership?	How good are our staff team?	How good is our setting?	How well is our care and support planned?	Recommendations	Requirements	Areas for improvement
Menstrie House Care Home Service	02/10/24	Very good	Not assessed	Very good	Not assessed	Not assessed	0	0	0
Bellfield Centre Care Home Service	22/11/2024	Very good	Not assessed	Very good	Not assessed	Not assessed	0	0	1
Riverbank Centre & Streets Ahead Support Service	08/02/25	Very good	Very good	Not assessed	Not assessed	Not assessed	0	0	0
Care Inspectorate									

Between April and September 2024 a Joint inspection of adult services Integration and outcomes – focus on people living with mental illness took place. The report was then published in November 2024.