INVERCLYDE HSCP
Health and Social Care Partnership

Health and Social Care Partnership

People and Partnerships, Making a Difference

Annual Performance Report (APR) 2024 - 2025

Inverclyde council

NHS Greater Glasgow and Clyde

Greenock Ocean Terminal, Inverclyde's new cruise ship visitor centre and community facility was officially opened on 25 August 2023. The project, led by Inverclyde Council, is part of the £1 billion Glasgow City Region City Deal funded by the Scottish and UK governments, with contributions from Peel Ports and the George Wyllie Foundation via Dunard Fund. The facility features an arrivals and departures hall, Scott's restaurant and bar, and the Wyllieum, an exhibition and gallery space, paying tribute to famous artist George Wyllie who worked in Greenock and lived in Gourock.

Photo: David Barbour Photography **Find out more about what Inverclyde has to offer at discoverinverclyde.com**

This document can be made available in other languages, large print, and audio format upon request.

Arabic
هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

Cantonese
本文件也可應要求，製作成其他語文或特大字體版本，也可製作成錄音帶。

Gaelic
Tha an sgrìobhainn seo cuideachd ri fhaotainn ann an cànanan eile, clò nas motha agus air teip ma tha sibh ga iarraidh.

Hindi
अनुरोध पर यह दस्तावेज़ अन्य भाषाओं में, बड़े अक्षरों की छपाई और सुनने वाले माध्यम पर भी उपलब्ध है

Kurdisch
Li ser daxwazê ev belge dikare bi zimanên din, çapa mezin, û formata dengî peyda bibe.

Mandarin
本文件也可应要求，制作成其它语文或特大字体版本，也可制作成录音带。

Polish
Dokument ten jest na życzenie udostępniany także w innych wersjach językowych, w dużym druku lub w formacie audio.

Punjabi
ਇਹ ਦਸਤਾਵੇਜ਼ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਵਿਚ, ਵੱਡੇ ਅੱਖਰਾਂ ਵਿਚ ਅਤੇ ਆਡੀਓ ਟੇਪ 'ਤੇ ਰਿਕਰਾਡ ਹੋਇਆ ਵੀ ਮੰਗ ਕੇ ਲਿਆ ਜਾ ਸਕਦਾ ਹੈ।

Soraini
ئەم بەڵگەنامەیە دەتوانرێت بە زمانەکانی تر و چاپی گەورە و فۆرماتێکی دەنگی لەسەر داواکاری بەردەست بکرێت.

Tigrinya
እዚ ሰነድ እዚ ብኻልኦ ቋንቋታት፡ ብዓቢ ፊደላትን ብድምጺ ቅርጽን ምስ ዝሕተት ክቐርብ ይኽእል።

Urdu
درخواست پر یہ دستاویز دیگر زبانوں میں، بڑے حروف کی چھپائی اور سننے والے ذرائع پر بھی میسر ہے۔

Ukrainian
За запитом цей документ може бути доступний іншими мовами, великим шрифтом та аудіоформатом.

Inverclyde HSCP, Clyde Square, Greenock, PA15 1NB ☎ 01475 715365

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FOREWORD

Kate Rocks
Chief Officer of
Inverclyde HSCP

Welcome to the Inverclyde Health and Social Care Partnership's (HSCP) Annual Performance Report (APR) for 2024/2025.

This report reflects the progress and impact of our work over the last year and offers a snapshot of the difference we are making to the lives of people, families, and communities across Inverclyde. While our previous Strategic Plan (2019–2024) was shaped around the Six Big Actions, this year marks the beginning of a new chapter for the HSCP with the launch of our Strategic Partnership Plan 2024–2027, which sets out our new Strategic Priorities. These priorities have been developed in response to the evolving needs of our population and reflect our ambition to achieve better outcomes for all.

We continue to operate in a context of complexity and challenge. Like many areas across Scotland, Inverclyde experiences persistent health inequalities, rising demand for services, and the far-reaching impacts of the national cost-of-living crisis. These pressures are felt most acutely by the people who need our support the most. Despite these challenges, Inverclyde HSCP remains committed to delivering high-quality, person-centred care and support that improves lives and enhances wellbeing.

Throughout 2024/2025, our teams have worked tirelessly, showing professionalism, resilience and compassion. Our strong partnerships with colleagues in the third and independent sectors, local communities, and wider public services have been key to sustaining and improving the support we offer. The integration of health and social care continues to bring real benefits to the people of Inverclyde, and this report demonstrates the value of that collective effort.

Our APR outlines our contribution towards delivering the National Health and Wellbeing Outcomes and illustrates how our new strategic direction is already beginning to shape the way we deliver services. It highlights both achievements and areas where improvement is needed – we are committed to ongoing reflection, learning, and improvement as part of our drive for excellence. Reflecting on the impact of our new outcome's framework, we are heading in the right direction in meeting our strategic priorities and showing the impact for our people and partnerships.

We remain ambitious for Inverclyde, for the people who live here and for the staff and partners who serve them. It is a privilege to lead this Partnership, and I am proud of everything we have accomplished together over the past year.

Kate Rocks
Chief Officer
Inverclyde HSCP

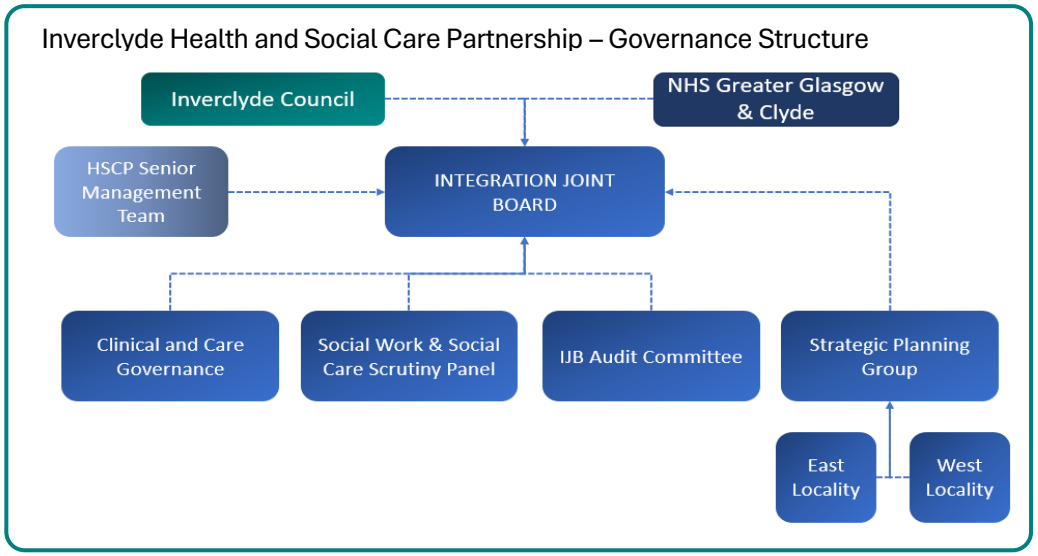
SECTION 1: INTRODUCTION

The Public Bodies (Joint Working) (Scotland) Act 2014 places an obligation on Integration Joint Boards (IJB) to publish an Annual Performance Report at the end of July each year. This report should cover the previous service year (from April 2024 to March 2025), and evidence how Inverclyde Integration Joint Board (IJB) has made progress towards local health and care priorities and the nine national health and wellbeing outcomes. (**Refer to Appendix 1** for the National Health and Wellbeing Outcomes and **Appendix 2** that outlines how our ambitions align with the National Health and Wellbeing Outcomes)

This is the ninth Annual Performance Report for Inverclyde Integration Joint Board (IJB). It provides an overview of our progress throughout 2024/2025 and marks the first year of reporting against our new Strategic Partnership Plan, *People and Partnerships, Making a Difference* (2024–2027). The report highlights key service developments and areas of innovation and reviews our performance against the National Integration Indicators (NII) and the indicators set by the Ministerial Steering Group (MSG) for Health and Community Care.

IJB Governance

This image shows the governance structure of Inverclyde IJB, highlighting the relationships with the parent organisations of Inverclyde Council and NHS Greater Glasgow and Clyde (NHSGGC) and identifies some of the key governance and strategic groups that support it.



How we monitor our Strategic Partnership Plan

Our Strategic Partnership Plan is monitored and overseen by our Strategic Planning Group (SPG). This group, chaired by the HSCPS Chief Officer, brings together key officers from the Health and Social Care Partnership (HSCP) and is established in line with national guidance under Section 32 of the Strategic Commissioning Plan regulations.

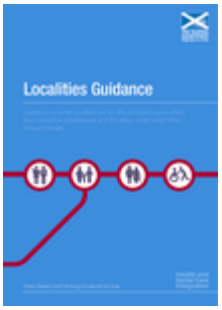
The group plays a vital role in shaping and reviewing our strategic priorities, ensuring we stay focused on delivering better outcomes for people and communities.

In line with legislation, the group includes representatives from a broad range of stakeholders, reflecting the voices and interests of those who use and deliver health and social care services. This includes:

- People who use health and social care services
- Carers
- Health and social care professionals
- Members of the Integration Joint Board
- Third sector organisations
- Housing providers
- Independent and voluntary care providers

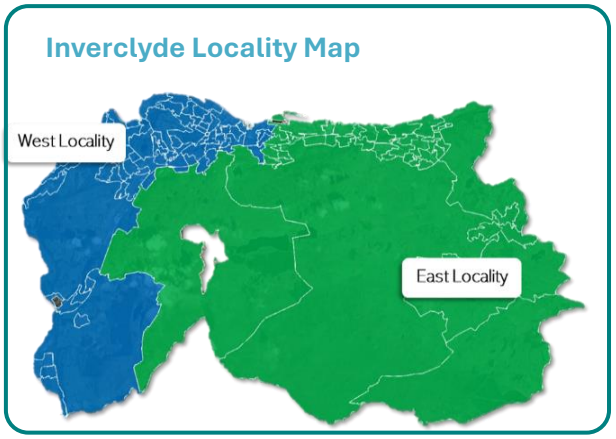
This inclusive approach helps ensure that our planning remains person-centred, collaborative, and responsive to the needs of our population.

Our People and Localities



People are at the heart of Inverclyde. By working in partnership with our communities and learning from your experiences, we can better support health and wellbeing and continue to improve how we design and deliver services.
We are committed to maintaining and strengthening our two Locality Planning Groups, which enable focused, meaningful conversations within communities about what matters most to local people.

- The **East Locality** includes Kilmacolm, Port Glasgow, and East Greenock.
- The **West Locality** includes Greenock Central, Greenock West, Gourock, Inverkip, and Wemyss Bay.



Progress on Locality Planning Groups (LPGs)

In 2024–25, Inverclyde HSCP made significant progress in strengthening our Locality Planning Groups (LPGs), building on the foundations and our ongoing commitment to community-led planning and co-production. A key milestone this year was the joint Locality Planning Groups (LPGs) development session held on Tuesday 26th November 2024 at Gibshill Community Centre, which brought together representatives from across East and West Inverclyde.

Highlights of the November Development Session

The development session, co-facilitated by HSCP officers and key Third Sector partners including CVS Inverclyde and Your Voice, served as a turning point in refreshing the vision and practice of our Locality Planning Groups (LPGs). Structured around the Appreciative Inquiry model, the session encouraged a strengths-based approach to future planning.

Key aims and outcomes included:

- Networking and relationship building across sectors and communities.
- Shared learning about the purpose, evolution, and future of LPGs.
- Participatory planning through structured conversations on discovery, dreaming, design, and destiny.
- Increased momentum and motivation, with a clear appetite for collaborative and inclusive change.

Themes Emerging from the Session

Participants including health and social care staff, community representatives, carers, people with lived experience and housing colleagues shared open, constructive reflections on what matters most in their communities. Key themes included:

- A call for stronger representation and inclusion, particularly of carers, young people, and people with lived experience.
- Clearer alignment with strategic priorities through focused, themed discussions at future

Locality Planning Group (LPG) meetings.

- A shared desire to reduce duplication, identify local service gaps, and enable more coordinated multi-agency responses.
- The need for safe, welcoming community spaces that promote meaningful engagement, supported by open, jargon-free communication.
- A commitment to genuine co-production, with HSCPs taking on a more facilitative, coordinating role.

These themes have helped shape our ongoing locality planning approach ensuring that community voices drive change, actions reflect local need, and partnerships deliver impact where it matters most.

Next Steps and Recommendations

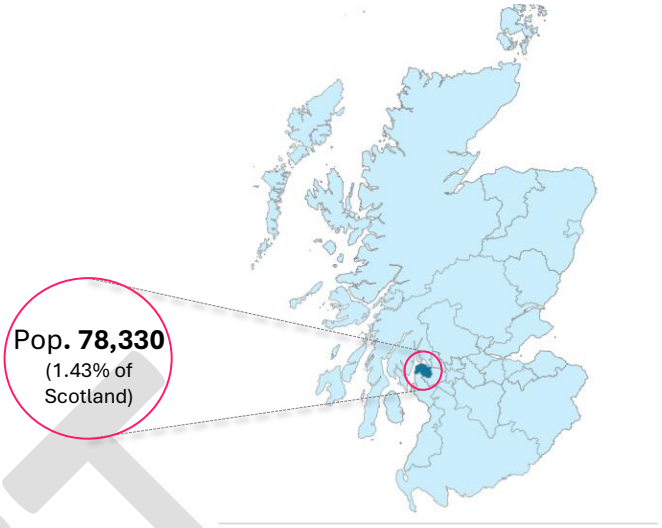
As a direct result of this session, we are:

- Developing clear terms of reference for Locality Planning Groups (LPGs) to outline purpose, scope, and member roles.
- Transitioning to community-based, hybrid meetings to improve accessibility and engagement. Exploring new models of leadership, with a view to community-led facilitation supported by HSCP.
- Enhancing membership diversity and lived experience representation.
- Creating mechanisms to ensure a “You said, we did” approach, tracking the impact of community input.

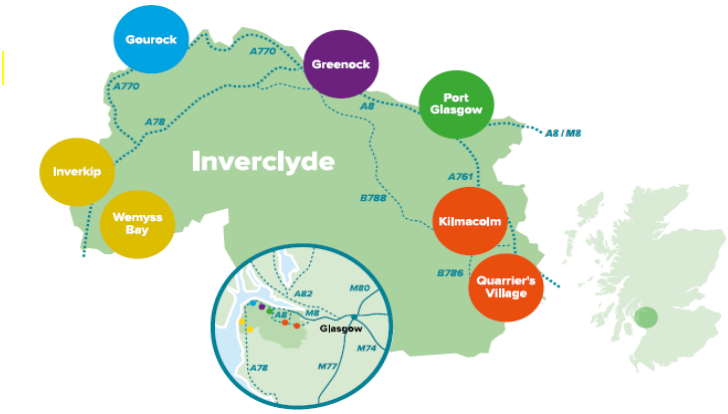
Our Locality Planning Groups play a pivotal role in shaping and directing our priorities, ensuring that planning leads to outcome-focused services within Inverclyde’s communities. We believe that planning for people must be done *with* people, and our "test, learn, develop" approach relies on the expertise and lived experience of residents to inform the future design and delivery of services. As we approach the end of the current strategic partnership plan cycle, our ambition is to evaluate the impact of Locality Planning Groups in delivering on our priorities and driving meaningful changes across the area.

Inverclyde Today

Inverclyde is in West Central Scotland, along the south bank of the River Clyde. It is amongst the smallest local authority areas in Scotland, home to **78,330 people**. This amounts to only 1.4% of Scotland overall population. Inverclyde's population continues to fall and is expected to decrease by 3.2% over the next four years. Within this decrease we are witnessing a shift in the local age structure, decreases in younger people and working age adults being offset by an increase in the population of those aged 65 and over.



Women account for **51.8%** of Inverclyde's population, with men accounting for **48.2%.** Women account for a greater proportion of the population of Inverclyde compared to Scotland, with women accounting for **51.4%** nationally.



Age Group	% Inverclyde	% Scotland
0 to 17	17.5%	18.5%
18 to 64	59.7%	61.2%
65 plus	22.8%	20.3%

Source: NRS population projections for Scottish Areas June 2022

Our Resources

Inverclyde HSCP has responsibility for, and delivers, an extensive range of services across primary care, health and social care and through several commissioned services.

Approx **1,713** (*1,401.6 Full Time Equivalent*) HSCP staff working across a range of services and disciplines.

- 13 GP Practices
- 10 Dental Practices
- 9 Opticians
- 19 Pharmacies
- 152 Commissioned Services

Strategic Direction

This report marks the beginning of a new chapter for the HSCP, aligning with the launch of our Strategic Partnership Plan 2024–2027. The achievements and evidence presented here reflect the collective efforts across our partnership to deliver on our newly defined Strategic Priorities. They also highlight our shared ambition to improve the outcomes and make a meaningful difference in the lives of the people we serve. Our Strategic Partnership Plan, 'People and Partnerships, Making a Difference', can be accessed here.

Our Strategic Vision

At Inverclyde Health and Social Care Partnership (HSCP), our vision is that everyone in Inverclyde can live full, healthy lives, free from barriers to opportunity and positive outcomes, supported by compassionate, person-centred services. This is captured in our Partnership Vision, which is:

> Inverclyde is a compassionate community, working together to ensure people live active, healthy, and fulfilling lives.

This vision drives our collective ambition and underpins all that we do. We recognise that realising this vision requires us to work differently - together with communities, staff and partners to address the complex health and social care challenges faced locally.

Our Context and Commitment

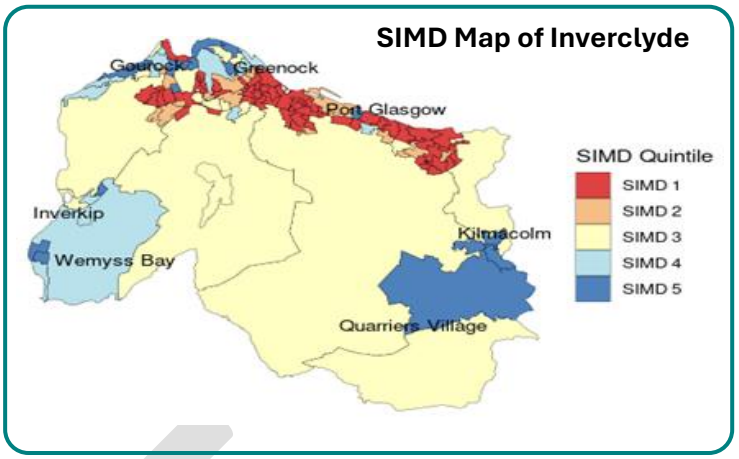
We know that not everyone in Inverclyde experiences the same opportunities for health, wellbeing, and quality of life. The Inverclyde Adult Health and Wellbeing Survey (Feb 2024) conducted by NHS Greater Glasgow and Clyde, confirms that inequalities have widened in the wake of the pandemic. Things are not equal for everyone, and we need to do something about that.

We are committed to tackling these inequalities head-on. This means making bold changes, being innovative in our approach and using our collective strengths across sectors to deliver better outcomes. Our vision is not just aspirational; it is shaped by real needs and geared towards actual results.

We recognise that a one-size-fits-all approach does not work. To make meaningful progress, we must focus our efforts and resources on the individuals and communities who face the greatest challenges. By doing so, we can lift overall outcomes while ensuring that those who need the most support receive it. This approach reflects our commitment to fairness, dignity and improving lives for all, not just the few.

Inverclyde is a caring and compassionate place. Our Strategic Partnership Plan (2024–2027), *People and Partnerships, Making a Difference*, sets out how we will build on this foundation by supporting individuals to live active, healthy, and fulfilling lives, particularly those facing the most significant barriers.

Some of our challenges



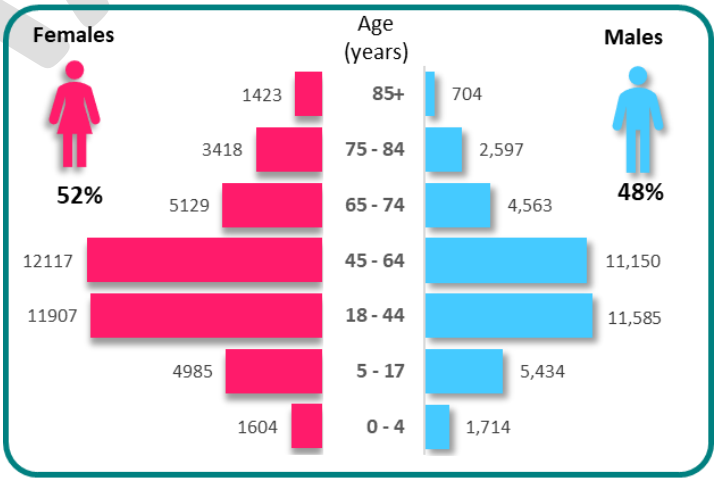
The level of poverty and inequality in Inverclyde is stark. According to the Scottish Index of Multiple Deprivation (SIMD), the levels of poverty and deprivation in Inverclyde are, proportionately amongst the highest in Scotland. It reports that **43%** of local people live in areas that are among the most deprived in the country (SIMD 1). This is second only to Glasgow, where 44% of the population live in SIMD 1 areas.
People living in those areas are more at risk of the negative impacts of poverty and deprivation. As a result, they are more likely to experience several adverse outcomes, including physical health challenges, complex long-term medical conditions, negative mental health and wellbeing, social exclusion, and food insecurity.

While levels of poverty and deprivation are high in Inverclyde, they are not spread evenly among the population. As figure 1.1 shows, areas of high deprivation are not dispersed across Inverclyde, instead high deprivation areas are clustered across specific communities, particularly in Port Glasgow and the East End of Greenock.
As a result, levels of inequality in Inverclyde are high with many people and communities experiencing significantly less positive social, economic and health and wellbeing outcomes than residents in least deprived areas.

Population

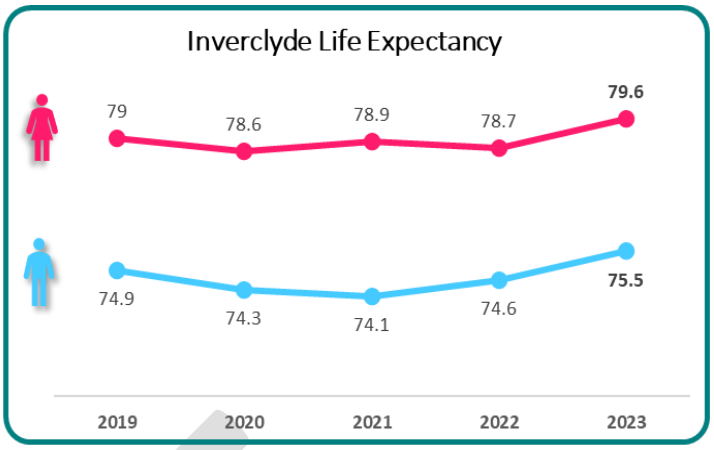
The latest population estimates for Inverclyde were published by National Records for Scotland (NRS) in October 2024, estimating for mid-year 2023.

Overall, Inverclyde had an estimated total population of 78,330. This accounts for only 1.4% of Scotland's total. Like other places in Scotland, the population of Inverclyde has decreased over the past few years. This is expected to continue with the local population expected to decrease by a further 3.2% by 2028. The image opposite, shows the breakdown of the local population by Sex and key age group. Overall, females account for 52% of the local population.



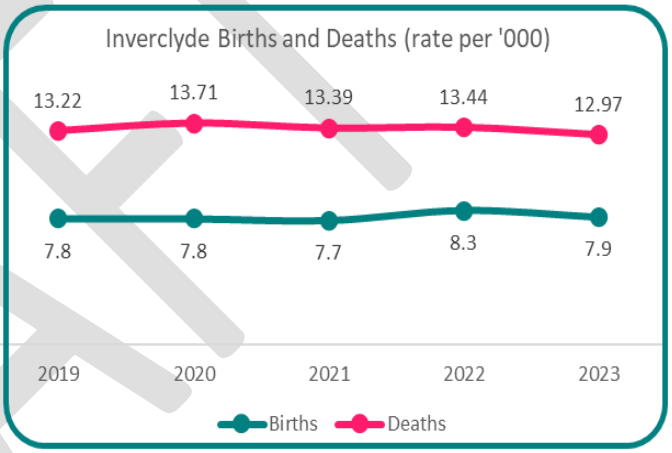
Life Expectancy

In the most recent reporting period, life expectancy for women in Inverclyde increased to 79.6 years, for men it increased to 75.5 years. While these increases are welcome, for both women and men, life expectancy falls below that of the national average (80.8 years for women and 76.8 years for men)
In terms of healthy life expectancy, women can expect to live only 59.3 years of their life in good health, and men 57.7 years. Again, these are lower than the Scottish average.



Births and Deaths

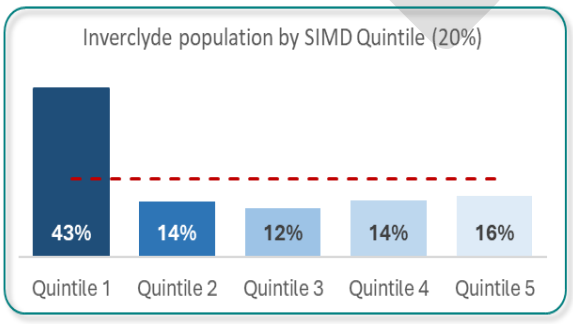
In 2023 NRS reported a decrease in the local birth rate in Inverclyde, rising to 7.9 births (crude rate per one thousand of the local population). This is compared to 8.3 reported in 2022. At 7.9, the birth rate in Inverclyde was lower than the overall Scottish figure of 8.4. NRS also reported a decrease in the rate of deaths in Inverclyde, falling to 12.97 per one thousand (age-sex standardised rate). This is compared to 13.44 per thousand reported in 2022. Again, the rate of deaths in Inverclyde is higher than 11.72 reported for Scotland as a whole.



The chart opposite demonstrates how the Inverclyde death rate has been continually higher than the birth rate over the past five years. This is a contributing factor to the local population decline.

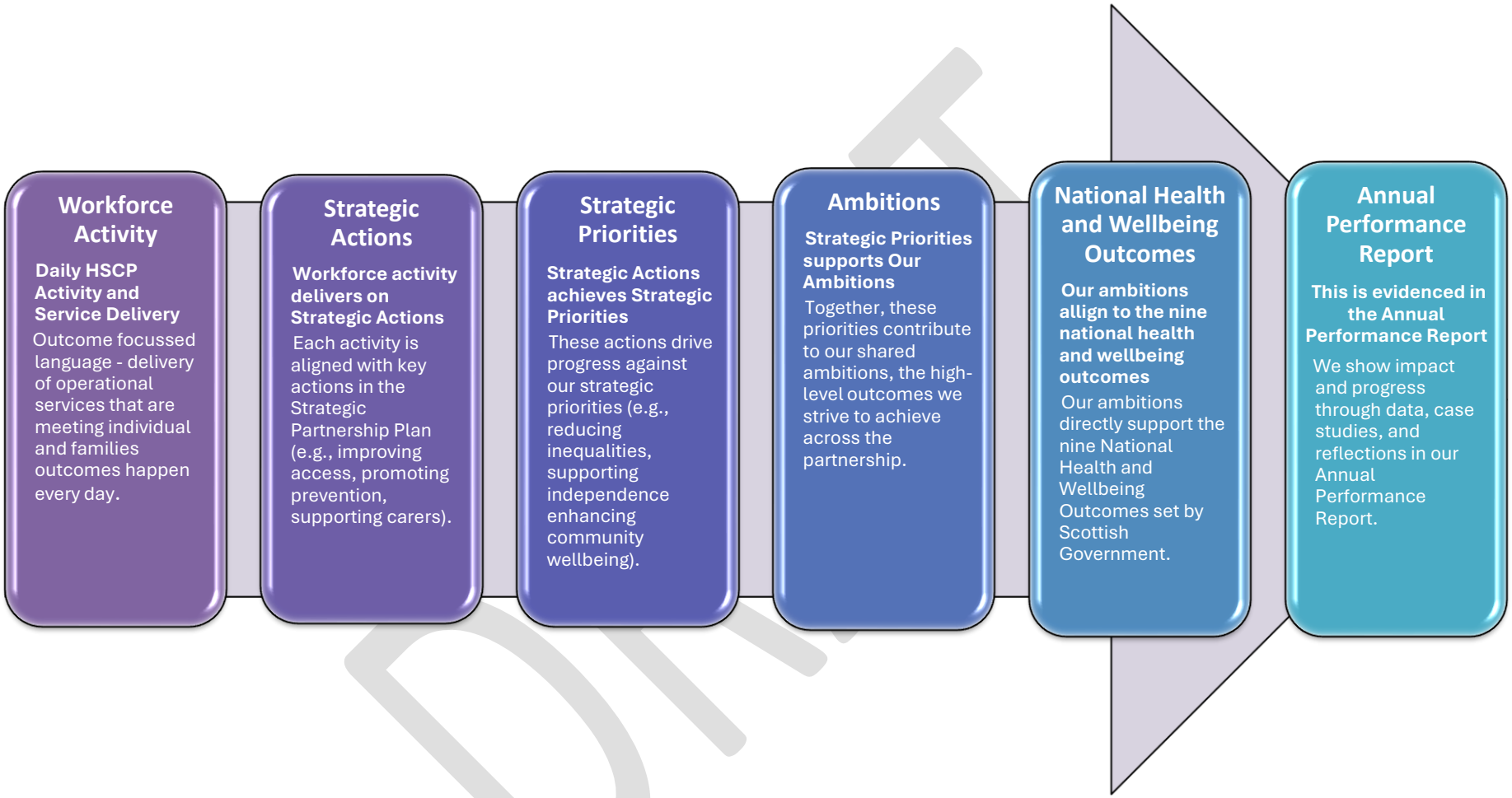
Deprivation

As highlighted before (page 7) Inverclyde faces a significant challenge in the form of poverty and deprivation. The most recent SIMD figures (2020) highlight that **43%** of the local population live in areas that are considered the most deprived in Scotland.



The opposite image demonstrates the breakdown of SIMD quintiles in Inverclyde. As highlighted, **over 40%** of the local population live in the most deprived quintile, with the rest of the population more evenly distributed across the other four. In addition, child poverty in Inverclyde is amongst the highest in Scotland, with almost 1 in 4 (24%) of local young people affected.

The Golden Thread of HSCP Work: From Daily Delivery to National Impact



Our Ambitions

To bring our vision to life, we have defined a series of ambitions that will guide how we deliver services and work in partnership with others:

1) We will listen to and learn from our people, staff, and communities to ensure timely and appropriate access to support.
2) We will target our resources to where they are needed most, addressing inequalities across our communities.
3) We will maintain and enhance the delivery of safe, effective, and timely care.
4) We will ensure all our services are trauma-informed and focus on recovery and continuous improvement.
5) We will co-design services with local people, ensuring they reflect lived experiences and meet real needs.
6) We will work alongside third and independent sector partners to support people with complex needs to live independently.
7) We will support carers and families, providing the help they need to continue in their caring roles.
8) We will empower our workforce to innovate and collaborate, enabling better responses to the needs of individuals and communities.
9) We will support people through key life transitions, particularly those with complex needs.
10) We will take a system-wide approach to care planning, ensuring it is proactive, person-centred, and sustainable.
11) We will ensure everyone who needs palliative care receives compassionate, high-quality support, aligned with their needs and wishes, from diagnosis to dying well.

Our Strategic Priorities

Informed by engagement, data and our learning we set **four strategic priorities** that replace the previous "Six Big Actions" and will shape our work over the next three years. These are:

- Provide Early Help and Intervention
- Improve Support for Mental Health, Wellbeing and Recovery
- Support Inclusive, Safe and Resilient Communities
- Strengthen Support to Families and Carers

These priorities are designed to tackle the varied and complex needs across Inverclyde, and the integrated approach required to address them. They are also closely aligned to the five local themes of the Inverclyde Partnership Plan 2023/33 - Inverclyde Council reinforcing our collective commitment to community wellbeing. In SECTION 3, we will outline what each of these priorities means in practice, how we plan to achieve them and the performance measures we will use to track progress.

Review of our Strategic Priorities

As part of our ongoing commitment to strengthen our strategic priorities, we have revisited the language used within them. This has been driven in response to feedback gathered through our locality planning group members, engagement sessions and our Strategic Partnership Group (SPG).

As below in the table, we are proposing changes to the wording of the priorities to better reflect the values of autonomy, collaboration and empowerment. Specifically, we have removed the use of *"support,"* as it was felt this could unintentionally suggest a more paternalistic approach, rather than one that encourages individuals to take ownership of their own health and wellbeing. Similarly, we have removed *"intervention"* following consistent feedback from those with lived experience who described this term as feeling like something *being done to them* rather than *with them*.

CURRENT Strategic Priority	PROPOSED CHANGE to Strategic Priority
Provide Early Help and Intervention	Provide Early Help
Improve Support for Mental Health, Wellbeing and Recovery	Improve Mental Health, Wellbeing and Recovery
Support Inclusive, Safe and Resilient Communities	Inclusive, Safe and Resilient Communities
Strengthen Support to Families and Carers	Strengthen Families and Carers

Equalities: Mainstreaming the Public Sector Equality Duty

As a listed public authority, Inverclyde Integration Joint Board (IJB) is committed to embedding equality and human rights across all strategic planning and delivery of health and social care services. In line with the requirements of the Equality Act 2010 and the Public Sector Equality Duty (PSED) Public Sector Equality Duty: guidance for public authorities - GOV.UK, the IJB published a revised Equality Outcomes Plan (2024–2028) in May 2024. This sets out the Board's approach to mainstreaming equality within everyday business.

The Plan outlines four local Equality Outcomes:

1. Inverclyde's most vulnerable and often excluded people are supported to be active and respected members of their community.
2. We have improved our knowledge of the local population who identify as belonging to protected groups and have a better understanding of the challenges they face.
3. Children and Young People who are at risk due to local inequalities, are identified early and supported to achieve positive health outcomes.
4. People that are New to Scotland, through resettlement or asylum, who make Inverclyde their home feel welcomed, are safe, and able to access the HSCP services they may need.

Progress is closely monitored, with six-monthly updates provided to the IJB. The first progress report (October 2024) confirmed that 16 out of 18 actions **(89%) were on track**, one action was completed, and one was under review.

The Equality Outcomes are not standalone they are closely aligned with the HSCP's Strategic Partnership Plan and delivery frameworks. For example, actions supporting Outcomes 2 and 3 are directly drawn from the Strategic Plan, demonstrating a clear commitment to mainstreaming equality rather than treating it as a parallel workstream. This approach ensures services are designed and delivered in ways that are equitable, inclusive, and responsive to the diverse needs of Inverclyde's population.

The IJB will continue to publish updates and is committed to producing a full progress report on the Equality Outcomes by May 2026, as required under the Equality Act (Specific Duties) (Scotland) Regulations.

Reviewing Our Equality Outcomes

As we continue to progress our Strategic Partnership Plan, we recognise the need to review our Equality Outcomes to ensure they are clearly aligned with our four strategic priorities. This will help us to better measure the impact of our work and ensure that our efforts remain focused on delivering what matters most to the people and communities we support.

Our Health and Social Care Partnership (HSCP) services are designed and targeted to help achieve these outcomes.

Strategic Partnership Plan on a Page 2024-27

OUR VISION	"Inverclyde is a compassionate community, working together to ensure people live active, healthy, and fulfilling lives"			
OUR APPROACH	Focussing resources where most needed	Person Centred/ Trauma Informed	Empowering Communities	Working in Partnership
Our Strategic Priorities and what we will do				
Provide Early Help and Intervention	**Improve Support for Mental Health, Wellbeing and Recovery**	**Support Inclusive, Safe and Resilient Communities**	**Strengthen Support to Families and Carers**	
Improve early and timely access to our services. People with complex health conditions are supported to remain independent with good health and wellbeing. Help divert people away from harmful behaviours that impact on their health and wellbeing. Improve services for the community that build on the individual's family and community strengths and assets whilst focussing on the impact of trauma and recovery focussed provision. We will build capacity in our workforce to build intervention approaches for our people and families.	Support people to identify the signs of wellbeing concerns and how to address them. We will ensure that we will improve how we deliver person-centred support for people, focussing on transitions. Work with partners to improve mental health and wellbeing support for those experiencing inter-generational trauma, homelessness, care experienced and the justice system. Continue to strengthen inter and intra relationships with all HSCP services. Through reviewing our commissioning strategy, we will strengthen our intentions to focus on people who have more complex needs.	Our children and young people will be provided with the effective care and support to keep them safe in their communities. Continue to welcome people new to Scotland. We will support people with less positive outcomes to live healthy, constructive, and purposeful lives within their community. We will work with our community to challenge the impact of stigma for people who have mental health and addictions. We will develop closer working relationships with local employability providers to improve access to work.	People will be at the heart of all decisions. In partnership we will provide services that support families and carers to keep family members at home. We will support the families and carers of people with less positive outcomes to live healthy, constructive, and purposeful lives within their community. We will provide support to people who can no longer remain in the family home helping them to avoid homelessness. We will implement the outcome of the respite review to deliver different models of care. Our workforce will be trained in evidence-based models that help strengthen the capacity of families and carers. Building on the assets of families, we will identify supports that are underpinned by the principles of the Self-directed Support (SDS) options.	

OUR ENABLERS	Service Redesign	Local People and Communities	Our Workforce	Local Partners	Our Financial Plan	Equality Outcomes Plan	Commissioning Plan	Housing Contribution Statement

OUR PERFORMANCE	Local Performance Measures	Local Outcomes Framework	National Integration Indicators	MSG Indicators	LGBF Indicators

SECTION 2: PERFORMANCE

To help ensure we are moving in the right direction, we use a broad range of key performance indicators. These measures tell us how we are performing in key areas of our service and help us in our decision-making as we continually seek to improve the services we provide to local people.

Many of our key performance indicators have been agreed upon by national organisations, and as such we are obligated to report on them. These national frameworks are:

- The Scottish Governments National Integration Indicators **(See Appendix 3a.)**
- The Ministerial Group Indicators **(See Appendix 3b.)**
- Local Government Benchmarking Framework Indicators **(See Appendix 3c.)**

At the local level we have developed an Outcome's Framework to help us evaluate how we are progressing against the key priorities identified in our Strategic Partnership Plan. This framework has been developed to help us demonstrate the impact of what we do has on those who access our services.

In this report, reporting against the measures in our outcome's framework is reported in Section 3, with scorecards presented at the end of each Priority Section.

Our Outcomes Framework

Following the publication of our Strategic Partnership Plan, we began developing a new Outcomes Framework. This was created in partnership to help us evaluate our progress in delivering our strategic vision and priorities. By focusing on outcomes and the difference our work makes to individuals, families and communities we aim to strengthen our impact, our people and our partnership. While we continue to monitor processes and measure outputs, this framework allows us to better demonstrate how our actions are improving the lives of those who access our services.

Our Approach

To shape our Strategic Partnership Plan, we collaborated closely with colleagues across the HSCP and wider partners to define a clear set of deliverables aligned to each of our four strategic priorities. This process resulted in 32 Strategic Actions; each linked to a specific and measurable outcome. To support this development, a series of performance workshops were held during summer 2024. These sessions focused on identifying meaningful outcome measures, those that best demonstrate the impact of our actions and our progress towards each desired outcome.

Our performance framework remains under development and review; we are working hard to further develop some of the agreed measures as they have not been previously collected. We are taking a test, learn and develop approach in the implementation of new services and as such measures will be developed in line with this. Some measures are dependent on the implementation of new service developments and will be introduced as those changes take effect, for others we continue to identify clear information sources and processes. We are committed to maintaining a dynamic and responsive outcomes framework, one that is regularly reviewed, evaluated and refined to ensure we are measuring what truly matters and that we remain focused on the delivery of our Strategic Partnership Plan.

SECTION 3: OUR IMPROVEMENT JOURNEY

Strategic Priority: Provide Early Help and Intervention

What strategic direction underpins this priority?

To improve the health and wellbeing of our communities, we are shifting our focus toward prevention and early help. Collaboration with our local partners demonstrates positive outcomes as we are developing and investing in community-based programmes that empower individuals to make healthier choices and manage their well-being more effectively. Inverclyde Health and Social Care Partnership (HSCP) is committed to transforming access to our services by redesigning our 'front doors', ensuring people and families are seamlessly connected to the right support, at the right time, in the right way. This approach is embedded across all life stages and transitions to ensure proportionate responses that reduce risk, promote resilience and improve long-term outcomes.

Strategic direction and performance overview

At the outset of this reporting period, we set out a clear strategic direction: to improve the health and wellbeing of our communities by focusing on early help and prevention, and more accessible, person-centred support. This section reflects on what we said we would do and what we have done, it highlights our progress, the impact and our learning and developmental needs.

Whole Family Wellbeing Fund: Supporting Families Early to Improve Outcomes

The Scottish Government's Whole Family Wellbeing Fund (WFWF) Whole Family Wellbeing Funding - Getting it right for every child (GIRFEC) - gov.scot launched in 2022. It aims to ensure families receive the right support at the right time for as long as needed, enabling children to grow up safely and thrive within their own families. The fund supports transformational change in how services work with families, with a national goal to reduce crisis intervention and the number of children entering care by 2030. A key ambition is to shift 5% of community-based health and social care investment towards early, preventative family support.

In Inverclyde, with a budget of £200k per year for two years, the Whole Family Wellbeing Fund (WFWF) has enabled us to scale up our outreach service, expand access to whole family support, and develop intensive, locally based services for children with complex needs contributing directly to the ambitions of The Promise. The early prevention work of the WFWF is showing measurable impact in reducing the pressure on the Request for Assistance Team in Social Work. The early Prevention Hub is working well with plans in place to ensure sustainability.

Local successes include

- Earlier and more coordinated support for children and families.
- Improved access to help before challenges escalate.
- Reduced need for statutory social work involvement.
- A measurable decrease in Interagency Referral Discussions (IRDs).

This work reflects our commitment to prevention, early help and supporting families to stay together and thrive, in line with national priorities and local aspirations.

Integrated Front Door Service Redesign and Innovation

As part of our commitment to the strategic priority of Early Help and prevention, we have made considerable progress this year in redesigning and modernising our approach to service delivery. A dedicated project group has been established to drive this transformation, and we are currently progressing through Phase 1, focusing on critical adult services including Adult Social Work, Access First (1st), Advice Services, rehabilitation and enablement services (RES), respite care, care at home, day care and the integration of assistive technology.

Work to date has involved an in-depth review of current processes, alongside extensive data gathering, stakeholder consultations is underway, and option appraisals are being developed to ensure future proposals are informed, inclusive, and evidence based. We are on track to present a Phase 1 proposal by the end of summer 2025, with implementation scheduled for winter 2025, ahead of progressing to Phase 2.

Recognising the importance of digital transformation in improving access and early help, we are test, learning and developing our capacity to modernise through digital infrastructure. A key component of this will be the development of an online referral system and apps, that are all aimed at streamlining access to services and reducing unnecessary delays for individuals and families in need.

Our improvement activity within Children and Families is progressing, with a focus on prevention and diverting Children and Young People from statutory services by strengthening our relationship with our third sector partners to provide family best solutions that build on the capacity and resilience of the child or young person. One of the key successes has been the development of multi-agency family wellbeing hub that has our third sector partners as key decision makers in response to early and coordinated support.

As we implement our test, learn and develop approach we are sharing the impact of this learning across the wider HSCP services to ensure that shared standards, approaches, and learning are embedded across all areas. This ensures alignment and consistency as we drive forward whole-system transformation. We are seeing whole system progress in ensuring a more joined-up, proactive, and digitally enabled model of care. Together, these efforts reflect real progress towards our strategic priorities, ensuring individuals and families receive the right help at the right time, while reducing pressure on crisis and statutory services.

Reducing Unscheduled Care through Prevention

Unscheduled care including Emergency Department (ED) visits, out-of-hours services and unplanned hospital admissions remains one of the most resource-intensive and challenging areas of the health and social care system. The impact of this can be distressing and disruptive for individuals and families, particularly those living with long-term conditions or frailty. A key ambition of early help and prevention is to shift the balance of care upstream, acting earlier to maximise independence to

retain physical and mental capacity, crisis avoidance and reduce the impact of deconditioning as a result of unnecessary hospital admissions.

This year, we are delighted to report that we are continuing to make strong progress in reducing the number of people accessing unscheduled care by embedding preventative, community-based approaches, particularly through the rollout of the Remote Patient Monitoring (RPM) Pathway for people with Chronic Obstructive Pulmonary Disease (COPD) in Inverclyde.

COPD remains a leading cause of unplanned hospital admissions locally, with rates above the national average, especially in our most deprived communities. To address this, we introduced a digital monitoring solution (Graphnet/Docobo) that allows patients to track their symptoms daily from home. Community nurses monitor this data in ***real time***, enabling early help and preventing escalation and reflects our commitment to person-centred care, supporting people to stay well at home, reducing avoidable hospital use and easing pressure on urgent care services.

The initial focus has been on the most frequent attenders at Inverclyde Royal Hospital (IRH), with the aim of shifting care from reactive to preventative. Results to date have shown significant benefits. The figures demonstrate the potential for digital tools to transform care, not only reducing the strain on acute services but more importantly, **improving outcomes** and quality of life for people with long-term conditions.

85% reduction in Emergency Department presentation

65% reduction in Hospital admissions due to COPD

45% reduction in bed days

Building Inclusive Pathways

We have also taken care to ensure the pathway is inclusive. Where people were not suitable for digital monitoring (due to vision issues, cognitive impairment, or other needs), alternative support was provided. This includes:

- Pharmacy-led reviews to ensure people are on optimal treatment.
- Education sessions to support self-management.
- Promotion of a COPD Rescue Medication Card, which allows access to emergency medication directly from pharmacies, reducing the need for GP appointments or delays.

The Remote Monitoring pathway is more than a service improvement; it is a culture shift in how we care. It demonstrates the power of digital innovation, person-centred design and collaboration to improve lives in a meaningful, measurable way. This model will inform future service developments as we look to replicate success across other long-term condition pathways continuing our journey toward a smarter, more sustainable system of care.

Technology Enabled Care – Digitisation of Service

The transition from analogue to digital alarm units was undertaken to modernise the alarm systems, improve reliability, and enhance functionality. The project involved upgrading existing analogue alarm units to digital systems, ensuring seamless integration with current infrastructure, and training staff to manage and operate the new systems effectively. Inverclyde HSCP have embraced this journey from the initial test stage to complete full digitisation of their Community Alarm estate.

Inverclyde HSCP have now been awarded **Platinum Accreditation** from the Digital Office for Scottish Local Government having successfully transitioned all current service users and have been operating successfully without serious issues or call failures.

Digital Transformation and Innovation: Utilising SOL Connect in Service Redesign

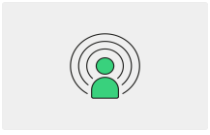
As part of our ongoing commitment to digital transformation, we are integrating SOL Connect into our service delivery model to enhance independence, safety and wellbeing for individuals supported by the Partnership. SOL Connect's technology-enabled care solutions are being actively deployed within our **Test, Learn and Develop** framework, allowing us to trial innovative digital supports in real-world settings, gather insights and refine approaches based on lived experience and measurable outcomes.

This approach enables us to:

- Test the effectiveness of digital approaches in helping people live more independently
- Learn from data, feedback and frontline experience to understand what works and where improvements are needed.
- Develop scalable, person-centred digital solutions that align with our strategic priorities for prevention, early help and sustainable care.

Embedding SOL Connect into our digitisation strategy, is modernising our service delivery but also co-producing solutions with individuals and carers, ensuring that technology enhances support.

Shared Alarm Receiving Centre - National Platform



Inverclyde HSCP's Technology Enabled Care (TEC) Service is undergoing a significant transition with its current Alarm Receiving Centre provider, Bield Response 24 (BR24), now joining the Shared Alarm Receiving Centre (ARC) Platform.

Led by the Digital Office for Scottish Local Government the Alarm Receiving Centre (ARC) Platform offers a shared, cloud-based telecare solution for providers across Scotland. This national initiative enhances service integration, personalisation, and user control, while improving scalability, cybersecurity and disaster recovery.

By supporting proactive care and reducing barriers to digital transformation, the ARC Platform represents a major step forward in modernising telecare delivery. To ensure the continued success and sustainability of digital transformation efforts, the following strategic actions are proposed:

- **Implement User-Focused, Interoperable Technologies** – Prioritise integrated systems tailored to individual needs, avoiding siloed solutions.
- **Enhance Digital Skills** – Provide continuous training to keep staff up to date with emerging tools and practices.
- **Test and Learn** – Use pilot projects and tests of change to evaluate innovations, using evidence to guide wider implementation

Despite the promising outlook, several challenges must be addressed to maintain momentum:

- **Rising Equipment Costs** – Post-warranty replacements and upgrades add pressure; budgets must account for ongoing lifecycle costs.
- **Funding Challenges** – Sustaining and scaling digital infrastructure requires significant investment, with upfront costs often outweighing short-term budgets.
- **Procurement Barriers** – Rigid processes can delay innovation; more agile procurement and stronger tech partnerships are needed.

Improving Outcomes for People with Long Term Conditions

This year, we have enhanced services for Long-Term Conditions to support individuals living with chronic and complex health conditions. The service focuses on person-centred, proactive care to improve quality of life, promote self-management, and reduce the risk of deterioration leading to hospital admission or loss of independence.

Prediabetes Identification Initiative

We have prioritised the Prediabetes Identification and Support Initiative to enable early action and help prevent Type 2 Diabetes. This proactive, structured approach is embedded in primary care and aligns with the HSCP's strategic goals of improving population health, reducing inequalities, and delivering person-centred care.

Project Overview:

Using data, patients identified as being within the prediabetic range have been extracted from practice systems and reviewed (data validation complete). Patients without a recent HbA1c (diabetic blood monitoring) result will be invited for an updated test. Those remaining in the prediabetic range will be referred to a dedicated prediabetes clinic, hosted within the practice on a weekly basis (anticipated launch: June 2025).

Clinic Design and Early Help Approach:

Each patient receives a 30-minute one-to-one consultation focused on understanding prediabetes, supporting behaviour change through motivational interviewing, and aligning care with individual goals. The session includes personalised lifestyle guidance, referral to additional services (e.g., weight management, diabetes remission), and ongoing support as needed

Next Steps
To build on current progress, we will:

- Further develop and define the role by representing Inverclyde on the newly established board-wide Long Term Conditions group and reporting insights locally.
- Review and improve access to existing resources through targeted tests of change.
- Strengthen preventative approaches by promoting awareness of available resources and processes, with the aim of empowering patients to improve self-management and confidence in their care.

Supporting Independence, Preventing Crisis: Our Impact Through Early Help

Our Centre for Independent Livings impact through early help, preventative support helps people in Inverclyde maintain independence and avoid crisis. In 2024/25, the service managed over **6,000 referrals**, responding to a wide range of needs including frailty, disability, rehabilitation and reablement. Over **30% of referrals** required a same-day or next-day response, demonstrating the service's agility in providing timely interventions that prevent hospital admission, support early discharge and reduce pressure on acute and community services.

A key measure of success is the services ability to deliver this rapid response while maintaining person-centred, quality care. Feedback from individuals and carers consistently highlights the impact of fast, appropriate support in helping people stay safely at home. Internally, the team has streamlined assessment and delivery processes, improving efficiency and turnaround times despite rising demand.

3,393 individuals were supported with **9,861 pieces of equipment**, helping them manage health conditions and live more independently.

Equipment was delivered quickly to support **urgent hospital discharge and crisis prevention**.

76% of uplifted equipment was successfully recycled, generating an estimated **£973,000 in system savings**, while contributing to environmental sustainability.

The Blue Badge service also reflects high operational throughput, with **2,259 approvals** processed last year, supporting mobility and access to essential services. This enables earlier re-engagement in community life following illness or injury, a key outcome of early help. Our approach ensures that people are not only assessed for immediate needs but are also supported to plan and manage long-term conditions. By intervening early, reducing unnecessary escalation and helping people remain in control of their care, the service contributes to the wider system's resilience and improves outcomes for individuals and families.

Maximising Independence – supporting self-management across Inverclyde

In line with our strategic aim to maximise independence and promote independent living, Inverclyde HSCP has continued to invest in a range of initiatives to enhance self-management of health and wellbeing across our communities. A key priority this year has been supporting the workforce to work collaboratively in enabling people to manage their own health more effectively.

Building Capacity for Self-Management

In line with our priority to provide early help and prevention, Inverclyde HSCP has strengthened its workforce, and community resources to support self-management, enabling people to keep and age well and reduce reliance on formal services.

Staff development has been central to this approach. A dedicated Community of Practice (CoP) and a series of self-management webinars have supported cross-sector learning and improved staff confidence in promoting independence. A self-management session is now embedded in the Home Care induction programme, ensuring new staff are equipped to support early help from day one.

To further enable early support, we are co-developing an 'Ageing Well' leaflet for housebound older adults and have piloted reflective practice sessions for multidisciplinary teams, helping staff consider their role in enabling self-management. We are also developing practical learning sessions focused on the skills needed to support self-management in everyday practice.

Feedback: "Reality check – will walk more."

Feedback: "Very useful and encouraging."

A Joint Action Plan continues to coordinate and track progress, ensuring a shared focus across services. Together, these actions are helping to build a confident, capable workforce and more empowered communities, laying the foundation for earlier and more effective support.

Early Impact and Outcomes

These activities are building a more confident and capable workforce, better equipped to support self-management. Staff report increased knowledge and practical understanding, while cross-sector collaboration has been strengthened through the Community of Practice and reflective sessions. Embedding self-management in induction training supports long-term sustainability.

Looking ahead, we will evaluate the reflective practice pilot to guide future delivery. Meanwhile, the launch of the Ageing Well leaflet and new learning sessions will help us broaden our reach and deepen our impact.

Promoting Active Ageing Through the Functional Fitness MOT

As part of our preventative and early help work, we have continued to invest in delivering the Functional Fitness MOT (FFMOT), a person-centred programme designed to support adults over

50 to stay physically active and maintain their independence for longer.

The tool uses seven physical function tests to assess an individual's fitness in comparison to their peers, helping to identify strengths, highlight areas for improvement and encourage realistic goal setting around increasing activity levels. We have established a Functional Fitness MOT Collaborative, coordinated by the Maximising Independence team. This brings together trained facilitators from across health and social care, housing and the third sector to deliver FFMOTs in accessible community settings.

- **23 FFMOT** events held
- **171** participants attended
- **15** partners involved
- **93%** likely to be more active
- **99%** found session helpful

Collaborative members include:

- Branchton Community Centre
- Community Learning Disability Team
- Community Occupational Therapy
- Gateway Walks
- Inverkip Hub
- Morton in the Community
- Rehabilitation & Enablement Service (RES)
- River Clyde Homes
- Your Voice

Through this partnership approach, we are embedding preventative support into the heart of communities, helping people to age well, remain active and reduce the risk of falls and functional decline.

Redesign of the Housing Options and Homelessness Advice Service

We are committed to transforming our models of care for people, families and the community that require homelessness service. Our ambition is to move away from the current building-based delivery to a community-based model that is more responsive, and trauma informed.

In recognition of this and to support our strategic priority of *Providing Early Help and Prevention*, we are closing the Inverclyde Centre and transitioning to a fully community-facing model. This shift is designed to enable more holistic, proactive and individualised support for people at risk of or experiencing homelessness.

The redesign of our Housing Options and Homelessness Advice Service (HOHAS) marks a major step forward in creating a more preventative, responsive and person-centred approach to assisting with housing matters. The work to date has focused on aligning services, roles and responsibilities underpinned by our Strategic Priorities that ensures that services will be delivered in the right place, at the right time, by the right people. The redesigned service will adopt a fully

community-facing approach to deliver better outcomes for individuals and families, with an emphasis on preventing homelessness before it occurs, offering timely advice and support, and helping people to sustain their tenancies over the long term.

Rapid Rehousing Support: Sustaining Tenancies and Preventing Crisis

Inverclyde's Rapid Rehousing Support Team continues to deliver strong outcomes in supporting individuals with complex needs to sustain permanent accommodation. In this reporting period **97% of clients supported by the team remained in their tenancies**, significantly outperforming the **Scottish average of 85%**.

This high sustainment rate reflects the effectiveness of our trauma-informed, person-centred approach, which prioritises early support, relationship-building and coordinated engagement with housing providers and wider services. By aligning our efforts to prevent crisis and reduce repeat homelessness, we are not only improving individual outcomes but also contributing to wider strategic goals around reducing inequalities, improving population health and delivering more responsive, integrated care.

The success of this model demonstrates the value of investing in proactive, wraparound support and highlights the importance of continued collaboration across services to maintain tenancy stability and promote long-term wellbeing.

Story: A Trauma-Informed Journey to Stability

A couple, each with lived experience of trauma, had long-standing involvement with services over many years. They faced multiple challenges including housing instability, repeated episodes of homelessness and barriers to accessing permanent accommodation. Their situation was further complicated by being widely known across local housing associations, which created additional difficulties despite support from the Homelessness Service.

In 2023, a new approach was introduced through the creation of the Rapid Rehousing Support Team. This team focused on building trusting relationships, sharing skills, and supporting individuals to make positive life choices. They also facilitated meaningful engagement with other services and organisations. The team was specifically designed to offer consistent, person-centred support to people experiencing complex and recurring challenges such as homelessness, substance use, and contact with the justice system.

A dedicated support worker worked closely with the couple, advocating on their behalf with housing providers and offering ongoing tenancy support. This led to an offer of housing with a 12-week probationary tenancy, which was successfully converted into a secure tenancy. The couple have remained stably housed, their support needs have reduced, and they are now actively involved in their community. They are also sharing their experiences to support others, helping to challenge stigma and demonstrate that recovery and stability are possible.

Strategy Development: Alcohol and Drug Support Services

Throughout 2024, Inverclyde's alcohol and drug services have been a key partner in the development of the Alcohol and Drug Partnership (ADP) strategy. undertook an extensive engagement programme to inform the development of a new Alcohol and Drug Partnership Strategy (2024–2029). This process included a series of multi-agency workshops, 'conversation cafes' with individuals with lived and living experience and family members, as well as a community-wide online survey.

Our collaboration has ensured that the new strategy is grounded in the voices of those most affected and reflects a shared commitment across partners to early support and prevention. This work has helped reshape our governance structure to deliver on the strategic priorities for people affected by alcohol and drugs. This will underpin a robust delivery framework and action plan aligned to the strategy's four core objectives:

1. Reduce drug- and alcohol-related deaths and improve lives.
2. Embed a whole family approach to treatment and recovery.
3. Ensure a coordinated, whole system response.
4. Deliver trauma-informed practice across all services.

This strategic realignment represents a key step forward in strengthening early help and integrated support for individuals and families affected by substance use in Inverclyde.

Enhancing Digital and Community Access

To reduce barriers and reach individuals who may be digitally excluded, we have implemented a multi-channel outreach strategy with our partners. This included printed information booklets, posters with QR codes and Z cards, each designed to increase awareness and facilitate quick access to local support services.

- Printed Information Booklets were delivered door-to-door in Inverclyde's most deprived areas and made available in GP surgeries, police station, community hubs and waiting areas, improving offline access to support pathways.
- Posters with QR Codes were placed in key public locations, offering immediate mobile access to the ADP website and services, enhancing visibility and engagement on the go.
- Z Cards were issued to frontline staff including police, wardens, and link workers, enabling discreet, rapid signposting to support services during community interactions.

Together, these measures ensured that critical information reached a wider audience, digitally and in person, supporting equity of access and encouraging earlier engagement with support services.

Commitment to Inclusive, Clear Pathways to Support

The overarching aim of this initiative has been to make alcohol and drug support pathways clear, accessible, and inclusive for everyone in Inverclyde. By combining digital tools with printed resources and direct community engagement, the ADP is breaking down barriers, whether digital, social, or geographical to help individuals take their first step toward recovery.

Advice Services

Advice Services in Inverclyde continue to play a critical role in supporting residents to navigate financial insecurity, maximise income, and access essential welfare rights. Over the past year, significant progress has been made in improving access and integration, particularly through strong partnership working and a focus on person-centred delivery.

A key success has been the continued development of the Welfare Advice and Health Partnership (WAHP) model, embedding advice services within GP practices. Access to EMIS has further enhanced the quality and continuity of service, particularly when supporting complex benefit applications and appeals. This integration of financial advice into health settings not only supports income maximisation but also promotes a more joined-up, dignified approach for those navigating both health and financial challenges.

Advice services are embedded in **10 GP practices** across Inverclyde, creating a robust **early help model** by enabling access at the point of healthcare contact.

A single case example resulted in a **financial gain of £538.90 per week**

equating to **£27,980.80 per year** illustrating the tangible impact of the service on household resilience and wellbeing

Similarly, the **MacMillan Welfare Rights Service** continues to deliver impactful, compassionate support to individuals and families affected by cancer. This includes outreach at the IRH oncology ward, Ardgowan Hospice, and within people's homes. Importantly, this service also acts as a pathway into broader HSCP supports, helping individuals and families access holistic care at times of greatest need.

Funding Uncertainty for MacMillan Services:

Charitable organisations are facing significant financial pressures. Many are operating with minimal reserves, making them vulnerable to further economic strain. These challenges are expected to impact the support they provide to communities, potentially increasing demand on HSCP services. We are actively monitoring these trends and preparing for possible funding pressures to ensure service continuity.

Advice Services in Inverclyde have achieved strong outcomes through innovative partnerships, particularly in healthcare and specialist outreach. As the service transforms through the Integrated Front Door programme, there is a clear opportunity to build on these strengths while tackling challenges around funding, data, and coordination to ensure long-term sustainability and impact.

Supporting Independent Living and Achieving Better Outcomes

Promoting independent living remains a core priority in our approach to person-centred care. Since the reopening of the Scottish Independent Living Fund (ILF) in 2023, our Learning Disability social work team has secured over 20 successful applications. These awards have directly increased care hours for individuals with complex needs, enabling them to live more independently at home. This has enhanced personal choice, improved quality of life and reduced reliance on more intensive forms of care.

In addition, our partnership with SOL Connect has expanded the use of Technology Enabled Care (TEC), offering flexible, tech-based solutions that support daily living. These innovations enable individuals to manage their own routines with greater autonomy, while also helping us deliver services more sustainably amid rising demand and workforce challenges. Together, these initiatives demonstrate our commitment to early help, maximising external ILF funding, and investing in creative, outcome-focused solutions that support people to live well longer.

Providing Early Help and Intervention – Performance Highlights

The infographics below offer a highlight of some of the key performance outputs that have been identified through our development of our outcome's framework.

Children referred on to a support in the community

386

Children redirected to community support

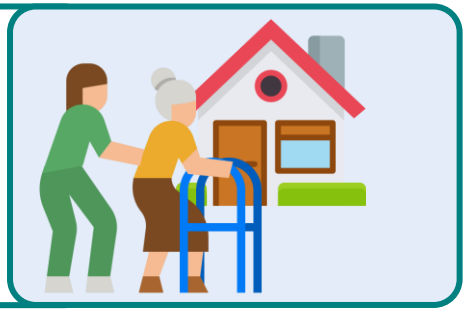
During 2024/25, we redirected **386** children away from Statutory Services onto community-based support groups.
Community-based supports can often provide children, young people and their families the effective support the need at an early stage. This can help families avoid the need for statutory involvement

Supporting independence through reablement

During 2024/25, we supported **187 (29%)** people, accessing reablement support, to become fully independent follow a period of care.
This demonstrates the HSCPs commitment to support people back to positive health within a community setting.

187

People fully independent following support



Supporting Recovery in the community

37

Referred to community supports

Throughout the year, 37 affected by addiction were referred onto local community-based support organisations, Your Voice and Moving-On.

By encouraging access community-based support, those in recovery can access peer support, and improve social connections that can support their recovery journey.

Strategic Priority: Improve Support for Mental Health, Wellbeing and Recovery

What strategic direction underpins this priority?

We are committed to improving mental health, wellbeing, and recovery support across Inverclyde by ensuring people can access the right help at the right time. Our vision is to deliver person-centred care that meets individual needs through local, community-based support that encapsulates the spectrum of early help to complex care. We have recognised the strengths and support networks people already have and we are encouraging and supporting individuals in achieving their recovery and wellbeing through self-management to clinical successes. Through our strong partnerships we have built a compassionate, responsive system that supports lifelong recovery and resilience although there continues more work to do in this area through our test, learn and develop approach.

Strategic direction and performance overview

At the outset of this reporting period, we set out a clear strategic direction: to improve support for mental health, wellbeing, and recovery by focusing on early help, prevention and accessible, person-centred care. This section reflects on our commitments and actions, what we said we would do and what we have achieved highlighting progress made, the impact of our work, and the areas where continued effort is needed to fully realise our vision in improving support for mental health, wellbeing and recovery.

Our response to Children and Young Peoples Mental Health and Wellbeing

This year, we have taken significant and innovative steps to ensure timely, compassionate and holistic mental health support is embedded throughout our services. Inverclyde has embraced a **trauma-informed** approach across services. Through multi-agency training and reflective practice, we are embedding the principles of trauma-informed care in how we support, communicate with and respond to our children and families.

For our care experienced children and young people, we have strengthened early identification of need through our Health4All team, which ensures all young people entering care receive a comprehensive health assessment. The post has evaluated extremely well with staff, carers and young people. The role continues to play a pivotal role, offering direct therapeutic support and guidance to residential staff, **foster carers and Kinship carers** to ensure young people have seamless access to the right help at the right time.

Our innovative Emotional Wellbeing Triage Meetings are enabling quicker, coordinated responses to mental health concerns, ensuring that no child is left waiting unnecessarily. Alongside this, young people aged 10-26 can now access **Kooth** our 24/7 online mental health platform. The service provides anonymous support, peer forums, one-to-one sessions and early evaluations show increasing engagement and positive feedback from users.

Action for children continues to offer school based emotional wellbeing service in groups and one to one support for children and young people in education.

Barnardos offer of support to children with neurodiversity, anxiety and family support continues to compliment the offer available to families in Inverclyde.

We remain committed to meeting the national Child and Adolescent Mental Health Services (CAMHS) referral-to-treatment target of 18 weeks and are continuously collaborating with partners to reduce waiting times and remove barriers to access. Young people are being supported to transition to adult services to ensure a smooth transition takes place. Care leavers continue to receive ongoing health reviews and support to maintain their wellbeing as they transition to adulthood, ensuring no young person is left behind.

By embedding trauma-informed, early help and youth-led approaches through our Corporate Parenting Plan, we are building a system of care that places mental health and recovery at the heart of every interaction, ensuring our young people feel safe, supported and able to thrive. Significant progress has been made in improving access to mental health and emotional wellbeing services for children, young people and their families. Inverclyde Emotional wellbeing Triage Hub where referrals are screened every two weeks, following a no wrong door and no 'rereferral' approach. A tiered model has been implemented in conjunction with education, social work, health and third sector which includes Action for Children, Barnardos and Kooth.

Strengthening the Primary Care Mental Health Team

In response to rising service demands and increasing clinical complexity, an interim review of Inverclyde's Primary Care Mental Health Team (PCMHT) was undertaken, pending the outcome of the wider NHS Greater Glasgow and Clyde review. Inverclyde was the only PCMHT in the board area operating with Band 5 nursing staff, despite national guidance and service needs requiring more advanced clinical expertise.

The local review examined workforce configuration, sustainability, and alignment with national psychological therapy standards. As a result, we have improved clinical capacity, enhanced continuity of care and addressing retention challenges, all within existing budget and staffing levels. This realignment brings Inverclyde's service in line with wider NHS GGC provision and directly supports the HSCP's strategic priority to improve mental health, wellbeing, and recovery by ensuring timely, safe, and skilled care in community settings.

Performance Outcomes

- Improved clinical capacity for psychological assessments and treatment planning.
- Greater flexibility to meet fluctuating demand and complexity.
- Increased staff retention through career progression opportunities
- Alignment with national standards for safe and effective psychological therapy delivery
- Maintained service delivery levels despite workforce adjustments.

Progressing Person Centered Alcohol Care: The Alcohol Recovery Pathway

In response to findings from significant adverse event reviews and a recognised inconsistency in alcohol care delivery, a new **Alcohol Recovery Pathway** was developed by Alcohol and Drug Recovery Services (ADRS). Rooted in the principles of Medication Assisted Treatment (MAT) standards Medication Assisted Treatment (MAT) standards: access, choice, support - gov.scot the pathway sets out 10 evidence-based principles designed to ensure safe, effective, and person-centred care for individuals affected by alcohol use.

We are currently meeting 9 out of the 10 national standards, reflecting strong progress across most areas. However, further work is required in the domain of management, with a particular focus on alcohol-related pathways. Addressing this will be a key priority moving forward.

The alcohol pathway has now been successfully implemented across all Health and Social Care Partnership (HSCP) areas within NHS Greater Glasgow and Clyde, ensuring a consistent and integrated approach to care delivery.

Looking ahead, we will be enhancing our approach to risk management in alignment with the self-assessment process. This will be applied consistently across all partnerships, supporting continuous improvement and ensuring robust governance across the board.

The pathway promotes timely access to care (Principle 3) and a chronic disease management approach (Principle 6), helping shift the focus from crisis response to prevention and sustained engagement. In Inverclyde, a face-to-face medical clinic is now operational, and physical health clinics are in the planning stage, improving early identification and continuity of care for those with alcohol-related health needs.

Key progress has been made towards ensuring services are psychologically and trauma-informed (Principle 4) and that people have access to mental health support at the point of delivery (Principle 5). Although still developing in some areas, these principles reinforce the delivery of care that recognises the complexity of need and promotes safety, dignity, and recovery.

Next Steps and Future Monitoring:

- A comprehensive evaluation of pathway implementation across all HSCPs is complete with a report to be submitted to the Alcohol and Drug Recovery Services Care Governance Committee.
- Ongoing local monitoring of risks will inform quality improvement and workforce planning.
- Permanent funding solutions are being explored to maintain key outreach roles that are critical to reaching the most vulnerable individuals.

The Alcohol Recovery Pathway is driving a system-wide shift toward more equitable, trauma-informed, and community-embedded care. In Inverclyde, progress is underway across several principles, with strengths in medical access, integrated care planning, and assertive outreach. Continued focus on sustainability and system alignment will be key to embedding and scaling this work in line with HSCP strategic priorities.

Embedding a 'No wrong door' approach as the foundation for collaborative practice

Our commitment to the "No Wrong Door" approach (Standard 1) continues to shape how we respond to individuals accessing support for substance use. This ensures that people receive the help they need regardless of where they first seek it.

Insights gathered through the FAIR (Facts, Analysis, Identify and Review) analysis have provided valuable experiential feedback directly from our people with lived experience. This feedback is being actively used as a springboard for service improvement, particularly in designing more inclusive, flexible and person-centred care pathways.

Although temporary funding across several workstreams presents challenges for long-term planning, we remain focused on whole system thinking, ensuring that available resources are deployed where they can have the greatest impact. This includes a strong emphasis on integrated working across health, social care, and community partners to address the wider determinants of recovery (Standard 9).

This foundation sets the stage for the collaborative work underway to promote informed choice and improve retention in care. We are strengthening connections between primary care, specialist addiction services and community recovery support to better engage those with repeat disengagement or co-occurring needs.

Collaborative Working to Support Informed Choices and Retention in Care

Building on our existing partnership approaches, we have further developed integrated, person-centred support for individuals affected by addiction substance use, particularly those who have experienced repeat disengagement or have co-occurring mental health needs.

GPs and our Primary Care colleagues are increasingly linking in with the Addictions Liaison Outreach Team to ensure early identification and joined-up planning for individuals who may benefit from specialist input whilst supporting a number of shared care clinics in primary care MAT standard 7. As part of this, the Addictions Liaison Outreach Nurse provides a targeted in reach service, engaging individuals who may experience barriers to accessing traditional services. This approach focuses on people who may be underserved or less consistently engaged with treatment pathways, helping to build trust and promote continuity of care.

The Addictions Liaison Outreach Team also offers structured psychosocial interventions, enabling individuals to develop coping strategies and make informed decisions about their treatment options MAT standard 6 and10. These efforts directly support MAT standard 2 by fostering informed choice, while the assertive outreach model enhances retention in care in line with MAT standard 3.

In addition, our collaboration with **Moving On Inverclyde | Recovery Service | Inverclyde, Scotland** continues to strengthen. Staff from the service attend our allocation meetings twice weekly, enabling real-time discussion and support planning for individuals presenting with lower level but concerning alcohol or drug use. Their preventative and recovery-focused input helps people identify and reshape harmful behaviours at an early stage, often avoiding escalation into

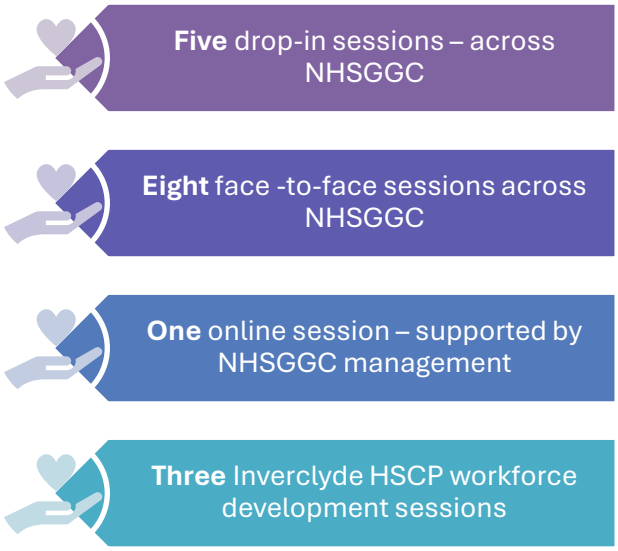
more acute service needs.

Regular communication with GPs, third sector partners and across multi-disciplinary teams, including implementation planning discussions, ensures these principles and standards are embedded in day-to-day service delivery. This collective, cross-sector approach supports sustained engagement and improves outcomes for individuals navigating complex recovery journeys.

Mental Health Strategy – Engagement

Over the past year, we have taken a proactive and leading role in supporting the development of the NHS Greater Glasgow and Clyde (NHSGGC) Mental Health Strategy for 2023–2028, with a particular focus on workforce engagement. Recognising the importance of ensuring that staff voices inform both the direction and delivery of our approach, we designed and implemented a meaningful engagement programme that reached staff across multiple settings and formats.

As part of our performance in this area during August and September 2024, we hosted five in-person 'drop-in' sessions and eight 'face to face' sessions (two of these sessions held in Inverclyde). We additionally supported one online engagement session, which was open to members of the public across NHSGGC. These sessions created inclusive spaces where participants were encouraged to share honest feedback, lived experience, and ideas for shaping future mental health services.



Building on this momentum, we also led three dedicated local staff development sessions in February and March 2025. These sessions offered deeper dialogue around psychological safety, trauma-informed practice and the evolving direction of care delivery.

Through this sustained engagement effort, we have demonstrated our ability to connect with our workforce in a way that is authentic, values-driven, and strategically aligned. The feedback gathered directly influenced the strategy's development and reinforced the shift toward more community-based, preventative care. Our performance reflects a strong commitment not only to listening but to translating insight into meaningful change.

Improvements in Statutory Mental Health Quality and Compliance

The service has achieved a significant and measurable improvement in the completion of Social Circumstances Reports (SCRs), ensuring full compliance with statutory duties under the Mental Health (Care and Treatment) (Scotland) Act 2003. Through strengthened processes and oversight, we are currently delivering **100% compliance** for individuals requiring an SCR at the point of detention. This represents a notable success in both operational performance and legal accountability.

These improvements have not only ensured that SCRs are completed on time and in line with statutory requirements but have also enhanced the quality and accuracy of reports. As a result, decision-making processes are better informed, and the overall standard of service delivery has been raised, providing assurance to both service users and partners.

Commitment to Improving Access to Residential Rehabilitation

In line with our commitment to review and improve pathways to residential rehabilitation for individuals experiencing harm from alcohol and drug use, The Alcohol and Drug Partnership, in collaboration with CORRA are funding the 'Pathways to Rehab' project in Inverclyde, with our commissioned partners, **Turning Point Scotland.**

Together over the last year we have enhanced access to residential rehab services for the people of Inverclyde, by introducing a quick and comprehensive assessment process, which is conducted by our Pathway to Rehab Nurse. People are supported from initial engagement by connecting them with Turning Points Lead Practitioner who supports in prehab stage, in placement and post rehab.

This is reflective of the improved pathways and the collaborative effort between Turning Point Scotland and Inverclyde's Alcohol and Drug Partnership (ADP) delivers robust and clear Residential Rehabilitation Pathway, which contributes directly to the National Drugs Mission to **save and improve lives**.

Over the last year referrals have more than doubled. Increasing by 138% from 13 to 31. Nearly half of the referrals were linked to residential rehabilitation, highlighting a significant demand for tailored provision in a structured recovery setting. Four individuals successfully completed their residential rehabilitation placement, a meaningful achievement given the complexity and intensity of the programme.

By collaborating closely with individuals and involving families, professionals, and advocacy services, we have demonstrated our **commitment to partnership working, person-centred care, and improved recovery outcomes**.

The pathway is person-centred and holistic, with tailored support provided before, during and after rehab. This includes:

- Assessing individual needs and accessibility
- Planning for funding and resourcing
- Preparing individuals for rehab with appropriate support structures
- Providing continuous support throughout the rehab stay
- Ensuring robust aftercare and connection to community-based recovery services

Strengthening Support to Families and Carers through Integrated Pathways

In alignment with the strategic action *Strengthen Support to Families and Carers*, Homeless Services and Alcohol and Drug Recovery Services (ADRS) have advanced partnership working to improve outcomes for individuals at risk of homelessness, relapse, or instability following unplanned or early prison release.

A key development has been the establishment of a decision-making forum bringing together ADRS, Mental Health, Justice Services and Homeless Services to coordinate support and address gaps in service delivery. The group enables real-time case discussion, strengthens referral pathways and ensures individuals are not discharged from custody without a clear, supported transition into community-based care.

This work complements the wider **Integrated Front Door model**, promoting person-centred, joined-up responses for those with complex needs. Early inclusion of Alcohol and Drug Recovery Services (ADRS) and Mental Health teams in case planning reflects a shift toward prevention and proactive support, with growing evidence of improved care continuity and reduced risk of homelessness.

By embedding this collaborative approach, we are not only enhancing service integration but also contributing to long-term recovery, housing stability and stronger support for families and carers impacted by addiction, justice involvement and insecure housing.

Mental Health Community Wellbeing Developments

The **Community Wellbeing Support Hub** continues to play a central role in providing early support and preventative care for adult mental health across Inverclyde. Through a multi-agency, trauma-informed approach, the Hub offers vital access to non-clinical mental health services for individuals who may not meet traditional service thresholds but still need timely and compassionate support.

Key Achievements

- **Improved Access**: Steady growth in referrals, with positive service user feedback indicating increased wellbeing, reduced isolation, and improved links to wider community supports.
- **Workforce Capacity Building**: Alcohol Brief Intervention (ABI) training has been embedded across HSCP teams, increasing recorded interventions from zero to over 100 annually. This work directly supports GGC-wide prevention targets and is now a routine feature in ADP reporting.
- **Prevention in Schools**: Young People's Wellbeing & Substance Use Officers continue to deliver targeted, stage-appropriate inputs across all six local secondary schools (S1–S6), supporting wider mental wellbeing and substance use education.
- **Joined-Up Working**: The service benefits from a strong partnership funding model through CLD, Health Improvement and the Alcohol and Drug Partnership, ensuring sustainability of prevention-focused roles and delivery.

Impact and Outcomes

- **User Experience**: Service users report high satisfaction, with many valuing the stigma-free, person-centred nature of the support received.
- **Pathways to Recovery**: The Hub enables timely access to community-based support and has successfully signposted individuals into longer-term mental health and wellbeing services.

Looking Forward

We will continue to build capacity across the system through workforce development, data-informed planning, and strengthened prevention pathways. The Hub is now a key element of our community-based mental health infrastructure and supports the delivery of our strategic aims for improved mental health, wellbeing, and recovery across Inverclyde.

Improve Support for Mental Health, Wellbeing and Recovery – Performance Highlights

The infographics below provide some performance highlights relating to Mental Health, Wellbeing and Recovery:

People returning to Statutory Mental Health Services

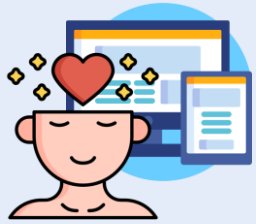
554
Adults returning for support

Through greater awareness and improved community-based support, we hope more people are confident to manage any mental health concerns they have and not need statutory support.
In the past year, **554** people returned to HSCP Mental Health Services requiring further support. As we enhance our local supports, we hope to see this number fall in future years.

People Completing Computerised Cognitive Behavioural Therapy

To support people to access mental health support as soon as possible, HSCP Community Health Services offer Computerised Cognitive Behavioural Therapy (cCBT). cCBT offers a digital platform to help address and treat many Mental Health concerns, providing a more flexible approach to support. In the past year, 26% of people accessing the support, completed their programmes.

26%
Completing cCBT



Suicide Prevention Training

91
Staff and Partners Training

Throughout the year, 37 affected by addiction were referred onto local community-based support organisations, Your Voice and Moving-On.

By encouraging access community-based support, those in recovery can access peer support, and improve social connections that can support their recovery journey.

Strategic Priority: Support Inclusive, Safe and Resilient Communities

What strategic direction underpins this priority?

We are committed to a future where communities are the foundation of safe, healthy, and active lives. Local networks and resources will be the first-place people turn to for support with health and wellbeing. By investing in community strengths and assets, we will empower individuals to take charge of their own lives. As a compassionate and inclusive partnership, we will work together to ensure everyone has a sense of belonging, and contribute, and thrive in the community. We will actively support efforts to reduce stigma and build communities that are welcoming and inclusive for all.

Strategic direction and performance overview

At the outset of this reporting period, we set out a clear strategic direction: to support inclusive, safe and resilient communities by supporting our people, particularly our cared-for young people, older adults, people new to Scotland, those affected by substance use, justice system involvement, or homelessness to feel safe and empowered. This section reflects on our commitments and actions, what we said we would do and what we have achieved and highlighting progress made, the impact of our work and the areas where continued effort is needed to fully realise our vision in supporting inclusive, safe and resilient communities.

Public Protection

Child Protection Performance Overview

In 2024/25, we continued to deliver effective child protection services, with 86 investigations involving 156 children, like last year. The average number of children on Inverclyde's Child Protection Register (CPR) was 41, slightly above the national average (3 per 1,000 vs. 2.1 per 1,000 in Scotland).

We have seen improvements in registration outcomes, with children spending less time on the child protection register. This reflects improved planning and early help.

86 investigations involving **156** children

Average number of children on the register: **41 children** at any one time during the year
▲ *Slight increase from 2022/23*

Rate per 1,000 children (aged 0–17):
Inverclyde: 3.0 per 1,000
National average (Scotland): 2.1 per 1,000

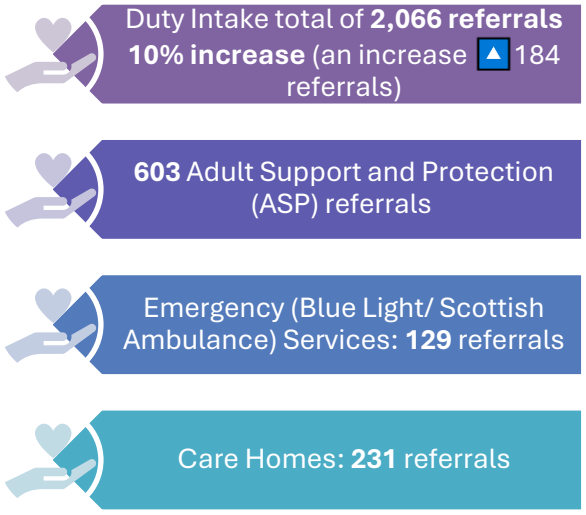
89% of children were on the register for less than one year**. 65%** were on for less than six months

Our multi-agency Child Protection Committee (CPC) continues to drive quality assurance and learning. Focus areas this year included data monitoring, practice improvement, learning reviews, and emerging risks like child exploitation.

We also launched the Signs of Safety and Healing programme, a transformational, three-year initiative to embed a strengths-based, relationship-focused model of child protection practice. All social work staff are being trained, with partner training next. This supports our commitment to **GIRFEC principles** GIRFEC principles and values - Getting it right for every child (GIRFEC) - gov.scot and ensuring every child gets the right support, at the right time.

Adult Protection Continuous Improvement Overview

Between April 2024 and April 2025, Duty Intake service received 2,066 referrals a 10% increase on the previous year, including 603 Adult Support and Protection (ASP) referrals.



This increase in referral reflects stronger multi-agency working, improved awareness of adult protection duties and clearer referral pathways, particularly with care homes and emergency services.

While this growth places ongoing pressure on capacity, it also demonstrates improved early identification and reporting of risk, aligning with the preventative intent of the Adult Support and Protection (Scotland) Act 2007.

Despite these pressures, performance has remained robust:

- **1,079 referrals (52%)** were responded to within **three working days.**
- The remainder were responded to within **ten working days**, meeting internal performance standards.

Inverclyde HSCP is exploring the implementation of trauma-informed approaches within Adult Support and Protection (ASP) practice, in line with national recommendations from the 2024 Quality Improvement Framework. This work aims to improve staff awareness, minimise re-traumatisation, and enhance the experience of adults at risk.

Despite rising ASP activity, the partnership has maintained strong performance, met statutory duties and advanced prevention, protection and personal outcomes through service redesign, digital innovation and national alignment.

Reducing Isolation in Inverclyde: How we are making a difference

Across Inverclyde, HSCP services and third sector partners have worked collaboratively to build strong, inclusive communities by strengthening local connections, supporting vulnerable groups, and reducing social isolation. This has led to improved mental wellbeing, increased community participation, and better access to local support networks. The following is a snapshot of the Your Voice activity in November 2024.

Over **2,100 people** were reached through in-person events, outreach, digital platforms, and peer groups. These included **256 individuals** attending regular peer support sessions, safe, welcoming spaces where people rebuilt confidence, formed friendships, and accessed vital emotional and practical support.

Your Voice's **#ConnectToWellbeing2024** campaign extended out, connecting the community to warm spaces, food support, and local activities. With over **7,600 social media impressions** and **240 unique web visitors**, the campaign helped raise awareness and reduce isolation by highlighting what is available locally.

Your Voice took action to ensure inclusive engagement, introducing evening meetings for those unable to attend during the day and phoning members without internet access to keep them informed and involved. Community consultations, such as those for the Greenock Towns Fund, were made accessible by hosting them in local hubs, ensuring everyone could have their say. Support for isolated and vulnerable individuals was a priority supporting **18 Community Connector** clients facing loneliness and mental health challenges, and provided **228 one-to-one support sessions**, including foodbank referrals, emotional support, and access to services.

We continued to empower people with lived experience. Our Recovery Lived Experience Network brought together 19 people, 10 of whom shared personal experiences to influence peer-led service design and support pathways.

Finally, the **Shopmobility service** gave an average of **91 users each month** the freedom to shop, attend appointments, and reconnect with their communities. **Feedback was clear:** users felt more independent, less isolated and more engaged with everyday life.

The collaborative work undertaken by our partner, Your Voice, demonstrates clear and sustained outcomes in promoting inclusion and tackling isolation through meaningful community connection, especially among those most vulnerable or at risk of being left behind. The collaboration between Inverclyde HSCP and third sector partners like Your Voice exemplifies an integrated, compassionate approach that empowers communities while strengthening resilience.

Support Inclusive, Safe and Resilient Communities – Performance Highlights

The infographics below provide some performance highlights as we have supported Inclusive safe and resilient communities:

Children looked after who remain in Inverclyde

72%

Looked after in Inverclyde

When children and young people are required to be looked after away from the family home, it is a priority of Inverclyde HSCP that they remain in Inverclyde and as close to their home community as possible.
During 2024/25, **72%** of all children looked after remained in Inverclyde.

Maximising Independence, promoting positive health

As part of our vision, we hope that people can remain in good health for most of their life. Through our maximising independence approach we are supporting people of all ages to take action to improve their health, fitness and mobility. Over the past year, the programme has resulted in **246** interactions with people, hosted **22** events, and worked with **33** local partners in the HSCP and across community organisations.

246

Total number of interactions

Addressing Poverty and Deprivation

£7,809,285

Income generated

Many people in Inverclyde are impacted by the effects of poverty. To help address this, our Advice Services support people in maximising their income. During 2024/25 they generated **£7,809,285** in additional income for some of the area's most vulnerable people. In addition, the service also directed **39** people onto employment support services.

Strategic Priority: Strengthen Support to Families and Carers

What strategic direction underpins this priority?

We believe that nurturing, caring households are vital to improving life outcomes. Families and carers play a vital role in supporting individuals at every stage of life. To ensure they can continue to provide this essential care, we will work to strengthen their capacity through targeted support and early help. Recognising the diverse challenges families face from raising children to managing complex health conditions and long-term care, we will provide the right help at the right time. By building on family strengths and resilience, we aim to give every child the best start in life and ensure carers are valued, supported, and empowered in their vital role.

Strategic direction and performance overview

At the outset of this reporting period, we set out a clear strategic direction: to strengthen support to families and carers recognising the vital role that local networks, families, and carers play in helping individuals live healthy, safe, and fulfilling lives. This section reflects on our approach, commitments and actions on strengthening community assets, what we said we would do and what we have achieved, highlighting progress made, the impact of our work, and the areas where continued effort is needed to fully realise our vision of strengthening support to families and carers.

Driving Digital Innovation to Support Families

Inverclyde's Health Visiting Team continues to lead on digital innovation, improving early help and access to trusted information for families. The launch of the **'Happy Healthy Tots' app** Happy Healthy Tots | Right Decisions, developed locally and now adopted across six NHS Greater Glasgow and Clyde areas, consolidates essential health information into a paperless, user-friendly format, enhancing health literacy and reducing barriers to support.

Building on this success, we have introduced the **HENRY app** Homepage | HENRY, a one-stop digital resource providing families with up-to-date guidance and direct access to advice lines. This complements our existing digital platforms and extends our reach, supporting families to give their children the best possible start in life.

Alongside digital tools, we maintain a blended support model through **Barnardo's Family Parenting Programmes**, offering nurturing groups that combine in-person engagement with digital flexibility, ensuring support remains accessible, personalised and impactful.

Children and Families and enhancing whole family supports

Inverclyde HSCP continues to demonstrate its unwavering commitment to keeping **The Promise** by ensuring that children and young people experience good childhoods, families receive the support they need, and our workforce is empowered to lead change. Our strategic focus has centred around three key priority areas: **Good Childhoods**, **Whole Family Support**, and **Supporting the Workforce**.

Young Person - Feedback
"It is a place that is instantly calming and meant I could plan normal stuff and didn't feel like I was in care."

A key initiative was our partnership with The Lens Project and the Promise Team to deliver the **Ideas to Action Programme**, driving innovation and co-production to improve outcomes for children and families.

A standout result was **Home from Home**, a bespoke family time venue, co-designed by a young person with support from social work and Promise colleagues. The space reflects their vision and fosters meaningful relationships in a welcoming, child-friendly setting.

This co-production continues to influence wider practice. One of our young people also produced a video of the space, to be shared with families and integrated into our co-produced Family Time Strategy. Feedback from another young person has informed the development of a storybook-style visual guide to help children prepare for family time visits, reducing anxiety and improving the experience.

Family Feedback
"For me, it is a place to be a mum for a few hours without confusing my kids about coming home. I can make their favourite tea which cannot be done in an office. There is less anxiety about bumping into people I know, they then know my business about my kids being in care."

We continue to develop *The Practice Pad* as a vital part of our approach to supporting young people transitioning to independent living. This service provides young people with the opportunity to build essential independent living skills at an earlier stage, within a safe and supported environment. By enabling them to practice living on their own before taking on a tenancy, *The Practice Pad* helps build confidence, resilience, and readiness for independent adulthood, reducing the risk of tenancy breakdown and promoting long-term stability.

This work exemplifies the HSCP's commitment to performance through partnership, supporting frontline innovation, and embedding The Promise in everything we do. Through this approach, we are building a sustainable culture of improvement and delivering tangible change for children, young people, and their families in Inverclyde.

Palliative Care and dying well - Principles and Strategy

Inverclyde HSCP demonstrated a clear commitment to improving outcomes in Palliative Care and care around dying through the development and implementation of a locally co-produced strategy and delivery plan. This work has been driven by a shared vision to enhance the quality, equity, and person-centred nature of care provided to individuals at the end of life. The strategy reflects the core values of health and social care and sets out measurable actions to ensure delivery of high-quality, compassionate support across Inverclyde.

Shared Vision: To ensure that everyone in Inverclyde who needs palliative and end-of-life care receives high-quality, compassionate care that respects their individual needs and wishes, wherever they choose to be cared for. That our health and care system provide support from the initial diagnosis through to end-of-life care. That our community is aware of all the services provided and knows how to access them

Key achievements this year:

- Established a shared local vision for high-quality, person-centred end of life care.
- Engaged professionals, and community partners in strategy development.
- Embedded local guiding principles into service planning and delivery.
- Laid the foundations for improved coordination, equity of access, and support for families and carers across all settings.
- Collaborated with individuals and families to achieve a preferred place of death to support dignity and comfort at end of life, while providing carers with emotional reassurance and a greater sense of involvement and closure.

These outcomes mark a significant step forward in our commitment to ensuring compassionate and consistent end of life care across Inverclyde.

Always came in with a smile, caring and compassionate.

"My mum was diagnosed with stomach cancer; her wish was to remain at home until she passed away. The District Nursing Team at Gourock Health Centre went above and beyond to keep her comfortable. They visited daily on some days more often if needed and at any hour of the day. It was very comforting to us as a family to know that we had such professional responsive support and this allowed us to care for our mum at home. They always came in with a smile, caring and compassionate, nothing was a problem. They came so quickly when my mum passed, and they were such a great support to our family. We can't praise or thank them enough."

Source: Care Opinion Always came in with a smile, caring and compassionate | Care Opinion

Progress in Partnership – Developing the Carers Strategy

The development of the Carers Strategy is a direct response to the strategic priority of strengthening support for families and carers. This work addresses the needs of diverse carer groups, including young carers, adult carers and carers from underserved communities, with a focus on sustainability, equity, and inclusion. The Carers Strategy will be a living document, designed to evolve with continued input and review. Ongoing co-production with carers ensures the strategy remains current and impactful. The Strategic Planning Group (SPG) will oversee progress to ensure accountability and alignment with broader strategic goals.

Collaborative Partnership Working

A core strength of this initiative is the robust partnership between Your Voice, Carers Gateway (Unity), and key stakeholders across health and social care. This collaborative approach ensures that the voices of carers are central to the strategy's development. Carers themselves have played an integral role through co-production and extensive engagement activities, leading to a more responsive and representative strategy.

To date, significant progress has been made in delivering on the strategic aim of strengthening support for families and carers. A solid foundation of multi-agency collaboration has been firmly established, with organisations working cohesively toward shared objectives. Through extensive engagement efforts, a broad and diverse cross-section of carers have had their voices heard, ensuring that the strategy reflects real-world experiences and needs. This inclusive engagement has led to the identification of key themes that resonate with carers' day-to-day challenges and aspirations. Furthermore, this insight has directly informed the development of a practical and actionable framework, fully aligned with broader system-wide priorities and capable of delivering meaningful, measurable outcomes.

> 55% of carers surveyed have not had a break in the last year.

Engagement and Emerging Themes

Engagement with carers and stakeholders has highlighted several key themes that shape the foundation of the strategy:

- **Young Carers:** The need for better recognition/support in education and healthcare settings
- **Access and Visibility:** Carers require clearer access to information, support services and entitlements.
- **Wellbeing and Support:** The need for consistent mental and physical health support
- **Financial Strain:** Ensuring pathways to financial assistance are clear and accessible.
- **Workplace Flexibility**: Support for carers balancing employment and caregiving responsibilities.

Next Steps

- Finalise the draft strategy and action plan.
- Conduct stakeholder review and feedback sessions.
- Implement pilot initiatives aligned with strategic priorities.
- Schedule regular reviews to monitor progress and adapt as needed.

Improving Mental Health Referral Pathways and Support for Carers

In partnership with Carers Gateway Inverclyde – Welcome | Carers Gateway we have over the past year strengthened our referral pathways to ensure carers receive timely, accessible and coordinated support. These improvements help to reduce barriers, enhance continuity, promote a consistent person-centred approach and improve the overall experience for families and unpaid carers.

Together, this work contributes to building a more supportive, proactive system for carers aligning with our strategic commitment to supporting carers.

Key Developments in Carer Support

- **Faster Access**: A dedicated referral pathway to Carers Gateway is now in place, enabling quicker access to carer support and improved tracking of outcomes.
- **Digital Access**: **QR codes** on Guardianship letters provide easy access to information and support for carers navigating Adults with Incapacity (AWI) processes.
- **Integrated Mental Health Support**: The Community Mental Health Team now has a direct referral route to Carers Gateway, ensuring carer needs are routinely addressed and monitored.
- **Continuous Improvement**: Regular review meetings between Carers Gateway and referring teams support ongoing refinement of the pathway and shared understanding of carer needs.
- **Targeted Training**: A carer session on mental health and wellbeing was delivered at Crown House, boosting confidence and understanding of service user challenges.
- **Advocacy Link**: A named Voiceability advocate now works closely with the Mental Health Officer (MHO) team, improving continuity and collaboration through relationship-building and role clarity.

Strengthening Support: Collaboration with Families Affected by Drugs and Alcohol

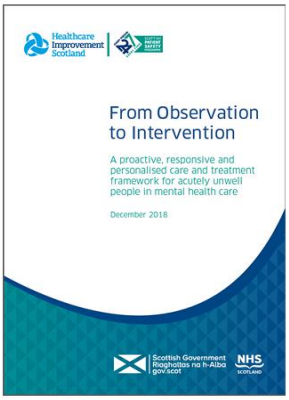
In partnership with the Alcohol and Drug Partnership we continue to strengthen its work with commissioned partner, Scottish Families Affected by Alcohol & Drugs Scottish Families Affected by Alcohol and Drugs plays a vital role in ensuring the voices of families and carers are represented and meaningfully included in service development and delivery.

The relationship between Inverclyde HSCP and Scottish Families Affected by Alcohol and Drugs (SFAD) is a key partnership in our ongoing work to develop consistent, family-focused services for those affected by substance use. This collaboration supports the delivery of our strategic priorities and planning intentions by ensuring that services are not only responsive and inclusive but also aligned with trauma-informed and whole-family approaches. Through this partnership, we are strengthening our capacity to provide meaningful support that promotes resilience, recovery, and long-term wellbeing for individuals and families across Inverclyde.

This partnership will continue to create valuable **opportunities for engagement** with families, including through facilitated sessions, and peer-based activities. These engagement routes are helping to strengthen existing pathways for families and carers, offering early help, consistent support, and stronger connections to local services.

By working in close partnership, we are aligning efforts to deliver on our strategic priorities and embedding lived experience in service development. This collaborative approach is enhancing not only the responsiveness of services but also ensuring families have a clear and active role in shaping the system that supports them.

Strengthening Support to Families and Carers through Continuous Interventions



In preparation for the implementation of the NHS Greater Glasgow and Clyde Continuous Intervention (CI) policy and Practice Guidance on 31st March 2025, a significant programme of groundwork was carried out to support its successful introduction. This included wide-ranging stakeholder engagement, alignment with national best practice, particularly Healthcare Improvement Scotland's (HIS) from Observation to Intervention framework and close collaboration across all inpatient services.

Existing practices were critically reviewed, and staff were equipped through targeted skills enhancement training and policy awareness sessions to embed the principles of proactive, person-centred care. This preparatory work created a strong foundation for the effective rollout of the Continuous Intervention (CI) policy across Mental Health, Learning Disability, and Forensic inpatient wards.

Continuous Intervention represents a proactive, person-centred approach that moves away from standardised observation levels toward continuous, therapeutic engagement tailored to each patient's needs. This approach helps reduce distress, manage risk, and promote recovery, directly impacting the wellbeing of patients and, by extension, the families and carers who support them.

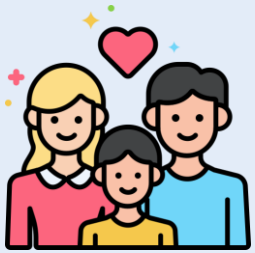
What this means for our families and carers:

- **Greater reassurance and trust:** Families and carers can feel more confident knowing that care is not only reactive but designed to anticipate and respond to patients' needs, reducing crisis episodes and distress.
- **Improved communication and transparency:** The use of person-centered care planning (PCCP) ensures that care is aligned with patient values, with clear documentation that can be shared and understood by families.
- **Multidisciplinary collaboration:** Continuous Intervention (CI) is delivered by skilled multidisciplinary teams, improving coordination of care and ensuring a consistent approach, which provides families with a more stable and coherent care experience.
- **Enhanced involvement:** The approach promotes shared decision-making and actively involves patients and by extension, their support networks in shaping care interventions that are meaningful and appropriate.
- **Focus on wellbeing and recovery:** The use of a wellbeing toolkit and the development of a proposed Wellbeing Hub Service model signals an ongoing commitment to whole-person care. This shift supports families and carers by focusing not only on managing risk, but also on restoring a sense of normalcy and progress for their loved ones.

Looking ahead: the intention to expand Continuous Intervention (CI) across general hospital sites suggests a continued focus on embedding person-centred, therapeutic care across the wider healthcare system, further strengthening the support offered to families and carers throughout the patient journey.

Strengthening Support to Families and Carers – Performance Highlights

The infographics below provide some performance highlights as we have supported families and carers:



Strengthening Families through Family Group Decision Making

41
Families Participating

During 2024/25, **41** local families participated in Family Group Decision Making. This approach supports the wellbeing of children and young people, by bringing family members to together, to work collaboratively to develop a plan, to help nurture and protect the children or young people. This is a key approach to strengthening families.

Listening to the Voice of young people

Listening to the voices of your people and learning their views is important to the HSCP as we continue to improve our service to young people.
Over the past year, Children and Families have used the digital Mind of My Own app to gather the views of young people. In total, 185 statements were provided by, or on behalf of children and young people.

185
Statements provide

Supporting Our Carers and Young Carers

421
Carer Support Plans Offered

158
Young Carers Statements Offered

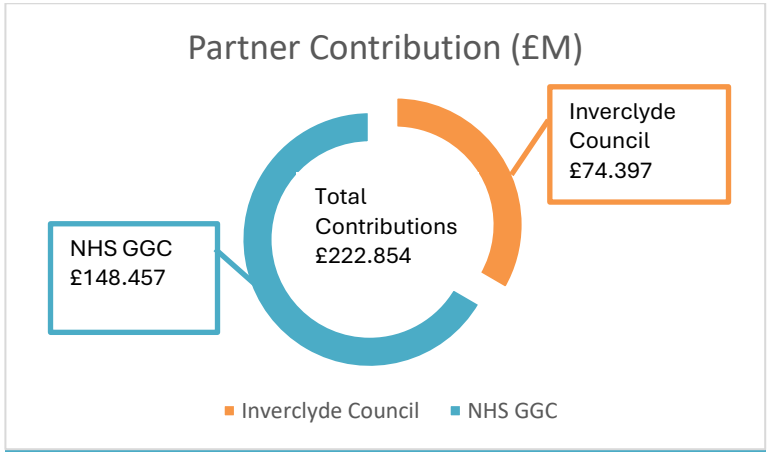
Our partners in Carers Gateway have provided much need support and guidance to local carers and young carers.
During the year, they offered support plans to **421** local carers, with 16% of people completing a plan. They also offered Young Carers Statements to **158** young people, with 47% completing

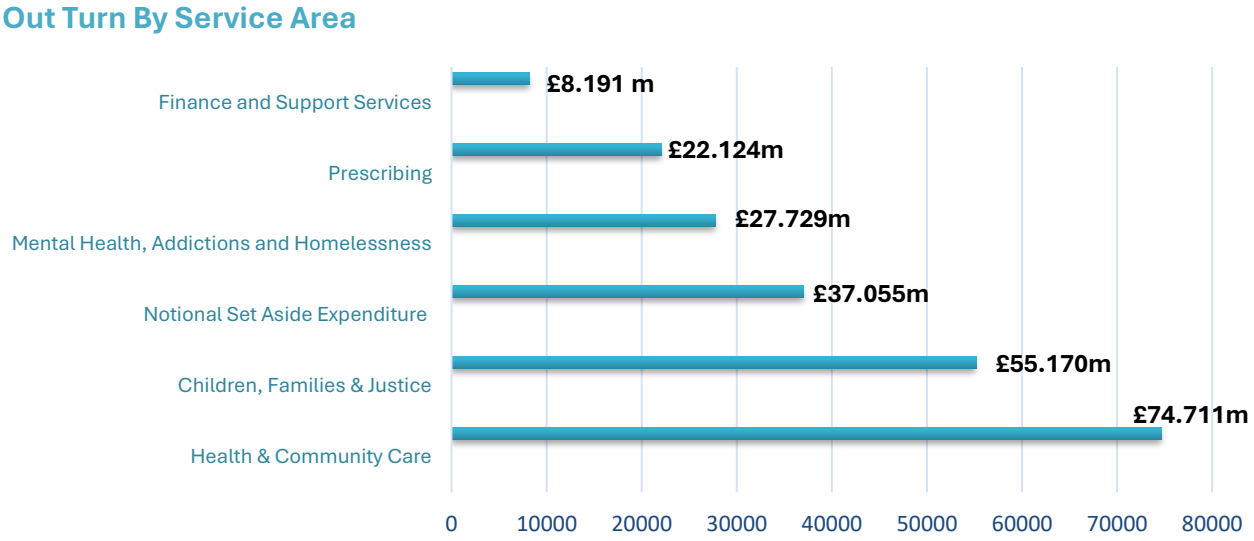
SECTION 4: FINANCE AND BEST VALUE

Resources

On 24th March 2025, the IJB approved the 2025/26 budget, including £2.3m in planned savings and efficiencies, along with the use of £0.373m of reserves in 2025/26 to meet the remaining budget gap for the year. How this budget was allocated is demonstrated in the image below:

Inverclyde HSCP 2024/25 Outturn





Financial Overview and How We Managed Our Resources

We continue to focus on using our resources effectively to support people and communities, making sure that services are delivered safely, sustainably and in line with local needs. Despite financial pressures during 2024/25, we maintained a balanced position and protected core service delivery.

At the end of the financial year, the Health and Social Care Partnership (HSCP) reported a small underspend of £0.051 million, which was added to our general reserves. Throughout the year, we also achieved £2.554 million in planned savings, which helped support the overall financial position.

Pressures in Social Care

We experienced increased demand and cost pressures in children and families' services, resulting in an overspend of £3.957 million. This was due to higher-than-planned spend on residential placements, fostering, adoption and kinship care.

These pressures were partly offset by a £1.146 million underspend across adult services, achieved through staff vacancies and higher income from client contributions. In addition, we used one-off savings, such as reduced pension-related costs, to help balance the position overall.

Pressures in Health

The prescribing budget was under pressure again this year, with an overspend of £1.453 million. However, this was offset by vacancy-related savings across Health.

Looking Ahead

At the start of the financial year, the HSCP held total reserves of £19.287 million. During the year, £6.020 million of earmarked reserves were used to support agreed projects and service delivery. A further £3.894 million was added to earmarked reserves, leaving a closing balance of £17.161 million available to support planned priorities in 2025/26 and future years.

Performance and Learning through Scrutiny

Joint Inspection of Adult Services

In May 2024, a joint inspection report was published by the Care Inspectorate and Healthcare Improvement Scotland (HIS), focusing on how effectively the Inverclyde HSCP delivers integrated and outcome-focused services for adults living with mental illness. The inspection reviewed strategic and operational delivery over a two-year period and explored the experiences of individuals and unpaid carers.

The report highlighted several key strengths, including the partnership's compassionate and inclusive vision, its investment in early help and prevention, strong community-based relationships and positive outcomes for people living with mental illness. Inverclyde was praised for the delivery in key national integration indicators such as living independently, improved quality of life and feeling safe.

Inspectors identified areas for improvement, particularly around improving support for unpaid carers, strengthening governance and oversight, enhancing co-location of services and better integration to ensure seamless support. These findings informed the development of a detailed improvement action plan, aligned to the inspection's priority recommendations. This plan builds on existing activity and is monitored through the Clinical and Care Governance Forum, with regular progress updates also reported to the IJB Audit Committee.

A significant development within the improvement action plan was the creation of a dedicated service manager post for mental health social work. The responsibilities of the post include strategic/professional management of statutory mental health social work functions, reflecting the inspection findings that areas for improvement included oversight and governance of social work practice, with reference to the statutory functions of mental health officers. This post provides the required scrutiny and oversight of statutory mental health social work services, including complex care and adult support and protection. The service manager post was filled in December 2024 and has a key role in mental health strategy and management of teams providing statutory Mental Health Officer duties, adults with incapacity and guardianship responsibilities.

Inspection of Learning Disability Support and Care at Home

In May 2024, inspectors undertook an inspection of this service and published their findings in June 2024. Inspectors found that managers and staff developed meaningful relationships with individuals who were also supported to participate in a wide range of community activities. Relationships were also developed with external health professionals, enhancing the health and wellbeing of people. Areas for improvement for improving systems around medication support/recording and how audit activity can better inform improvement were included within an improvement action plan and continue to be reported to the Social Work and Social Care Scrutiny Panel, with oversight provided by the HSCP Clinical and Care Governance Forum.

Inspection of Fostering, Adoption and Continuing Care Services

In May 2024, as part of their cycle of scrutiny activity, the Care Inspectorate undertook an inspection of adoption, fostering and continuing care services in Inverclyde. The inspection reports were published in June 2024 and evaluated services against three key questions, namely how children and young people's wellbeing is supported, leadership and how well care and support are planned. Key strengths included recognition that children and young people developed meaningful, affectionate and secure relationships with their caregiver families; siblings were kept together where possible and there was a culture of promoting continuing care embedded within the service where young people were thriving with their caregiver families.

Inspectors also identified areas for improvement, particularly around the development of clearer processes when fostering placements end in an unplanned way, consistent approaches in the training, development and supervision of foster carers and ensuring that quality assurance systems are robust and support improvement. Comprehensive improvement action plans for each service were developed, incorporating improvement activity that pre-dated the inspection and these reflect the findings and key messages of the inspection reports. Progress to achieve these actions has been provided to the Social Work and Social Care Scrutiny Panel and is monitored through the Clinical and Care Governance Forum.

Key achievements to-date include review of systems and processes to improve matching of children's needs to the availability and experience of fostering households, reflective supervision (staff and foster carers), practice improvements around unplanned placement endings and development of a learning and development framework that reflects the knowledge, experience and learning needs of foster carers.

Inspection of children's residential houses: The View

The Care Inspectorate also commenced their regular cycle of inspection activity related to our three residential children's houses. The report on one inspection of 'The View' children's house, was published by 31 March 2025 and noted that young people living there were cared for by a committed staff team who knew them well. Inspectors also noted positive relationships based on trust, understanding and genuine care and cited a consistent staff team having contributed to the stability of the house. Young people were listed to and supported to share their views through access to advocacy and all young people living in The View were attending some form of education with some also having part-time jobs. An ongoing area of improvement was the mechanism to report events to the Care Inspectorate, and this was implemented by the date of the report's publication. The outcome of the inspection was that the service was graded as 'very good.' Inspection reports on our other two children's houses will be included in the next annual performance report.

Appendices

Appendix 1. Nine National Health and Wellbeing Outcomes

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long-term conditions or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.
7. People using health and social care services are safe from harm.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care services.

National Health and Wellbeing Outcomes: A framework for improving the planning and delivery of integrated health and social care services

Appendix 2. How our ambitions align to the Nine National Health and Wellbeing Outcomes

Ambitions	Alignment to Strategic Priority	National Health and Wellbeing Outcomes
We will listen to and learn from our people, staff, and communities to ensure timely and appropriate access to support	1) Provide Early Help and Intervention 2) Improve Support for Mental Health, Wellbeing and Recovery 3) Support Inclusive, Safe and Resilient Communities 4) Strengthen Support to Families and Carers	**1, 3, 4, 7, 8**
We will target our resources to where they are needed most, addressing inequalities across our communities	1) Provide Early Help and Intervention 2) Improve Support for Mental Health, Wellbeing and Recovery 3) Support Inclusive, Safe and Resilient Communities 4) Strengthen Support to Families and Carers	**1, 2, 5, 9**
We will maintain and enhance the delivery of safe, effective, and timely care	1) Provide Early Help and Intervention 2) Improve Support for Mental Health, Wellbeing and Recovery 3) Support Inclusive, Safe and Resilient Communities	**3, 4, 7, 9**
We will ensure all our services are trauma-informed and focus on recovery and continuous improvement	1) Provide Early Help and Intervention 2) Improve Support for Mental Health, Wellbeing and Recovery 3) Support Inclusive, Safe and Resilient Communities	**3, 4, 7, 8**
We will co-design services with local people, ensuring they reflect lived experiences and meet real needs.	1) Support Inclusive, Safe and Resilient Communities 2) Strengthen Support to Families and Carers	**3, 4, 5, 8**
We will work alongside third and independent sector partners to support people with complex needs to live independently	1) Provide Early Help and Intervention 2) Support Inclusive, Safe and Resilient Communities 3) Strengthen Support to Families and Carers	**2, 4, 5, 9**
We will support carers and families, providing the help they need to continue in their caring roles	1) Strengthen Support to Families and Carers 2) Improve Support for Mental Health, Wellbeing and Recovery	**1, 2, 3, 4, 5, 6**

We will empower our workforce to innovate and collaborate, enabling better responses to the needs of individuals and communities.	1) Improve Support for Mental Health, Wellbeing and Recovery	**1, 4, 8, 9**
We will support people through key life transitions, particularly those with complex needs	1) Provide Early Help and Intervention 2) Improve Support for Mental Health, Wellbeing and Recovery 3) Support Inclusive, Safe and Resilient Communities 4) Strengthen Support to Families and Carers	**1, 2, 4**
We will take a system-wide approach to care planning, ensuring it is proactive, person-centred and sustainable	1) Provide Early Help and Intervention 2) Improve Support for Mental Health, Wellbeing and Recovery 3) Support Inclusive, Safe and Resilient Communities 4) Strengthen Support to Families and Carers	**2, 5, 9**
We will ensure everyone who needs palliative and end-of-life care receives compassionate, high-quality support, aligned with their needs and wishes, from diagnosis through to end-of-life	1) Provide Early Help and Intervention 2) Strengthen Support to Families and Carers	**2, 3, 4, 5, 9**

Appendix 3. National Performance Scorecards

We require to report on the nine National Health and Wellbeing Outcomes for adult health and social care services, and the national outcomes for Children, Families and Justice. Again, they are all structured and reported using our Six Big Actions.

These following appendices contain information on

- the 23 National Integration Indicators (NII),
- the Ministerial Steering Group (MSG) Indicators, and
- the Local Government Benchmarking Framework (LGBF).

The following scorecards have been collated to show how Inverclyde Health and Social Care Partnership has performed against a variety of measures in the last year. This year's performance has been compared against previous years and against the rest of Scotland as a benchmark. The following table shows what is included in the scorecards and how to interpret the information.

Column	Description	Symbol/colour and definition
Indicator	Description of the measure being shown. Type of measure also shown (Total, %, Rate per 1,000 population)	
Value	The most recent measure for Inverclyde HSCP	
Difference from Previous Year (%)	Percentage change in last year of recording.	 Performance has improved since the previous year Performance has stayed the same since the previous year Performance has declined since the previous year
Difference from Scotland (%)	Percentage difference from the most recent Scottish average.	 Performance is better than the Scottish average Performance is the same as the Scottish average Performance is below the Scottish average
HSCP Rank	Ranks Inverclyde within the 31 HSCPs across Scotland. The rank number and colour show	 Performance rank position (1 - 16) Performance rank position (17 to 24)

	whether a high rank signals good performance or bad performance. Rank 1 for an indicator signifies the best performing area. NOTE: For the LGBF indicators - these are ranked 1 to 32 for the Local Authorities instead of 31 HSCPs.		Performance rank position (25 - 31)
5-year Trend	A spark-line chart showing the trend in Inverclyde in the past 5 years. The red dots represent the highest and lowest points		

Appendix 3a. National Integration Indicators

There are 23 National Integration Indicators. These indicators support and demonstrate progress towards the 9 National Health and Wellbeing Outcomes (**Appendix 1**) and are used by all HSCPs in Scotland.
This information is provided by colleagues in Public Health Scotland and is broken down into two types of complementary measures.

1. Outcome indicators 1 to 9 - are based on survey feedback- The Health and Care Experience survey (HACE) is sent to a random sample of patients who are registered with a GP practice in Scotland. Updated every two years – most recent data is 2023/24. As such, there is no update to these indicators in this iteration of our annual performance report.

2. Data indicators, 11 to 20 - are primarily sourced from Scottish Morbidity Records (SMRs) which are nationally collected discharge-based hospital records. In accordance with PHS recommendations, the most recent reporting period available is calendar year 2023; this ensures that these indicators are based on the most complete and robust data currently available.

The most recent data for these indicators is shown in the scorecard overleaf, but some key points to note are:

- During 2024/25, the number of days people (aged 75 and over) spent in hospital when they are ready for discharge decreased by **35.1%** and was reported as significantly lower than the national figure. Overall, Inverclyde ranked 5 out of all 31 HSCPs for this measure.

- The rate (per 100,000) of Premature Mortality for people under the age of 75 has increased by **2.4%** in the past year and is higher than the overall Scottish Average.

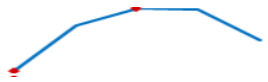
- There is a reported **2.8%** increase in our emergency admission rate in 2024/25 compared to the previous year. This is higher than the Scottish Average. However, while the Emergency bed day rate in Inverclyde is higher than the Scottish average, in 2024/25, Inverclyde experienced a decrease in this rate of **5.4%.**

- While Inverclyde experienced a **2%** increase in the number of adult readmissions to hospitals within 28 days of discharge, we ranked **6th** overall across all HSCPs and performed better than the national average.

- We improved our proportion of Care Services graded ‘good’ (4) by Care Inspectorate inspections by **3%,** and performing above the national average.

National Integration Indicators (NII) Scorecard

Indicator Number	Indicator	Value	Difference from Previous Year (%)	Difference from Scotland (%)	HSCP Rank	5 Year Trend (spark line)	Notes	Most recent data
1	Percentage of adults able to look after their health very well or quite well	88.9%	-1.2%	-1.7%	26		Data is published every 2 years.	2023/24
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	75.9%	NA	+3.5%	13		Data is published every 2 years. Results for 2023/24 are not comparable to previous years due to changes in survey wording.	2023/24
3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	67.8%	NA	+8.2%	6		Data is published every 2 years. Results for 2023/24 are not comparable to previous years due to changes in survey wording.	2023/24
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	68.7%	NA	+7.3%	5		Data is published every 2 years. Results for 2023/24 are not comparable to previous years due to changes in survey wording.	2023/24
5	Total % of adults receiving any care or support who rated it as excellent or good	70.7%	NA	+0.7%	16		Data is published every 2 years. Results for 2023/24 are not comparable to previous years due to changes in survey wording.	2023/24
6	Percentage of people with positive experience of the care provided by their GP practice	65.0%	+6.3%	-3.6%	22		Data is published every 2 years.	2023/24
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	73.6%	NA	+3.9%	10		Data is published every 2 years. Results for 2023/24 are not comparable to previous years due to changes in survey wording.	2023/24
8	Total combined percentage of carers who feel supported to continue in their caring role	31.9%	+3.2%	+0.7%	15		Data is published every 2 years.	2023/24

9	Percentage of adults supported at home who agreed they felt safe	72.7%	NA	0.0%	16		Data is published every 2 years. Results for 2023/24 are not comparable to previous years due to changes in survey wording.	2023/24
11	Premature mortality rate for people under age 75 per 100,000 persons	531.9	+2.4%	+20.5%	28			2023
12	Emergency admission rate (per 100,000 population) for adults (18+)	12,937	+2.8%	+11.9%	19		For the most recent data, calendar year 2024 is used as a proxy for 2024/25 as data for the full financial year is incomplete. However, financial years are used for earlier years as normal.	2024
13	Emergency bed day rate (per 100,000 population) for adults (18+)	146,476	-5.4%	+28.9%	28		For the most recent data, calendar year 2024 is used as a proxy for 2024/25 as data for the full financial year is incomplete. However, financial years are used for earlier years as normal.	2024
14	Emergency readmissions to hospital for adults (18+) within 28 days of discharge (per 1,000 discharges)	82.7	+2.0%	-19.5%	6		For the most recent data, calendar year 2024 is used as a proxy for 2024/25 as data for the full financial year is incomplete. However, financial years are used for earlier years as normal.	2024
15	Proportion of last 6 months of life spent at home or in a community setting	88.2%	+1.3%	-1.0%	22		For the most recent data, calendar year 2024 is used as a proxy for 2024/25 as data for the full financial year is incomplete. However, financial years are used for earlier years as normal.	2024
16	Falls rate per 1,000 population aged 65+	24.1	-3.2%	+7.1%	23		For the most recent data, calendar year 2024 is used as a proxy for 2024/25 as data for the full financial year is incomplete. However, financial years are used for earlier years as normal.	2024

17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	83.6%	+3.0%	+1.7%	15			2024/25
18	Percentage of adults with intensive care needs receiving care at home	66.6%	-0.8%	+1.9%	11			2024
19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) (age 75+)	340.1	-35.1%	-64.3%	5			2024/25
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	25.3%	+0.4%	+1.3%	24		Information is not published beyond 2019/20 as detailed cost information is not available.	2019/20

Appendix 3b. Ministerial Steering Group (MSG) Indicators

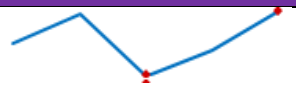
The MSG Performance indicators provide a focus on hospital-based performance within HSCP areas, specifically around Unscheduled Care such as Accident and Emergency attends, Emergency Admissions and Unplanned Bed Days (in hospital).

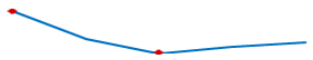
Due to a change in national reporting requirements, MSG indicators are only provided at the local authority level and will no longer include a comparison to the overall national figures or provide a national ranking. As such, only the Inverclyde trend information is provided.

These indicators are used extensively by services to predict surges in demand and to plan our services effectively. The information provided in the following Scorecard is the most recent annual figures available. Some key points to note are:

- Inverclyde HSCP experienced a **44.9%** reduction in the number of unplanned bed days for Geriatric Long Stays.
- The service also experienced a **14.1%** reduction in the number of unplanned bed days for Mental Health patients.
- The number of people (18 and over) who experience a delayed discharge from hospital, decreased by **52.1%** during 2024/25.
- There was a slight, **0.9%** decrease in the number of people who spent the last 6 months of life in a community setting. This was offset by an **0.8%** increase in those spending the last 6 months of life in a large hospital setting.
- In terms of the balance of care for those 65 and over, there were small changes across the range settings recorded, with the most significant change being a **0.3%** decrease in the local population supported at home. There was no change for those supported in a Hospice/Palliative Care Unit, Community Hospital of Large Hospital.

MSG Scorecard

Indicator Number	Indicator	Value	Difference from Previous Year (%)	5 Year Trend	Notes	Most recent data
1	Number of emergency admissions (18+)	7,893	+4.5%			2024
2a	Number of unplanned bed days - Acute (all ages)	79,120	-0.9%			2024
2b	Number of unplanned bed days - Geriatric Long Stay (all ages)	167	-44.9%			2024
2c	Number of unplanned bed days - Mental Health (all ages)	17,909	-14.1%			2024
3a	Number of A&E attendances (all ages)	29,489	-1.4%			2024/25
3b	A&E % Seen within 4 hrs	75.5%	-0.7%			2024/25
4	Number of delayed discharge bed days (Age 18+)	3,146	-52.1%			2024/25
5	% of Last Six Months of Life by Setting (Community - all ages)	86.9%	-0.9%		Figures for 2023/24 are provisional and may be revised in the future.	2023/24p
5	% of Last Six Months of Life by Setting (Hospice / PCU - all ages)	0.7%	+0.05%		Figures for 2023/24 are provisional and may be revised in the future.	2023/24p

5	% of Last Six Months of Life by Setting (Community Hospital - all ages)	0.0%	+0.03%		Figures for 2023/24 are provisional and may be revised in the future.	2023/24p
5	% of Last Six Months of Life by Setting (Large Hospital - all ages)	12.4%	+0.8%		Figures for 2023/24 are provisional and may be revised in the future.	2023/24p
6	Balance of Care: % of pop in community or institutional settings (Home unsupported - 65+)	90.3%	+0.2%			2023/24
6	Balance of Care: % of pop in community or institutional settings (Home supported - 65+)	5.3%	-0.3%		Inverclyde did not submit Care at Home data for quarter 3 of financial year 2023/24.	2023/24
6	Balance of Care: % of pop in community or institutional settings (Care home - 65+)	3.2%	+0.1%			2023/24
6	Balance of Care: % of pop in community or institutional settings (Hospice / PCU - 65+)	0.01%	0.00%			2023/24
6	Balance of Care: % of pop in community or institutional settings (Community hospital - 65+)	0.0%	0.00%			2023/24
6	Balance of Care: % of pop in community or institutional settings (Large hospital - 65+)	1.1%	0.00%			2023/24

Appendix 3c. Local Government Benchmarking Framework

The Local Government Benchmarking Framework (LGBF), is a high-level benchmarking tool which aims to develop better measurement and comparable data as a catalyst for improving services, targeting resources to areas of greatest impact and enhancing public accountability. Several of the indicators are for services delivered by the HSCP (children and adult services) and are therefore included within this annual Performance Report. Further detail on the indicators can be found at Benchmarking | Benchmarking (improvementservice.org.uk)

The framework provides high-level 'can openers' which are designed to focus questions on why variations in cost and performance are occurring between similar councils. The LGBF helps councils compare their performance against a suite of efficiency, output and outcome indicators that cover all areas of local government activity. To note, information is primarily sourced from national statistical returns to Scottish Government, as a result the most recent reporting period available is for **2023/24.**

Some key highlights from this data include:

- Inverclyde HSCP experienced a **57.6%** increase in the weekly Gross Cost of Children looked After in a Residential setting. Inverclyde ranked 25th out of 32 local authority areas for this measure. While there was an **8.3%** increase in the weekly Gross Cost of children looked after in a community setting, Inverclyde performed better than the Scottish Average and ranked **10th** out of 32 local authorities for this measure.

- During the reporting period there was a **11.3%** increase in the number of care experienced children with more than 1 placement in the reporting year. It also reported as **3.1%** above the Scottish average.

- Inverclyde reported a **4.3%** increase in Direct Payments and Personalised Budgets for adults 18 and over as a percentage of total social work spend. For this measure we also reported as **7.1%** higher than the Scottish Average and Ranked **2nd** out of 32 local authority areas.

- During the reporting period, there was a **3.2%** increase in the number of local carers who felt supported to continue in there caring role.

- There was a **16.4%** decrease in the weekly Residential Costs for people aged 65 and over.

- While the rate of readmission to hospital with 28 days increased by 4.3% during the reporting period, Inverclyde performed significantly better than Scotland as whole and ranked 5th of 32 local authorities for this measure.

LGBF Scorecard

Indicator Number	Indicator	Value	Difference from Previous Year (%)	Difference from Scotland (%)	Local Authority Rank	5 Year Trend (spark line)	Notes	Most recent data
CHN8a	The Gross Cost of "Children Looked After" in Residential Based Services per Child per Week	£6,562	+57.6%	+24.2%	25		Please see note in key regarding LA rankings	2023/24
CHN8b	The Gross Cost of "children looked after" in a community setting per child per week	£391	+8.3%	-17.6%	10			2023/24
CHN9	Percentage of children being looked after in the community	86.8%	+5.6%	-2.0%	19			2023/24
CHN17	Percentage of children meeting developmental milestones	79.3%	+4.1%	-4.0%	28			2023/24
CHN22	Percentage of child protection re-registrations within 18 months	9.0%	+9.0%	+3.1%	24			2023/24
CHN23	Percentage LAC with more than 1 placement in the last year	25.3%	+11.3%	+7.8%	28			2023/24
CHN24	Percentage of children living in poverty (after housing costs)	26.1%	+1.7%	+4.3%	22			2022/23

SW01	Home care costs per hour for people aged 65 or over	£50.23	-1.0%	+49.4%	28			2023/24
SW02	Direct Payments and Managed Personalised Budgets spend on adults 18+ as a percentage of total social work spend on adults 18+	16.1%	+4.3%	+7.1%	2			2023/24
SW03a	Percentage of people aged 65 or over with long-term care needs receiving personal care at home	66.5%	+8.2%	+3.9%	9			2023/24
SW04b	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	73.6%	-6.0%	+3.9%	10		Data is published every 2 years. The trend is looking at past 6 years.	2023/24
SW04c	Percentage of adults supported at home who agree that they are supported to live as independently as possible	75.9%	-7.0%	+3.5%	13		Data is published every 2 years. The trend is looking at past 6 years.	2023/24
SW04d	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	67.8%	+1.1%	+8.2%	6		Data is published every 2 years. The trend is looking at past 6 years.	2023/24
SW04e	Percentage of carers who feel supported to continue in their caring role	31.9%	+3.2%	+0.7%	15		Data is published every 2 years. The trend is looking at past 6 years.	2023/24
SW05	Residential costs per week per resident for people aged 65 or over	£ 707	-16.4%	-2.2%	14			2023/24

SW06	Rate of readmission to hospital within 28 days per 1,000 discharges	79	+4.3%	-23.8%	5			2023/24
SW07	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	80.6%	+0.6%	+3.6%	16			2023/24
SW08	Number of days people spend in hospital when they are ready to be discharged, per 1,000 population (75+)	514	+18.1%	-38.9%	10			2023/24

Appendix 4. Glossary of terms

ABBREVIATION	DEFINITION
ABI	Alcohol brief Intervention
ADP	Alcohol and Drug Partnership
ADRS	Alcohol and Drug Recovery Services
APR	Annual Performance Report
ASO	Assessment and Support Officers
CI	Continuous Intervention
CoP	Community of Practice
COPD	Chronic Obstructive Pulmonary Disease
CPC	Child Protection Committee
ED	Emergency Department
GIRFE	Getting it for everyone
GIRFEC	Getting it right for every child
HOHAS	Housing Options and Homelessness Advice Services (HOHAS)
HSCP	Health and Social Care Partnership
IJB	Integration Joint Board
IRD	Interagency Referral Discussions
LGBF	Local Government Benchmarking Framework
LPGs	Locality Planning Groups
MHO	Mental Health Officer
MSG	Ministerial Strategic Group
NHS	National Health Service
NII	National Integration Indicators (NII)
OOH	Out of Hours
PCCP	Person-centered care planning
PCMHT	Primary Care Mental Health team
PCU	Palliative Care Unit
RES	Rehabilitation and Enablement Service

RfA	Request for Assistance
RPM	Remote Patient Monitoring
RRSW	Rapid Rehousing Support Workers
SCR	Social Circumstances Report
SIMD	Scottish Index of Multiple Deprivation
SMT	Senior Management Team
SPG	Strategic Planning Group
WFWF	Whole Family Wellbeing Fund (WFWF)