West Dunbartonshire Council

West Dunbartonshire Health & Social Care Partnership

NHS Greater Glasgow and Clyde

West Dunbartonshire Health and Social Care Partnership

Clinical & Care Governance Annual Report 2024

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1. Introduction

- **Background to Service and Report**

Introduction

1.1 Each Health and Social Care Partnership is requested by NHS Greater Glasgow and Clyde to provide an Annual Clinical and Care Governance Report. The Health Act 1999 requires that NHSGGC "put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals".

1.2 The report outlines arrangements for Clinical and Care governance in WDHSCP and is framed around the three Quality ambitions outlined in NHS Scotland Quality Strategy; Safe, Effective, Person Centred Care. The Healthcare Quality Strategy sits within the context of the Patients' Rights Act which became law in Scotland in 2011. This provides a legal basis requiring the NHS in Scotland to provide care, which is person centred, safe and effective.

1.3 This report demonstrates West Dunbartonshire Health and Social Care Partnerships (WDHSCP) approach to assuring and improving the quality of health and care services we provide. Recognising the complex interdependencies in delivering safe effective person centred care in an integrated context, it includes West Dunbartonshire Council Social Work and Social Care governance framework.

1.4 This report describes West Dunbartonshire HSCPs arrangements for scrutiny of care quality, across the services which the HSCP provides, and those that it commissions. This report presents some of our key activities during the reporting period and describes how we are building capacity and capability for this work. A selection of activities and interventions are highlighted to demonstrate our strong focus on quality improvement, these are illustrative rather than comprehensive.

West Dunbartonshire Health and Social Care Partnership

2.1 West Dunbartonshire Health and Social Care Partnership (HSCP) was established on 1st July 2015 as the Integration Authority for West Dunbartonshire in response to the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

2.2 The Vision of West Dunbartonshire Health and Social Care Partnership is '*Improving lives with the people of West Dunbartonshire'* through achievement of our strategic outcomes.

2.3 West Dunbartonshire HSCP employs over 900 health, social work and social care staff. There is also a significant workforce in the independent NHS contractor service for example, GPs, Dentists, Optometrists, and Community Pharmacists and third sector and independent social care providers. West Dunbartonshire HSCP hosts Musculoskeletal Physiotherapy and Diabetic Retinopathy services on behalf of NHSGGC.

2.4 Between 2018 and 2028, the population of West Dunbartonshire is projected to decrease from 89,130 to 87,141. This is due to fewer babies being born each year and more people moving out of the area than moving in. 18% of the population are aged 0-15, and 9.7% of the population are aged 16-24. In terms of overall size, the 45 to 64 age group remains the largest at 25, 6646 (29%).People aged 65 and over make up 19% of West Dunbartonshire's population, which is similar to Scottish population.

2.5 West Dunbartonshire contains the third equal highest share of the most deprived data zones out of Scotland's 32 local authority areas. 22.6% of children live in low income families. Life expectancy is lower than the Scottish average with those living in the most deprived communities spending, on average, 24 years fewer in good health than those living in the least deprived areas. With those in the most deprived areas also dying younger, they spend more than one third of their lives in poor health. Healthy life expectancy has decreased in West Dunbartonshire to 58.1 years for males and 58.5 for females.

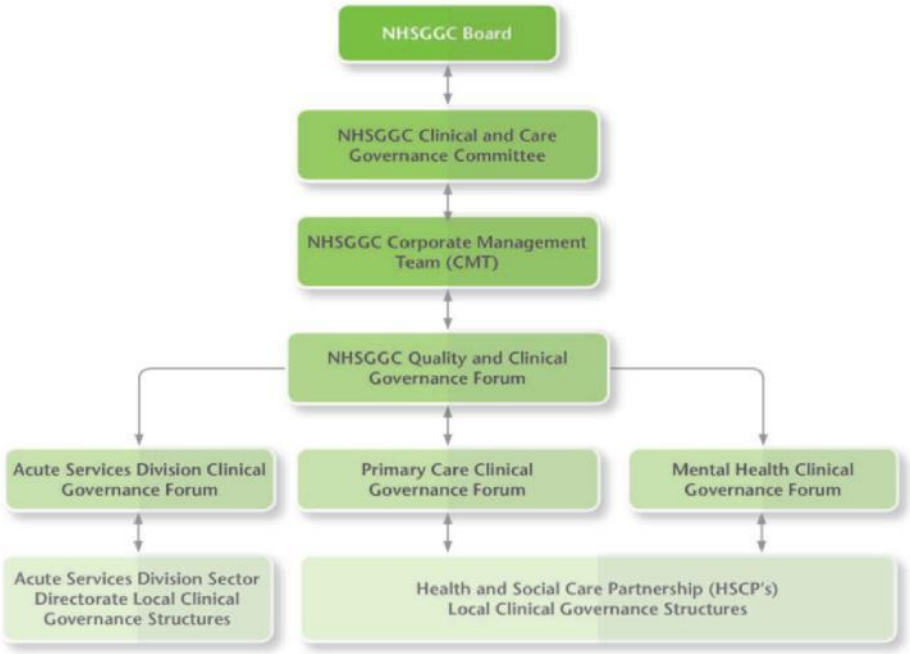
2.6 Delayed hospital discharges and high use of unscheduled care remain challenging. We need to promote a preventative agenda, support a shift in the balance of care from acute to community services, using a collaborative approach that ensures people have choice and control over the services they receive. Delivering the best possible outcomes for the people of West Dunbartonshire is contingent on, supporting our staff to deliver high quality care and, optimising the use of resources to deliver high quality community-based services, particularly for those with higher levels of need, while keeping more people safe at home. The wide range of improvement activity to support this endeavour is reflected throughout this report.

2.7 The Partnership continues to be challenged with funding pressures, staff shortages in certain areas, an ageing population and high demand for services. Budget Setting has highlighted the financial pressures the Partnership is facing. There is evidence that poor quality increases costs through harm, waste and variation. It is imperative therefore that we remain assured of our ability to deliver high quality care whilst overcoming financial constraints. The challenging fiscal environment we face across all of our public services is evident not only this year but in years to come making it vitally important that we continue to scrutinise and provide assurance on the quality of the care services we provide to ensure best value and optimum outcomes for service users and their families.

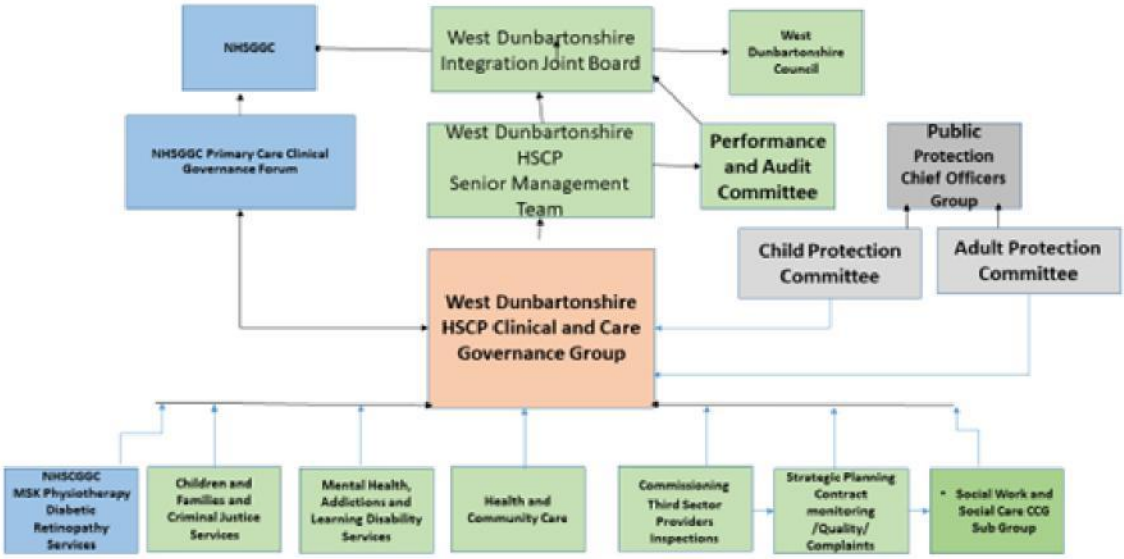
3. Clinical Governance Arrangements

- **Schematic of Clinical Governance Structure**

3.1 NHSGGC Corporate Level Clinical and Care Governance Arrangements



3.2 West Dunbartonshire HSCP Clinical and Care Governance Arrangements



. Maintenance of Clinical Governance Arrangements

3.3 West Dunbartonshire HSCP CCG meet quarterly to assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The group assess, monitor, mitigate and escalate risks as appropriate. A co-ordinated risk management system is implemented using risk registers, complaints, feedback and an adverse events/incident system, ensuring that this focuses on learning, assurance and improvement.

3.4 Heads of Service (HOS), Chief Nurse, Chief Social Work Officer, Clinical Director and Hosted services provide quarterly exception reports to the HSCP CCG setting out how they assess, monitor, and continuously improve the quality and safety of their services. Registered services delivered by the HSCP report via HOS. The CSWO Officer provides a quarterly exception report from the Social Work and Social Care Governance sub group. The Lead Optometrist for independent contractors within NHSGGC also reports via WDHSCP CCG. Externally commissioned registered services are monitored via the HSCP Contracts, Commissioning and Quality Team.

3.5 Care Inspectorate Reports for internal and external registered services are reported via Clinical and Care Governance Group and the IJB Audit and Performance Committee.

3.6 An Annual Clinical and Care Governance report is prepared for NHSGGC Health Board and West Dunbartonshire Integration Joint Board Audit and Performance Committee.

. Remit of West Dunbartonshire HSCP Clinical Governance Group

3.7

I. Consider matters relating to strategic plan development, governance, risk management, service user feedback, complaints, standards, care assurance, education, professional registration, validation, learning, continuous improvement and inspection activity.

II. Provide assurance to the Health & Social Care Partnership Board, the Council and NHSGGC, via the Chief Officer, that the professional standards of staff working in Integrated Services are maintained and that appropriate professional leadership is in place.

III. Review significant and adverse events and ensure learning is applied. Support staff in continuously improving the quality and safety of care. Ensure that service user / patient views on their health and care experiences are actively sought and listened to by services.

IV. Create a culture of quality improvement and ensure that this is embedded in the organisation by facilitating improvement activity including self-evaluation and clinical governance actions. Provide oversight and assurance regarding the quality and safety of care including public protection, inspections and contract monitoring.

V. The Clinical Director chairs the HSCP CCG group and the Chief Social Work Officer is Co- Chair. The membership includes the Chief Nurse, the Heads of Service from all HSCP services areas including hosted services and a representative form NHSGG&C Clinical Risk Department.

VI. There has been ongoing reflection on the purpose and direction of the group and the role of clinical and care governance, and promotion of the quality agenda within the Strategic Plan.

- **Clinical and Care Governance Work Plan**

3.8 The CCG work plan for 2024 (Appendix 1) demonstrates progress with the systemic developments to support capture and oversight of reportable incidents across social work and social care services. Development of Care-First system strengthened quality and performance reporting on Social work and Social Care services. Clear, robust, accurate and timely information on the quality of service performance has enhanced oversight and systematic monitoring, assessment and management of risk to care quality. Progress and preparation for the implementation of 'Care Opinion' to enables service users and carers / community to provide feedback on the service they receive is also evident. The 2025 work-plan priorities are detailed in Appendix 2.

- **How emerging concerns over the quality and safety of care or services are recognised and escalated**

3.9 Datix is the NHS Greater Glasgow & Clyde incident risk management and patient safety system used to capture clinical incident activity within health services delivered by West Dunbartonshire HSCP including Board Wide Musculoskeletal (MSK) Physiotherapy and Diabetic Retinal Screening Services (DRSS). The system is used to systematically identify and measures risks faced by the organisation with the focus on learning so that we might reduce or eliminate future risk.

3.10 All incidents are ascribed a severity score using NHSGGC risk matrix and severity impact assessment. Minor and negligible incidents may require to be investigated in addition to the review and approval process. This is at the discretion of the line manager who receives the report. If the severity is minor or low this does not mean that the incident can be ignored. These incidents represent small failures and vulnerabilities that may signal action to avoid repeat or escalation of a situation. The opportunity for learning exists at times without a significant adverse outcome for the patient, e.g. a near miss or a lower impact incident which exposes potential clinical system weaknesses that could lead to further significant harm.

3.11 Moderate rated incidents are reviewed by the Local Management Teams and action plans drawn up to eliminate or reduce the risk of recurrence. If the rating is a 4- Major, or 5- Extreme, there must be an investigation of causation. For all incidents severity graded 4 or 5 there is discussion and with the Clinical Risk Team, Clinical Director and Manager to determine whether the severity of the incident is such that it merits formal classification as a 'Significant Incident' requiring a Significant Adverse Event review. This is not necessarily the case for all category 4/5 incidents. Most category 4/5 incidents occur in mental health and addiction services. Incidents are rarely due to a single act or omission. Usually an incident occurs because of a combination of actions, events and the surrounding circumstances

3.12 From the full range of clinical incidents reported there is a smaller set of instances where there is a risk of significant harm to patients. We ensure these incidents are appropriately investigated to minimise the risk of recurrence by applying lessons

learned. These events are referred to as Significant Adverse Events (SAE). These are usually incidents that have been categorised as severity 4 or 5.

3.13 Work has been undertaken to strengthen the content of monthly data reports received by SMT to ensure these capture key performance metrics across the range of service areas strengthening our quality control mechanisms by ensuring that clear robust, accurate and timely information on the quality of service performance is effectively scrutinised and used to inform self- evaluation activity that informs improvement priorities supports continuous improvement in the quality of health and social care service planning and delivery.

3.14 The Clinical Director ! Chief Nurse ! CSWO complete an exception report four times per year to submit to NHSGGC Primary Care Clinical and Care Governance Forum (PCCCGF).

3.15 HSCP Services also report via NHSGGC board wide Mental Health, Learning Disability, and Specialist Children's Services Clinical and Care Governance Systems.

3.16 WD CCG exception report is scrutinised by the HSCP Senior Management Team as per local governance arrangements to ensure all pertinent matters are reported and emerging risks highlighted and escalated appropriately via NHSGGC Primary care clinical Governance Group. This informs completion and review of risk and informs the HSCP strategic risk register which is reviewed on a quarterly basis via the IJB Audit and Performance sub- committee.

3.17 Excellence in Care is a national approach which aims to ensure people have confidence they will receive a consistent standard of high-quality of care no matter where they receive treatment in NHS Scotland. West Dunbartonshire nursing teams undertake a planned programme of self-evaluation using a ratified combined care assurance assessment tools (CCAT). These report on core nursing and midwifery family specific quality indicators. The CCAT Care Assurance and Improvement tool allows staff to view and understand their data over time, respond appropriately and plan improvement. This ensures effective arrangements are in place to enable these health care professionals to be accountable for standards of care and services provided.

- **Compliance with Statutory Requirements and Duties**

3.18 Effective implementation of clinical and care governance for integrated health and social care services requires co-ordination across a range of services, including the third sector with the people we serve at the centre.

3.19 The Integration Joint Board and Senior Extended Management Team promote an organisational culture that promotes human rights and social justice, values partnership working and affirms the contribution of staff through the application of best practice.

3.20 West Dunbartonshire HSCP is committed to moving away from transactional based commissioning to a more outcomes focused collaborative commissioning underpinned by ethical commissioning standards. Standardising our approach to commissioning supports the future implementation of the Service Improvement and Quality Assurance

Frameworks in line with WD HSCPs strategic plan. Ensure that the rights, experience, expertise, interests and concerns of service users, carers and communities inform and are central to the planning,

3.21 Services aim to make sure everyone has access to vital support when they need it, regardless of their background, age, or circumstances. All proposals for service development / modification require and equality impact assessment to be undertaken.

3.22 The Health and Care (Staffing) (Scotland) Act (HCSSA) passed by the Scottish parliament in May 2019 came into force on the 1st April 2024.The legislation provides a statutory basis for the provision of appropriate staffing in health and care services, to enable safe and high quality care and improved outcomes for service users. NHS GGC Health Board has delegated healthcare functions to West Dunbartonshire Integration Authority and they must be included in all reporting. The HSCP was required to submit the first quarterly assurance report to the Health Board by April 2025. We are able to provide reasonable assurance with compliance levels with respect to the guiding principles and duties within the act across health services delivered by West Dunbartonshire HSCP. Actins to secure substantial assurance have been identified. Local authorities and integration authorities consider the requirements of the Act when they plan or secure care services, and report on this annually to the Scottish Ministers. Care reporting is scheduled annually with the first report required by the end of June 2025.

3.23 Staff are supported when they raise concerns in relation to practice that endangers the safety of service users and other wrong doing in line with local policies for whistleblowing and regulatory requirements.

3.24 There are established lines of communication and professional accountability from point of care to Executive Directors and Chief Professional Officers accountable for clinical and care governance. This includes strengthening the articulation of the mechanisms for taking account of professional advice.

3.25 Quality monitoring and governance arrangements are in place that include compliance with professional registration and codes of practice , legislation, standards, guidance and these are regularly open to scrutiny.

3.26 The organisational duty of candour provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 set out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).

. Processes for Professional Support and Learning

3.27 The Chief Social Work Officer has a core responsibility to provide professional oversight and leadership regarding the provision of social work services and to ensure that the social services workforce practices within the standards and codes of practice as set out by the Scottish Social Services Council (SSSC). This complementary activity is captured within the Chief Social Work Officers Annual Report which is shared with the Clinical and Care Group to provide assurance on statutory social work functions.

3.28 The Chief Nurse post is to lead, and promote systemic improvements in clinical care and Healthcare Quality to the nursing staff within the HSCP and foster a culture which values continuing professional development and strives for excellence in all aspects of the delivery of patient safety and care. The role provides professional and clinical leadership support to the HSCP, ensuring that a framework is in place to make certain all nursing staff are appropriately managed and are clinically and professionally developed to ensure they are, efficient, effective, engaged and highly motivated in line with the National Nursing and Midwifery Quality Assurance Framework and the NHS Greater Glasgow and Clyde Healthcare Quality Strategy.

3.29 The Clinical Directors are critical members of the team with a number of key roles including – Advisor to our Integrated Board, link between GPs and the HSCP providing an overview of the Primary Care improvement Plan. They provide clinical leadership and expertise to improve the quality and effectiveness of healthcare services within the partnership. They ensure that services align with national and local priorities, promoting good governance and working collaboratively to deliver high-quality care.

3.30 Practitioners have access to regular supervision as per their organisational policies. This is a formal process where qualified supervisors provide guidance, support, and development to health, social work and social care professionals, focusing on their l practice and skills. It's a relationship-based approach that facilitates reflection, learning, and improved care. Supervision helps new and experienced professionals, and it's a vital part of continuing professional development.

3.31 All staff undertake regular statutory training as mandated by law and their statutory bodies, and mandatory training determined by the organization or service commissioners based on risk assessments and policies. In addition all staff undertake Personal Development Planning and Review (PDP&R), a process that helps individuals develop their skills and potential by identifying their needs, setting goals, and taking action to achieve them. It involves regular conversations between individuals and their managers/reviewers to discuss progress, challenges, and future opportunities.

4. Safe Care

Safe: 'There will be no avoidable injury or harm to people from the care they receive, and an appropriate, clean and safe environment will be provided for the delivery of all services at all times'.

- **Incident Management, Reporting and Investigation**

4.1 Datix is the NHS Greater Glasgow & Clyde incident reporting system. 602 incidents were reported between January and December 2025. Clinical incidents were reported across 25 incident categories. The top 10 incident categories are shown in Table 2. The composition of these is similar to previous year report.

Table 1: Top 10 Incident Categories

Category	
Slips, Trips and Falls	**121**
Pressure Ulcer Care	**118**
Other Incidents	**111**
Medication - Prescribing	**66**
Violence and Aggression	**41**
Medication - Dispensing/Supply	**24**
Medication - Administration	**24**
Communication	**17**
Information Governance	**14**
Challenging Behaviour	**10**
Treatment Problem	**10**
Grand Total	**556**

4.2 Slips, trips and falls account for the highest recorded category (121). The majority of Slips, trips and falls occurred within Mental Health Services, 95.5% of Mental Health falls occurred in the Older Peoples Mental Health Service. The majority of the incidents were considered minor resulting in minor or no harm to the patient. One fall was commissioned as a Serious Adverse Event Review. Falls within inpatient areas is correlated to aggression within our inpatient settings, with some inpatients falling as a result of altercations with peers. The inpatient team have worked closely with the falls co-ordinator to review our current practices and implement appropriate measures to reduce the number of slips, trips and falls. All staff are up to date with their falls training and we are following best practice and policy. Teams are also reviewing how to improve management of aggression across inpatient wards and all patients have stress and distress care plans in place.

4.3 There were 118 Pressure Ulcer Care incidents reported during this period. Health and Community Care (District Nursing) Services recorded the highest number of pressure ulcer incidents (115) and the majority of these incident were categorised as unavoidable. One incident progressed to a SAER.

4.4 Other Incidents was the third highest category, with 111 incidents occurring. Many 'other incidents' appear to be adult support and protection and sudden illness/deterioration or collapse. During 2024 West Dunbartonshire CCG were supported by NHSGGC Clinical Governance Support Unit to create packaged reports on Datix submitted in relation to adult and child protection to strengthen identification and oversight of these incidents.

4.5 The Diabetic Retinal Screening Service (DRS) reported 5 incidents. Including 3 slips trips and falls. The severity of these incidents were categorised as minor or negligible.

4.6 MSK Physiotherapy reported 51 incidents. 6 incidents involving communication, 6 information governance, 6 health records, 1 medication- administration, 1 security incident, 11 slips trips and falls, 1 suicide and 3 treatment problems. Datix are reviewed for themes on an ongoing basis. The slips, trips and falls were deemed unavoidable (many of these were incidents in the physiotherapy gyms which were supervised and unavoidable). The incident recorded "suicide" was suicidal thoughts and appropriate care was taken. There has been an ongoing theme around incorrect appointment letters being handed to patients with their return appointment details (i.e. letters relating to another patient). This is due to communal printers and staff have been reminded to check the patient name and CHI number before handing over the letter.

Incident Outcomes

4.7 When an incident is submitted, the reporter records the outcome. This is verified as a final outcome by the reviewer and approver. Table 2 displays the final outcomes of the 571 incidents which have been finally approved. 31 incidents were awaiting a final outcomes when the report was created.

Table 2: Incident Outcomes

Final Outcome	Grand Total
Minor Injury/Illness	284
No injury, harm or adverse outcome	142
Near miss	73
Not Recorded	31
Death	29
Unable to Assess Outcome	14
Moderate Injury/Illness	10
Disruption to services	9
Other	7
Ill Health	2
Blood products wasted	1
Grand Total	602

4.8 All incidents are ascribed a severity score using NHSGGC risk matrix and severity impact assessment. Minor and negligible incidents may require to be investigated in addition to the review and approval process. This is at the discretion of the line manager who receives the report. If the severity is minor or low this does not mean that the incident can be ignored. These incidents represent small failures and vulnerabilities that may signal action to avoid repeat or escalation of a situation. The opportunity for learning exists at times without a significant adverse outcome for the patient, e.g. a near miss or a lower impact incident which exposes potential clinical system weaknesses that could lead to further significant harm.

4.9 Moderate rated incidents are reviewed by the Local Management Teams and action plans drawn up to eliminate or reduce the risk of recurrence. If the rating is a 4- Major, or 5- Extreme, there must be an investigation of causation. For all incidents severity graded 4 or 5 there is discussion and with the Clinical Risk Team, Clinical Director and Manager to determine whether the severity of the incident is such that it merits formal classification as a 'Significant Incident' requiring a Significant Adverse Event review. This is not necessarily the case for all category 4/5 incidents. Most category 4/5 incidents occur in mental health and addiction services. Incidents are rarely due to a single act or omission. Usually an incident occurs because of a combination of actions, events and the surrounding circumstances.

- **Implementation of the Management of Significant Adverse Event Policy**

Significant Adverse Event Reviews (SAER)

4.10 From the full range of clinical incidents reported there is a smaller set of instances where there is a risk of significant harm to patients. We ensure these incidents are appropriately investigated to minimise the risk of recurrence by applying lessons learned. These events are referred to as Significant Adverse Events (SAE). These are usually incidents that have been categorised as severity 4 or 5. These may lead to a significant adverse event review (SAER).

4.11 The purpose of the review is to determine whether there are learning points or improvements for the service and wider organisation. It is then our responsibility to implement those improvements that are identified as producing a greater level of safety for those we care for.

4.12 Table 3. SAER Commissioned by Service Area January–December 2024

ID	Specialty	Incident date	Risk Commissioned Date	Risk SAE Status
827146	Children and Families	17/04/2024	20/06/2024	Under Review
837081	District Nursing	28/07/2024	29/08/2024	In QA
822334	Community Mental Health	07/03/2024	30/05/2024	In QA
809622	Older People's Mental Health	04/03/2024	03/05/2024	Under Review
830831	Crisis Team	08/07/2024	26/07/2024	Closed

4.13 Table 4: SAER Reviews concluded between January and December 2024.

ID	Specialty	Risk SAE - Closed	Investigation Timeframe Days	Outcome of investigation	Is this a Duty of Candour?
748646	Community Mental Health Team	09/02/2024	479	2. Issues identified but they did not contribute to the event	No
743769	District Nursing	24/01/2024	559	3. Issues identified which may have caused or contributed to the event	Yes
685415	Community Mental Health Team	04/10/2024	1060	2. Issues identified but they did not contribute to the event	No
740326	Community Mental Health Team	29/05/2024	546	2. Issues identified but they did not contribute to the event	No
753308	Community Mental Health Team	22/03/2024	395	2. Issues identified but they did not contribute to the event	No
748482	Older People's Mental Health	25/10/2024	712	3. Issues identified which may have caused or contributed to the event	Yes

Duty of Candour

4.14 Two of the closed SAERs met the threshold for organisational duty of candour. The first SAER revealed numerous contributory factors which resulted in an incident outcome of level 3. Contributory factors including failure/malfunction of equipment supplies, staff errors in judgement/knowledge/inadequate training, inadequate handover, guidance not being followed, failure to document risks and failure to escalate concerns appropriately. The learning led to a number of changes to daily practice, taking a person-centred approach. Additional training in moving and handling and stress and distress was provided for all staff and all documentation is now recorded in an electronic management information system (EMIS) meaning local variances have been removed.

The second incident related to sub optimal record keeping. The Review Team concluded, an avoidable pressure ulcer had occurred while Mr X was on the District Nurse caseload. There were however elements of good care demonstrated as evidenced from the notes written in the visit modules, where it is documented that pressure areas were reviewed and assessed on the first visit and pressure ulcer equipment was provided and contact with care at home servics to change visiting times to reduce time spent in bed. The cause of the incident is the lack of full assessments as per Pressure Ulcer Prevention policy. The SSKIN bundle is a care package designed to prevent pressure ulcers, also. It focuses on five key areas: Surface, Skin inspection, Keep moving, Incontinence/moisture, and Nutrition. By addressing these factors, healthcare professionals can reduce the risk of pressure ulcers and improve patient outcomes. This had not been fully completed. There were some contributing factors identified including pateints non-compliance with ue of pressure relieving equipment, there were workload pressures which reduc ed

availability of senior leadership available in the team. Since the incident further training has been created and delivered. A Red Day checklist tool to ensure all required documentation and processes has been completed, sample SSKINS careplans and record keeping update sessions. Staff have reflected on the incident are confident and competent in accurate grading of pressure ulcers, vigilant with their record keeping and attend all training opportunities offered to them to ensure safe effective care is provided at all times. The review team concluded this incident as a level 3 meaning the Issues identified which may have caused or contributed to the event.

. Clinical Governance Key Performance Indicators (KPI)

4.15 NHSGGC Management of Significant Adverse Events Policy highlights that SAE Reviews should be commissioned within 10 working days of an incident occurring (or being made aware of it); and that SAE Reviews should aim be concluded within 90 working days, with a further 40 working days to carry out Quality Assurance. None of the SAERs were completed within the policy timeframe and the average closing time was 625 days. Of the 5 incidents commissioned during this period none were commissioned within the mandated 10 working days and the average opening time was 51 days. This will be an area for focussed improvement in 2025.

Public Protection

4.16 Ensuring safe care includes meeting the needs of the most vulnerable people in communities are being met. Through the wider Public Protection agenda, the Health and Social Care Partnership work to ensure that people, particularly those at risk, are kept safe from harm and risks to individuals and groups are identified and managed appropriately. The Public Protection Chief Officers Group (PPCOG) holds responsibility for strategic leadership, scrutiny, and accountability in respect of public protection services. This incorporates a range of measures including multi-agency strategic planning and operational services providing protections to children, young people and adults at risk, with management of high risk offenders through Multi Agency Public Protection arrangements (MAPPA), Alcohol and Drugs Partnership, Violence Against Women Group, and Community Safety also make significant contributions.

4.17 PPCOG continue to strengthen their assurance and risk management processes. This includes quarterly review of multiagency, operational and strategic risk registers. The PPCOG Performance and Assurance Reporting Framework data set continues to be strengthened and developed.

4.18 NHS GGC Public Protection Unit developed a Public Protection Strategy and Quality Assurance Framework during 2023. Implementation supports enhanced oversight of corporate and local HSCP monitoring of compliance with standards and implementation of the associated action plan.

Learning Reviews

4.19 A Learning Review is multi-agency, bringing practitioners together with the review team in a structured process in order to reflect, increase understanding and identify key learning. They provide a means for public bodies and office holders with responsibilities relating to the protection of adults and children at risk of harm to learn lessons by considering the circumstances where an adult or child at risk has died or been significantly harmed. They are carried out by the Adult / Child Protection Committees under their functions of keeping procedures and practices under review, giving information and advice to public bodies and helping or encouraging improvement.

4.20 During 2024 West Dunbartonshire Adult Protection Committee commissioned two and concluded three learning reviews. West Dunbartonshire Child Protection Committee commissioned two Child Learning review and concluded two.

4.21 All Learning Reviews have associated improvement plans the progress of which is overseen by the West Dunbartonshire Adult / Child protection Committee.

5. Effective care; care at the right time, right place by right person and no unnecessary variance in quality of care and outcomes for service users'.

5.1 The Health and Social Care Standards (*2018)* set out what individuals can expect when using health, social work or social care services in Scotland. They aim to ensure better outcomes for everyone, that people are treated with respect and dignity, and that basic human rights are upheld. The Care Inspectorate, Health Improvement Scotland and other scrutiny bodies all take cognisance of these standards in relation to their work around inspection and registration of health and care services.

. Improvement Work and Programmes

5.2 A range of improvement activity was undertaken during 2024. Some examples of local partnership led improvement are included below.

Older Peoples Care Homes

5.3 West Dunbartonshire Local authority Care homes gained A Bronze sustainable catering award. The Food for Life Scotland (FFLS) programme, provides a framework through which local authorities and public sector sites can ensure they are serving good food. This is done by meeting a set of standards to achieve the FFLSH certification at Bronze, Silver or Gold level. Care home caterers in West Dunbartonshire have achieved a national award for serving fresh and sustainable menus, in a first for public sector food in Scotland.

West Dunbartonshire HSCP caterers at Crosslet House in Dumbarton and Queens Quay House in Clydebank gained the Food for Life Served Here (FFLSH) Bronze award, for serving food that's good for health, the environment and the local economy. These sites serve more than 50,000 meals each year.

West Dunbartonshire HSCP Collaborative Care Home Support Team (CCHST)

5.4 Maintaining high quality care in Care Homes remains a key priority within the partnership. The care home sector continues to face challenges in terms of recruitment and retention of staff and commercial viability. Continued enhanced support for adult and older people's care homes mitigates these risks and ongoing support for improvement will continue to be delivered in line with available HSCP and NHSGGC Care Home Collaborative resources.

5.5 West Dunbartonshire HSCP Collaborative Care Home Support Team (CCHST) continues to work in collaboration with care homes, to focus on improvement, sustainability and viability. This ensures that local assurance and support arrangements link effectively with, rather than duplicate, wider regulation activity by the Care Inspectorate.

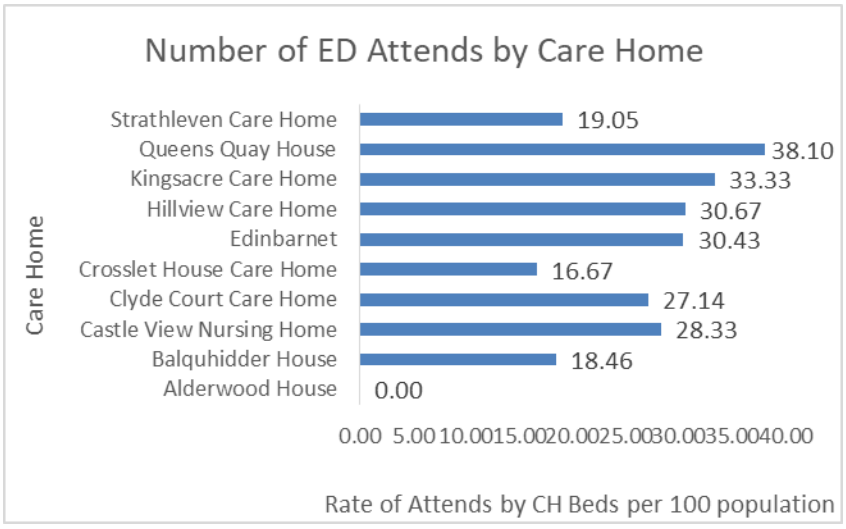
5.6 Care assurance visits are one part of the supportive framework around care homes and sit alongside HSCP commissioning relationships with individual care homes, review arrangements, and daily care home huddle reports via TURAS. These arrangements link effectively with, rather than seek to duplicate, wider regulation activity by the Care Inspectorate. The Care Assurance [CHAT] visits focus on four key themes. Theme 1 - Infection Prevention Control, Theme 2 – Resident Health Care Needs, Theme 3 – Workforce Leadership and Culture, Theme 4- Action Planning for Assurance.

Unscheduled Care - Emergency Department Attendance from Care Homes

5.7 NHSGG created a dashboard for care homes that aligns with Call before You Convey (CB4YC) activity so that efforts to understand and prevent avoidable conveyancing of residents to hospital emergency departments might be targeted.

5.8 West Dunbartonshire Care Homes had 180 attends and 97 admissions May – August 2024 a 54% conversion rate across our care homes. When this is converted to a rate per 100 beds West Dunbartonshire had no care homes in the top 20 for emergency attendances however, neither did we have any care homes in the bottom 20.

Figure 1: Rate of Emergency Department Attendances By care Home per 100 Population



5.9 There have been a number of improvement activities aimed at reducing unnecessary conveyancing and admission avoidance to date. These include,

I. Call Before You Convey aims to increase support to Care Homes to avoid unnecessary conveyances to hospital for care home residents. By providing better support Care Home residents and staff in caring for residents during a period of illness, injury or deterioration it is possible to avoid and reduce unnecessary conveyances to hospital, and inappropriate referrals to primary and secondary care, maintaining person in their home where safe to do so. This support was extended to all Care Homes in West Dunbartonshire from November 2024. A Pre-Weekend Ward Round was introduced allowing Care Homes to identify and refer anyone they felt was unwell and at risk of potential conveyance to hospital without review or intervention. The Care Home Liaison Nurse (CHLN) schedules a review to provide support and interventions aimed at maintaining the person safely in care home setting.

II. Chronic Obstructive Pulmonary Disease (COPD) review and Rescue Medication

III. District Nurse Test of Change – weekend prescribing Urinary Tract Infection (UTI), Upper respiratory Tract Infection (URTI), Cellulitis,

IV. End of Life (EOL) Care enhanced advice and support via District Nursing and CHLN.

5.10 Creation of the Care Home Dashboard will enable us to track the impact of this planned activity to reduce unnecessary conveyancing from care homes over time in order to assess the impact of these activities and focus future improvement activity.

- **Use of Clinical Quality and Clinical and Care Outcome measures** External

Scrutiny - Care Inspectorate Inspection West Dunbartonshire Care Homes

5.11 The Care Inspectorate is responsible for inspecting standards of care in Scotland. They use a quality framework that sets out key elements to help answer key questions about the difference care is making to people, and the quality and effectiveness of the things that contribute to that. The primary purpose of a quality framework is to support services to self-evaluate their own performance. The same framework is then used by inspectors to provide independent assurance about the quality of care and support.

5.12 The Care Inspectorate now use Key Questions rather than Quality Themes in their inspections. Key Questions:-

KQ1 – How well we do we support people's wellbeing;

KQ2 – How good is our Leadership;

KQ3 – How good is our staff team;

KQ4 – How good is our setting;

KQ5 – How well is our care and support plan

KQ6 – Capacity for improvement

The Care Inspectorate use a six point scale: 1 – Unsatisfactory, 2 – Weak, 3 – Adequate, 4- Good, 5- Very Good, to 6 – Excellent against each quality indicator.

Table 5: Care Inspectorate Inspections - Grades Awarded 2024 [or most recent inspection]

Care Home	Date of Inspection	Inspection Grades					No of Requirements A = Achieved E = Extended O= Ongoing	No of Areas for Improvement	Grades Relative to previous Inspection
		KQ 1	KQ 2	KQ 3	KQ 4	KQ 5			↑ ↔ ↓
Alderwood	23.01.24	3	3	3	3	3	8 = A	2	↑
Balquhidder	07.06.22	3	3	5	N/A	N/A	0	5	↓
Castle View	21.09.23	4	4	4	N/A	4	0	2	↑
Clyde Court	30.09.24	3	3	3	4	4	1 = O	4	↔
Crosslet	18.12.23	5	5	N/A	N/A	N/A	0	4	↔
Dunn St - Respite	03.10.22	5	5	5	N/A	N/A	0	0	↑
Edinbarnet	17.10.24	4	4	5	4	4	0	10	↔
Hill View	23.10.24	2	2	2	2	2	1 = O	0	↓
Kingsacre	04.10.24 &20.12.24	4	5	4	4	4	1 = A	3	↑
Queens Quay	19.12.24	4	N/A	4	N/A	3	1 = O	3	↔
Strathleven	10.10.24	5	5	5	4	4	0	0	↑

5.13 The Care Inspectorate uses requirements and recommendations to help regulated care services improve. A requirement is a statement which sets out what a care service must do to improve outcomes for people who use services and must be linked to a breach in the Public Services Reform (Scotland) Act 2010 regulations or orders made under the Act, or a condition of registration. Requirements are enforceable in law. A recommendation is a statement that sets out actions that a care service provider should take to improve or develop the quality of the service, but where failure to do so would not directly result in enforcement.

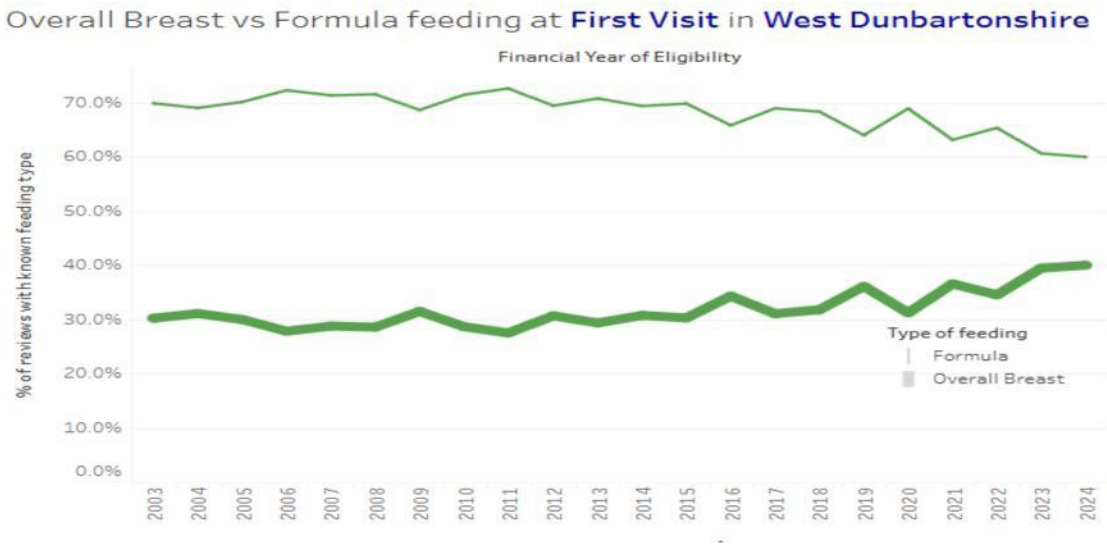
5.14 The HSCP placed a Moratorium on admissions in three care homes during 2024 due to care quality concerns. This was designed to support care homes and enable them to focus on achieving required improvements in care quality.

Children and Families - Health Visiting

5.15 Breast Feeding gives babies the best start in life reducing risks from infection, Sudden Unexpected Deaths in Infancy (SUDI), obesity and can support attachment. West Dunbartonshire is proactive in promoting, protecting and supporting breastfeeding having maintained UNICEF Gold accreditation since 2018. The Unicef Baby Friendly Gold award is the highest level of accreditation and celebrates excellent and sustained practice in the support of infant feeding and parent-infant relationships.

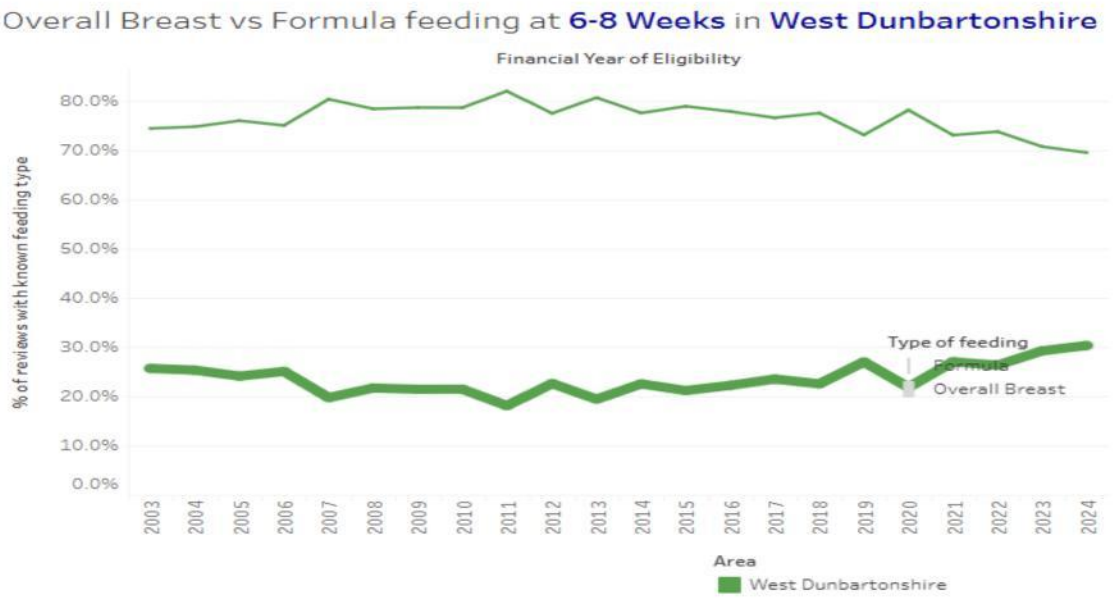
5.16 Figure 2 demonstrates the decline in bottle feeding and increase in breast feeding between 2018- 2024.

Figure 2:



5.17 Figure 3 shows that at 6-8 weeks while marginally fewer mothers are exclusively breast feeding, than 2022/23 more are offering some breast milk - with the proportion recorded as mixed increasing. We are seeing an increase in the proportion of babies who are receiving breastmilk at 6-8 weeks but a reduction in the proportion who breastfed exclusively at this point.

Figure 3



Family Nurse Partnership

5.18 Family Nurse Partnership (FNP) is a preventive licensed voluntary programme for first time mothers aged 19 years and under and currently Care Experienced first-time mothers aged up to 22 years. It offers intensive and structured home visiting, delivered by specially trained nurses (Family Nurses), from early pregnancy until the child is two years old. It is an intensive, structured intervention for young first-time mothers and their children to enhance parenting capacity and achieve the 3 programme outcomes to improve pregnancy and birth outcomes, through improved prenatal health behaviours, child health and development, through positive, responsive caregiving and the economic stability of the family, through developing their vision and realising their plans for their future. The programme aims to modify behavioural risk and enhance protective factors through intensive home visiting using a strengths-based approach, through motivational interviewing and specialised interventions.

5.19 The Scottish Government's Vision for the Family Nurse Partnership programme in Scotland is for it to become a universal service available to all eligible young women aged 21 years and under, and all care experienced pregnant women aged 25 years and under at LMP regardless of where they live. Recruitment pathway improvement activity has been successful with notifications mainly from maternity services. To date there have been 215 clients enrolled in programme in West Dunbartonshire. High engagement rate of entitled clients = 82% and very low attrition disengaged = 3%. 83% of clients from most deprived quintiles so the service is reaching the clients with most need .as shown in Table 12.

Table 6

	West Dun Locality Data* ≤ 19yrs	All of GGC FNP Data ≤ 19yrs *	West Dun Locality Data* ≤ 20yrs Care Experienced Data	All of GGC* ≤ 20yrs Care Experienced Data
No. of Notifications to FNP	312	2775	3	23
No. of Clients Enrolled on FNP	213	1876	2	14
Average Age @ Enrolment	18	18	22	20
Age Range of Clients	15-19	12-22	20-22	20-22
SIMD Q1 & Q2	258	2215	3	12
Attrition – disengaged clients only	6	75	0	0
Total Number of Births	191	1750	0	6
Graduated Clients	119	1041	0	0

All figures shown are based on the new concurrent model since the expansion of FNP GG&C from September 2017 to 31st Dec 2024

Mental Health Services

5.20 In June 2024 The Mental Welfare Commission required the service to strengthen its statutory requirement to supervise private Guardians in line with the prescribed timescales. There were a number of outstanding reviews and existing processes were adapted to address this. Procedures were altered so that Mental Health Officers now complete the initial three month supervision visit. Fortnightly Guardianship Governance meetings have been established to review progress and strengthen CareFirst recording to support regular reporting via the data reports developed. The HSCP Adults with Incapacity (AWI) procedures and guidance have been updated and an online AWI resource page on the intranet is under development. Information that is shared with prospective Guardianship applicants has been standardised so that consistent and up to date information is given. This includes the use of QR codes and other digital means of access.

5.21 In Scotland, a Social Circumstances Report (SCR) is a document prepared by a Mental Health Officer (MHO) within 21 days of a person being detained under a Short Term Detention Certificate (STDC), or under other specified circumstances. The SCR provides details of the individual's circumstances leading to detention and aims to reflect their views on their detention. It's a crucial document for monitoring the use of compulsory powers under the Mental Health (Care and Treatment) (Scotland) Act 2003. The Team have made significant improvements have been made in this area via a review of the entire process for prompting and documenting the completion of SCRs. CareFirst activities are now used by all MHOs on a proactive basis to prompt the completion of an SCR following a relevant event. The MHO and Senior Management Team receive monthly reports on the completion of SCRs (as well as all other areas of MHO practice) and the data around this is used as a basis for discussions in team meetings and individual supervision sessions where necessary and to evidence improvement as shown below Table 7 .

Table 7: Improvement in Completion Social Circumstance Reviews

	STDC	SCR	SCR1 No report	Missing
2022-23		**25%**	**25%**	**50%**
2023-24		**28%**	**45%**	**27%**
2024 -25	**91**	**48%**	**34%**	**18%**

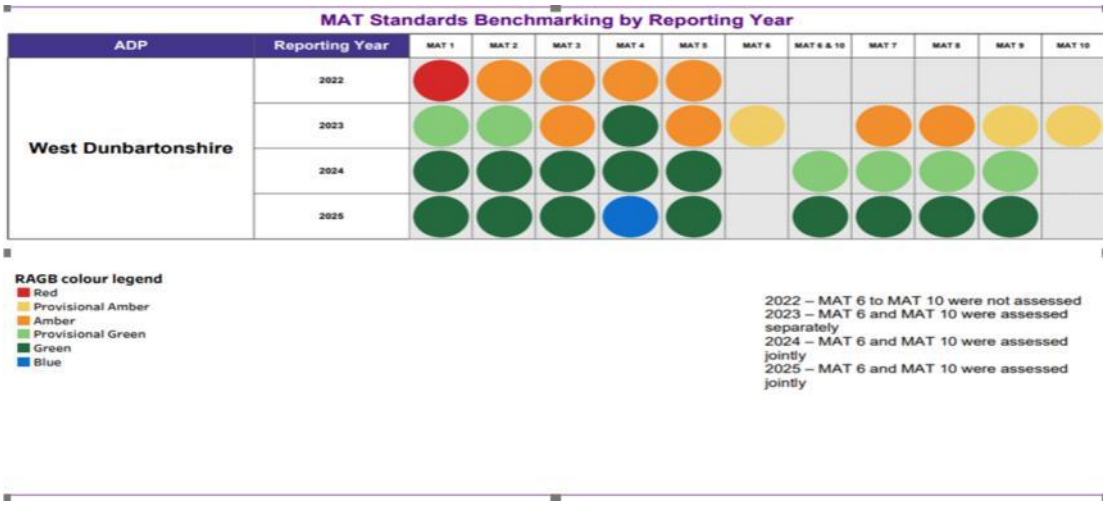
Alcohol and Drug Recovery Service (ADRS)

5.22 Medication Assisted Treatment Standards (MAT) were introduced in 2021 and came into force in 2022 to improve access, choice and support for those affected by drug related harms. Through effective implementation of these standards each year we can evidence that West Dunbartonshire is supporting individuals, families and communities to reduce drug harms and drug deaths. A key priority is to ensure people receive high quality treatment and care. An experiential programme was introduced alongside the implementation of the MAT Standards as a qualitative measure designed to explore how people accessing services evaluate their experience. This measure and approach was designed by lived and living experienced individuals alongside family members. The programme was to ensure that the MAT Standards were meeting the aims and objectives of those they were designed to help.

5.23 It has been evidenced that those who enter into a program of substitute prescribing have increased chances of better health outcomes. That is why this critical intervention helps to support people through problematic drug use.

5.24 Each year the MAT Implementation Support Team (MIST) sends out the benching marking report from the evidence that has been submitted through numerical data and process documentation. Once they have received this information they can then score each of the standards accordingly producing a RAG rating. The objective for all the standards is to achieve a green status and as you can see from the table below in West Dunbartonshire we have progressed each year, obtaining full implementation for 2024/25, demonstrating our commitment to delivering the highest standard in treatment and care to all service users. MAT standards 6 and 10 are submitted to NHS Greater and Clyde and omitted from the table however, full implementation was achieved. Through each standard we incorporate a holistic approach that covers all services and organisations that are responsible for the delivery of care in a Recovery Orientated System.

Table 8: MAT Standards benchmarking by Reporting Year



*Blue - (sustained implementation) because this standard has been Green for the previous 2 consecutive years

5.25 In support of MAT Standard 9, improving joint working with ADRS and Mental health services, several steps have been taken to improve working and to improve overall mental health support available to patients of ADRS, addressing the divide identified by Mental Welfare Commissions report – Ending the exclusion. We know the impact of trauma, often leads to poor mental health and addiction. However, for the first time, we are now seeing the benefits of joint working with our patients, giving them the appropriate support to address mental health needs and reduce dependency at the same time. Having introduced this change to clinical practice we anticipate a reduction in relapse and self-harm and suicide among our patient group.

Children and Families Health Visiting – Delivery of the Universal Pathway

5.26 The Health Visitor service contributes to positive health and wellbeing outcomes for pre-school children and their families. Those outcomes are however also impacted by a myriad of other factors and it is challenging to definitively and confidently measure the specific impact of the health visiting service. The Universal Health Visiting Pathway places importance on health visitors providing support in the home. It is a key delivery mechanism for early prevention, identification and intervention. The programme provides a core home visiting programme delivered by Health Visitors. This consists of 11 home visits offered to all families; 8 within the first year of life and three further Child Health Reviews (13-15 months; 27-30 months; 4-5 years) involving formal assessment of the child's developmental progress.

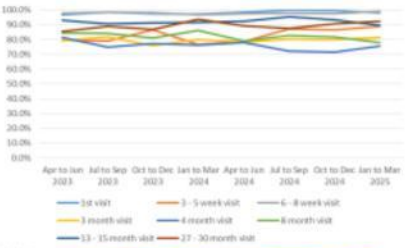
5.27 Table 10 displays the % of eligible children who received each universal pathway contact and of these the % who received the visit on time. The Pathway is a key component in reducing early developmental concerns as contact with the child and family in the home supports the identification of needs and focuses on early intervention and prevention. There are however opportunities to measure the full and consistent delivery of the UHVP. This can provide an indication of the extent to which pre-school children and their families are receiving support from a Health Visitor and potentially having their outcomes positively influenced as result.

Table 9: Percentage of Eligible Children Receiving universal Pathway Visits

West Duns trend - % Completed & % On time

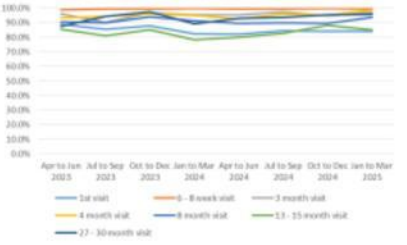
% Completion

Visit	Apr to Jun 2023	Jul to Sep 2023	Oct to Dec 2023	Jan to Mar 2024	Apr to Jun 2024	Jul to Sep 2024	Oct to Dec 2024	Jan to Mar 2025	Total
1st visit	96.8%	98.6%	97.6%	97.0%	98.6%	100.0%	99.5%	98.1%	98.3%
3 - 5 week visit	79.7%	78.9%	86.7%	76.5%	78.7%	87.1%	86.7%	89.1%	82.8%
6 - 8 week visit	97.9%	98.6%	98.1%	96.9%	97.3%	97.9%	97.3%	99.0%	97.9%
3 month visit	79.5%	81.9%	75.8%	79.9%	78.2%	80.3%	80.0%	81.4%	79.6%
4 month visit	81.5%	75.0%	77.4%	76.4%	78.0%	72.2%	71.6%	75.5%	75.9%
8 month visit	84.5%	84.2%	81.0%	86.2%	79.0%	82.8%	81.8%	78.0%	82.2%
13 - 15 month visit	93.1%	90.6%	91.3%	91.7%	92.2%	95.3%	93.4%	89.7%	92.2%
27 - 30 month visit	85.4%	88.9%	86.8%	93.9%	89.4%	87.5%	90.7%	92.4%	89.4%
4 - 5 year visit	90.4%	90.4%	91.8%	89.6%	75.5%	62.9%	50.6%	34.2%	73.7%



% On time

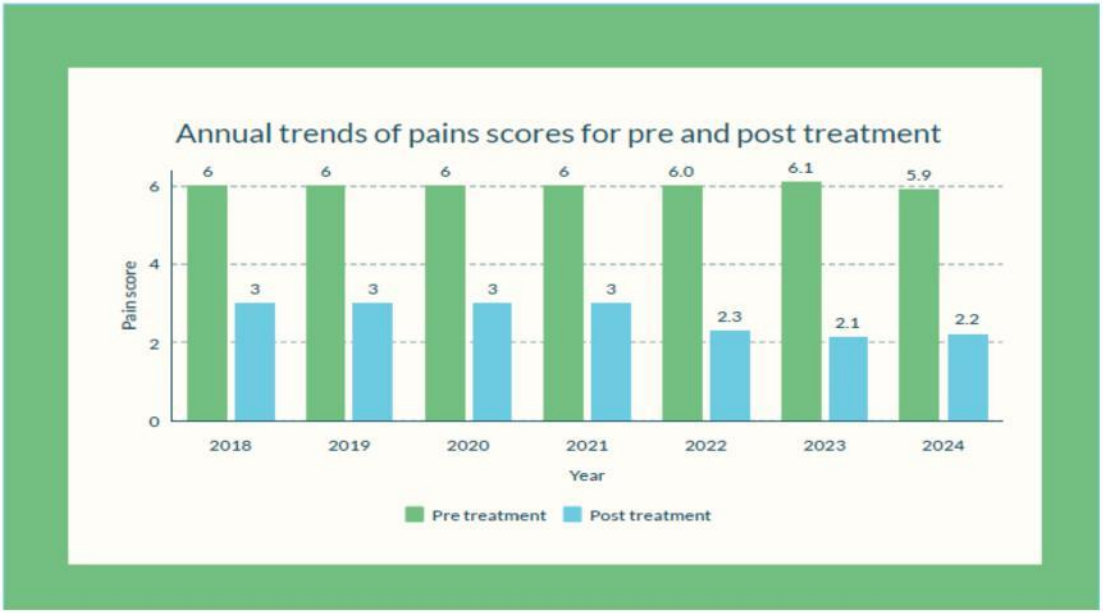
Visit	Apr to Jun 2023	Jul to Sep 2023	Oct to Dec 2023	Jan to Mar 2024	Apr to Jun 2024	Jul to Sep 2024	Oct to Dec 2024	Jan to Mar 2025	Total
1st visit	88.9%	85.4%	87.8%	82.6%	82.1%	84.6%	84.3%	84.1%	85.0%
6 - 8 week visit	98.9%	99.5%	99.5%	100.0%	99.4%	99.5%	100.0%	99.5%	99.5%
3 month visit	96.1%	90.3%	96.9%	95.6%	95.4%	97.5%	94.7%	97.0%	95.4%
4 month visit	93.3%	94.6%	96.0%	95.2%	92.8%	96.2%	95.0%	98.7%	95.2%
8 month visit	90.6%	90.0%	94.0%	91.4%	89.8%	89.9%	89.5%	93.8%	91.1%
13 - 15 month visit	85.7%	81.1%	85.0%	78.3%	79.9%	83.0%	88.3%	85.3%	83.3%
27 - 30 month visit	87.6%	94.4%	97.7%	89.1%	93.1%	93.7%	96.4%	95.6%	93.1%
4 - 5 year visit	79.6%	78.2%	94.5%	97.7%	93.1%	100.0%	100.0%	100.0%	91.4%



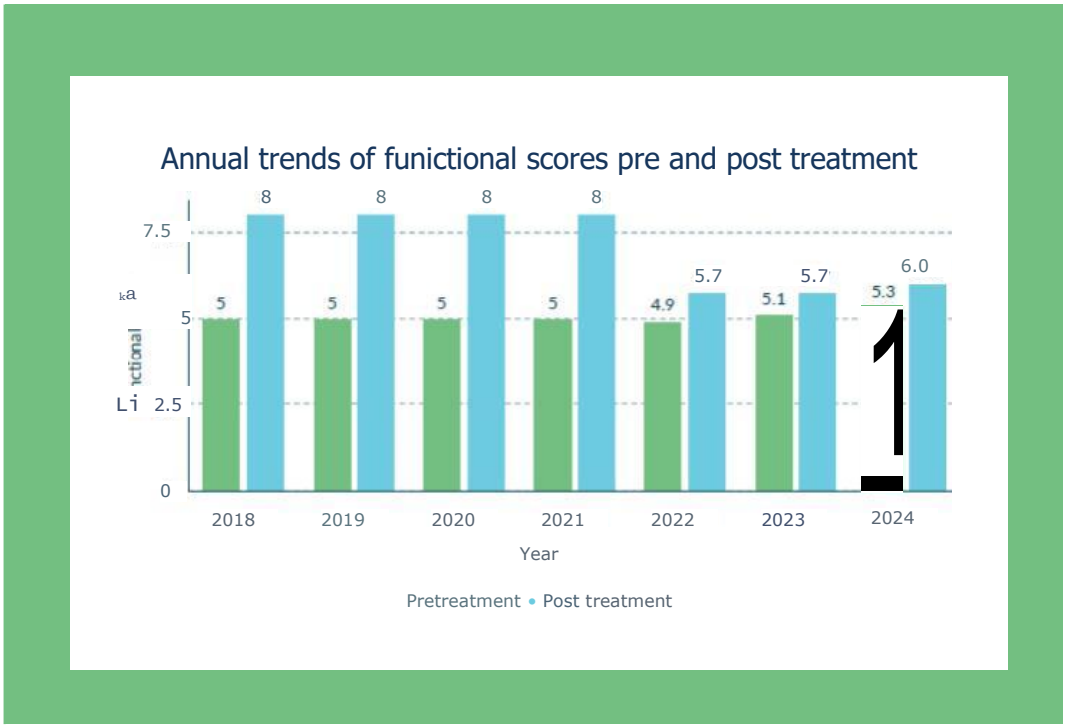
NHSGGC Musculoskeletal (MSK) Physiotherapy

5.28 NHSGGC GGC MSK Physiotherapy Service continues to measure and achieve Impressive results with the patient recorded outcome measures (PROMs). The MSK staff have again increased the number of completed PROMs from 2023 into 2024-25 as shown in Figure 4 below.

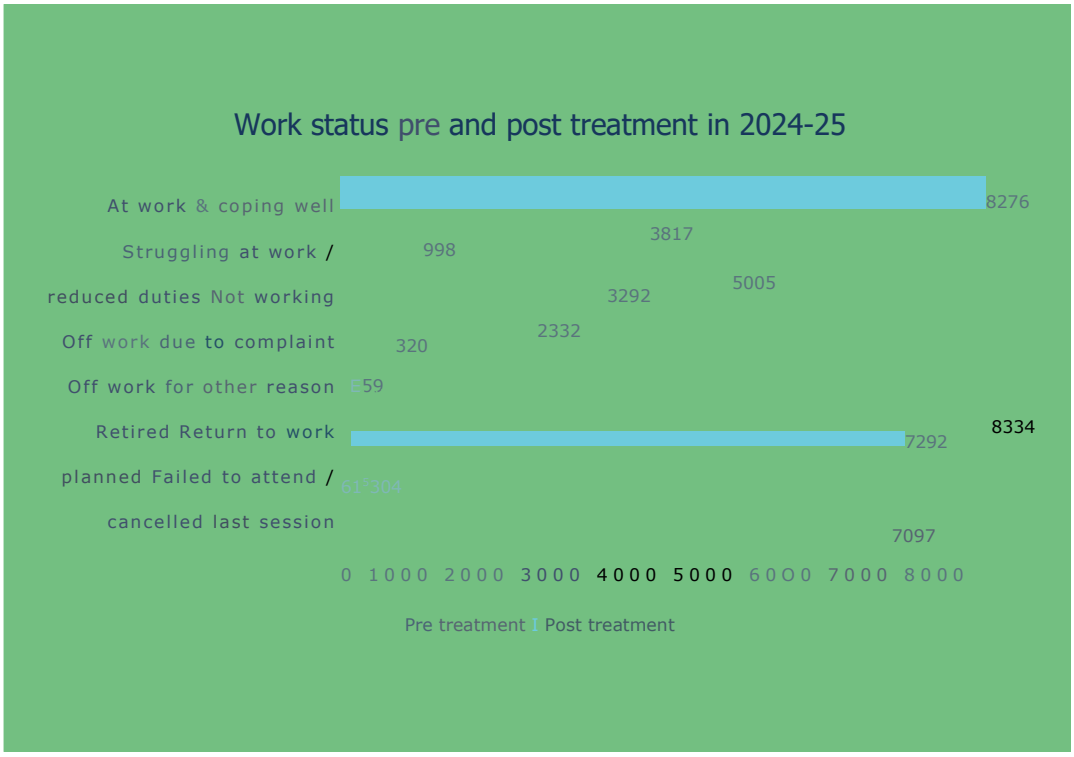
5.29 Figure 5 shows the paired pain scores collected have remained consistent since 2022 (when we saw a positive change in the data).



5.30 Figure 6 shows the consistent improvement with the paired functional scores



5.31 Figure 7 demonstrates year on year positive trends in improving work status



5.32 The majority of people would prefer to die at home. Honouring preferences is critical for the delivery of high-quality care. As a crucial starting point to enhance strategies to align care with patient and family preferences Excellence in Care Indicators for Palliative and End of Life Care (PEOLC) have been set nationally; these are specific to people who have received District Nursing care in the last month of their life and who had an identified PEOLC need. The national target for the following aims is:

60% of people who had their preferred place of death (PPD) recorded

60% of those people with a PPD who achieved their preferred place of death (PPA)

5.33 NHSGGC HSCPs have set a more ambitious target of HSCP PPD – target: 85% by March 2025.

Table 10: Preferred place of Death Recorded

HSCP	January 2025		February 2025		March 2025	
West Dunbartonshire	95%	n =21	100%	n=22	100%	n=22

Table 11: Preferred Place of death Achieved

HSCP	January 2025		February 2025		March 2025	
West Dunbartonshire	86%	n =21	86%	n =22	94%	n =18

Primary Care

5.34 As implementation of the Primary Care Improvement Plan progress the benefits of the multidisciplinary (MDT approach mean that some presentations can be assessed, reviewed or treated efficiently and effectively by a more appropriate professional. This allows General Practitioners' time to focus on more complex presentations.

5.35 The expansion of the MDT (Vaccination Transformation Programme, Pharmacy Team, Advanced Nurse Practitioners, Advanced Physiotherapists, Community Link Workers and Wellbeing Nurses) all contribute to additional capacity in primary care services. The traditional receptionist role has evolved. They support people to get the right care from the right professional at the right time.

5.36 A significant piece of work carried out by GP practices and the Prescribing team with regard to de-prescribing of Lidocaine patches which was identified by the Health Board as a prescribing saving, due to cost and the recognition that this is a drug of Low Clinical Value. The work carried out has resulted in significant reductions in lidocaine prescribing exceeding savings targets (219%) without a significant increase in prescribing of alternative pain medication.

5.37 GP Clusters continue to work with Practice Quality Leads from each practice attending one of the 3 GP Clusters within West Dunbartonshire. Support is provided by GGC Quality Improvement Team and LIST analysts. Projects are agreed within clusters

based on local population and health care needs. Some of the projects worked on in 2024-25 include:

- COPD and provision of rescue medications
- Late stage cancer diagnoses in particular lung cancer
- Improving access to Long Acting Reversible Contraception by increased training for insertion of Intrauterine devices
- Medication safety audits
- Veteran health care
- Modernising General Practice by increased use of IT

Diabetic Retinal Screening

5.38 Of the 70,897 eligible individuals, 57,982 (81.4%) were screened during 2024, exceeding the 80% uptake target. Improvements in workflow management resulted in reduced waiting times at Level 3 Grading from 54 days on 3rd January 2024 to 22 days on 10th December 2024.

5.39 The Autumn 2024 External Quality Assurance Report showed Greater Glasgow and Clyde's Level 1 & 2 graders achieved an average Sensitivity of 95.6% and Specificity of 95.9%, both well in excess of the requisite 80% target. Sensitivity refers to the test's ability to correctly identify individuals with the disease. Measures the proportion of individuals with the disease who are correctly identified as positive by the test. A high sensitivity means that the test is good at detecting the disease and minimizing false negatives. Specificity refers to the test's ability to correctly identify individuals without the disease. Measures the proportion of individuals without the disease who are correctly identified as negative by the test. A high specificity means that the test is good at correctly identifying healthy individuals and minimizing false positives.

5.40 In response to an internal 2023/24 Public Health audit's recommendations all local polices were reviewed, revised and authorised by the steering group with clearly documented failsafe mechanisms highlighted. New policies and screening pathways were introduced to ensure appropriate management and outcomes for diabetic patients being prescribed new treatment options (GLP-1 Analog and Hybrid Closed Loop Therapy) which can exacerbate pre-existing diabetic retinopathy in the short term.

6. Person Centred Care : 'compassion, continuity, communication, co-production and shared decision making'

- **Systems and processes in place to gather patient experience and feedback**

6.1 An NHSGGC board standard is being developed for Person Centred Care which will likely have an impact on how we measure this area of work in 2025. Each Nursing family have a work plan on person centred care planning outlining their work intentions and progress for this agenda forward. Each nursing family use a different system for recording so while care planning may look different in format, they will work to the same principles for recording their person centred features of care.

Future Care Planning

6.2 Future care planning is about thinking and planning ahead for people at any age or stage of their life. It is particularly helpful when someone has one or more health conditions or disabilities that mean their health will change, is living with a serious illness, or is getting older and less well. Future care planning conversations include 'What matters to you?' and shared decision making about available options for care and treatments. A person-led, future care plan summarises what people say about themselves alongside clinical advice to guide treatment and care if they become unwell.

6.3 Non-recurring funding supported additional Band 5 bank nurse hours to review, update and transfer Future Care Plans from Care Home records onto Clinical Portal ensuring these were accessible to all practitioners involved in the residents care.

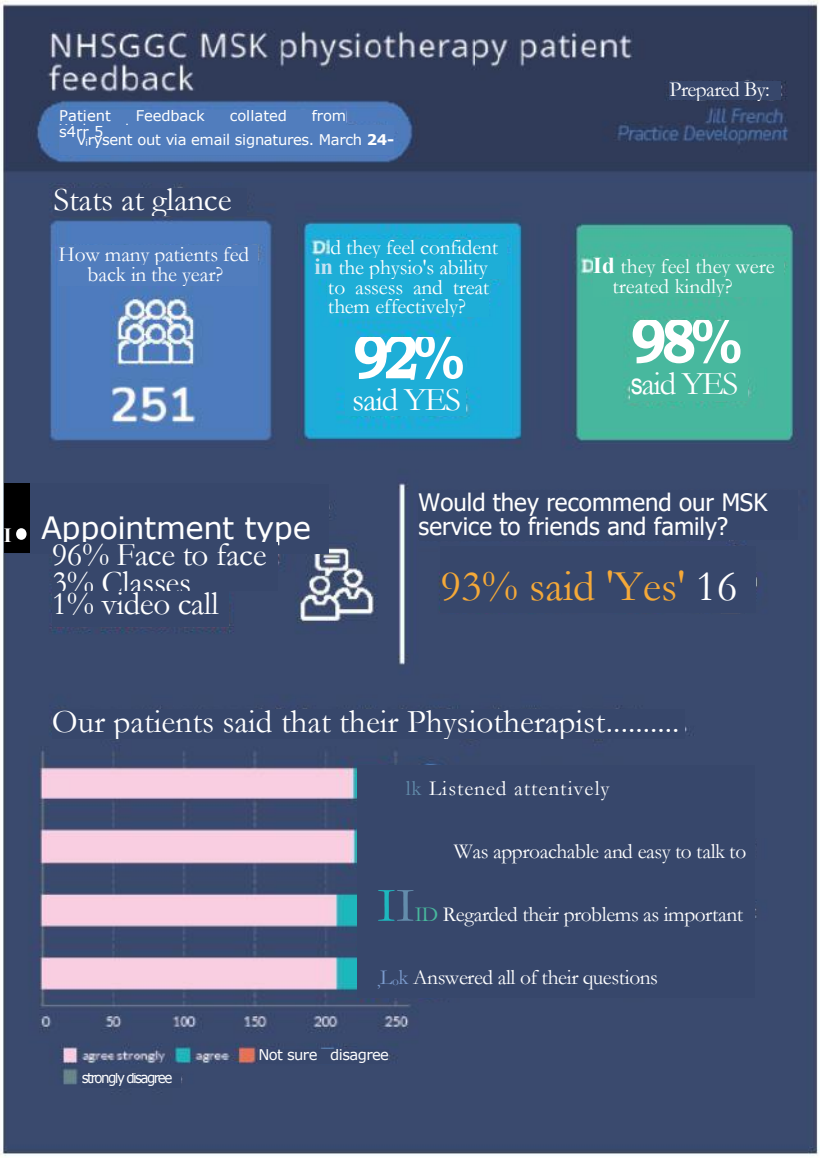
6.4 The Rockwood Clinical Frailty Scale (CFS) is a tool used to assess a person's overall health and frailty status, ranging from 1 (very fit) to 9 (terminally ill). It's a judgment-based scale that considers factors like illnesses, function, and cognition to determine a frailty score. The District Nurses service surpassed the NHSGGC target requiring 85% of patients with a frailty score of 9 on their caseload to have a FCP completed by December 2024. Moreover they are working to extend this and currently 60 % of all clients on the DN caseload have an FCP in place.

MSK Physiotherapy Service

6.5 The MSK Physiotherapy service currently generates patient feedback through the Consultation and Relational Empathy (CARE) measure, Care Opinion website and through a QR code added to staff emails that invites patients to provide feedback on their experience of MSK physiotherapy. This breadth of methods ensures that the service gets continuous feedback from patients throughout the year. They are always striving to explore new and more effective ways to generate and respond to feedback from patients.

6.6 The CARE measure is a recognised and validated tool to measure empathy and has a direct correlation to improved patients outcomes. Between May and August 2024 4000 individual CARE reports were generated. The average score for the service was 4.89 / 5. This tells us that staff build positive and empathic relationships with their patients. Staff also get the opportunity to reflect upon qualitative feedback from patients as part of the completion of the CARE measure and can use this to inform their Personal Development Plan and learning and development needs.

6.7



6.8

What patients said:

I can't praise the service enough, it's been excellent. I thought I would be crippled for life but I am so much better!

Had a great appointment this morning at culawat. I felt listened too and I was so impressed with his knowledge and kindness. I feel like there is light at the end of the tunnel. Thank you so much NHS.

District Nurse Service - Palliative Care Survey Feedback from Families

6.9 A telephone survey is undertaken by the District Nursing Team to secure feedback from families on their experience palliative care delivered by the HSCP.

'I found caring for my husband stressful having support from the District nurse Team made it so much easier I wouldn't have coped without the input from the nurses'

'I was really grateful for the care my husband received you can't improve on perfect'

'My Wife felt very supported at home from DN service and carers services. The Carer staff who attended latterly provided excellent care'.

GP was very appreciative of the OOH service and mentioned that one of his palliative patient's family members couldn't speak highly enough of the Out of Hours nurses who provided palliative care for her late husband recently, saying they couldn't have managed without the nurse's care which made a very difficult time so much easier.

. 'I couldn't speak highly enough of the care my mum received, everyone was so kind and caring, I felt that the out of hours service was exemplary …it was so comforting knowing my Mum was in good hands for the night and I could go home and rest.'

6.10 Fruin and Katrine Wards are mental health assessment and treatment in-patient facilities in West Dunbartonshire. They received a visit from the Mental Welfare Commission (MWC) all the relatives and patients who spoke with them were very positive about their experience of care on the ward. They were told that all staff were very proactive in communicating with relatives and that service users and their families felt fully involved and informed regarding any care decisions. They heard that medical staff were accessible and responsive to requests for contact. One relative advised that, having raised a concern, they were invited to meet with the consultant, the staff grade and the senior charge nurse the next day to discuss their concern and the issue was promptly resolved. Everyone spoken to felt welcome while on the ward, and encouraged to be involved in all aspects of their loved one's care, and supported to maintain their relationship. People spoke of being able to take their loved ones out or being able to bring in a meal and have a private visiting space to enjoy dinner together occasionally. Arrangements had been made to support a

whole family visit with children and grandchildren. Relatives told the MWC that staff provided support to them as well as their family member and that they felt confident leaving the ward knowing their loved one was being well cared for. Patients advised that they were treated well. One patient reported that the ward had "saved their life" and that staff are "generous in their care." Staff were initially anxious about the introduction of person-centred visiting, however this has been fully embraced and staff were very positive about the benefits of this for everyone involved.

6.11 Care Opinion

The Patient Rights (Scotland) Act 2011 introduced the right for people to give feedback, comments, concerns, and complaints about the services they receive. As part of this Act all NHS staff have a legal duty to actively encourage, monitor, take action and share learning from the feedback they receive and use it to improve care and services. Care Opinion is an independent, not-for-profit website, where people can provide anonymous feedback to HSCP services about their experience of care. It is intended to complement HSCP processes for dealing with feedback and complaints. The HSCP are progressing with the implementation of care opinion on a phased basis. This will go live for health services in the HSCP from September 2025.

7. Exemplar Case Studies

Health and Community Care

7.1 *The adult nursing service have recently been invited to the HSCP Multi Agency Forum to enhance integrated service delivery for our most vulnerable clients. During this meeting a vulnerable adult within the community who was subject to coercive controlling behaviour from their partner and physical assault, was discussed. The Treatment Room nursing service raised an adult support and protection concern regarding a patient accessing the service. This led to enhanced multiagency working to support the vulnerable adult. The Treatment Room service became an anchor for the patient; with social work services attending the treatment room appointments to allow the patient to gain access to the safety mechanisms within the HSCP which supports vulnerable people at risk of domestic abuse such as the 'holly app' and storm warning on their address and to explore options of alternative housing and offer of wellbeing support.*

Learning Disability

7.2 *The Health and Care (Staffing) (Scotland) Act 2019 provides a statutory basis for the provision of appropriate staffing in health and care services, enabling safe and high-quality care and improved outcomes for service users. For care settings, the Act places a duty on those who provide care services to ensure both appropriate staffing and appropriate training of staff. In preparation for the implementation of the act, Housing Support Services had discussions at our team meetings to raise awareness and understanding of the duties around the new safer staffing legislation. Furthermore, all staff were supported to sign up to TURAS learning site and complete the required training (4 domains in level 1). Staff completed this between April & July*

2024. Following this, we were able to develop a staffing protocol for each service showing what staff was required/where they were required and the reasons why (for safer staffing) This equipped staff with better knowledge and understanding of the legislation and how it applies in the social care setting. This resulted in it being highlighted as an area of good practice by the Care Inspectorate during an unannounced inspection in December 2024.The inspection report commented positively on the evidence they found.

"We observed the staffing compliment was very good on both inspection days and people were coming and going out to activities as well as being supported with day to day living tasks. As a result, people were very excited and looking happy from their activities. We noted the staff rota demonstrated the reasons why extra staff had been called in or specific staff being used."

"Almost all staff had completed training on the recent and new legislation, the Health and Care (Staffing) (Scotland) Act 2019 enacted on 1 April 2024. Staff spoke very confidently and competently about their knowledge of the Act and felt very happy with the current staffing arrangements."

Appendix 1: West Dunbartonshire HSCP CCG Workplan 2024

Appendix 2: West Dunbartonshire HSCP CCG Workplan 2025

West Dunbartonshire HSCP
Clinical and Care Governance Draft Work Plan 2025-2026

The essential function of Clinical and Care Governance Groups is to support the delivery of consistently high quality clinical care, and to provide assurance that appropriate clinical governance mechanisms are in place.

A Clinical and Care Governance work plan is a living document that captures the active programmes of work being undertaken by a Clinical and care Governance Group. Items on the work plan should link to the Reporting Schedule! Annual Cycle or Business, so that updates for approval, decision making or focused discussion; or for assurance, noting or information, are planned and tabled at the meeting as required.

Key items that you may wish to consider within the work plan are listed below, these provide an aide memoire and are not exhaustive.

SAFE CARE

- Board safety priorities
- Work generated from the review of themes! trends and learning from clinical incidents, SAERs (Significant Adverse Event Reviews) and M&Ms
- Areas of work relating to key organisational risks including medicines governance, consent to treatment, clinical communication and interfaces in the pathway of care

EFFECTIVE CARE

- Prioritised quality improvement programmes, which will improve and sustain the delivery of the service
- Development of a plan to increase the Quality Improvement capability within the Sector ! Directorate ! HSCP
- Work related to the development or management of clinical standards including locally developed clinical guidelines

PERSON CENTRED CARE

- Work generated from the analysis of themes! trends and outcomes from Patient Feedback and Complaints

ASSURANCE

- Commissioning of projects that ensure greater transparency of data, enabling access and support to clinical teams, so information is practically applied in support of quality improvement
- Adequacy of the escalation of feedback resulting from external quality publications and guidelines e.g., SIGN (Scottish Intercollegiate Guidelines Network), NICE (National Institute for Clinical Excellence)
- Areas of work relating to high-risk issues of infection prevention and control, medicines governance, Child protection! Adult protection, clinical communication, and interfaces in the pathway of care
- Adequacy of the established controls assurance for clinical and care quality

1. SAFE CARE

	Project/ Aim	Monitoring/ Assurance Arrangements	Update	Completion Date /RAG	Lead
1.1	Ensure there is evidence and oversight of systematic monitoring, assessment and management of risk to care quality.	Develop SMT! CCG Core quality data set ! report to provide oversight care quality related reporting across H&SC (to include Internal and external inspection! self-evaluation and progress with related improvement plans)			VT !MJ!L
		Planning and Commissioning Quality Team to develop and implement quality reporting tool for all commissioned services			MJC
		Quarterly Exception reports provided by all service areas. Heads of service have CCG mechanisms in place to monitor assessment and risk to care quality.			ALL
		Improve compliance with Datix and SAER policy and compliance with NHSGGC KPI – quarterly scrutiny Datix !SAER reports			HOS
		Quarterly update report from HSCP Clinical and Care governance committee to IJB audit and performance ! SMT			VT
1.2	**Systemic development is required to capture reportable incidents across social work and social care services**	**1.2.1 Systemic development is required to capture reportable incidents across social work and social care services**			MJ LJ Sc FT
1.3	**Improve oversight of work generated from the review of themes/ trends and learning from clinical incidents, SAERs (Significant Adverse Event Reviews) and Learning Reviews**	Via WD HSCP CCG Quarterly Meetings Via NHHs GGC CP QI Oversight Group Via NhS GGC Learning disability Mental and ADRS CCG groups Via NHSGGC Primary care Clinic and Care governance Group Learning Brief shared and circulated and also seven minute briefings			HOS

2. EFFECTIVE CARE

	Project/ Aim	Monitoring/ Assurance Arrangements	Update	Completion Date /RAG	Lead
2.1	We will increase the Quality Improvement Capability across West Dunbartonshire HSCP Establish baseline and set some targets	Establish baseline of no of staff with SCIL / SClip and			
2.2	We will strengthen our arrangements for Enhanced Collaborative Clinical and Care Support for Care Homes to build on our local approach to support the sector	Quarterly reports from West Dunbartonshire Collaborative Care Home Support team to NHSGGC care Home framework group Annual report from CCHST – X2 per year Care Assurance Visits HSCP Quarterly Quality and Monitoring Compliance Visits – Commissioning and Quality Team (includes Complaints / ASP) External Inspection reports – CI			VT
2.3	Effective arrangements are in place to monitor standards of care quality for services provided by the third and independent sector.	CI reports HSCP Quality and Commissioning Team – provide report on monitoring reports for all commissioned services – quarterly Oversight vis West Dunbartonshire Social work and Social care CCGG sub group			MJC
2.5	Effective arrangements are in place to monitor standards of care quality of hosted services	Quarterly Exception report WD CCG Committee MSK Physio – Annual report – includes proms and prems – monthly update SMT Retinal Screening –report compliance with national KPI standards- monitored via Nhsggc Screening Oversight Board	Robust mechanisms in place via NHSGGC Screening group DRS – and via msk		

	Project/ Aim	Monitoring/ Assurance Arrangements	Update	Completion Date /RAG	Lead
			physiotherapy services		

3. PERSON-CENTRED CARE

	Project/ Aim	Monitoring/ Assurance Arrangements	Update		
3.1	The HSCP enables service users and carers / community to make a complaint about integrated health and social care services	Quarterly reports to A&P / CCG			
	The HSCP enables service users and carers / community to provide feedback	Implementation of Care Opinion MSK Physiotherapy Patient related experience measures (Prems)			
	The HSCP can demonstrate learning from complaints from complaints/ service user feed- back and the related	Complaints reporting mechanism and annual report in place			

4. ASSURANCE

	Project/ Aim	Monitoring/ Assurance Arrangements		
4.1	Publish an annual clinical and care governance report clear, robust, with accurate and timely information on the quality of health and social care services in West Dunbartonshire.	Annual CCG Report		
		4.2.2 Via the implementation of (nursing) CCAT Quarterly Report		

	Project/ Aim	Monitoring/ Assurance Arrangements		
		Excellence in Care across Excellence in Care (healthcareimprovementscotland.org)		
4.3	We will work in an integrated way to support teams through health care inspection	Oversight of preparation and planning for anticipated inspection –		
4.4	Improve oversight of all regulatory inspections progress against all existing inspection improvement plans	Exception Report to CCG Quarterly All regulatory inspections to be reported to sub group and then escalated by exception to CCG. (Lesley)Reports re commissioned services shred with CCG social work social care sub group.		HOS
4.5	Effective arrangements are in place to monitor standards of care quality	CCAT Reports Nursing – quarterly Self-evaluation plan social work and social care services (tbc) External Inspections e.g. HIS CI MWC Quarterly Exception reports provided by all service areas. Heads of service have CCG mechanisms in place to monitor assessment and risk to care quality.		ALL

5. COMMISSIONED/ PROJECT WORK

	Project/ Aim	Monitoring/ Assurance Arrangements		
	Development and Implementation of WSHSCP Quality Framework	West Dunbartonshire CCG group IJB audit and Performance Committee		MJC