AGENDA ITEM NO: 10

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**8 September 2025**
Report By:	**Kate Rocks, Chief Officer Inverclyde HSCP**	**Report No:**	**IJB/89/2025/HM**
Contact Officer:	**Dr Hector MacDonald Clinical Director Inverclyde HSCP**	**Contact No:**	**01475 724477**
Subject:	**Clinical and Care Governance Annual Report 2024 – 2025**		

1.0 PURPOSE AND SUMMARY

1.1 ☐For Decision ☒For Information/Noting

1.2 This report provides a summary of the yearly activity of the Clinical and Care Governance Group Structures for 2024 -2025. Members of the IJB are asked to note the report. This report has been sent to NHS Greater Glasgow and Clyde as all Health and Social Care Partnerships are requested to provide an Annual Report covering an overview of clinical and care governance.

2.0 RECOMMENDATIONS

2.1 Inverclyde HSCP is requested to provide an Annual Report for Clinical and Care Governance which is based on Safe, Effective and Person Centred Care. This report is for information and provides a summary of the main aspects for clinical and care governance for Inverclyde HSCP.

Kate Rocks
Chief Officer
Inverclyde Health and Social Care Partnership

3.0 BACKGROUND AND CONTEXT

3.1 Inverclyde HSCP have a clinical and care governance structure that provides assurance to NHS Greater Glasgow and Clyde.

This report provides a summary of the main areas of activity from 31st March 2024 to 31st March 2025.

4.0 PROPOSALS

4.1 The Integration Joint Board are asked to note the Annual Report for Clinical and Care Governance 2024 – 2025 and this report has been sent to NHS Greater Glasgow and Clyde.

5.0 IMPLICATIONS

5.1 The table below shows whether risks and implications apply if the recommendation(s) is(are) agreed:

SUBJECT	YES	NO
Financial		x
Legal/Risk		x
Human Resources		x
Strategic Plan Priorities	x	
Equalities, Fairer Scotland Duty & Children and Young People		x
Clinical or Care Governance	x	
National Wellbeing Outcomes		x
Environmental & Sustainability		x
Data Protection		x

5.2 **Finance**

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report	Virement From	Other Comments

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact	Virement From (If Applicable)	Other Comments

5.3 **Legal/Risk**

None

5.4 **Human Resources**

None

5.5 **Strategic Plan Priorities**

None.

5.6 **Equalities**

(a) Equalities

This report has been considered under the Corporate Equalities Impact Assessment (EqIA) process with the following outcome:

	YES – Assessed as relevant and an EqIA is required.
x	NO – This report does not introduce a new policy, function or strategy or recommend a substantive change to an existing policy, function or strategy. Therefore, assessed as not relevant and no EqIA is required. Provide any other relevant reasons why an EqIA is not necessary/screening statement.

(b) Equality Outcomes

How does this report address our Equality Outcomes?

Equalities Outcome	**Implications**
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.	N/A
Children and Young People who are at risk due to local inequalities, are identified early and supported to achieve positive health outcomes.	N/A
Inverclyde's most vulnerable and often excluded people are supported to be active and respected members of their community.	N/A
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.	N/A

(c) Fairer Scotland Duty

If this report affects or proposes any major strategic decision:-

Has there been active consideration of how this report's recommendations reduce inequalities of outcome?

	YES – A written statement showing how this report's recommendations reduce inequalities of outcome caused by socio-economic disadvantage has been completed.
x	NO – Assessed as not relevant under the Fairer Scotland Duty for the following reasons: Provide reasons why the report has been assessed as not relevant.

(d) **Children and Young People**

Has a Children's Rights and Wellbeing Impact Assessment been carried out?

	YES – Assessed as relevant and a CRWIA is required.
x	NO – Assessed as not relevant as this report does not involve a new policy, function or strategy or recommends a substantive change to an existing policy, function or strategy which will have an impact on children's rights.

5.7 **Clinical or Care Governance**

There are assurance implications to NHS Greater Glasgow and Clyde and the Integration Joint Board which is provided by the Annual Report for Clinical and Care Governance 2023 -2024.

5.8 **National Wellbeing Outcomes**

How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	**Implications**
People are able to look after and improve their own health and wellbeing and live in good health for longer.	N/A
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	N/A
People who use health and social care services have positive experiences of those services, and have their dignity respected.	N/A
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	N/A
Health and social care services contribute to reducing health inequalities.	N/A
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.	N/A
People using health and social care services are safe from harm.	N/A
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.	N/A
Resources are used effectively in the provision of health and social care services.	N/A

5.9 **Environmental/Sustainability**

Summarise any environmental / climate change impacts which relate to this report.

Has a Strategic Environmental Assessment been carried out?

	YES – assessed as relevant and a Strategic Environmental Assessment is required.
x	NO – This report does not propose or seek approval for a plan, policy, programme, strategy or document which is like to have significant environmental effects, if implemented.

5.10 **Data Protection**

Has a Data Protection Impact Assessment been carried out?

	YES – This report involves data processing which may result in a high risk to the rights and freedoms of individuals.
x	NO – Assessed as not relevant as this report does not involve data processing which may result in a high risk to the rights and freedoms of individuals.

6.0 DIRECTIONS

6.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	x
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

7.0 CONSULTATION

7.1 None

8.0 BACKGROUND PAPERS

8.1 Attached

INVERCLYDE HSCP
Health and Social Care Partnership

Appendix 1

Health and Social Care Partnership

Clinical and Care Governance Annual Report 2024 - 2025

NHS Greater Glasgow and Clyde

Inverclyde council

INVERCLYDE HSCP Health and Social Care Partnership

Inverclyde Health and Social Care Partnership

Clinical & Care Governance Annual Report

April 2024 to March 2025

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1. Inverclyde HSCP Background

1. Inverclyde Health and Social Care Partnership is one of six partnerships operating within the NHS Greater Glasgow and Clyde Health Board area. We work closely with our fellow partnerships and continue to build on new and existing relationships with a focus on sharing good practice, developing, and delivering consistent approaches to working with our colleagues in acute hospital services. Inverclyde's population is spread in the main across the three towns of Greenock, Port Glasgow and Gourock with the remainder of the population living in the villages of Inverkip, Wemyss Bay, Kilmacolm and Quarriers Village.

2. 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 dispersed across Inverclyde, instead high deprivation areas are clustered across specific communities, particularly in Port Glasgow and the East End of Greenock.

3. Overall, Inverclyde has an estimated total population of 78,340. 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.

4. The HSCP delivers a range of services across primary care, health and social care and through several commissioned providers. There are 13 GP Practices, 11 Dental Practices, 7 Opticians, 19 Pharmacies and 158 Commissioned Services.

2. Clinical and Care Governance Arrangements for Inverclyde HSCP

5. Figure 1 describes the clinical and care governance arrangements for Inverclyde HSCP. The HSCP has a Clinical and Care Governance Group that meets quarterly. The group is chaired by the Clinical Director. The membership of the group comprises of heads of service and staff side representatives. The group met on 3 June 2024; 17th September 2024; 19th November 2024 and 4th March 2025.

6. There are 3 clinical and care governance groups that report by exception to the HSCP Clinical and Care Governance Group.

7. These groups are the Health and Community Care Clinical and Care Governance Group; Children and Families and Justice Clinical and Care Governance Group and the Mental Health, Alcohol and Drug Recovery Services (ADRS) and Homelessness Clinical and Care Governance Group. There is a Mental Health and ADRS Incident Review Group that reports by exception to the Mental Health, ADRS and Homelessness Clinical and Care Governance Group.

8. The HSCP report progress to NHS Greater Glasgow and Clyde to the Primary Care Community Clinical Governance Group 6 times a year. The Clinical Director and Chief Nurse who deputises, represents the HSCP at this meeting.

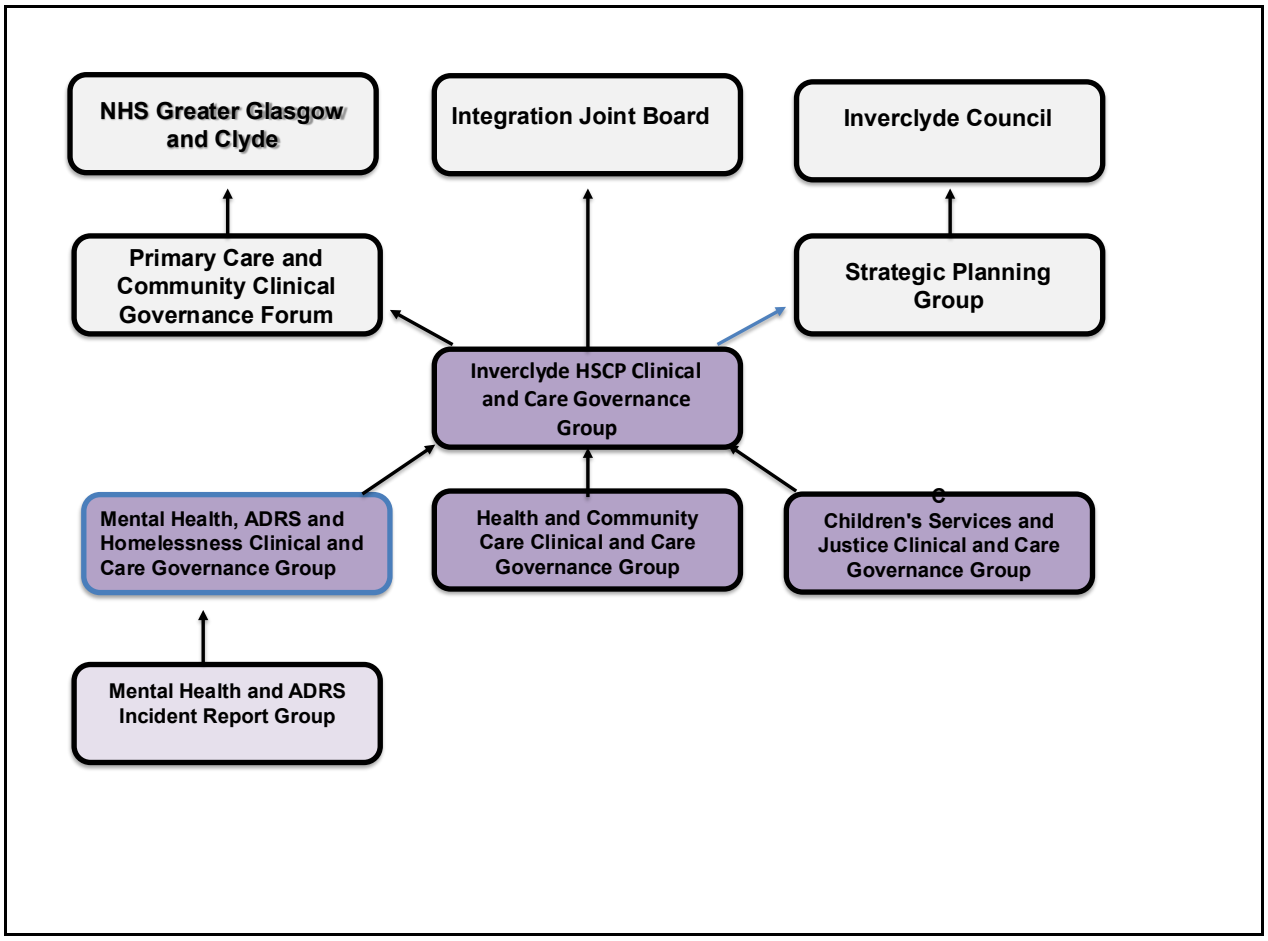
9. Arrangements for clinical and care governance are supported by 2 staff. There is a Clinical and Care Governance Facilitator who supports the HSCP, this post is shared with East Renfrewshire HSCP. There is a Clinical Governance Facilitator who supports the Mental Health and ADRS Incident Review Group.

10. The remit of the HSCP Clinical and Care Governance Group is defined in its Terms of Reference. Each local clinical and care governance group has its own Terms of Reference to support safe, effective and person-centred care to provide assurance to NHS Greater Glasgow and Clyde and the Integration Joint Board.

11. All clinical and care governance groups complete exception reports. This provides a summary of issues regarding safe, effective and person-centred care. The service risk register is reviewed at every meeting. Compliance with the use of the Datix system will be highlighted at each local meeting. Datix compliance is also supported by the Clinical Risk Team, who attend the HSCP Clinical and Care Governance Group twice a year and provide a report on areas of concern and compliance. The HSCP maintains an Integration Joint Board Risk Register and the main areas of risk for the HSCP are drawn from the service risk registers to highlight the main risks to the Integration Joint Board.

12. Updates on inspection activity and action plans will be reviewed by the HSCP Clinical and Care Governance Group, as well as sharing the learning from all reviews into health and social care.

Figure 1 Inverclyde Clinical and Care Governance Structure



3. Safe Care

13. Significant Adverse Events

14. Inverclyde HSCP use the Datix system to comply with the requirements of the Significant Adverse Event Policy from NHS Greater Glasgow and Clyde.

15. There is a set of instances where there is a risk of significant harm to persons receiving care from the HSCP. We have a responsibility to ensure these events are appropriately reviewed to minimise the risk of recurrence by applying lessons learned. This opportunity for learning exists at times without a significant adverse outcome for the person, e.g. a near miss or a lower impact event which exposes potential clinical and care system weaknesses that could lead to further significant harm. Such events have been traditionally referred to as Significant Adverse Events (SAE).

    The criteria is as follows:

16. *Whenever events lead to concerns about the quality and safety of care these should be subjected to an appropriate review.*

17. *When a review of the quality and safety of care is undertaken, the principle of being open with patients (and families) should be followed.*

18. *When the events meet the description of a SAE, then policy should be applied. 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 clinical safety for our patients. The management of a SAE forms part of the current Clinical Risk Management arrangements and should be recognised as an important means of improving the quality of care and identifying and minimising risk.*

19. Inverclyde HSCP utilise the Datix system to record incidents and this is the system that is recognised by NHS Greater Glasgow and Clyde.
20. For the purposes of this report, there will be an overview of the number of incidents recorded and what that means in terms of how the service identifies the incidents of actual and potential harm.
21. There was **3** completed Significant Adverse Events for 2024 -2025 for Inverclyde HSCP.

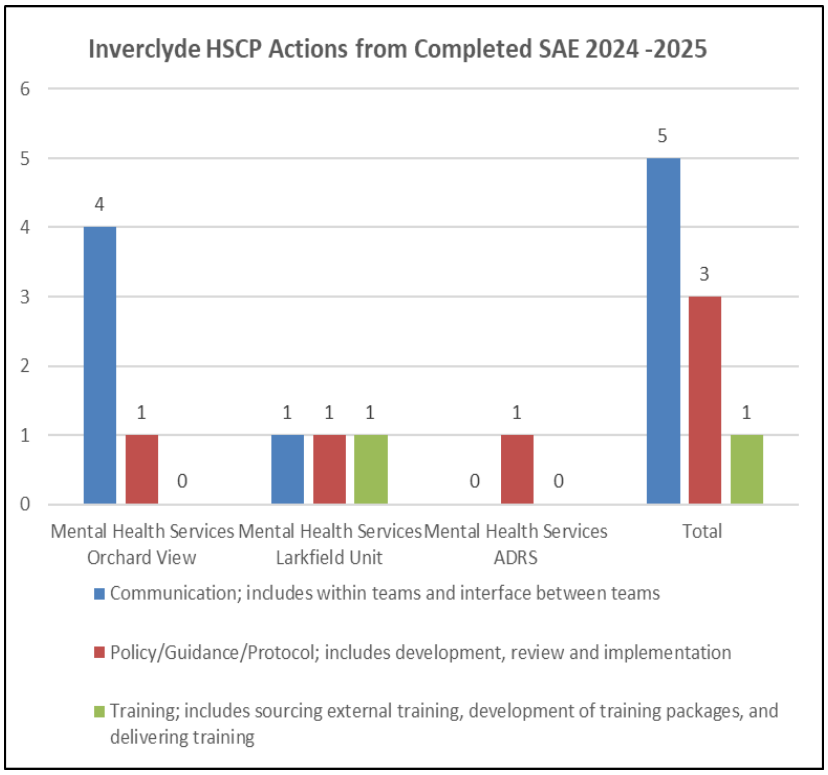
Table 1 Completed Significant Adverse Events Inverclyde HSCP			
Datix ID	**Specialty**	**Category**	**Date completed**
766575	Mental Health Services – Orchard View	Abscondment / Missing	22/8/2024
783258	Older People Mental Health – Larkfield Unit	Slip Trips and Falls	26/2/2025
790357	Alcohol and Drug Recovery Services	Death	24/1/2025

22. There were **9** actions that were identified and for the purposes of this report, the detail of what the actions involved have been included. This ensures that the main recommendations arising from the report are identified and tracked to ensure that they are completed and contribute to thematic analysis provided by the board.
    These actions when placed on the Datix system allow services to both demonstrate what has been achieved to meet each recommendation and to extract the themes to review.
    This is most regularly achieved through NHS Greater Glasgow and Clyde and key themes and learning from all HSCP's and the wider NHS are shared.
    For example, an NHSGGC Cross HSCP Quality Improvement Group was established to oversee activity and learning in relation to ongoing and closed Child Protection (CP) Significant Adverse Event Reviews (SAERs). This information is shared with Chief Officers to disseminate to the relevant teams.

There is a Patient Safety Bulletin that is sent to all NHS Greater Glasgow and Clyde staff and teams that provides a quarterly summary of the main themes and learning from SAE. The Clinical Risk team from NHS Greater Glasgow and Clyde support Inverclyde HSCP in compliance and sharing the learning.

Figure 2 provides a summary of the actions by theme. The need to improve communication was the most common theme followed by updates needed to policies and protocols and then training.

Figure 2 Themes from Completed Actions 2024 -2025



23. Duty of Candour

The organisational duty of candour procedure is a legal duty which sets out how organisations should tell those affected that an unintended or unexpected incident appears to have caused harm or death. Organisations are required to apologise and to meaningfully involve individuals in a review of what happened.

Inverclyde HSCP identify such incidents through the Significant Adverse Event Policy. Each SAE identifies where a Duty of Candour is required.

Table 2 Duty of Candour 2024 -2025 for completed Significant Adverse Events

There was 1 SAE that was identified as applicable for Duty of Candour and the outcomes are summarised below in Table 2.

Table 2 Duty of Candour from Significant Adverse Events 2024 -2025

Is this a Duty of Candour event	**Specialty**	**Category of Harm**	**Patient / Family/ Appropriate Person Notified?**	**Apology offered**	**Patient / Family/ Appropriate Person involved in review?**
No	Mental Health Services Orchard View	N/A	Yes	Yes	Yes
Yes	**Mental Health Services Larkfield Unit**	**Changes to the structure of the person's body**	**Yes**	**Yes**	**Yes**
No	Mental Health Services Alcohol and Drug Recovery Services	N/A	Yes	Yes	Yes

24. INSPECTION ACTIVITY 2024 – 2025

The following is a summary of the external inspection activity for the HSCP.

25. Inspection Fostering, Adoption and Continuing Care

The Care Inspectorate commenced an inspection of Inverclyde's fostering, adoption and continuing care services on 22nd April 2024.

Services were inspected in line with the Quality Framework for Fostering, Adoption and Adult Placement Services and considered the following quality indicators:

How well do we support children, young people's wellbeing?

- Children, young people, adults and their care giver families experience compassion, dignity and respect.
- Children, young people and adults get the most out of life.

- Children, young people and adults' health and wellbeing benefits from the care and support they receive.
- Children, young people, adults and their care giver families get the service that is right for them.

How good is your leadership?

- Quality assurance and improvement is led well.

How well is our care and support planned?

- Assessment and care planning reflects the outcomes and wishes of the children, young people and adults.

  The inspection team primarily looked at children and young people's experiences and outcomes over the preceding two years which included a period of the coronavirus pandemic. A particular focus looked at how regulated services promote children's rights to continuing care and how children and young people are helped to understand their rights.

  The services achieved the following grades for the quality indicators above, using the six-point scale applied by the Care Inspectorate ranging from unsatisfactory to excellent:

	Fostering	**Adoption**	**Continuing Care**
How well do we support people's wellbeing	Adequate	Adequate	Good
How good is our leadership	Adequate	Adequate	Good
How well is our care and support planned?	Adequate	Good	Very Good

Inspectors noted that no complaints for the fostering, adoption or continuing care services had been upheld since the previous inspections. Inspectors also noted that all areas for improvement identified during the previous inspection had been completed and improvement action taken.

26. Joint inspection of adult services Inverclyde Health and Social Care Partnership Integration and outcomes – focus on people living with mental illness.

    The above inspection report was published in May 2024.It was conducted by the Care Inspectorate and Healthcare Improvement Scotland.

    The inspection addressed how well Inverclyde HSCP is working together, strategically and operationally, to deliver seamless services that achieve good health and wellbeing outcomes for adults.

Key Strengths

Most people living with mental illness in Inverclyde had positive experiences of health and social care services that contributed to good outcomes for their health, wellbeing and quality of life.

The partnership's vision focused on inclusion and compassion. It was committed to investing in community-based early intervention and prevention initiatives to support whole population mental health and wellbeing.

Leaders promoted a collaborative culture, which was broadly understood by staff and communities. Longstanding integrated and co-located services provided a good basis for the provision of seamless services.

The partnership had robust contract commissioning processes and there were good relationships with providers.

Priority areas for improvement

- The partnership should develop processes for capturing information about the outcomes of people living with mental illness and their unpaid carers. This should include meaningful opportunities for people to feed back about their experience of services. The partnership should use this information to support plans for improving outcomes.
- The partnership should support staff in mental health services to identify and respond to the needs of unpaid carers of people living with mental illness. It should monitor the impact of its approach.
- The partnership should review the effectiveness of its arrangements for integrated and co-located teams, with a view to maximising opportunities for delivering seamless services for people living with mental illness.
- The partnership should ensure that all staff working in mental health services are confident in the principles and practice of self-directed support, to maximise choice and control for people and unpaid carers.
- The partnership should strengthen its oversight and governance of social work practice, with reference to the statutory functions of mental health officers.
- The partnership should agree and implement its approach to identifying and addressing priorities for improving mental health services. This should include agreement on how it will monitor the progress and impact of improvement activities.

Good Practice Example

Women's Supported Living Service

Staff in the community learning disability team identified a gap in provision for vulnerable women. There were challenges in supporting women who wanted to live independently, but needed a high level of support and were at risk of exploitation in the community.

The partnership worked with a local registered social landlord and a third sector support provider to develop a service response. The resulting housing support service, operational in August 2021, provided a resource across two service areas: learning disability and mental health. It enabled seven women with learning disabilities and/or mental ill health to live in their own tenancies, with flexible and responsive support. Robust telecare arrangements offered tenants the reassurance of being able to call for help at any time. The service was provided as an addition to an existing service that had been developed collaboratively between Inverclyde and Renfrewshire health and social care partnerships.

The service worked in an integrated way, with staff from the support and housing providers and the partnership working together to provide personalised responses to each tenant.

The partnership identified a range of positive outcomes for the women supported by the service, including:

- Being able to live more independently than previously
- Improved mental health and reduced mental health in-patient admissions
- Being more involved in their local community
- Improved family relationships
- Feeling and being safer.

The HSCP has updated the Integration Joint Board on progress of the next steps following the inspection.

27. Inverclyde Learning Disability Support & Care at Home Service Housing Support Service – 6 and 7 February 2025

Inverclyde Learning Disability Support and Care at Home Service enable people with learning disabilities to live in their own homes throughout Inverclyde.

There are three elements within the service, including two supported living services and a dispersed service supporting people in their individual tenancies across the local area.
At the time of the inspection 22 people were supported.

The inspection took place on 06 February and 07 February 2025 and was carried out by one inspector from the Care Inspectorate.

In evaluating quality, the Care Inspectorate use a six-point scale where 1 is unsatisfactory and 6 is excellent. The service was evaluated Good as laid out below.

How well do we support people's wellbeing?	**4 - Good**
How good is our leadership?	**4 - Good**
How well is our care and support planned?	**4 - Good**

28. The Health and Care (Staffing) (Scotland) Act (HCSSA)

The above Act was passed by the Scottish Parliament in May 2019 to come into force on the 1st of April 2024.

The HCSSA 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. It builds on existing policies and procedures within both health and care services.

Effective implementation aims to embed a culture of openness and transparency, ensuring staff are informed about decisions relating to staffing and able to raise concerns.

HSCPs report on services they directly deliver, across all professions, unless in the agreed exceptions, for example pharmacy and on an ongoing basis Inverclyde HSCP will be required to submit quarterly assurance reports to the Health Board using the agreed HCSA Assurance template.

Inverclyde HSCP's return to NHS Greater Glasgow and Clyde showed reasonable assurance reported across all areas of Inverclyde HSCP services with only two duties for Health Visiting and School Nursing reporting limited assurance and no services reporting no assurance for any of the duties. The Senior Management Team has been kept fully informed of all relevant staffing concerns and the mitigations in place to address them. Four duties overall were reported as Substantial Assurance This level of assurance was in line with the expected NHSGGC overall position.

Following the process of completing the assurance templates for April 2025 the HCSSA Programme Board are supporting services to update the workplan for next year. The workplan will focus on developing / enhancing and regularly updating local Standard Operating Procedures (SOPs) to align with NHSGGC available SOPs, in addition to agreement and documentation of escalation processes. The workplan will emphasise ongoing workforce planning, risk

management, and feedback processes, while ensuring the integration of these updates into daily team activities and quarterly reporting.

29. Pressure Ulcer Prevention.

Pressure Ulcer Prevention is embedded within the District Nurse team, there has been **no avoidable** Pressure Ulcer's recorded since September 2024.The table below is an indicator including all HSCPs.

There has been considerable improvement activity in the recording and management of pressure ulcers by the service in 2024 -2025 and this is reflected in the data that Inverclyde HSCP have presented and reviewed by NHS Greater Glasgow and Clyde, that is supported by the Chief Nurse.

Month	HSCP	Total Unique Wounds	Total PU Patients	Total Caseload Patients	PU Per 1000 Caseload
Apr-25	East Dunbartonshire CHP	0	0	1,183	0
	East Renfrewshire CHCP	0	0	841	0
	Glasgow North East CHP	2	2	1,771	1
	Glasgow North West CHP	0	0	1,684	0
	Glasgow South CHP	0	0	2,389	0
	Inverclyde CHP	0	0	1,233	0
	Renfrewshire CHP	1	1	2,553	0
	West Dunbartonshire CHP	0	0	1,064	0
Total		3	3	12,718	0

- **5.4%** of total GGC Pressure ulcers (PU) recorded (April 2025) (n-8) Inverclyde
- **8** new pressure ulcers admitted to caseload (April 25)
- **0** Avoidable pressure ulcers (April 25)
- **100%** (n-8) grading accuracy
- **100%** SSKINs compliance **(**April 2025)

30. Palliative and End of Life Care (PEOLC)

Excellence in Care indicators for PEOLC has 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 tables below indicate the Inverclyde HSCP position as reported for May 2025.

Out of 920 patients on the caseload there are 100 palliative care patients. For the last 12 months, the preferred place of death out of 282 patients was 229, which was 82% of the total.

4.Effective care

The following section highlights improvement activity that has been initiated or completed in 2024 -2025.

31. Primary Care Transformation

Pharmacy

Public Communication

The Pharmacy Service have been promoting several campaigns including Medicine Waste and Antibiotic Stewardship.
These key messages have been delivered to our local population through a variety of ways including:

- displaying on GP Practice and Health Centre media screens,
- promotion across our digital billboards,
- cascade of promotional material around all staff networks
- Physical medicine waste materials will be available in the next quarter across Community Pharmacy, General Practice and Nursing teams.
- These materials will include a trifold and stickers for Pharmacy Prescription bags.

Digital media boards continue to provide a 'Talking Point' for both Primary Care and Community Pharmacy.

Highlighting Pharmacy roles and services provide that added direction of patients to the 'Right Care in the Right Place'

32. Pharmacy Frailty Polypharmacy Review Pathway

The service has developed a pathway for those living with frailty for referral for a polypharmacy review. This will help to reduce medicines related harm in those living with frailty.

A form has been developed to allow teams in the Community and Acute settings to refer patients who fit the criteria.

Community based Health Care Professionals including Rehab teams, Frailty Practitioners and ANPs can refer when they have patient concerns around Frailty and medication risk.

It will also roll out and be promoted to Community Pharmacies to request review when appropriate.

The MS form is automatically directed to the Inverclyde Pharmacy Hub to be triaged and redirected to either Care Home Pharmacist, Interface Pharmacist or Practice Pharmacist for medication review.

33. Care at Home Service Redesign

The existing model of Care at Home in Inverclyde needed enhancement due to the increasing number of older, complex service users.

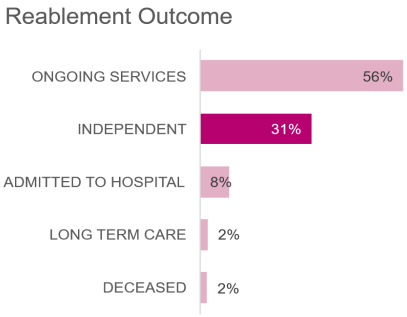
The goals were to address recruitment and retention issues whilst maintaining a high-quality support for service users.

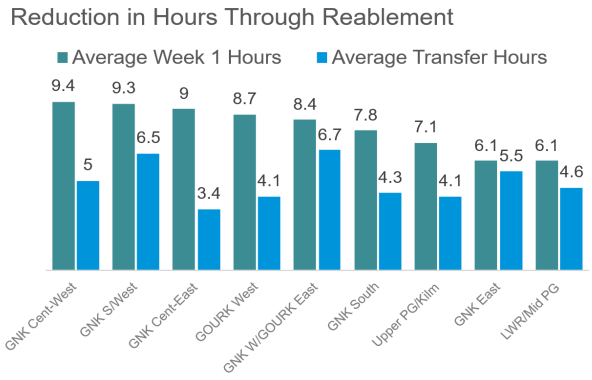
There has been a marked improvement in reablement as well as recruitment and retention and delayed discharge improvements.

Service Redesign and Impact

SUCCESS OF REDESIGN AND IMPACT

High percentage of service users regain independence through reablement services (**31%** as of April 7, 2025).

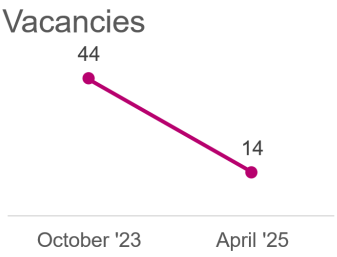




Outcome

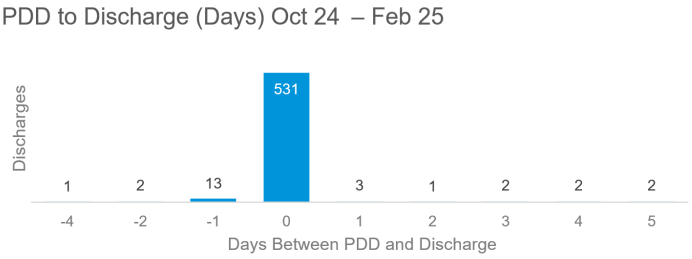
RECRUITMENT & RETENTION

The redesign of the service, along with the change in staff grading, has had a significant positive impact on our recruitment and retention efforts.



DELAYED DISCHARGES

We have almost eradicated delays in hospital discharges due to waiting for a package of care



Service Capacity & Governance of Commissioned Providers

1099 Unique Care at Home Service Users

Internal Service Delivery

Supporting 912 service users internally with 5,117 weekly hours of care

External Service Delivery

Commissioning 4,023 weekly hours of care for 312 service users.

Internal, 56% | External, 44%

Regular performance monitoring and consistency in KPI measurement using ECMS

Continuity of Care
Punctuality
Service Duration
Compliance

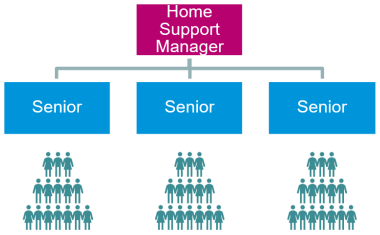
Key Changes to Improve Service Delivery

FLEXIBILITY & EFFICIENCY

Removal of fixed boundaries, introduction of smaller, fluid boundary lines.

TEAM RESTRUCTURE

Integration of Reablement teams into mainstream teams, creating nine new teams



STAFF TRAINING

Training all staff in the Reablement ethos.

REDISTRIBUTION OF EXPERIENCED STAFF

Strategic dispersal of experienced Reablement staff into new teams

34. Platinum Digital Telecare Implementation Award

Inverclyde HSCP have embraced the journey from initial test stage to complete full digitalisation of the Community Alarm provision. Building on previous recognition, Digital Telecare for Scottish Local Government recently confirmed that Inverclyde HSCP has been awarded the Platinum Digital Telecare Implementation Award in recognition of this recent completion of full analogue to digital telecare transition project. Platinum Accreditation was awarded on the 4 April 2025.

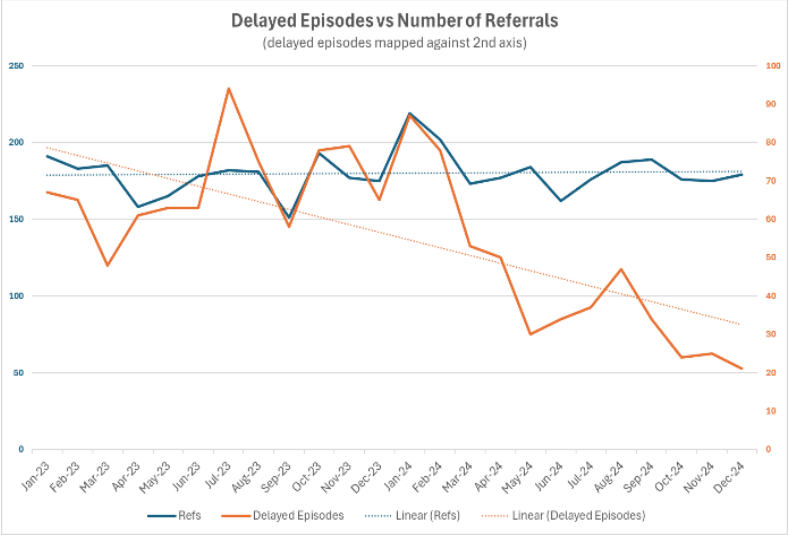
This is a remarkable achievement and the final major milestone in the transition to digital telecare. Next steps include further integration with commissioned providers, continuous improvement and upskilling of staff, robust monitoring and evaluation frameworks to track the performance of digital systems and identify areas for further, sustained improvement.

35. Delayed Discharge

As part of the work of the teams within the HSCP to providing high quality and impactful services, delayed discharge performance continues to be a key priority, to strive to eliminate any citizen remaining in hospital once they are well enough to leave. To achieve this, HSCP and Acute colleagues have worked to develop new pathways and reinvigorate existing pathways to support people to return home.

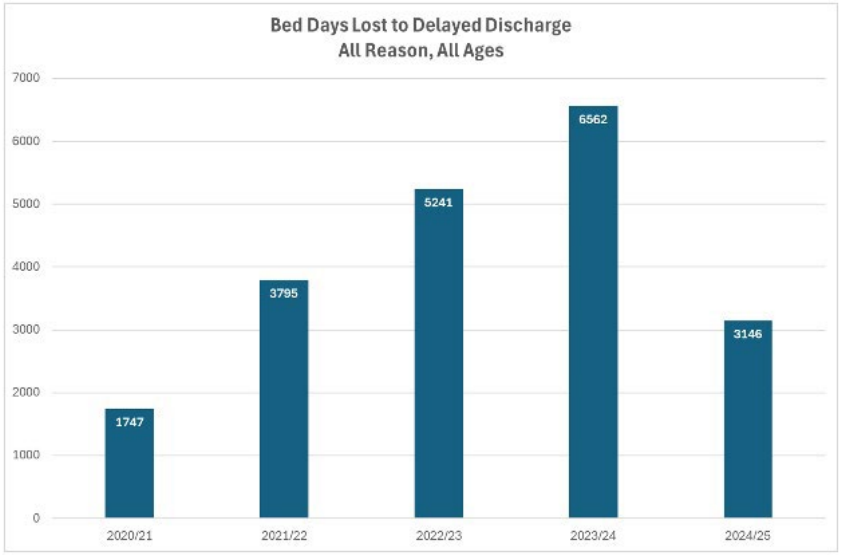
This includes a pathway for those who have attended the local Emergency Department and do not need to be admitted to hospital but require support to return home. Working collaboratively, supports can be put in place immediately to prevent an unnecessary admission. While this work is in its early stages, it is being used successfully and will continue to be reviewed and improved.

Discharge options have also been enhanced to include people moving into a care home for a short stay to enable ongoing assessment and, when needed, rehabilitation, to enable a safe transfer back home within a few weeks. The graph below illustrates a sustained level of referral for support to return home. Despite the ongoing high volume of referrals for support, we have reduced the number of people becoming unnecessarily delayed in hospital.



The chart below, demonstrates how this improvement has impacted on the number of bed days lost. Bed days lost increased through the Covid pandemic and continued to rise, peaking in 2023-2024.

In 2024-2025 the number of bed days lost has been halved, increasing local hospital capacity. It is important to recognise this positive impact, alongside the continuing commitment to further reducing unnecessary delays



5.Person Centred Care

36. Inverclyde HSCP have been actively promoting Care Opinion (www.careopinion.org.uk) for 3 years now. This has been reflected upon in the last two annual reports for Clinical and Care Governance.

Table 3 shows for 2024 -2025 there have been 33 stories received from Care Opinion.

Table 3: When stories were told 2024 -2025

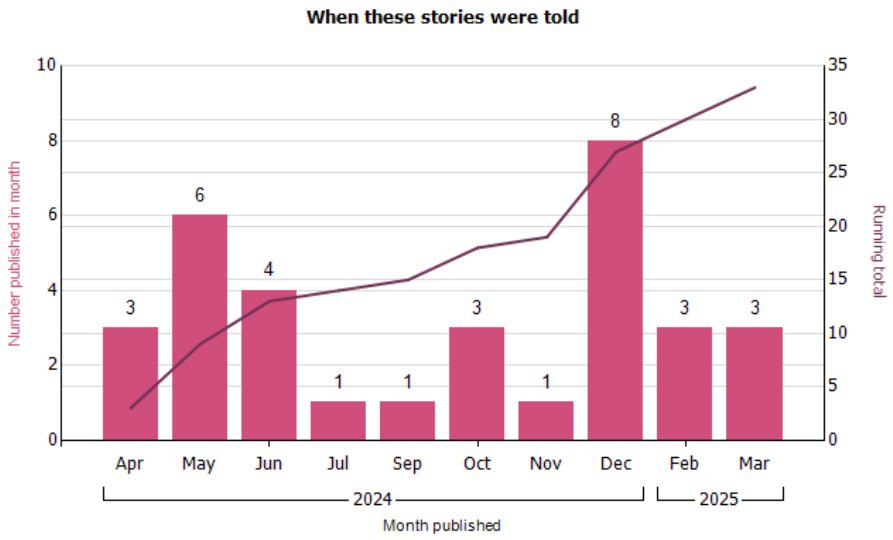


Table 4 shows how authors of the stories identify themselves. The majority of stories are for people who describe themselves as the patient or service user but stories are received for those who describe themselves as a relative, parent or carer.

Table 4 How Authors of Stories identify themselves 2024 -2025

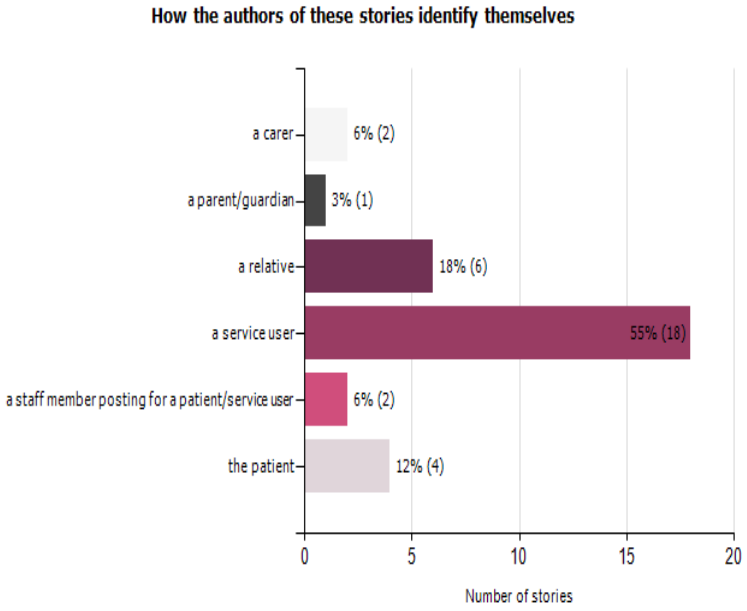


Table 5 shows how the stories were submitted.

It is encouraging to see the amount of stories that have been submitted via Freepost Envelopes (leaflet). This is provided as part of the HSCP subscirption and helps to improve the accessiblity for Care Opinion that can't or struggle to use the web based platform.

Table 5 How stories were submitted 2024 -2025

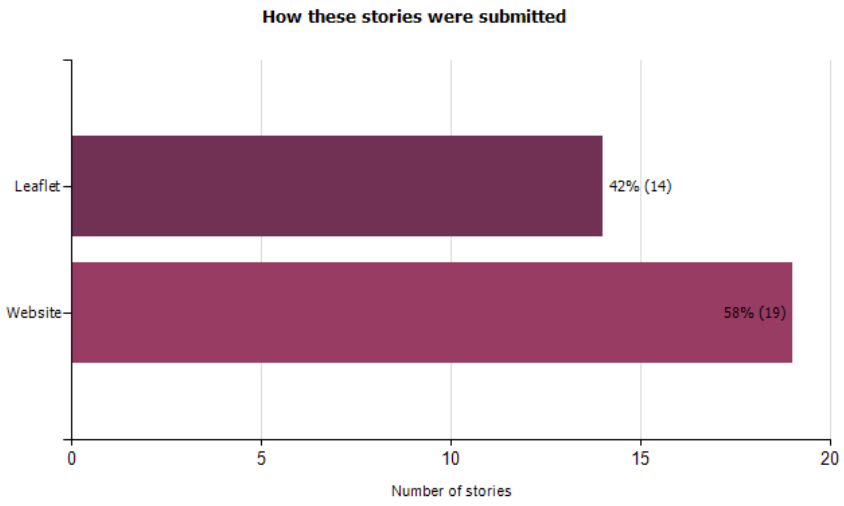


Table 6 shows how Care Opinion have rated how critical the stories are.

The majority of feedback (79%) is not critical and every story has had a response.

Table 6 How Care Opinion moderators have rated the criticality of stories 2024 -2025

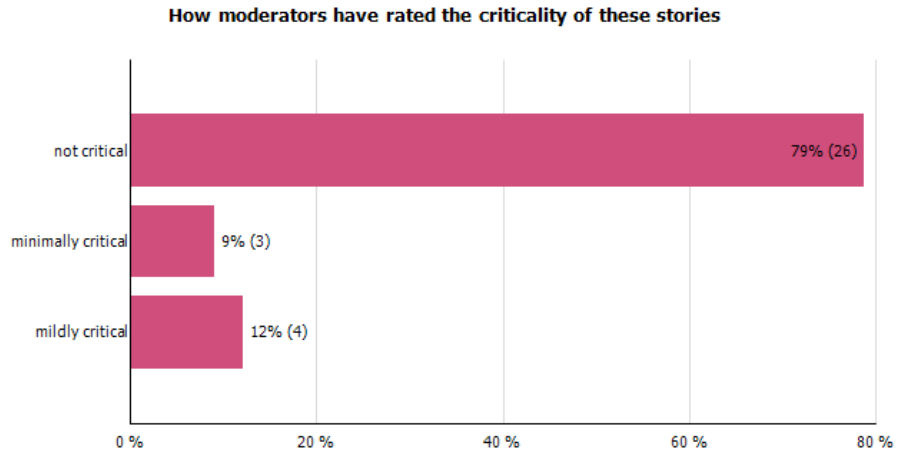


Figure 3 below shows ‘What was good’ for 2024 -2025.

Helpful, Friendly and Professional Staff.

Figure 3 What was Good 2024 -2025

The following 2 examples have been chosen to showcase the kind of feedback that has been received.

On the day of a big storm, I went outdoors to investigate how much damage was done to my roof from an embankment at the rear end of my garden. On the way back down, I slipped and broke my ankle.

I was taken by ambulance to the Royal Alexander in Paisley, where I had surgery. I needed a metal plate and 11 pins to fix it. I am grateful to the skill of the surgical team and nurses for all what they did for me that day.

When I got out of hospital, I was cared for by the team of Gourock district nurses who attended me at my home to change my wound dressings twice a week. Their care and compassion were second to none and I am extremely grateful to them and the NHS.

I am now back to full health and fitness and grateful to all those in our amazing NHS.

https://www.careopinion.org.uk/1357698

Yesterday my mum took unwell within her care home, I work in healthcare and got a call at work to attend.

A nurse Stuart from my mums practice attended and carried out a full, thorough assessment. His knowledge was exceptional, and he sensitively advised me on courses of action touching on pros and cons of whether escalation to hospital was appropriate.

My mum appeared to have had a TIA/stroke along with chest infection and the nurses knowledge was exceptional. His calm professional approach was outstanding, it made me feel reassured she was in good hands.

He assisted me with getting her into bed and went beyond the call of duty, he fed back to the GP who in turn phoned me with a plan.

Stuart was kind, helpful and highly skilled.

https://www.careopinion.org.uk/1261962

37. Housing Options and Housing Advice Service (HOHAS) – Person Centred Support

The redesign of the Housing Options and Housing Advice Service is nearing completion, and this will include strengthening our pro-active support to prioritise early intervention and prevention and support for people to sustain their tenancies in the longer term.
Below is a case study that exemplifies the compassionate and person-centred support provided by the teams.

Client A has experienced homelessness over several years, as well as being involved with the criminal justice system including periods in custody, during which he was not able to keep in contact with homelessness services. He talked about “taking panic attacks because I knew I was getting out of the jail and I didn’t know what was happening”, adding that “people would rather be in the jail than be running about the streets homeless”.

Client A has a long history of substance use and has been known to local substance use teams and lives with significant underlying health problems.

In June 2023, A was identified as a potential Housing First candidate and put forward to the team for support. He currently receives support for four hours per week and this will increase when he moves to his own tenancy. Client A has been able to actively engage with services, reflecting that the new help he receives has supported him to attend doctors’ appointments, community groups, resolve his benefits and “simple run of the mill things you would get complacent in”, saying that he often struggled to stay on top of general housekeeping but that he has “noticed a big difference” in the support received from the service.

Client A said he would previously have struggled to accept this support but that he built trust with his worker and is also being supported by the ‘Inverclyde Faith in Throughcare’ charity who are helping him to avoid offending. Client A has now managed to stay out of prison for three years, compared to previously being returned to custody within months of returning to the community and has now started a college course. Without support Client A said, “I don’t think college would have happened”. Client A and his girlfriend are currently in temporary accommodation; however, work is ongoing to see if this could become his permanent tenancy. Client A has talked about having a set routine to care for his home and there has been a real improvement from the previous temporary accommodation.

6. Conclusion

The HSCP has been negotiating significant challenges throughout 2024 - 2025. One of the main aspects of this is meeting the requirements for the Health and Care (Staffing) (Scotland) 2019 Act.

The HSCP has reasonable assurance through the work that has been ongoing on the legal requirements for the Act. The HSCP has an implementation group to oversee progress. Care Opinion will be a vital aspect that has been incorporated into this work to feedback on progress from the public’s perspective. Existing systems will be used to record staff concerns, such as Datix. There are Standard Operating Procedures developed to monitor the real time staffing aspect. This status will be carefully monitored and is a standard agenda item for the HSCP Clinical and Care Governance Group.

The Terms of Reference for the Clinical and Care Governance Group will be reviewed in 2025.

The implications of any changes to the Significant Adverse Event Review process will also be discussed at local governance groups and the HSCP Clinical and Care Governance Group. Issues will be escalated to the Primary Care and Community Clinical Governance Forum.

The structure for clinical and care governance, shown in Figure 1, provides assurance that all services report by exception to the HSCP Clinical and Care Governance Group. This ensures that NHS Greater Glasgow and Clyde have an accurate and up to date overview of the risks and issues for the HSCP.

Exemplar Case Studies

Case Study 1

Inverclyde HSCP Community In – Reach

The aims of the service are to:

- Provide link from acute to primary care.
- Prevent delays through Health and DN services.
- Ensure no one remains in Hospital for longer than necessary.
- Preferred Place of Care/Death is met.
- Community Palliative Kardex.
- Scottish Palliative Care Guidelines for Rapid Discharge for Patients who are in the Last Days of Life.
- District Nursing Service via Clinical Portal to allow staff to access if patient known to District Nursing service and active care plans

This service is community based within Inverclyde Royal Hospital.
They accept referrals for complex discharges including:

- Wound Management
- Diabetes Management
- Insulin Management
- Palliative Care and Rapid End of Life Discharges
- Pressure relieving equipment
- Support and advice regarding District Nursing Services and resources.

The team liaise with:

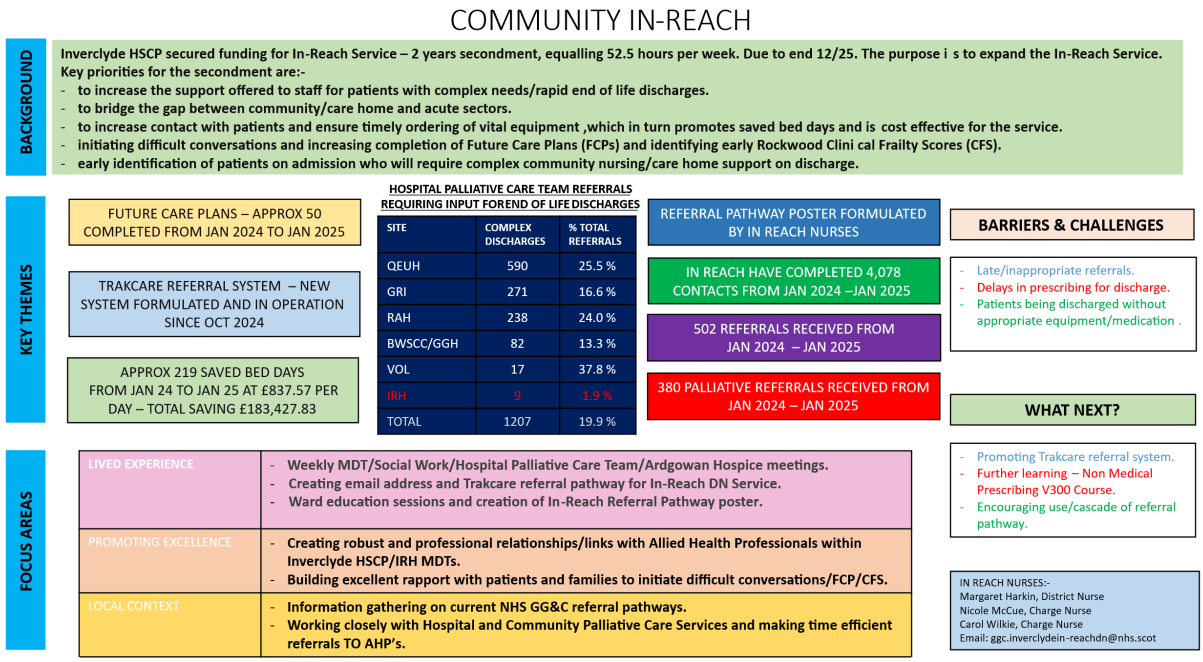
- Social Work
- Hospital Palliative Care Team
- Allied Health Professionals
- Community Nurse Specialists and Nutrition Nurse Practitioners
- Home Care
- Ardgowan Hospice
- Family and Carers

The impact of the service:

- Contribute to the vision, approach and strategic priorities of the Strategic Partnership Plan.
- Contribute to the End-of-Life Palliative Care Strategy.
- Contribute to reducing workloads on other services and retaining care delivery within community nursing where appropriate.
- Increased support offered to staff for patients with complex needs/rapid End-of-Life discharges.
- Bridged the gap between Community/Care Home and Acute Sectors.

- Increased the number of completed Future Care Plans (FCP) and identified early Rockwood Clinical Frailty Scores (CFS).
- Contributed to the reduction in complaints and Datix due to improved communication.
- Improved timely ordering of equipment, which in turn promotes saved bed days and cost effectiveness of the service.
- Identify at an earlier stage patients on admission who will require complex community nursing/care home support on discharge.
- Liaise with families to support the people in our communities, therefore reducing inequalities.

The following graphic is a flash report which shows how the service communicates key concepts and progress with other staff and teams.



Case Study 2

Inverclyde Chronic Obstructive Pulmonary Disease (COPD) Pathway Remote Patient Monitoring

Hospital admissions with a diagnosis of COPD are significantly higher for people living in the most deprived areas of Scotland compared to those in the least deprived areas. Within Inverclyde we have an average rate across the last 5 years of 3 per 100 patients requiring hospital admissions.

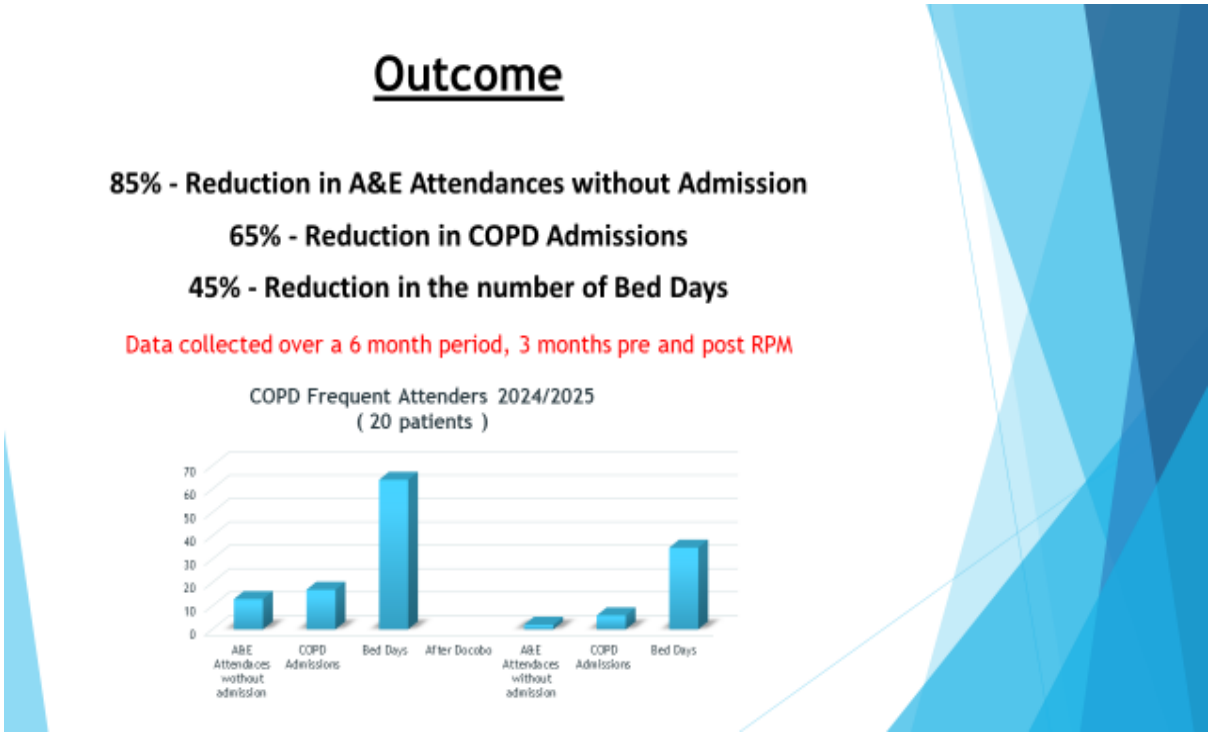
Inverclyde's rate is above both the NHS Greater Glasgow & Clyde and Scotland rate per 100 000 population.

The aim of the remote monitoring pathway is to utilise existing resources and workforce to target residents of Inverclyde who are diagnosed with COPD. The main aim is to avoid unnecessary admissions and form a preventative approach that can be built into normal practice for COPD care. The initial focus was on the most frequent attenders who are admitted to Inverclyde Royal Hospital (IRH) due to exacerbation of COPD.

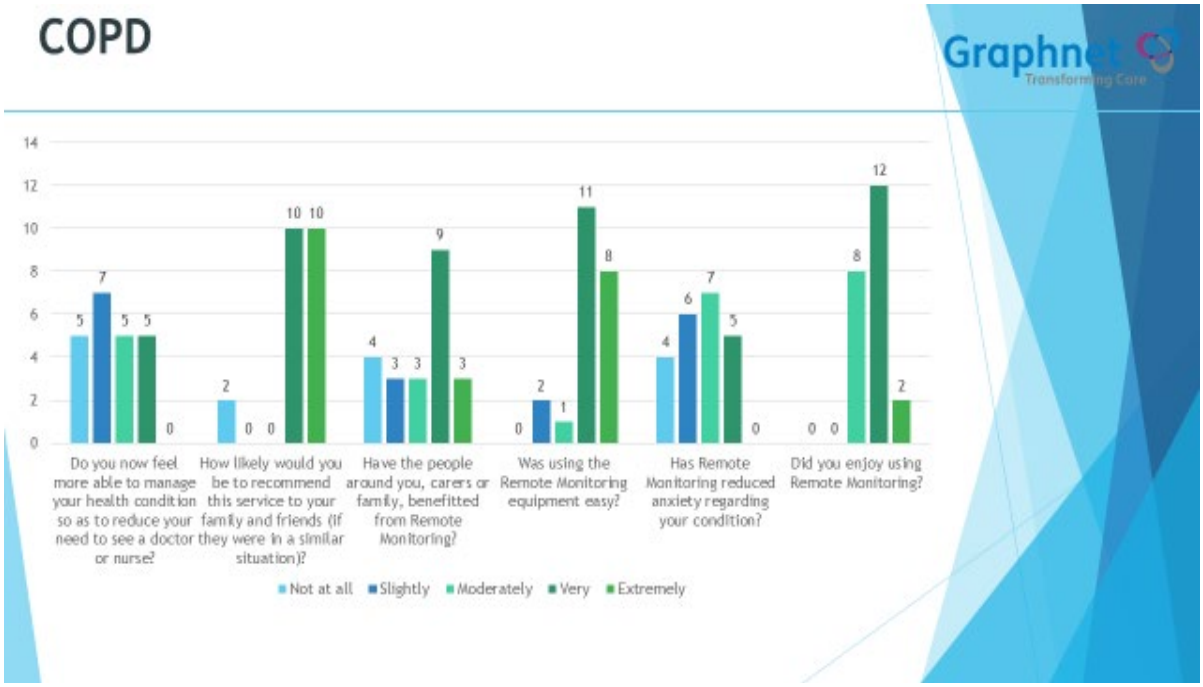
The method is to utilise existing preventative tools, the focus of this pathway is to re-introduce the remote patient monitoring (RPM) system, Graphnet/Docobo. This system allows the patient to input daily observations and answers a question set (COPD) which are assessed daily by a Community Nurse, with the aim of initiating treatment if required at an early stage to prevent unnecessary hospital admission.

This pathway empowers patients to take an active role in their health, supporting self-care and improving well-being.

Currently Inverclyde has 93 COPD patients who attended IRH 720 times 2024 -2025 for exacerbations of COPD. Of this cohort 20 patients have been established on the system, 18 patients were excluded for not meeting the criteria due to reasons such as visual impairment, assisted living, brain injury or dexterity issues. 4 refused to participate and 3 patients sadly passed away during screening.



Patients using the system have responded positively to the experience and provided the feedback outlined below.



Looking into the future

A new referral pathway is set up through Access 1st allowing all professionals to refer into the service. (GP, ANP's, Practice Nurse, District Nurse etc.). The Long-Term Conditions Nurse continues to engage with all GP Practices and the Respiratory Team and IRH whist picking up referrals from Access 1st and continuing to target the remaining frequent attendee cohort of patients with the intention of establishing a large percentage on either remote monitoring, medication review or sign them up for a rescue medication card.

The Inverclyde Care Home 5G Project in partnership with Graphnet/Docobo went live on the 27th of January 2025 within 2 care homes in Inverclyde, involving a total of 81 residents.

This expansion into long term care home settings has seen additional pathways being set up with remote patient monitoring along with the use video consultation including:

1. The 'monthly wellness check' – Each month a carer completes these questions with a resident to monitor their baseline measurements. This fits with the My health, My Care, My Home National Care Home Framework (2022) and current unscheduled care work on Call before You Convey.

2. The 'deteriorating resident' or 'my resident is unwell' – is completed when a resident is feeling unwell or demonstrating signs of deterioration.

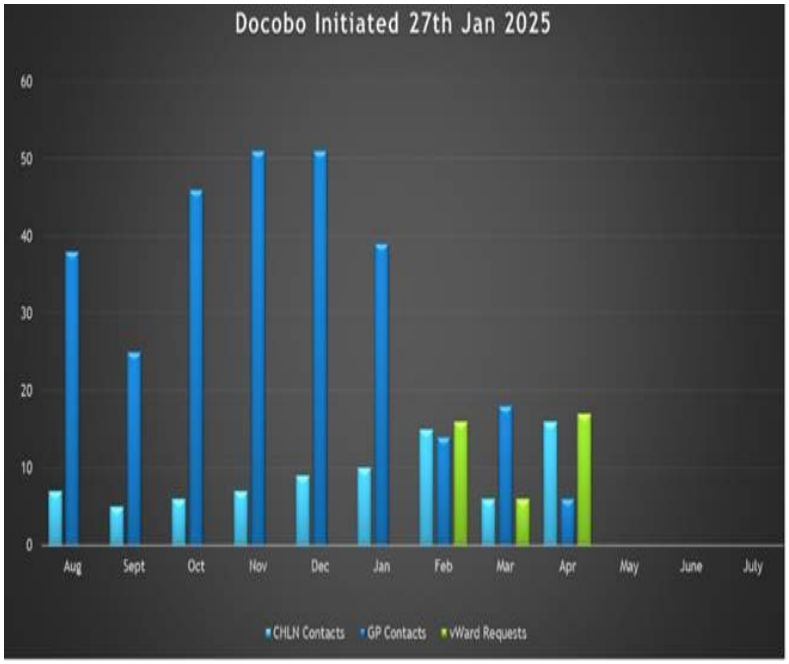
3. The 'virtual ward round' – Highlights specific residents and health concerns that need to be reviewed at ward round with the residents' CHLN.

The project aims to improve individuals' quality of life through technology enabled integrated care delivery, leading to below objectives:

- Reduced GP appointments/contacts, hospital attendance and admissions
- Improved clinical capacity and assessment
- Clinical improved triage
- Regular monitoring to support the progress from reactive to proactive preventative
- Keeping individuals in their preferred homely setting
- Clear recording and history of individual notes

Unfortunately, one care home withdrew due to difficulties supporting 2 additional electronic systems within their care home.

The example shown provides data in a Care Home from February to April 2025 where the number of GP contacts has signifcantly reduced for that time period.


Docobo Initiated 27th Jan 2025
60
50
40
30
20
10
0
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
June
July
CHLN Contacts
GP Contacts
vWard Requests

Case Study 3

Urgent Hub Centre for Independent Living Team

The service is an integrated Council and NHS Team.

The Urgent Hub is a dedicated integrated team with a focus on prevention of admission to hospital, supporting hospital discharges and crisis prevention to support care at home and informal carers.

The resource was launched in 2022 to differentiate between urgent and routine work coming into the centre.

Previously the team were getting into a cycle of prioritising crisis work over routine resulting in routine work getting to crisis stage and the waiting lists increasing.

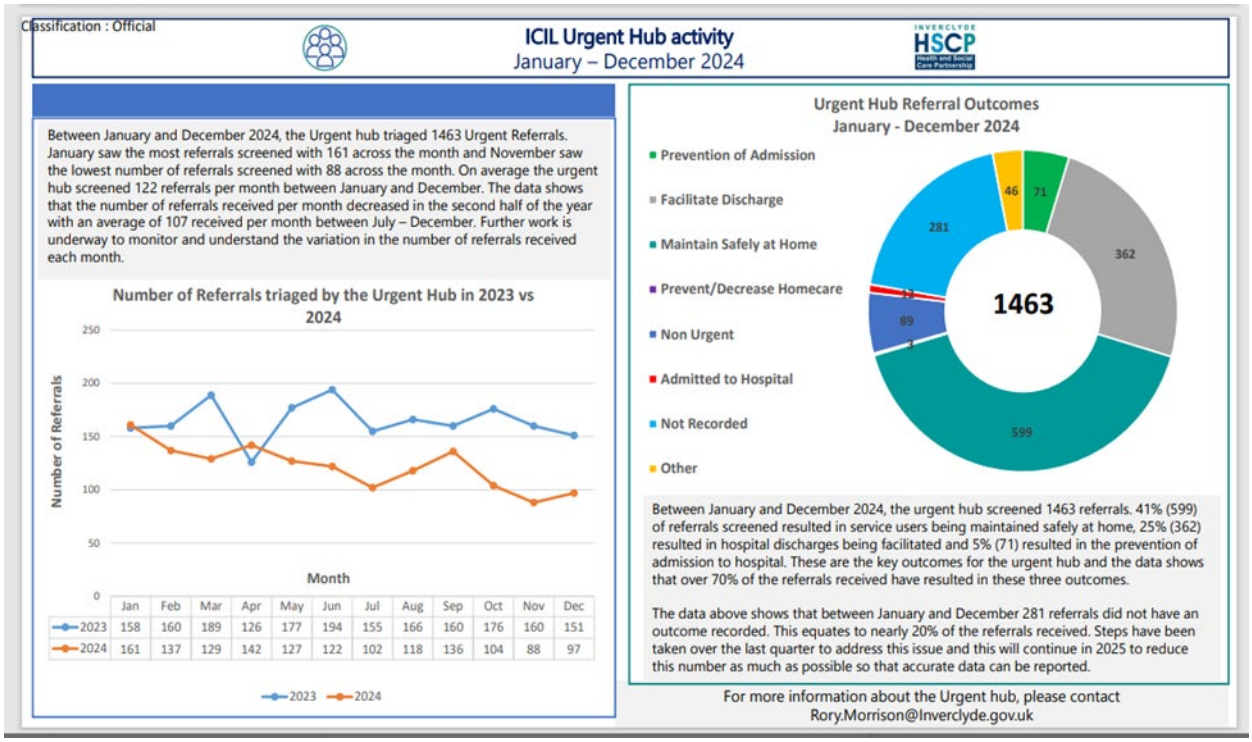
The aims are to:

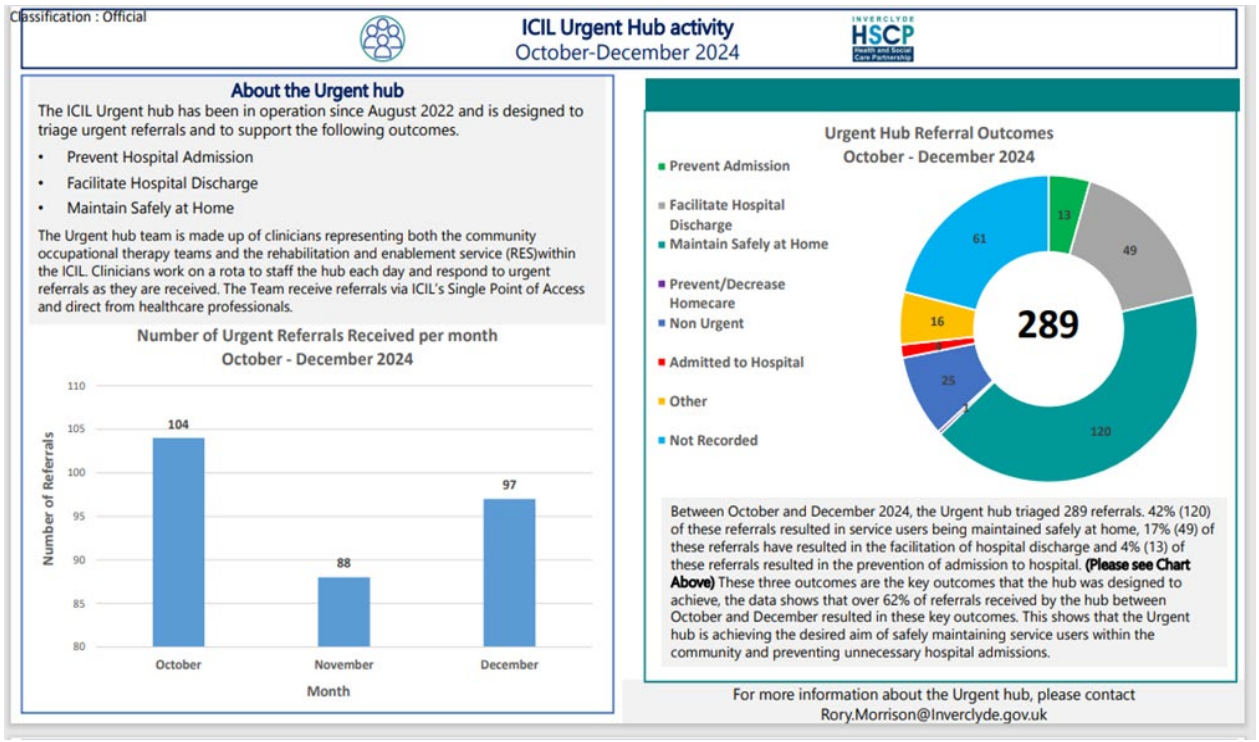
1. Achieve best outcomes for service users and families
2. Joint working
3. Right Care, Right Person and Right Time
4. Pressure off non -urgent staff to work on routine caseload

It was realised that the idea worked but there was no data to back the work up. A data recording system was designed and put into practice August 2022. The system scores the outcome of each referral that is triaged by the Urgent Hub. There are 9 categories of outcome including:

1. Prevention of Admission
2. Facilitate Hospital Discharge
3. Maintain Safely at Home
4. Prevent/Decrease Home Care
5. Non-Urgent
6. Admitted to Hospital
7. Refer to Nurse
8. Patient Declined
9. Falls level 2 – falls team disbanded and increase in referrals who would previously have gone to falls service

Data collection





Data gathered so far since the launch in 2022:

- **Since the launch of the urgent hub – triaged 4355 referrals**
- **1757 service users have been maintained safely at home**
- **538 admissions to hospital have been prevented**
- **273 referrals have been downgraded as non-urgent**
- **1051 Discharges from hospital have been facilitated**

This shows that a planned, improvement-based approach is having a positive impact. This impact can be evidenced due to the data collection methods described.