NHS
Greater Glasgow and Clyde

West Dunbartonshire
Health & Social Care Partnership

WEST DUNBARTONSHIRE CLINICAL GOVERNANCE ANNUAL REPORT 2015/2016

CONTENTS

The Chief Officer and the Senior Management Team would like to thank everyone who contributed to the development of this Clinical Governance Annual Report; and all those staff and colleagues who continue to work so hard to deliver high quality services to the communities of West Dunbartonshire.

Electronic copies of this Clinical Governance Annual Report are available at www.wdhscp.org.uk

INTRODUCTION

This report is a summary of West Dunbartonshire Health & Social Care Partnership's clinical governance and clinical effectiveness activity during what was another important transition year. July 2015 saw the establishment of our new Health & Social Care Partnership arrangements – which saw West Dunbartonshire being one of the first areas in Scotland to implement the requirements of the *Public Bodies (Joint Working) Act*. This included the new Health & Social Care Partnership Board confirming its two localities within West Dunbartonshire: Clydebank and Dumbarton/Alexandria.

2015/16 also saw the Scottish Government publish its first unified *Clinical and Care Governance Framework*. The Framework states that all aspects of the work of Integration Authorities, Health Boards and local authorities should be driven by and designed to support efforts to deliver the best possible quality of health and social care. Through the course of 2015/16, a considerable amount of thought and work has been invested in refreshing the HSCP's approach to clinical and care governance across its services. This was shaped by and benefitted from engagement and constructive feedback from management and lead/senior professionals across all disciplines and service areas. Importantly though, the refreshed arrangements place a clear emphasis on clinical and care governance being led at and within operational service areas. This fits with two key themes of both the recently published *National Clinical Strategy for Scotland* and the Scottish Government's *Chief Medical Officer's Annual Report (2014-2015)*: i.e. the importance of strengthening multi-disciplinary team working; and the importance of all care professionals delivering at the top of their registration and grade.

This is my final annual report before completing my tenure with the HSCP and returning to general practice full-time. With that in mind, I do hope that it provides a reassuring sense of the continuing investment that I have seen from colleagues across services (and at all levels) in providing good quality care for local people.

Kevin P Fellows - Clinical Director (April 2016)

EXAMPLES OF QUALITY IMPROVEMENT INITIATIVES

Anticipatory Care Planning

The Scottish Government's Integrated Care Fund intends to build on the work of the preceding Change Fund for Older People, seeking the development of further work for people of all ages with long term conditions and multi-morbidity. The work being driven by the local HSCP led Community Planning Partnership Integrated Care Fund Plan reflects a collective commitment to:

- Optimal outcomes for individual service users.
- A client-centred approach appropriate to individual needs through an emphasis on informed self-care, co-production and personalisation of services.
- Effective and safe services that draw upon the best available evidence and local feedback from service users.
- Equalities-sensitive practice.
- Acceptability of service provision informed through constructive engagement with local stakeholders – including staff, community groups and elected representatives.
- Affordable and efficient services that continue to be reflective of the relative demands across the West Dunbartonshire population as a whole.

Good care planning and communication across teams and with carers improves co-ordination of care, enables early intervention and provides better access to safe and effective alternatives to avoidable hospital care. Some of these shared decisions will be based on thinking ahead about preferences for future care. A key element of the Integrated Care Fund programme of work has been the ongoing development of anticipatory care planning. Anticipatory care encourages people to make positive choices about what they should do themselves, and from whom they should seek support in the event of a flare up or deterioration in their condition, or in the event of a carer crisis. The Anticipatory Care Plan (ACP) is a dynamic record that should be developed over time through an evolving conversation, collaborative interactions and shared decision making. The ACP will also include information about the person's concerns and goals; their understanding about their illness and prognosis; and their wishes for end of life care, including preferred place of care, as well as their views about the degree of interventions, treatments and cardiopulmonary resuscitation welcomed. Key information should be recorded on the electronic key information system on the Electronic Key Information System (e-KIS). The ACP is a summary of "thinking ahead" discussions between the person, those close to them and the practitioner.

During 2015/16, the HSCP recruited three Integrated Care Fund (ICF) Nurses to build on anticipatory care planning within General Practice. In addition to the 1821 ACPs created or reviewed within General Practice during 2015/16, the ICF Nurses have undertaken a further 241 reviews of patients identified by GP practices. The review has included a full nursing assessment, referral to services as required and key anticipatory care information has been captured within and shared with unscheduled care services.

Hospital Discharge and Early Assessor Service

The HSCP's Hospital Discharge Team – with its Early Assessment process - provides early assessment/support to facilitate people's safe and timely discharge from hospital through an integrated approach to care, maximising independence and opportunities for recovery at home. The service has adapted and developed to increasingly ensure timely discharge and access to services. The Team is comprised of health and social care professionals working in both the hospital and community, within one integrated service and management structure. They aim to:

- Maximise the potential for timely discharge by anticipating needs for appropriate care, support or accommodation.
- Dedicate time and knowledge to plan a person's discharge.
- Ensure that the individual has the opportunity to be involved and heard in person-centred planning.
- Reduce delayed discharge and readmission to hospital
- Undertake early identification and support people unable to return home.

Preparation within the hospital setting is crucial in planning successful discharge. This was enhanced in 2015 with the development of Hospital Discharge Liaison Workers to provide early assessment and practical support in the ward setting. They promote early referrals and discharge planning; promote awareness with Consultants and ward staff; work in parallel with medical treatment; assess need at the earliest opportunity, with referral/information shared from the point of admission; and identify people who cannot return home or who lack capacity. The wider Hospital Discharge Team can then involve patients and carers sooner; develop and deliver integrated care and support packages; ensure the most appropriate care and opportunities at the point of discharge; and monitor and review care packages for four weeks.

The Team has seen increasing success in supporting discharge home when people are medically fit. As the graph shows, delayed discharge figures for the HSCP have continued to fall overall, with noticeable and sustained improvement since the Early Assessor commenced (February 2015) showing a pattern of no delayed discharge.

Community Access To Review For Asthma Patients

Three people die every day in the UK from asthma, and thousands are hospitalised annually. A review of patients in West Dunbartonshire (2013) found that 15-20% of adult asthmatic patients were failing to attend their GP practice for an annual review. Patients failing to attend review are at greater risk of their asthma being poorly controlled, a risk factor for exacerbations which may result in an admission to hospital. This preventative initiative aimed to improve uptake of annual asthma reviews for hard to reach patients in the community, recognising that for those more vulnerable adults who struggle to engage with their GP practice, offering the community pharmacy as a setting can be more effective.

The HSCP's local community pharmacy approach to proactive clinical review of people with asthma (known to improve clinical outcomes) provides people with flexible access to review, increasing the numbers now attending their crucial annual reviews. A Locally Enhanced Service (LES) was developed that included community pharmacies undertaking asthma reviews for up to 20 patients who had not attended their GP practice. Crucially, the HSCP worked in partnership with local GPs and local community pharmacies to identify and support attendance at review - and thus support individuals to better self-manage their conditions.

There has been significant success in promoting review through this approach, with:

- 900 "hard to reach" patients receiving a review.
- Two thirds of the patients seen had at least one care issue - 40% of which were clinically significant.
- A significant proportion (33%) of patients with clinically significant care issues re-engaged with traditional Primary Care Services after advice from their Community Pharmacist.

This approach process has been extended to Community Pharmacies across the NHSGGC area.

Community Management of Indwelling Catheters

People living with an indwelling urethral catheter often experience catheter related issues, which can be debilitating and affect their quality of life. Research was undertaken across West Dunbartonshire to explore the experience of patients, carers, community nurses and other health and social care staff in relation to urethral catheter issues resulting in callouts. It was a collaboration between the HSCP's District Nursing Service and the School of Health Nursing and Midwifery at University of the West of Scotland.

District nurses recorded data relating to catheterised patients and the incidence of blocked urethral catheters. These data were collected in two localities, Clydebank and Vale of Leven/ Dumbarton, over the same two months. One to one interviews, either face to face or by telephone, were carried out with health and social care staff with a role in managing urethral catheter care in the community, catheterised community living patients and relatives/carers supporting a person with a catheter.

The study found:

- That the most common reasons for callouts related to urethral catheters were bypassing or blockage.
- A wide variety of patient experiences, ranging from those who lived well in terms of catheter management to those whose quality of life was severely reduced.
- That staff reported feeling confident about their roles regarding urethral catheter care, with a strong team ethic evident.
- That patients and their carers reported a lack of available information about how the catheter worked, how best to manage it and what to do if something went wrong.

Based on the findings, an evidenced-based educational resource has been developed focusing on urethral catheters that can be used in the future to inform patients and their carers and potentially empower them to use self-care strategies.

Chronic Pain Primary Care Pilot

Around 18% of the population have chronic pain, potentially reducing quality of life. West Dunbartonshire HSCP and NHSGGC Primary Care Chronic Pain Project piloted a whole system approach to supporting people in the community to manage chronic pain and assess potential patient pathway improvements. This has led to significant developments in how community provision supports people to understand and manage chronic pain.

West Dunbartonshire's testing (October 2014- June 2015) included:

- Pharmacist led pain clinics in GP practices (including a template of core interventions for GP software systems).
- Enhancing MSK physiotherapists' chronic pain management skills.
- A locally available integrated educational programme for patients.
- A core universal education and training programme for health care professionals.
- A community pharmacy chronic pain pilot which provided access to local quality information and review with signposting to appropriate services.
- Chronic Pain training delivered to MSK physiotherapists, GPs and community pharmacies.
- Patient education classes developed and delivered in partnership with Pain Concern.
- Pharmacist-led pain clinics being delivered.

The Community Pharmacist Pain pilot evaluation demonstrated the feasibility of holistic chronic pain reviews in community pharmacy settings, signposting to MSK Physiotherapy, GP practices and education classes. It was shown that pharmacists were satisfactorily resolving issues and supporting patients without re-referral to GPs. Importantly, patients involved have reported that they now manage and understand their pain better. The pilot has now been rolled about across West Dunbartonshire and other areas within NHSGGC.

Identifying and Responding to Frailty

Managing frailty is a key issue for health and social care services. Older people living with frailty are at risk of adverse outcomes following a relatively minor event. This often leads to repeated unscheduled hospital admissions, a need for health and social care services and often leads to a loss of independence.

Building on their good understanding of how frailty is defined and the models for identifying frailty, the HSCP's Community Older People's Team has been undertaking work to identify evidence-based interventions to support individuals with frailty, so as to minimise their risks and improve their outcomes. This work has been taken forward at a *locality* level. It is exploring a system for identifying patients by looking at specific data; and comparing with Anticipatory Care Plans and Case Management cases to identify potential gaps in service for those deemed most frail within our communities.

Four potential groups of patients/clients have been identified:

- Patients 65+ admitted twice or more as an emergency who have not had an assessment (rolling year).
- Patients identified with Intensive Care Needs.
- Patients referred to Day Hospital.

Data was sourced from GP records to identify those with intensive care needs - the data related to patients with more than two admissions; and patients with intensive care needs (10 hours or more per week of home support). These patients were cross referenced with those with Anticipatory Care Plans and who were being case managed. To provide a baseline, a list of patients with no assessment following admission to hospital is being reviewed to look at impact and outcomes for the patient. At the time of writing this report, that analysis was still being undertaken; and the findings are anticipated later in 2016.

<u>Dementia Friendly West Dunbartonshire</u>

Dementia Friendly West Dunbartonshire (DFWD) is a community-led and multi-agency (statutory, independent and third sector) initiative that has improved dementia awareness and support to people living with dementia in local communities. With the anticipated increase in numbers living with dementia in the community, this sustainable approach to supporting people in their homes, neighbourhoods and social networks is crucial. DFWD is increasing community knowledge, identifying signs, challenging stigma and enhancing communication.

DFWD aims to Engage, Educate, Enthuse and Enable the community – so as to:

- Build dementia awareness in the community.
- Develop Dementia Friendly shopping areas involving local retailers.
- Establish a Dementia Awareness trainers network throughout statutory, private and third sector partners

- Support individuals/organisations to pledge enhancements, improving the quality of life for those living in the area.
- Promote community support to people living with dementia for everyday activities (e.g. hobbies, shopping and banking).

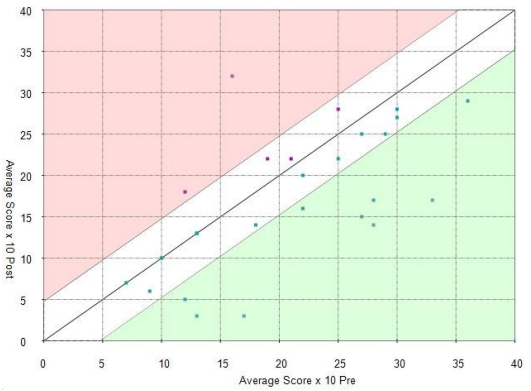
Evaluation through the ISM model (individual, societal, material) saw 143 pledges by stakeholders, identifying three key outcome areas: greater understanding; increased personal confidence of dealing with dementia; and a thirst for knowledge.

Integrated Psychological Therapies Groupwork

Enhanced access to Psychological Therapy programmes across West Dunbartonshire HSCP Mental Health community based services has led to clinically significant improved symptoms for local patients. By implementing a strategic approach to integrating resources across teams and supporting staff skills development through peer mentoring, service users with anxiety, stress and depression have been supported to improve their mental health.

A mapping exercise found that provision was still *ad hoc* – thus some service users did not always receive the best programme for them. Evidence indicates that where people engage in structured programmes, they respond well clinically. Consequently, an annual integrated group programme co-facilitated by multi-disciplinary staff - including Nurses, Occupational Therapists, Social Workers and Psychologists – was developed and implemented. Programmes provided include:

- Cognitive Behavioural Therapy in Action.
- Mindfulness.
- Emotional Skills.
- STEPPS (Systems Training for Emotional Predictability and Problem Solving).



Service user access to evidence based interventions has tripled, with 180 people receiving groupwork between July 2015 and February 2016.

Improved outcomes for participants are monitored and recorded (see example CORE record on left).

The streamlining of processes has led to clients having faster and more direct access and signposting to the right groupwork.

Providing a Community-Based Blood Borne Virus Service

The Scottish Government's Sexual Health & Blood Borne Virus Framework 2015-2020 emphasises that people affected by blood borne viruses – i.e. Hepatitis B, Hepatitis C and HIV - should be able to access the best treatment and care and can lead a healthy life in all senses of the word; and that many people affected by blood borne virus are vulnerable and will have multiple needs.

The West Dunbartonshire HSCP's Blood Borne Virus (BBV) service ensures that, as far as is clinically appropriate, every aspect of the assessment/treatment process is fully facilitated within the community. The team of nurses complete all investigations - which include a Full Health Assessment; Liver Ultrasound; and an innovative approach to determining liver stiffness by performing a Fibroscan.

The assessment and treatment process in itself can be a very stressful time for patients. Anti-viral treatment duration can vary from 8 – 48 weeks. Often the nurses are required to work with patients for several months prior to them commencing anti-viral therapy. It is an essential part of the nurse's role to build a therapeutic relationship throughout the assessment/treatment process to ensure a successful treatment outcome. The team's commitment to supporting patients to successfully complete their treatment includes:

- Regular nurse-led clinic appointments within their local health centre or addiction service.
- A local consultant-led clinic.
- Home visits.
- Easy direct access to nursing staff via telephone (within working hours).
- Liaising with community and hospital-based pharmacies.
- A final assessment undertaken by a consultant in infectious diseases, with access to support from the Community Mental Health Team if required.

The national Sexual Health & Blood Borne Virus Framework 2015-2020 sets out an ambition that "*Scotland should aim to deliver hepatitis C therapy for most infected people in community settings*." The HSCP's Blood Borne Virus (BBV) service is the only community outreach service of its type within the NHSGGC area actively treating chronic Hepatitis C positive patients outwith the hospital setting. During 2015-16, it was providing six weekly nurse-led clinics across West

Dunbartonshire, with an attendance rate of over 70%; and offered 700 return patient appointments. Over 100 previously hard to reach/non-attending patients have been supported to complete treatment, leading to healthier outcomes.

Introducing an Integrated Pathway For Autistic Spectrum Disorder

Autism - or Autism Spectrum Disorder - is a term used to describe a group of lifelong, neuro-developmental disorders marked by impairments in social interaction, impairments in communication and patterns of restricted, stereotyped or repetitive behaviour. Autism Spectrum Disorder covers a broad range of intellectual ability, and some individuals have special areas of exceptional talent whilst others are severely disabled by the disorder and require a high level of support throughout their lives. A significant number of people have learning disabilities and many have mental health problems.

In January 2016 a standardised Integrated Pathway for Autistic Spectrum Disorder (ASD) Service was introduced. This service works within the principles of Getting it Right for Every Child (GIRFEC) and to the relevant SIGN Guidelines. All staff working within the ASD Service work to the standards and quality measurements agreed across NHSGGC; and meet the agreed level of training and competencies required.

Referrals for an ASD assessment can be made by any health professional and educational psychologist. The named person will also have the ability to refer for an assessment. For pre-school children any health professional can refer. Nursery staff for the pre-school child should discuss concerns with the child's Health Visitor or Educational Psychologist who can then refer if appropriate. School-aged children referred for ASD diagnosis by Council Educational Services should have been discussed at the staged intervention meeting with representation from appropriate individuals prior to referral by the Head Teacher (as the Named Person). The Head Teacher should send the single agency assessment information with the referral paperwork. This would reflect all professional opinions and incorporate the views of the parent/carer and child/young person as appropriate. Referrals are received through Specialist Community Paediatric teams and discussed at the weekly Care Co-ordination Meeting. The Care Co-ordination meeting allocates a Pathway Co-ordinator and progress to the ASD Pathway to trigger the ASD Administration process. All pre-school children referred for consideration of an ASD diagnosis enter the Disability Pathway; and any who are subsequently identified as requiring an ASD assessment are allocated by a paediatrician to the ASD Pathway (triggering the ASD Administration Process).

The Child and Adolescent Mental Health Service (CAMHS) referral process is through the existing Choice and Partnership Approach. Importantly diagnosis continues within CAMHS, as these tend to be complex cases where there are co-morbidities; or where the possibility of ASD is raised as part of a complex assessment/formulation of a child's difficulties. The ASD assessment follows the same process as within the Specialist Children's Services ASD Diagnostic Service.

Getting It Right For Every Child

For children and young people to do well now and in the future they have to be safe, healthy, active, nurtured, achieving, responsible, respected and included (SHANARRI wellbeing indicators). These wellbeing indicators are central to the Getting It Right for Every Child (GIRFEC) approach that is currently threaded through all existing legislation, policy, practice and systems for children and young people in Scotland. The Children and Young People (Scotland) Act 2014 was passed in the Scottish Parliament in early 2014 and a number of duties and provisions within this Act will commence in August 2016. Part 4 of the Act requires that relevant authorities, Health Boards for pre-school children and usually Local Authorities for school age children, provide a Named Person service that will integrate the Named Person functions described in the Act into existing roles of practitioners e.g. health visitors and promoted teachers. Amongst other things, the Act will introduce a legal duty to share information about a child's wellbeing that meets specific criteria with their Named Person. This would be when there is a concern for the child's wellbeing. Also the Act introduces a single planning framework for many children receiving targeted support. This approach relies on strong working relationships within individual agencies and across agencies.

In 2015 a number of practices in Clydebank Health Centre nominated themselves to take part in a national pilot in 'Information Sharing between GPs and the Education Named Person Service'. This was led by a GP Child Protection Specialist in conjunction with the HSCP's Head of Children's Health Care and Criminal Justice Services as well as colleagues in Education Services. This pilot has proved to be very effective and has considerably improved the understanding of the roles of different professionals; the amount of involvement education professionals have in the lives of families; and the information already held by schools. It has established trusting relationships and improved information sharing - which has in turn positively impacted on the lives of children, young people and their families (as evidenced by a number of case studies).

This pilot has highlighted that the building and supporting of relationships between GPs and education professionals can lead to better information sharing between two universal services that already identify and support vulnerable families. The findings from this pilot have been shared locally; and also reported at a recent and well-received two day Masterclass held by the Scottish Government GIRFEC team and attended by all 32 Local Authorities.

Child Protection

As at 31st March 2016 there were 28 children on the Child Protection Register (CPR) in West Dunbartonshire, compared with 34 children the year before. This represents a reduction of 17% from last year. The local HSCP-led and multi-agency Child Protection Committee (CPC) monitors the numbers of children on the CPR and the variance over the course of the year. It regularly reviews the prevalence and variation in order to ensure that practice is robust; and to inform the multi-agency Public Protection Chief Officers Group (PPCOG) of the likely reasons for the variance.

A workshop was held in February 2016 with Clydebank Locality Group which looked at child wellbeing and child protection. It included examining levels of vulnerability as associated with the Scottish Index of Multiple Deprivation (SIMD); and the prevalence of domestic abuse and child protection referrals across all practices. In addition there was an analysis of the contributing factors that led to children in West Dunbartonshire being placed on the Child Protection Register (CPR). The overwhelming contributory factor was 'neglect'. It is welcomed therefore that 'neglect' features as one of the main work streams within the recent announcement of the national *Child Protection Improvement Framework*.

One area of particular importance both nationally and locally is the management of Child Sexual Exploitation (CSE). A recent national awareness-raising campaign has highlighted the concerns and the risks posed to children and young people. In West Dunbartonshire a multi-agency CSE Strategy Group has been established. Initially its main focus has been on providing training for staff and sustaining this training through the development of local trainers. Importantly, work has been undertaken to engage with young people directly to involve them in the development of local approaches. Colleagues in Education Services and the HSCP Health Improvement Team are developing inputs for the school curriculum; and through Police Scotland are part of a national pilot within two of the secondary schools. The aim of this pilot – which is at a very early stage - is to develop older pupils in providing mentoring and support to the younger pupils entering the school.

Corporate Parenting

Corporate Parenting has been introduced into legislation through the *Children & Young People (Scotland) Act 2014* to place 'corporate parenting' (the duties of local authorities and other public bodies) on a statutory footing. Prior to the introduction of this legislation, West Dunbartonshire Community Planning Partners had already been focused on embedding a positive Corporate Parenting ethos across all partners. Despite the positive, proactive approach to Corporate Parenting, national statistics show that looked-after young people are more likely to experience difficulties with their mental health, are over represented in the justice and prison services and are at greater risk of both homelessness and unemployment. The HSCP is committed to working in partnership to improve both supports and services and eventual outcomes for all local looked-after children and young people.

Following a successful Community Planning event in the summer of 2015, the West Dunbartonshire Community Planning Corporate Parenting Strategy and Action Plan was refreshed. A Corporate Parenting Board has been established - with the involvement of young people - to act as a sounding board for children and young people to convey the issues that most affect them in their journey through life as a looked-after child or young person. The HSCP recognises that all agencies have a role to play as Corporate Parents and the importance of continuing to raise awareness of this duty, as well as the reasons why this group of children require additional assistance to overcome the difficulties that come with having been looked after.

SHARED LEARNING & COLLECTIVE REFLECTION

As part of implementing its refreshed clinical and care governance arrangements, the HSCP established its local Clinical and Care Governance Forum during the year, bringing together all HSCP senior managers and lead professionals on a quarterly basis, for the purpose of discussing key quality issues; reflecting on learning; and highlighting good practice. These have proven to be vibrant and well-evaluated sessions, as well as providing a valuable opportunity for multi-disciplinary networking and peer support within the HSCP.

The HSCP's refreshed clinical and care governance arrangements also seek to work with general practice and other key stakeholders to promote critical review, learning and development. This is undertaken at a predominantly locality level.

The HSCP supported a series of lunchtime education sessions for GPs and other clinical staff on key educational topics which were aligned to national and locality priorities including antibiotic guidance; asthma; COPD; diabetes; pre-school growth and nutrition; atrial fibrillation and heart failure (in conjunction with the British Heart Foundation).

At a West Dunbartonshire-wide level, the HSCP held its main Protected Learning Event (PLE) on 26th November 2015 at Clydebank Town Hall. Its focus was on physical activity, with the interconnected themes of preventing, improving and restoring. As has also been highlighted, the HSCP continued to work with GP practices and staff to improve child protection arrangements. In February 2016 a workshop was held that brought together the extended multi-disciplinary health and social care team to further develop their collective knowledge and understanding of child protection within the context of Getting it Right For Every Child (GIRFEC) and the Children and Young People Act. The HSCP has committed to build on this and provide Level 3 Child Protection Training annually. The feedback from these sessions proved to be very constructive and will help shape the planning for the local Clinical and Care Governance Symposium that will be arranged for later in 2016-17 (as the successor to the previous West Dunbartonshire-wide PLE).

EXAMPLES OF SECTOR LEADING PRACTICE

- The HSCP's local integrated palliative care programme has been recognized nationally as:
  - A finalist at the *Scottish Health Awards 2015*.
  - The winner of the best integration award at the *NHSScotland Event 2015*.
  - The winner of the Health & Social Care Integration category at the *Herald Society Awards 2015*.

- The HSCP's Youth Mentoring Team won two categories at the *Scottish Mentoring Network Awards*:
  - Justice Project of the Year.
  - Exceptional Contribution Award for Ronnie Rearden, one of our local mentors.

- Pamela McIntyre, the HSCP's lead pharmacist, was recognised with the Leading and Managing for Quality Award at the *Scottish Health Awards*.

- The HSCP's Vitality physical activity programme – a partnership with West Dunbartonshire Leisure Trust - as a finalist in the *Herald Society Awards 2015*.

- The Link Up initiative - a partnership with WD CVS – added to its previous recognitions with a Commendation at the *MJ Local Government Achievement Awards 2015*.

- At the November 2015 *NHSGGC Celebrating Success Staff Awards*, The HSCP's local Care at Home Pharmacy initiative – represented by Pamela McIntyre, Lynne Meldrum and Richard Heard - won the Health Board-wide Improving Health category.

- At the 2015 *NHSGGC Celebrating Success Staff Awards*, the HSCP also commended the following local initiatives, teams and staff:
  - The Young People in Mind Team, represented by Brendan Kelly, Louise Grant, Emma Marshall, Karen Ferguson and Janice Murphy.
  - Angela Sprott for her leadership of our Acquired Brain Injury Team.
  - The Work Connect Initiative, represented by Ingram Wilson and Lorraine Davin.
  - Heather Irving for her work enabling local quality improvement.
  - Our Community Older People's Team, represented by Mary-Angela McKenna, Caroline Thomson, Linda Young, Helen Faye and Hazel Kelly.

- At the March 2016 *WDC Employee Recognition Awards*, the following HSCP initiatives, teams and staff were recognised:
  - Ronnie Reardon (Youth Mentoring Team) - Employee of the Year
  - Sean McAdam (Dumbarton Day Centre) - Young Ambassador Award
  - Mary Angela McKenna (Community Adult Team) - Team Leader of the Year
  - Alternative to Care Team - Team of the Year
  - Hospital Discharge Team - Outstanding Achievement Award

We are conscious that - as always - local progress and improvement is a product of the diligence and energy of a wider team of staff - well done to all involved.