DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

PERFORMANCE MANAGEMENT

AREA COMMITTEE REPORT

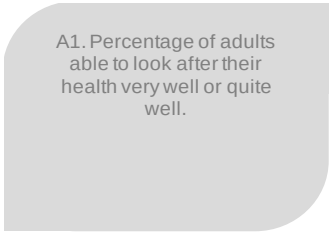
DUMFRIES AND GALLOWAY
Health and Social Care

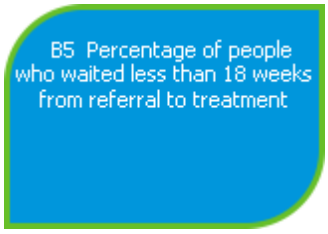
Stewartry

Apr - Sep 2016

Contents

Document Features





At the start of each section there is an overview page summarising the sections content. This is done using 'leaves'.

If the leaf is **grey** then that indicator/measurement has not been included in this edition of the quarterly report. There should be a date on the leaf to indicate when it will be next available. If the leaf is **coloured in** then that indicator/measurement is included in this edition.

The border of the leaf will be coloured according to the following:

Grey – there is insufficient data available at this time to determine whether or not we are being successful in attaining our outcomes.

Green – the indicator or measurement suggests that we are being successful in attaining our outcomes.

Amber – early warning that the indicator or measure suggests that we may not be successful in attaining our outcomes.

Red – the indicator or measure suggests that we have/will not attain our outcomes.

This section indicates which of the 9 National Outcomes for Integration the measurement/indicator supports.

This section indicates which of the 10 Areas of Priority for Dumfries & Galloway as described in the Strategic Plan the measurement/indicator supports.

A recap of the "We Will" commitments from the locality plan that directly relate to the indicator and their Red/Amber/Green status.

Indicators with an "A" code are from the "Core Suite of Integration Indicators" defined by the Scottish Government.
Indicators with a "B" code are the NHS Publically Accountable Measures.
Indicators with a "C" code are the Local Authority Publically Accountable Measures for adult social work services.
Indicators with a "D" code are locally agreed measures.

National Outcomes

The Scottish Government has set out nine national health and well-being outcomes for people. These outcomes are central to the strategic plan and the locality plans in Dumfries & Galloway. They are the long term objectives the Integration Joint Board are striving to achieve.

The progress Dumfries & Galloway is making towards achieving the national outcomes is measured in different ways: quantitative, qualitative, and process measures. Each measure may relate to more than one outcome but it is unlikely that any one measure will indicate progress to all outcomes at the same time. In this report, each measure is mapped to one or more of the national outcomes. Combined these measures provide an overall assessment of Dumfries & Galloway's progress towards these outcomes.

1. People are able to look after and improve their own health and wellbeing and live in good health for longer

2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

3. People who use health and social care services have positive experiences of those services, and have their dignity respected

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

5. Health and social care services contribute to reducing health inequalities

6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing

7. People who use health and social care services are safe from harm

8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

9. Resources are used effectively and efficiently in the provision of health and social care services

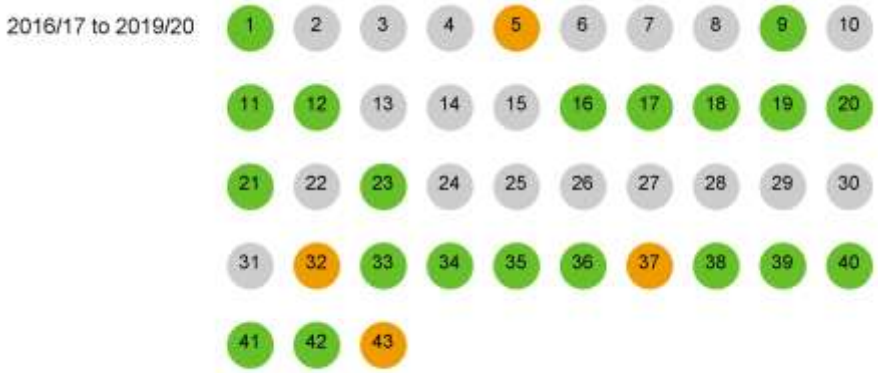
Dumfries & Galloway Priority Areas

To deliver the nine national health and well-being outcomes, the Strategic Plan identified ten priority areas of focus. Each measure in this report is also mapped to one or more of these ten priority areas.

1. Enabling people to have more choice and control
2. Supporting Carers
3. Developing and strengthening communities
4. Making the most of well-being
5. Maintaining safe, high quality care and protecting vulnerable adults
6. Shifting the focus from institutional care to home and community based care
7. Integrated ways of working
8. Reducing health inequalities
9. Working efficiently and effectively
10. Making the best use of technology

Locality Plan "We Will" Commitments

Red/Amber/Green status of each "We Will" commitment in the Stewartry Locality Plan



How RAG (red – amber – green) status is assigned:
Grey = This part of the locality delivery plan is not scheduled to commence yet.
Red = Work on this part of the locality delivery plan is behind schedule/target or has not started as planned.
Amber = Work on this part of the locality delivery plan is slightly behind schedule/target.
Green = Work on this part of the locality delivery plan is on schedule/target.

In the first six months of integration, Stewartry locality has started to move forward 24 out of the 43 'we will' commitments identified in the Stewartry Locality Plan. The amber areas above relate, in the main, to the logistical challenges with non-compatible information and technology systems.

Locality Planning and Development Group: This is the integrated partnership with overarching responsibility for the change programme, ensuring the delivery of the actions developed through the work streams and governance arrangements are being adhered to.

Five work streams have been established within the locality. These work streams and their functions are highlighted below:

1) Integrated Pathways Work Stream
Previously there were 2 work streams; 'Cottage Hospital' and 'One Team'. They have now combined under this 'Integrated Pathways Work Stream' to develop a sustainable model of clinical care. A Flow Team has been established to review delayed discharges and other delays in the health and social care system. Options around a new model of care are currently being developed.

2) Health and Wellbeing Work Stream
This work stream has concentrated on a range of initiatives related to improving health and wellbeing. This has included the introduction of a befriending service and working with day centres to look at a joint approach to future service development. It has also included working with two communities (Auchencairn and New Galloway) to develop assets-based project plans and working in partnership with Loreburn Housing Association in the development of the Galloway Gateway project.

3) Housing Work Stream
This work stream has been involved in the development of the Health and Housing Needs Assessment and is working with the regional housing partnership. In addition, the work stream has worked with stakeholders to establish clearer and prompter communication channels around equipment & adaptations. The work stream has also focussed on developing Technology Enabled Care (TEC) solutions.

4) Workforce and Organisational Development Work Stream
Information has been submitted for sustainability of the 'Healthy Working Lives' Gold Award. Customer service standards are being developed. A staff health and wellbeing plan is also under development.

5) General Practice Cluster
5 GP practices are now working as one 'cluster' (Cluster as defined in the new GP contract). Additional pharmacy support has been allocated to all GP practices in order to improve health outcomes and reduce prescribing spend. There are a number of different posts being recruited to support the work in general practice; Advanced Nurse Practitioners, Mental Health Primary Care Nurse and Psychology Liaison Professionals.

Next Steps Over the next six months Stewartry locality will focus on the following areas:

1) A new model of clinical care fully scoped and ready for appraisal
2) An action plan agreed for day centres
3) A working group will be established to identify health and wellbeing support opportunities and develop a co-ordinated approach to delivery of these
4) In Auchencairn and New Galloway develop Community Health and Wellbeing plans
5) Partnership working with Loreburn Housing Association to support new housing development at School Close 6) Consider further skill mix for GP practices
7) Develop a programme of learning and information events for staff

We envisage that Year 1 will provide us with the detailed information required to make informed decisions that will shape services to meet the needs of the local population and improve outcomes for people in an effective and efficient manner.

Performance Indicator Overview

Clinical and Care Governance

C1 Percentage of adults accessing Telecare of all adults who are supported to live at home

C2 The number of adults accessing Self Directed Support (SDS) Option 1

C4 The number of adults accessing Self Directed Support (SDS) Option 3

C5 Number of Carers receiving support

C6 Percentage of people 65 and over receiving care at home considered to have intensive needs (10 hours or more)

C7 The number of adults under 65 receiving personal care at home

Finance and Resources

C8 Rate of total Home Care hours provided per 1,000 population aged 65 and over

D6 The number of times people access 'virtual services'

Quality

C9 Percentage of referrers receiving feedback on actions taken within 5 days of receipt of adult protection referral

Stakeholder Experience

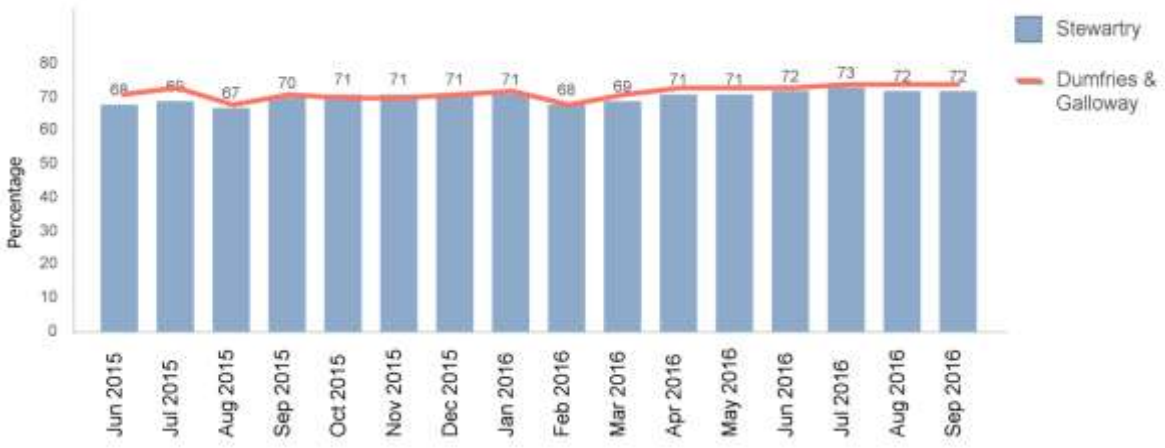
D11 The proportion of Carers who agree they receive the support needed to continue in their caring role

D14 Proportion of people who agree that they were well communicated with and listened to

D15 Proportion of people who are satisfied with local health and social care services

C1 Adults accessing Telecare as a percentage of the total number of adults supported to live at home

Percentage of adults accessing Telecare of all adults who are supported to live at home; Stewartry



Key Points

The percentage of adults supported to live at home who are accessing telecare in Stewartry was 72% in September 2016. Stewartry performance is similar to that of Dumfries & Galloway where 74% of adults supported to live at home access telecare. This rate for Stewartry has remained stable since April 2015.

The Wider Context

Telecare has the potential to enable people to live with greater independence for longer in their own home and release resource that can be used elsewhere. The term 'telecare' includes a wide range of services from Care Call to sensors linked to a 24 hour call centre.

It is recognised that the provision of telecare in Dumfries & Galloway is lower than that for other local authority areas across Scotland. The local authority with the highest rate of uptake achieved 82% according to figures published by the Scottish Government for 2015.

Improvement Actions

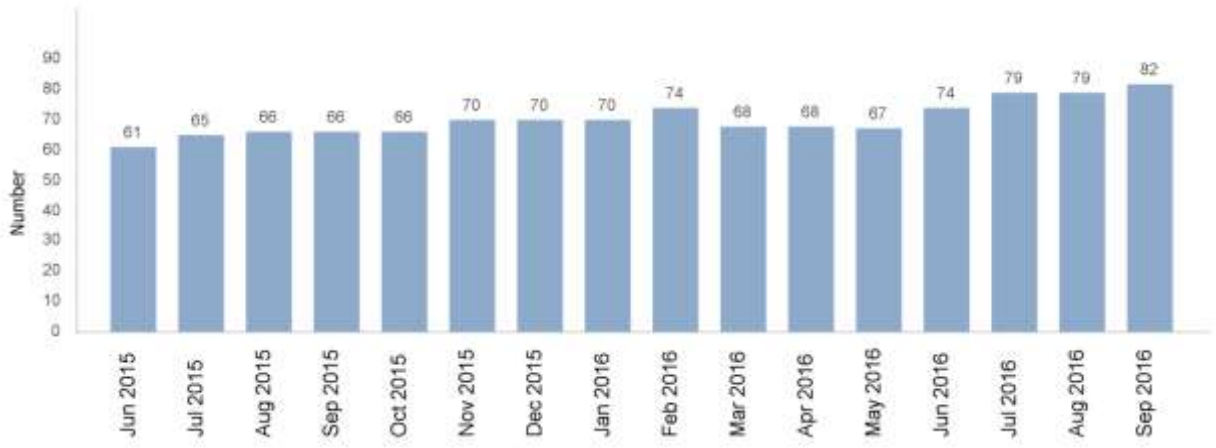
To improve accessibility and awareness of telecare, a team of Telecare Assessor Installers has been established. This team has started to hold education and demonstration events with staff and public including one with the Older People's Consultation Group. They are looking to hold similar events with other stakeholder groups. A new appointment of Technology Enabled Care (TEC) Project Lead was made in September 2016. This post will support the development of technology enabled care across Dumfries & Galloway.

In Stewartry stronger links will be made over the coming months with the Telecare team to ensure the locality team is better informed about the resources available so they can be better promoted to people.

In Stewartry there are challenges relating to responder services following the withdrawal of the Red Cross Volunteer Responders Scheme. Stewartry are currently considering local community solutions through the Health and Wellbeing Workstream.

C2 The number of adults receiving care at home via SDS Option 1

The number of adults accessing Self Directed Support (SDS) Option 1; Stewartry



Key Points

The number of adults from Stewartry receiving care at home through Self Directed Support (SDS) Option 1 was 82 people in September 2016.

This number has steadily increased since May 2016 when there were 67 people from Stewartry receiving care at home through SDS Option 1.

The Wider Context

SDS Option 1 enables people to take ownership and control of purchasing their own care.

Improvement Actions

The regional lead for SDS will be holding events about all the SDS Options available. The events will cover the principles of SDS, outline the challenges in the different locality areas and look at the support available to overcome these.

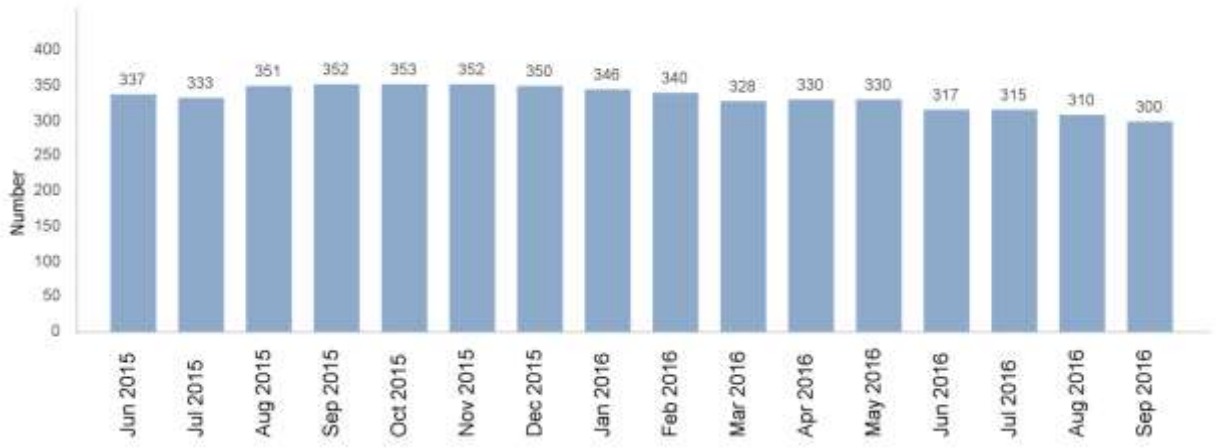
A survey about 'Personal Assistants', to find out the training and support needs of staff that will enable them to advise people more effectively on Option 1, has been sent out by the regional lead for SDS.

An easy read leaflet for SDS will be available in early 2017 for all partners.

To increase the choices available to people in receipt of care and support, work is underway to introduce SDS Option 2 for early 2017. This is when the person chooses the organisation they want to be supported by and the relevant statutory body transfers funding to that organisation who then arrange the care that will meet the person's agreed outcomes. In line with the rest of Scotland it has taken some time to establish how Option 2 will work both within Stewartry and Dumfries & Galloway as a whole. Introducing Option 2 should mean a change in the proportion of people taking Options 1 and Option 3 as people become more familiar and confident with Option 2.

C4 Number of adults receiving care at home (via SDS Option 3)

The number of adults accessing Self Directed Support (SDS) Option 3; Stewartry



Key Points

In September 2016 there were 300 adults from Stewartry receiving care at home through Self Directed Support (SDS) Option 3.

Since a peak in October 2015 when there were 353 people from Stewartry, there has been a 15% decrease in the number of people supported through SDS Option 3. A decrease of 7.6% has been observed across Dumfries & Galloway over the same period.

The Wider Context

SDS Option 3 is where Social Work Services organise and purchase care for people. It is expected that there will be a reduction in the proportion of people who receive care through Option 3 as people become more familiar with purchasing care through Options 1 and 2.

Indicator C2 and Indicator C4 provide different perspectives on the uptake of SDS options. Across Dumfries & Galloway the number of people supported through SDS Option 1 has remained relatively static whereas the number of people supported through SDS Option 3 has steadily declined.

Improvement Actions

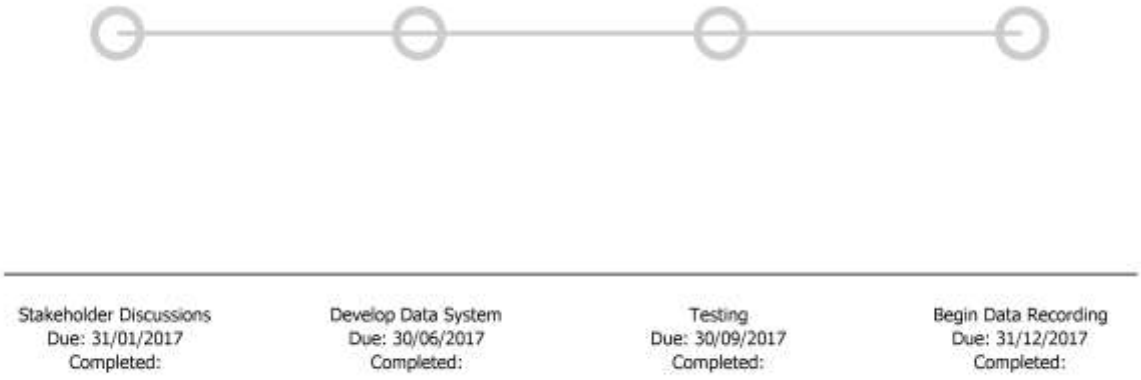
An online Open University Course (SDS KG097) will be made available in January 2017 to develop staff knowledge and skills in relation to SDS. There is an intention to roll this out to other partners in the future following feedback. Staff in Stewartry will be encouraged to sign up for the course.

To increase the choices available to people in receipt of care and support, work is underway to introduce SDS Option 2 for early 2017. This is when the person chooses the organisation they want to be supported by and the relevant statutory body transfers funding to that organisation who then arrange the care that will meet the person's agreed outcomes. In line with the rest of Scotland it has taken some time to establish how Option 2 will work both within Stewartry and Dumfries & Galloway as a whole. Introducing Option 2 should mean a change in the proportion of people taking Options 1 and Option 3 as people become more familiar and confident with Option 2.

C5 Carers receiving support

National Outcomes	Dumfries & Galloway Priority Area	'We Will Commitments
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 10	25 26 27

Number of Carers receiving support; Stewartry



Key Points

Development of this indicator is on schedule.

The Wider Context

There are a number of organisations across Dumfries & Galloway who provide support to Carers. A new Carers Strategy is being developed and this is due to be published in 2017.

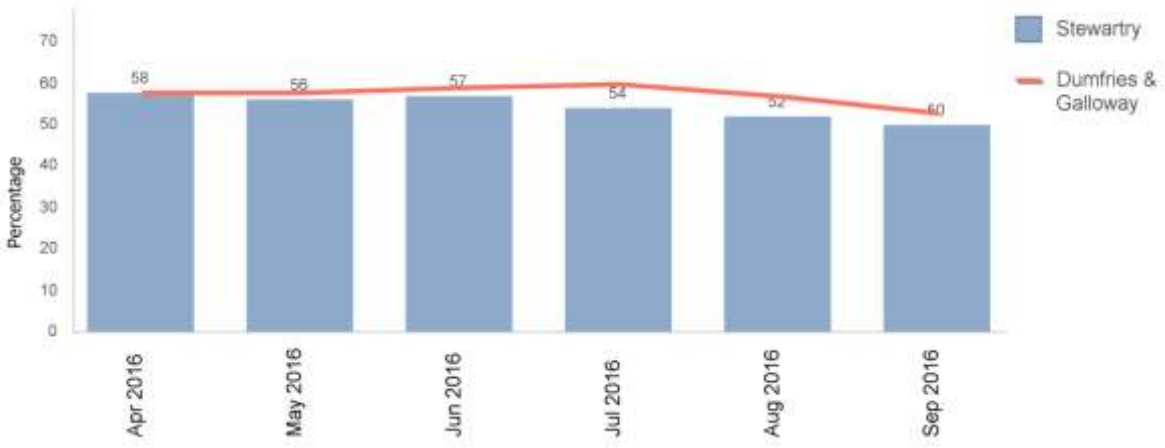
Discussions with organisations that support Carers across Dumfries & Galloway have started regarding how best to capture information for this indicator. Next steps are to agree common definitions in relation to this indicator and to test capturing this information across multiple organisations.

Improvement Actions

Carers will be a priority for Year 2 in Stewartry with a particular focus on Carer's Health and Wellbeing.

C6 Proportion of people 65 and over receiving care at home (via option 3) with intensive care needs

Percentage of people 65 and over receiving care at home considered to have intensive needs (10 hours or more); Stewartry



Key Points

The percentage of people aged 65 and over receiving care at home through Self Direct Support (SDS) Option 3 who have intensive care needs (10 hours or more) from Stewartry was 50% in September 2016. This rate is marginally lower than that seen across Dumfries & Galloway at 53%. It is not clear what the underlying causes for the recent decrease are.

The Wider Context

SDS Option 3 is where Social Work Services organise and purchase care for people. In this context “intensive care needs” is defined as needing 10 or more hours of paid care per week. ‘Personal care’ for people aged 65 and over is free of charge. The denominator for this indicator is the number of people aged 65 and over receiving care at home.

There are a number of factors that may influence the proportion of people receiving an ‘intensive’ level of care at home. Needs may be being met through other means such as attending day centres or receiving care from unpaid Carers. People may have moved to a residential or nursing home setting. Alternatively, there may be an impediment to providing the assessed level of care required such as a lack of care at home capacity/availability in some areas.

Improvement Actions

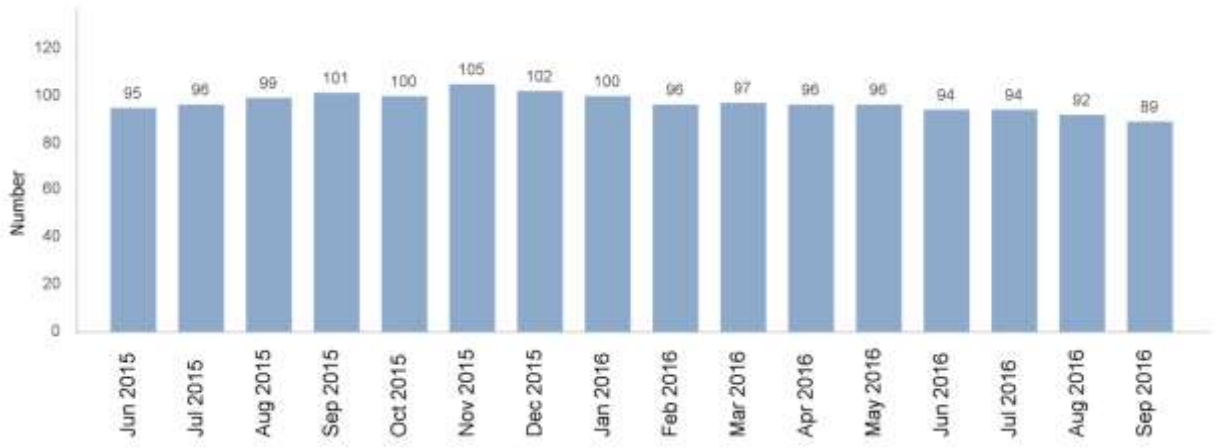
People with intensive care needs receiving care at home are reviewed to ensure the care and support they receive meets their personal outcomes.

The regional lead for SDS will be holding events about all the SDS Options available. The events will cover the principles of SDS, outline the challenges in the different locality areas and look at the support available to overcome these.

An online Open University Course (SDS KG097) will be made available in January 2017 to develop staff knowledge and skills in relation to SDS. There is an intention to roll this out to other partners in the future following feedback. Staff in Stewartry will be encouraged to sign up for the course.

C7 The number of adults under 65 receiving personal care at home (via self-directed support option 3)

The number of adults under 65 receiving personal care at home; Stewartry



Key Points

The number of adults from Stewartry aged under 65 years receiving personal care at home through Self Directed Support (SDS) Option 3 was 89 in September 2016.

Performance against this indicator in Stewartry has been relatively stable since February 2016.

Since November 2015 there has been a 7.2% decrease in the number of adults under 65 receiving care through SDS Option 3. This mirrors the decrease observed under indicator C4.

The Wider Context

SDS Option 3 is where Social Work Services organise and purchase care for people. For people under the age of 65 and depending upon individual financial assessments, personal care may be charged for. There are multiple factors that can influence the number of people under 65 receiving personal care at home: they may be accessing other services such as day care or optimising the use of their own assets to meet their personal outcomes. Alternatively, there may be an impediment to providing the assessed level of care required such as a lack of care at home capacity/availability in some areas.

Improvement Actions

An online Open University Course (SDS KG097) will be made available in January 2017 to develop staff knowledge and skills in relation to SDS. There is an intention to roll this out to other partners in the future following feedback. Staff in Stewartry will be encouraged to sign up for the course.

C8 Total number of Home Care hours provided as a rate per 1,000 population aged 65 and over

Rate of total Home Care hours provided per 1,000 population aged 65 and over; Stewartry

Key Points

In September 2016 the rate of Home Care provision in Stewartry was 363 hours per 1,000 population aged 65 or older.

This rate has fallen each month over the last 6 months in Stewartry.

The rate for Stewartry is persistently lower than the rate observed across Dumfries & Galloway (605 hours per 1,000 population aged 65 or older).

The Wider Context

Across Dumfries & Galloway approximately 1 million hours of Home Care are provided each year.

The results for this indicator are directly influenced by the changing distribution and health of the population in Dumfries & Galloway. As identified in the Strategic Plan, Dumfries & Galloway has an ageing population with the distribution of disease and ill-health changing amongst people aged 65 and over. Increasingly there are more people that are healthy in the 65-75 age group. Consequently, it is expected that the rate of Home Care hours provided per 1,000 population aged over 65 will naturally decrease as these population changes take effect. It is expected that this rate will decrease further as more people take control of their own care needs through SDS Options 1 and 2.

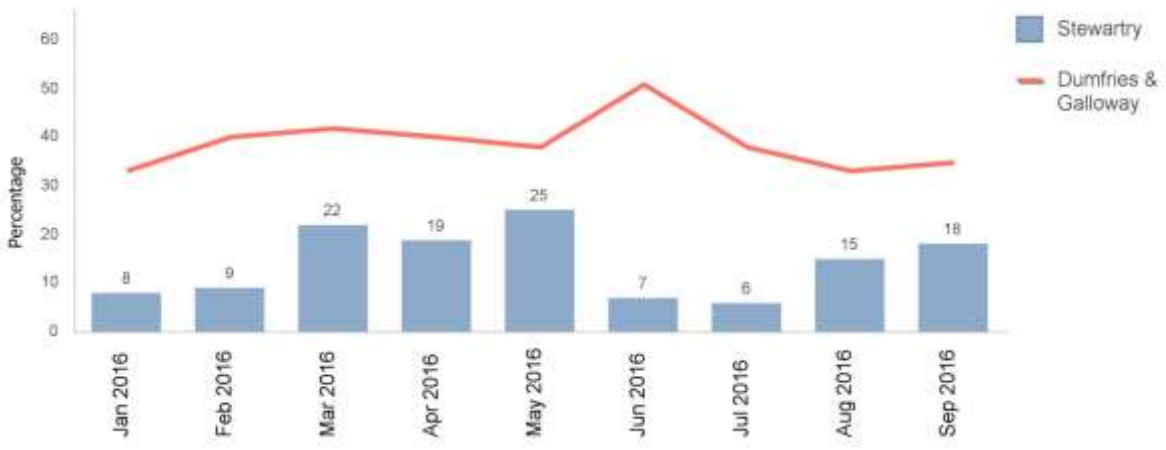
Improvement Actions

No improvement actions required at this time.

C9 Feedback received by referrers on actions taken within 5 days of receipt of adult protection referral

National Outcomes	Dumfries & Galloway Priority Area	'We Will Commitments
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 10	31

Percentage of referrers receiving feedback on actions taken within 5 days of receipt of adult protection referral; Stewartry



Key Points

In September 2016 across Stewartry 18% of referrers to adult protection received feedback within 5 days of receipt of referral. This is lower than the rate observed across Dumfries & Galloway (35%). Despite this, performance in Stewartry has started to improve in recent months.

The Wider Context

Across Stewartry there are typically 15 to 20 adult protection referrals per month. Small numbers such as these can lead to marked variation from month to month. This indicator was introduced in January 2016.

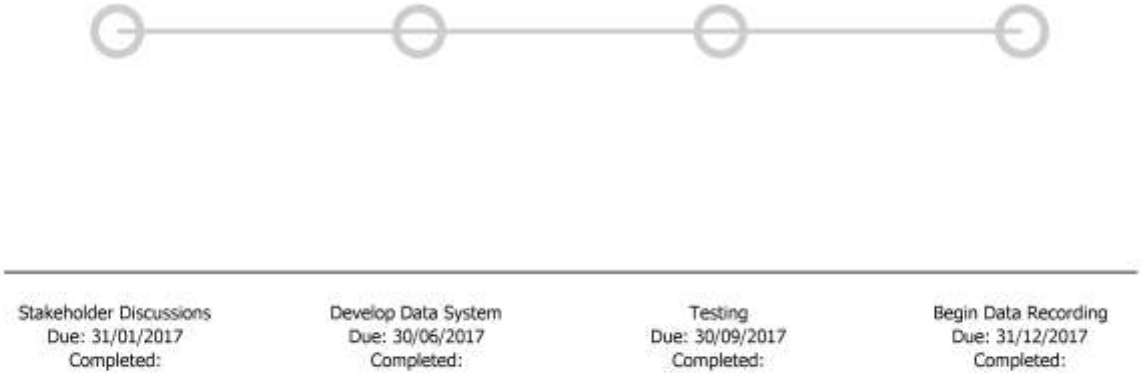
Improvement Actions

Improving the communication between Adult Support and Protection and referrers was identified as a priority through the work of the Adult Services Executive Group and the Adult Support and Protection Committee. In mid September 2016 the Adult Services Multi-Agency Safeguarding Hub (MASH) was established and has been implemented for Annandale & Eskdale and Nithsdale so far. Currently this is run from Crichton Hall however, the intention is to move to police headquarters, Cornwall Mount within the next 3 months to further improve communication and ultimately have a positive impact on outcomes for people. This action is anticipated to result in an immediate improvement in performance against this indicator.

Stewartry will be represented by a member of staff at the MASH as this rolls out.

D6 Technology Enabled Care - Virtual Services

The number of times people access 'virtual services'; Stewartry



Key Points

Development of this indicator is on schedule.

The Wider Context

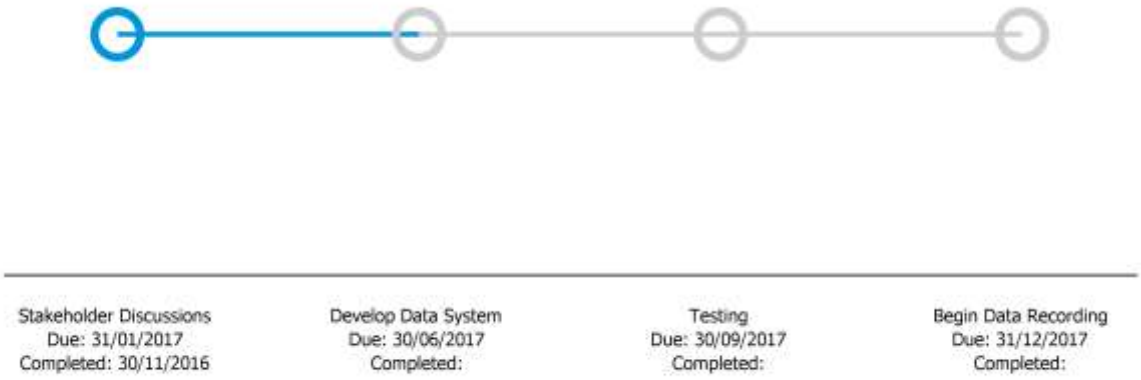
Dumfries & Galloway have made a commitment in the Strategic Plan to develop a Technology Enabled Care (TEC) programme that will explore the use of virtual services, such as text messaging, apps and video conferencing, and their use within health and social care settings.

Improvement Actions

A TEC project lead was appointed in September 2016 and a TEC sub-group of the e-Health Board was established in December 2016. It is anticipated that a TEC programme for Dumfries & Galloway will be developed in 2017 to align with the Scottish Governments TEC Action Plan and the new Digital Health and Care Strategy which is currently in development. In Stewartry pilot projects have been identified and are expected to begin early next year. These will include establishing video conferencing consultations between Castle Douglas Cottage Hospital and Craignair General Practice.

D11 Carers who agree they receive the support needed to continue in theer caring role

The proportion of Carers who agree they receive the support needed to continue in their caring role; Stewartry



Key Points

Development of this indicator is on schedule.

The Wider Context

This indicator has been adapted from a question in the two-yearly Health and Social Care Experience Survey carried out by the Scottish Government. Carers are an important partner in delivering health and social care. It has been agreed that this question should be asked of more Carers, more regularly than currently, to provide better local knowledge of the challenges faced by Carers.

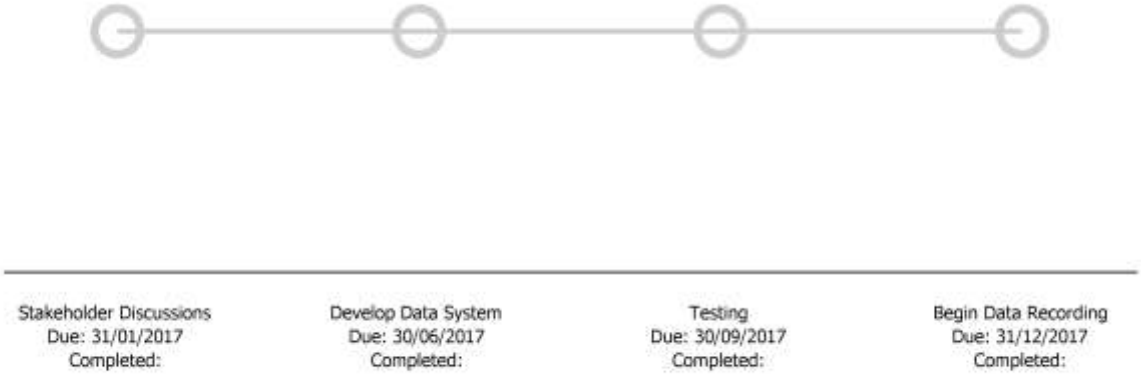
Discussions with organisations that support Carers across Dumfries & Galloway have started regarding how best to capture information for this indicator. Next steps are to agree common definitions in relation to this indicator and to test capturing this information across multiple organisations. Dumfries and Galloway Health and Social Care are collaborating with computing science students from the University of Glasgow to develop a database and tools to collect this data. This includes development of a web-app and a mobile app as well as looking at options to scan paper questionnaires.

Improvement Actions

Carers will be a priority for Year 2 in Stewartry with a particular focus on Carer's Health and Wellbeing.

D14 Well communicated with and listened to

Proportion of people who agree that they were well communicated with and listened to; Stewartry



Key Points

Development of this indicator is on schedule

The Wider Context

This indicator is being developed as part of the new suite of locally agreed indicators for health and social care integration that focus on outcomes for people and their experience of services.

Dumfries and Galloway Health and Social Care is collaborating with computing science students from the University of Glasgow to develop a database and tools to capture people's responses to different "customer satisfaction" style questions such as this indicator. The students are developing web-apps, mobile apps and considering scanning technologies to capture data submitted on paper forms. Suitable settings for testing these new technologies are being identified.

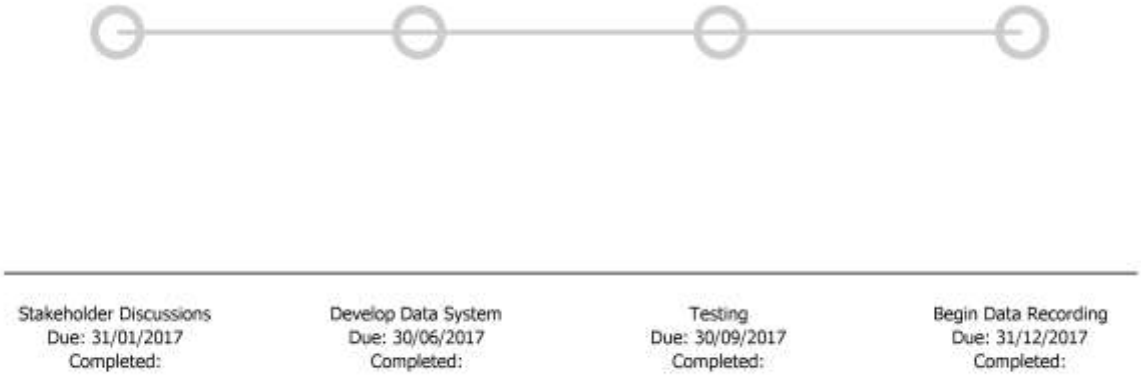
Improvement Actions

Stewartry locality is supporting people who live in Auchencairn and New Galloway to develop community health and wellbeing plans.

The locality team are looking to utilise social media platforms, introduced over the past six months, as a vehicle to capture feedback from staff and the public. The team are also looking to develop feedback mechanisms across the partnership and have recently started early discussions with 'Patient Opinion' on extending their existing system to include social care feedback

D15 Satisfaction with Local Health and Social Care Services

Proportion of people who are satisfied with local health and social care services; Stewartry



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Dumfries and Galloway Health and Social Care is collaborating with computing science students from the University of Glasgow to develop a database and tools to capture people's responses to different "customer satisfaction" style questions such as this indicator. The students are developing web-apps, mobile apps and considering scanning technologies to capture data submitted on paper forms. Suitable settings for testing these new technologies are being identified.

Improvement Actions

In Stewartry customer standards will be produced that will be based on the draft customer standards currently being developed by the Scottish Government.

The team are looking to develop feedback mechanisms across the partnership and have recently started early discussions with 'Patient Opinion' on extending their existing system to include social care feedback. The team are also looking at ways to communicate feedback and learning from the Connecting Quality group through a Stewartry representative.

Appendix 1: Table of “We Wills”

Ref	Description	RAG Status
1	We will further expand the community link approach to support people to become involved in their communities; and work with individuals and our partners to provide relevant information that will allow people to make the best use of local assets to meet their health and wellbeing need.	
2	We will work with staff and partners to explore different approaches to early intervention and ensure staff have the necessary skills and knowledge to adopt these approaches	
3	We will support people to identify potential future health and care needs, and to plan ahead at an earlier stage, where appropriate	
4	We will explore transport initiatives which will allow people to have easy access to support, activities and services in their local community.	
5	We will support the development of a range of community based day services to meet with local need.	
6	We will work with staff and partners to explore different approaches to early intervention and ensure staff have the necessary skills and knowledge to adopt these approaches.	
7	We will encourage people to use self management techniques and build people’s confidence and skills around this.	
8	We will develop approaches which will support early discharge from hospital and prevent hospital admission (e.g. rapid response service / managing conditions in a day case setting.)	
9	We will continue to work towards providing or sourcing appropriate support that enables people to remain in their local communities (e.g. Dementia Friendly communities, Befriending or shopping services).	
10	We will work in partnership with care providers to develop sustainable care at home services which strive to optimise people’s independence and quality of life.	
11	We will take account of housing needs and work with individual and partners to consider housing and support options that will enable independent living.	
12	We will, through our communication and engagement framework, provide a listening platform for people to communicate their views and needs; share learning across the partnership and raise awareness of issues that will influence the design of services.	
13	We will ensure that person centred approaches and a focus on personal outcomes are central to health and social care work; paying attention to protected characteristics and any specific needs thereof.	
14	We will hold conversations with people to identify what really matters to them and help them develop a plan that will enable them to maintain or improve their quality of life and independence	
15	We will promote living well and end of life care in our communities, respecting the needs and wishes of individuals and their families.	

16	We will develop a culture where people using our services can expect a high level of customer service.	
17	We will promote the value of self directed support and person centred care, as it relates to individual outcomes and ensure this is embedded in our practice.	
18	We will develop joint systems and processes (including I.T. systems) across the partnership to improve communication, reduce duplication, promote continuity of care and maximise individual outcomes.	
19	We will explore, in partnership with our GP practices, options in relation to skill mix	
20	We will explore different models of care for out cottage hospitals	
21	We will make sure staff across all sectors are skilled and have the most up-to-date knowledge and information to provide continuously improving support, care and treatment for individuals.	
22	We will work with appropriate partners to address some of the logistical challenges presented to some individuals which prevent universal access to services (e.g. transport links, wheelchair access)	
23	We will further develop links with housing and other specialist service providers to foster approaches which, where possible, present problems from arising (e.g. earlier access to aids and adaptations)	
24	We will identify and work directly with groups and communities identified with specific health challenges.	
25	We will actively identify unpaid carers in our community and within our workforce and signpost them to the most appropriate support.	
26	We will promote the value of the carer's strategy and work with partners and carers to develop solutions to support the health and, wellbeing of unpaid carers and identify alternative support options.	
27	We will explore respite options for carers and identify timely support options that will reduce the need for crisis management.	
28	We will ensure that all staff are trained appropriate to their role in assessing a person's capacity and assessing and managing risks to the person.	
29	We will ensure that all partners are trained in a consistent manner in relation to Adult Support and Protection to enable prompt identification of individuals at risk.	
30	We will work with our wider partners (e.g. Police Scotland and Fire and Rescue) to address issues related to community safety for the most vulnerable members of our communities.	
31	We will explore ways of safely managing the sharing of information across the locality partnership.	
32	We will develop a programme of audits across the partnership which will allow us to regularly monitor and review our performance in the locality	
33	We will use the learning and build upon existing initiatives (e.g. Safer Patient / Adverse incidents) to reduce un-necessary harm to people.	

34	We will actively listen to the views and ideas of staff from across the partnership and keep them updated on the actions we have taken to respond.	
35	We will provide regular information for staff to keep them up to date and abreast of developments in the locality.	
36	We will provide a variety of support mechanisms for staff to access to help them manage the programme of change which is required across the health and social care setting.	
37	We will explore new ways and opportunities to recruit, retain and increase the skills within our existing workforce to meet future need (e.g. new career pathways)	
38	We will identify ways for staff to access the most appropriate information at the most appropriate time to support optimum care giving.	
39	We will work in partnership to develop alternative, sustainable models of care which maximise the use of existing resources.	
40	We will support our workforce in gaining an understanding of the value of working in partnership within an integrated system, and how collective resources can be employed to deliver services; ultimately reducing duplication.	
41	We will continue to introduce and promote prescribing initiatives to ensure safe, appropriate, effective prescribing.	
42	We will regularly review health and social care packages as multi-disciplinary teams to make sure that they are right for the individual, achieve agreed outcomes and promote well-being.	
43	We will maximise the use of technology to reduce waste and duplication in the system.	