DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

PERFORMANCE MANAGEMENT

AREA COMMITTEE REPORT

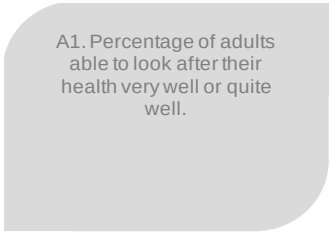
DUMFRIES AND GALLOWAY
Health and Social Care

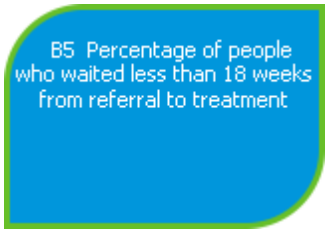
Wigtownshire

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

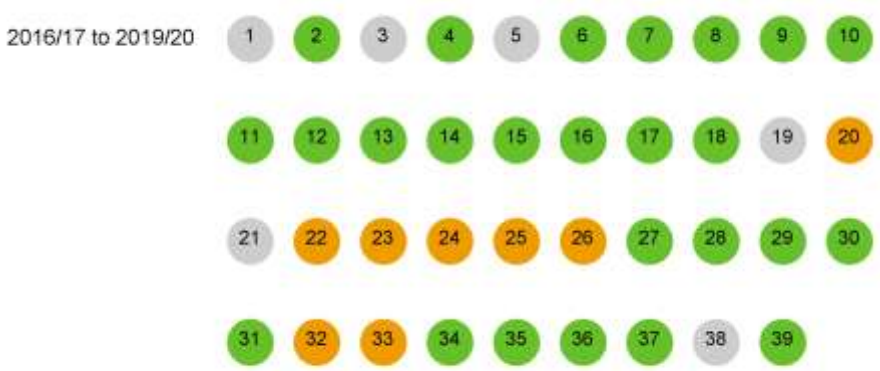
Dumfries & Galloway Priority Areas

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 Wigtownshire 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.

The ambition is to make Wigtownshire's communities the best places to live active, safe and health lives by promoting independence, choice and control. To achieve this requires health and social care professionals, third sector, independent providers and communities across Wigtownshire to work in partnership to create models of care that are pioneering, courageous and innovative. The ihub (Healthcare Improvement Scotland) have supported the locality in developing new contemporary models of care.

The areas of focus for the period April to September 2016 have been:

1) The development of the Health and Social Care Locality Leadership Team. This, more cohesive health and social care management team, will ensure that there is a greater understanding of each other's services and promote integrated Health and Social Care services to the population of Wigtownshire.

2) Developing the local workforce to "grow our own" to overcome the challenges of attracting health and social care applicants from outside the area.

3) Engaging with people who use services through several workshops to focus on the development of a locality action plan to implement the Carers' strategy, transport options for the locality and communications and engagement planning. A dementia workshop is planned for January 2017. 4) The focus of the general practice work stream is to develop new ways of prescribing to the population of Wigtownshire and supporting GPs to develop new ways of working that will sustain the provision of GP services across the locality.

5) Collaborating with independent providers including Loreburn Housing Association and Community Integrated Care Home Provider (CIC) to develop innovative solutions to deliver sustainable services.

General Practice is facing challenges across Scotland. These are magnified across Wigtownshire due to the rurality of the area. Increased workload, increased risk to staff and premises, recruitment and retention are all factors in the challenge to deliver sustainable local GP services. Wigtown and Merrick GP practices have merged to form the new Galloway Hills Practice. General practice requires a team approach relying on clinical and non-clinical staff including medicine, nursing, healthcare assistance and practice

management. The local approach (which is mirrored across Scotland) is to extend this core practice-based team to include additional professionals; initially this will be pharmacy and mental health professionals and advanced nurse practitioners. This is expected to free up GPs to enable them to focus on more complex care and provide more clinical leadership. The locality is developing an extended core practice-based team in Stranraer due to the continued challenge of recruiting GPs.

In line with national trends, prescribing costs continue to rise across the locality. In an attempt to support and enhance access to primary care services the Scottish Government plan to invest £16.2m over three years, to recruit up to 140 whole time equivalent additional pharmacists with advanced clinical skills training across Scotland. They will work directly with GP practices to support the care of people with long term conditions and so free up GP time to spend with other people. By year 3, all of these pharmacists should be independent prescribers with advanced clinical skills. Wigtownshire have appointed two part-time pharmacists who are working with GP practices across the locality including GP services in Stranraer.

The South West of Scotland Transport Partnership (SWESTRANS) have made changes to the way they provide public transport. The Scottish Ambulance Service (SAS) have also made changes to their model of service delivery. As a result of these changes, Wigtownshire Health & Social Care services, in collaboration with the general public, are required to design innovative ways for people to attend appointments and access health and social care and support.

A workshop was held to develop a local action plan focussing on three areas: 1) What people want from transport services 2) Potential pilot projects 3) Participation and engagement.

Engaging with people has provided opportunities to test new ways of attending appointments, including car sharing. Further engagement with communities is required to explore more local solutions.

Partnership working between Wigtownshire Health and Social Care Locality and Loreburn Housing Association has identified a need for a 'Technology Enabled Care (TEC) Equipment and Adaptations Enabler' to assist in the development of transitional support interventions in the locality.

Loreburn has purchased the former Garrick Hospital Site in Stranraer. They are developing a housing, employability, health and social care and digital health skills campus as a response to the regional and locality challenges. The campus will consist of a Young Person's Foyer (with potentially up to 12 flats above a community and employability resource centre) and a Transitional Support Building (TSB) (potentially up to 8 bedrooms in a single storey bungalow style development). This Campus development is due to commence on site summer 2017 and completion and handover in summer 2018.

It is proposed that the TSB will take referrals from both GPs and hospitals and offer a period of Recovery, Rehabilitation and Reablement followed by the Return to home or a homely setting – the four Rs model of Transitional Support. The intended maximum stay is 2 to 3 months with an optimum stay of 1 month. At the optimum stay rate, transitional support can be provided to 96 people per year.

To maximise the opportunity the Garrick Campus TSB offers, there is a need for a 'Transitional Support Enabler'. This will provide an opportunity for key stakeholders to jointly test, trial and develop a suite of TEC solutions, home adaptations and equipment that best meets people's needs in their home environment. This is in keeping with the achievement of National Health and Wellbeing outcome 2.

The Transitional Support Enabler will assist in the development of domiciliary care plans and support Loreburn's major adaptations service, Care & Repair in Dumfries & Galloway. IT will also support major adaptations services for other registered social landlords.

Loreburn and Wigtownshire Health and Social Care locality have identified the former Warden's House at Loreburn's Millburn Court, Sheltered Housing Development, as the preferred location for the Enabler. This property is currently empty and is in the grounds of Millburn Court. The use of 38 Millburn Court is as a 'home from home' pop up show house that will be used for 3 months commencing from 1 January 2017 to show professionals, Carers, customers and families the portfolio of equipment and interventions that can be made in a standard home to support independent living.

The project was also to show innovation and partnership working across the sectors to help deliver national health and wellbeing outcome 2 within Wigtownshire.

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

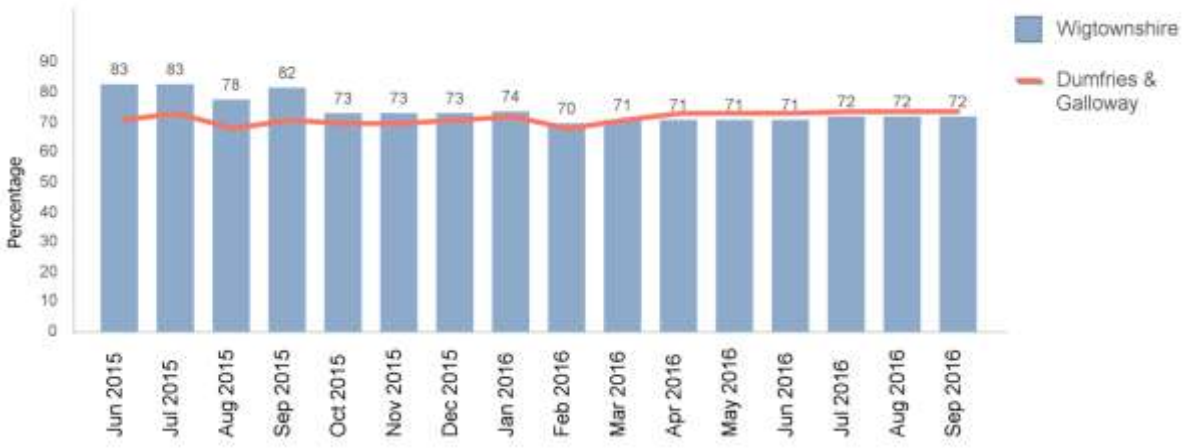
D11 The proportion of Carers who agree they receive the support needed to continue in their caring role

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; Wigtownshire



Key Points

The percentage of adults supported to live at home who are accessing telecare in Wigtownshire was 72% in September 2016 and has remained stable since March 2015. Wigtownshire performance is similar to that of Dumfries & Galloway (74%).

The Wider Context

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

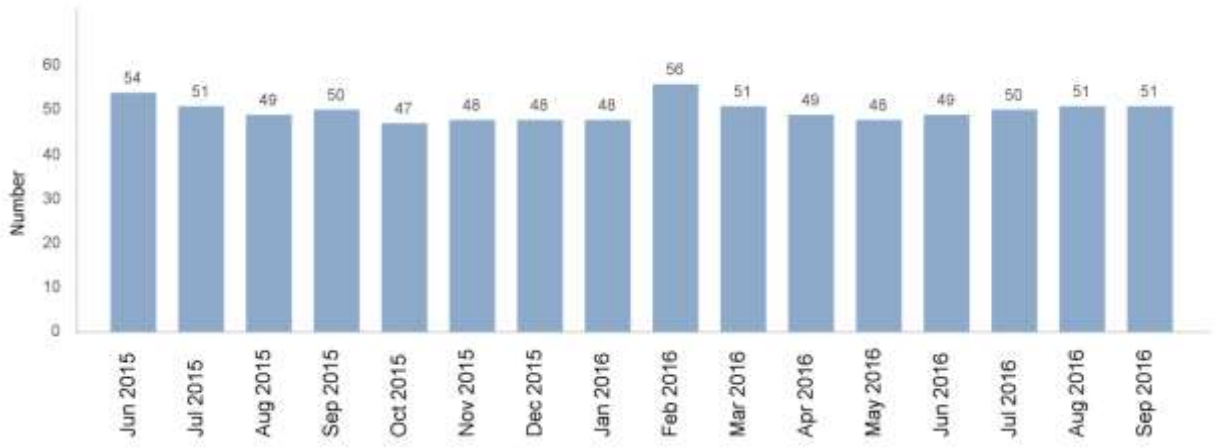
Partnership working between Wigtownshire Health and Social Care Locality and Loreburn Housing Association has identified a need for a Technology Enabled Care (TEC) Equipment and Adaptations Enabler to assist in the development of transitional support interventions in the locality. Loreburn has purchased the former Garrick Hospital Site in Stranraer and is developing a housing, employability, health and social care and digital health skills campus as a response to the regional and locality challenges. The campus will consist of a Young Person's Foyer with potentially up to 12 flats above a community and employability resource centre and a Transitional Support Building (TSB) of potentially up to 8 bedrooms in a single storey bungalow style development.

To maximise the opportunity the Garrick Campus TSB offers, there is a need for a 'Transitional Support Enabler'. This will provide an opportunity for key stakeholders to jointly test, trial and develop a suite of TEC solutions, home adaptations and equipment that best meets people's needs in their home environment. This is in keeping with the achievement of National Health and Wellbeing outcome 2. The pilot will run from January to March 2017.

The Campus development is due to commence on site summer 2017 and completion and handover in summer 2018.

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

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



Key Points

The number of adults from Wigtownshire receiving care at home through Self Directed Support (SDS) Option 1 was 51 people in September 2016.

This number has remained stable since March 2016 when there were also 51 people from Wigtownshire receiving care at home through SDS Option 1.

The Wider Context

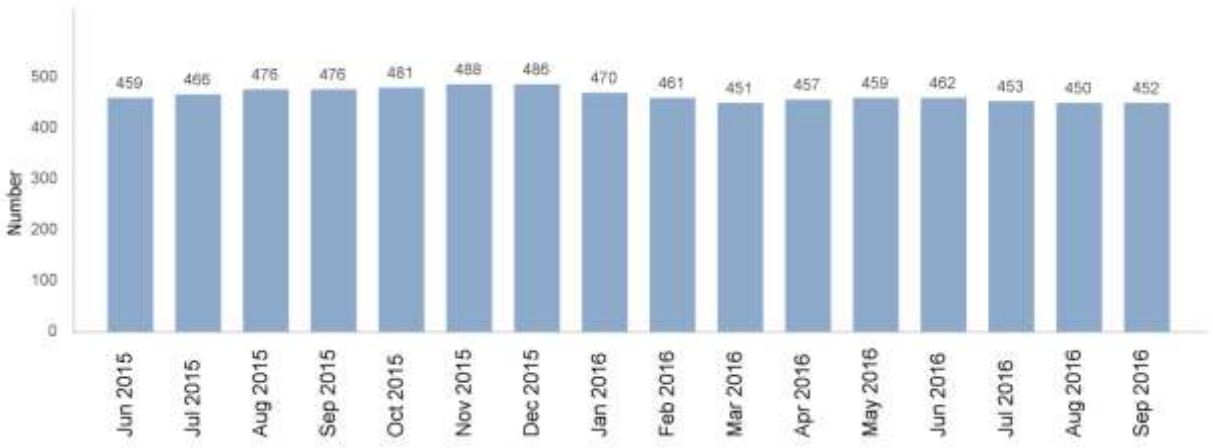
SDS Option 1 enables people to take ownership and control of purchasing their own care.

Improvement Actions

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 Wigtownshire 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; Wigtownshire



Key Points

In September 2016 there were 452 adults from Wigtownshire receiving care at home through Self Directed Support (SDS) Option 3.

Since a peak in November 2015 when there were 488 people from Wigtownshire, there has been a 7.4% decrease in the number of people supported through SDS Option 3. This pattern has been observed across Dumfries & Galloway.

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.

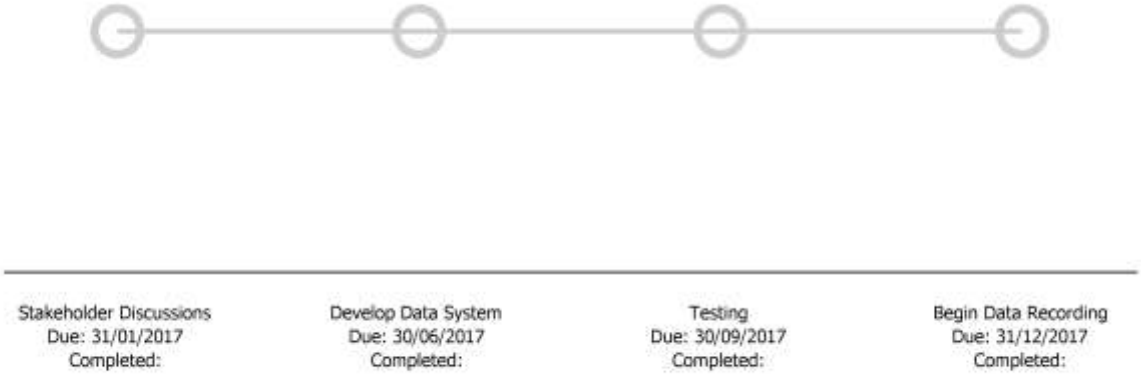
Indicator C2 and Indicator C4 provide different perspectives on the uptake of SDS options. Across Dumfries & Galloway the number of people supported through SDS Option 1 has remained relatively static whereas the number of people supported through SDS Option 3 has steadily declined.

Improvement Actions

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 Wigtownshire 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

Number of Carers receiving support; Wigtownshire



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

A Carers' engagement session was held in November 2016 to consider:

1) How to ensure that all Carers are informed of their rights to an Adult Carer Support Plan (ACSP), previously known as a Carers Assessment, so that the needs of the Carer are identified and addressed in their own right

2) How to identify and promote local services and resources to help improve the quality of life for Carers

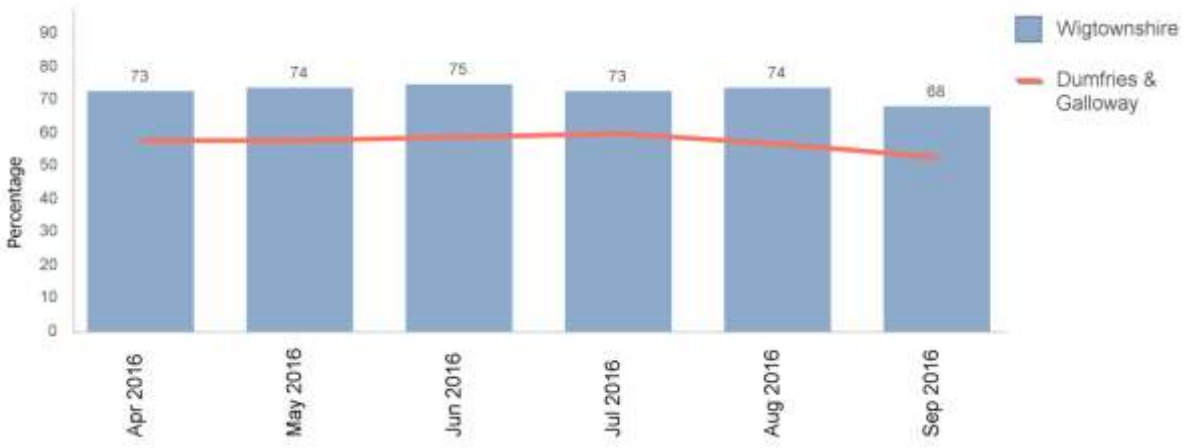
3) How to identify current and potential Carers as soon as possible

4) How to better listen to the views of Carers and take appropriate actions in response

It was recognised that, whilst some work has been taken forward to engage with Carers across each of these four areas, further work is required to support Carers across Wigtownshire. An action plan has been developed that includes a focus on Carer training awareness to be carried out during February 2017.

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); Wigtownshire



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 or more hours) was 53% in September 2016.

The percentage for September 2016 (53%) is a small decrease from the result in July 2016 (60%).

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.

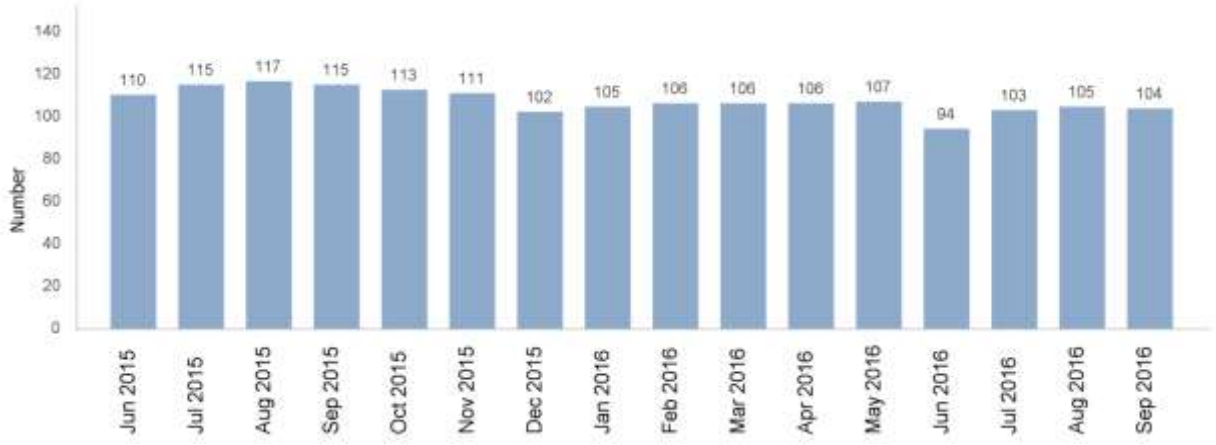
There are a number of factors that may influence the proportion of people receiving an ‘intensive’ level of care at home. Needs may be being met through other means such as attending day centres or receiving care from unpaid Carers. People may have moved to a residential or nursing home setting. Alternatively, 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.

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; Wigtownshire



Key Points

The number of adults from Wigtownshire aged under 65 years receiving personal care at home through Self Directed Support (SDS) Option 3 was 104 in September 2016.

Performance against this indicator in Wigtownshire has been relatively stable since December 2015.

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

Wigtownshire locality continues to encourage people aged under 65 to move to SDS Options 1 or 2 through which they can take more control of their care. The locality team also continues to try to bring people who are currently placed out with the locality back to their home area and this is done on a case by case basis.

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; Wigtownshire

Key Points

In September 2016 the rate of Home Care provision in Wigtownshire was 867 hours per 1,000 population aged 65 or older. This has been a decrease since August 2016.

The rate for Wigtownshire is higher 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

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

Key Points

In September 2016 across Wigtownshire 25% of referrers to adult protection received feedback within 5 days of receipt of referral. Performance against this indicator has dropped significantly in Wigtownshire from 56% in August 2016.

The rate in Wigtownshire is below the rate observed across Dumfries & Galloway (35%) in September 2016.

The Wider Context

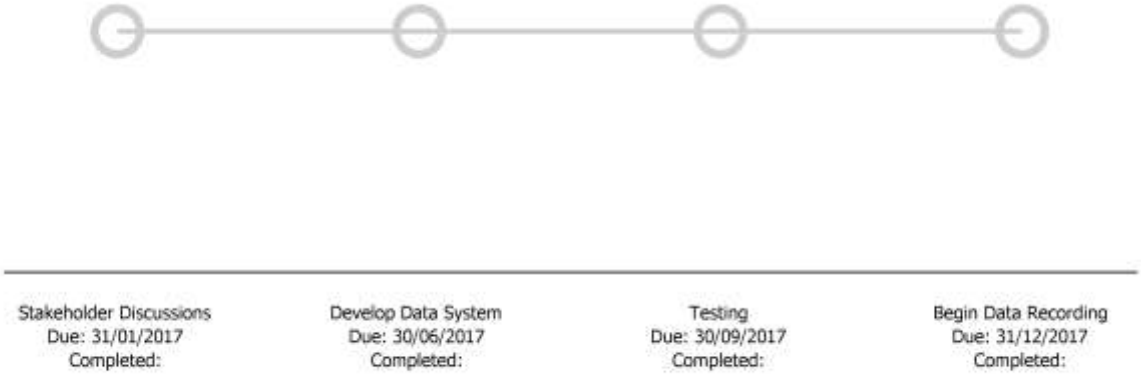
Across Wigtownshire there are typically 20 to 25 adult protection referrals per month. Small numbers such as these can lead to marked variation from month to month. This indicator was introduced in January 2016.

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, which has been implemented for Annandale & Eskdale and Nithsdale so far and further rollout anticipated. 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.

D6 Technology Enabled Care - Virtual Services

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



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.

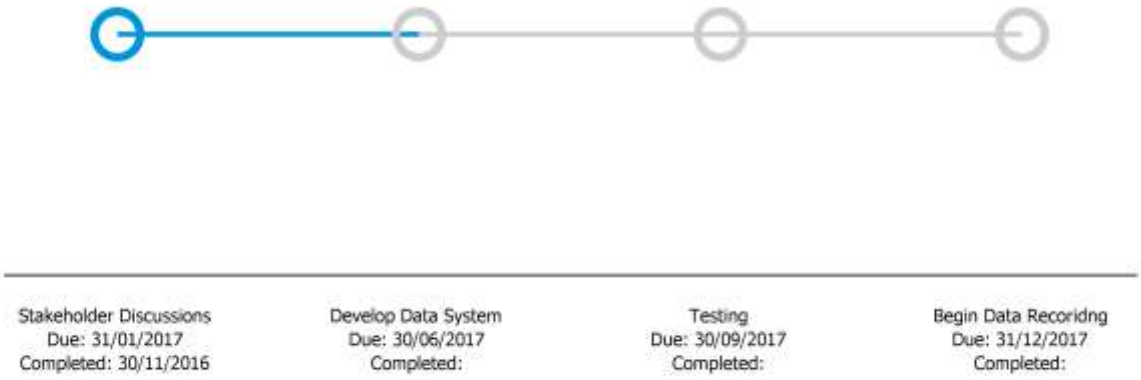
Improvement Actions

Regionally, 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.

Partnership working between Wigtownshire Health and Social Care Locality and Loreburn Housing Association has identified a need for a 'Technology Enabled Care (TEC) Equipment and Adaptations Enabler' to assist in the development of transitional support interventions in the locality. This has the potential to extend the provision of TEC in Wigtownshire. Exploring the use of technology will support the development of primary care services.

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

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



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, 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.

Improvement Actions

A Carers' engagement session was held in November 2016 to consider:

1) How to ensure that all Carers are informed of their rights to an Adult Carer Support Plan (ACSP), previously known as a Carers Assessment, so that the needs of the Carer are identified and addressed in their own right

2) How to identify and promote local services and resources to help improve the quality of life for Carers

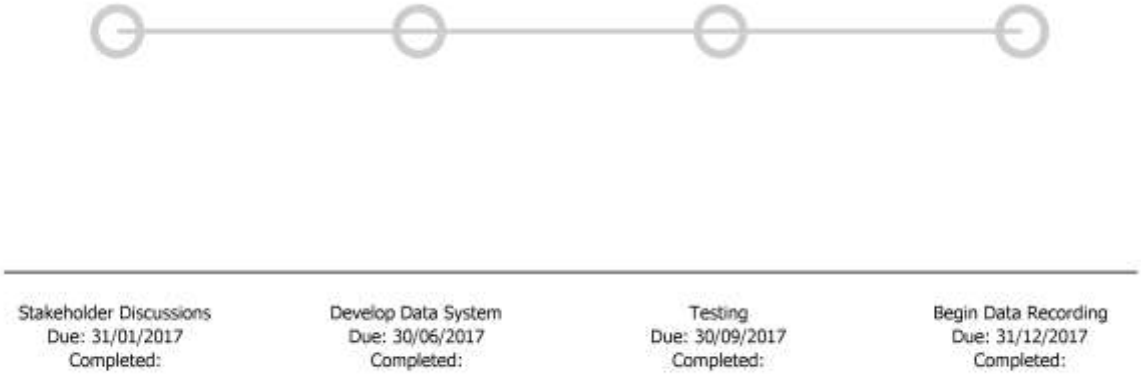
3) How to identify current and potential Carers as soon as possible

4) How to better listen to the views of Carers and take appropriate actions in response

It was recognised that, whilst some work has been taken forward to engage with Carers across each of these four areas, further work is required to support Carers across Wigtownshire. An action plan has been developed that includes a focus on Carer training awareness to be carried out during February 2017.

D14 Well communicated with and listened to

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



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.

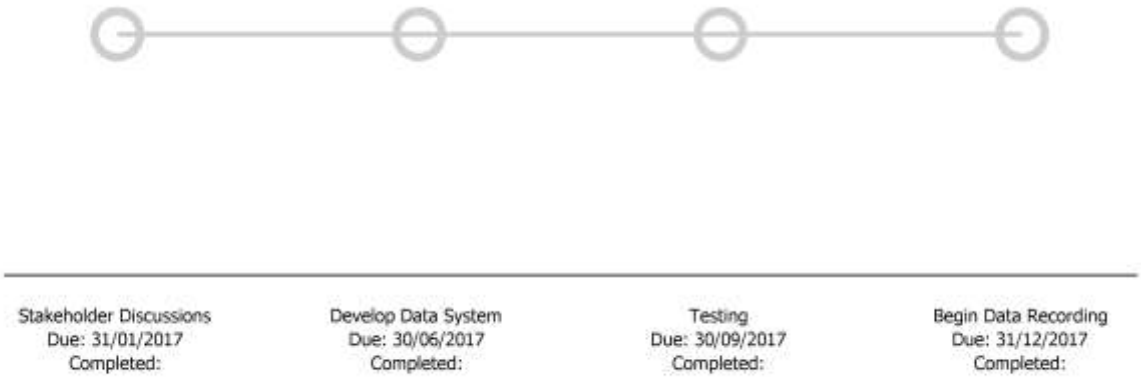
Dumfries and Galloway Health and Social Care is collaborating with computing science students from the University of Glasgow to develop a database and tools to capture people's responses to different "customer satisfaction" style questions such as this indicator. The students are developing web-apps, 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

Engagement with people across Wigtownshire is providing a greater understanding of their views and experiences of health and social care services. Wigtownshire locality will test capturing people's responses to "customer satisfaction" style questions and the technology being developed by the students at the University of Glasgow during 2017.

D15 Satisfaction with Local Health and Social Care Services

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



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

Engagement with people across Wigtownshire is providing a greater understanding of their views and experiences of health and social care services. Wigtownshire locality will test capturing people's responses to "customer satisfaction" style questions and the technology being developed by the students at the University of Glasgow during 2017.

Appendix 1: Table of "We Wills"

Ref	Description	RAG Status
1	Develop information and make this information accessible to people and relevant to their own circumstances so that they can take responsibility for and be in control of their own their own health and wellbeing.	
2	Actively develop alternatives to traditional services to support people to maintain their health and wellbeing -both physical health and mental wellbeing.	
3	Support people to develop their knowledge and skills to lead healthier lifestyles and be more in control of their own health and wellbeing.	
4	Continue to deliver and build on existing initiatives that promote health and wellbeing such as Let's Cook, Walking Groups, living life to the full and Mindfulness.	
5	Ensure that Person Centred Planning, Record Keeping and Risk Assessments are developed in partnership (Outcomes 1: Performance management; 2, Person Centred Planning; 5, Record keeping, D&G Partnership Improvement Action Plan)	
6	Develop the way we work with people and in particular to support people to plan their own care to maintain their health and retain as much personal responsibility and control as possible. This includes supporting people to build and retain their confidence and skills.	
7	Work across all the partners to understand local current and future housing needs so that we can develop a full range of suitable housing options.	
8	Develop our use of assistive technology and other aids and adaptations to support people to be as independent as possible	
9	Ensure that any Operational Service improvement or development is outcome focussed (Outcome 3: Operational Delivery, D&G Partnership Improvement Action Plan)	
10	We will continue to explore ways of ensuring that our care at home and care home provision meets local demand	
11	We will continue to explore and implement approaches to move towards more sustainable Primary Care services, such as the training of Advanced Nurse Practitioners to support GP's. However it is accepted that this alone will not solve the problem, more will be required.	
12	Work together to create "dementia-friendly communities"	
13	Develop and implement approaches to seek feedback from people who use services with a view to better understanding what is working well and what is not working well. Learn from feedback about service and use this to continually improve services	
14	Improve how we monitor, evaluate and manage performance across the whole system. (Outcome 1: Performance Management: D&G Partnership Improvement Action Plan)	

15	Fully implement the principles, values and practice of self-directed support. We will focus on keeping the person at the centre and in control as far as possible of their own of care and support. For example, we will develop approaches to planning for the future with Forward Looking Care Plans and supported self-assessment and care and support plans.	
16	Continue to develop staff across the organisation to support people to be in control and to focus on outcomes for people.	
17	We will build on training and other outcomes focussed training initiatives already underway.	
18	Develop approaches that will evaluate and record outcomes achieved in practice.	
19	Through the provision of appropriate information we will support people to take more control of their own health and wellbeing.	
20	We will begin to set out priorities around addressing health inequalities and seek opportunities to work with other partners across sectors.	
21	We will to begin to address key factors affecting health inequalities, such as employment, education and housing	
22	We will work in partnership with care providers to develop sustainable care at home and care home services which strive to optimise people's independence and quality of life.	
23	Identify current and potential Carers as early as possible;	
24	Listen to the views of Carers and take appropriate action in response	
25	Ensure all Carers are informed of their right to an Adult Carer Support Plan (previously known as Carer Assessment), so that the needs of the Carer are addressed in their own right;	
26	Identify and promote local services and resources to help improve the quality of life of Carers;	
27	Continue to raise "Carer awareness" across our workforce following the Equal Partners in Care core principles.	
28	Promote approaches that help people to be more knowledgeable and aware of their own personal safety and that of others	
29	Ensure that all staff are trained appropriate to their role in assessing a person capacity and assessing and managing risks to the person	
30	Ensure that all partners are trained in and consistently work to agreed Multi-Agency Adult Support and Protection Procedures	
31	Ensure that we learn from adverse incidents of all kinds across services.	
32	Improve communication within and between services and develop working arrangements within multidisciplinary team so that staff across services feel valued and engaged in practice decisions and service developments.	
33	Acknowledge the pressures on staff providing support and care. Develop and implement approaches to seek feedback from staff with a view to better understanding what is working well and what is not working well.	

34	Explore opportunities to address issues about recruitment and retention including how to make care more attractive as a career choice for local people	
35	Work in partnership across sectors and with local communities to develop alternative models of care and support.	
36	Develop a shared understanding of each other's roles and responsibilities across the different sectors including the voluntary sector and community groups and how resources people and finance is currently used	
37	Actively seek to reduce duplication in health and social care provision and explore options as to how we could redesign and develop systems and services to become more efficient and effective.	
38	Actively support people to make the best choices to use services and products supplied by the Partnership effectively and efficiently.	
39	Develop processes to help us to assess and utilise our efficiency and effectiveness, making change where it is required. (Outcome 4: Whole System, , D&G Partnership Improvement Action Plan)	