APPENDIX 1

Annual Performance Report
2022-23

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Outcome 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.

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

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

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1. FOREWORD

Welcome to the seventh Annual Performance Report (APR) by Moray Integration Joint Board (MIJB) on the performance of integrated health and social care provision within Moray.

During 2022-23, we have started to recover from the many challenges created by the coronavirus (COVID-19) pandemic. Service models and methods of delivery have continued to flex and adapt rapidly during this period of transition. Once again, we would like to take this opportunity to recognise and celebrate our workforce, unpaid carers and community volunteers for their unwavering commitment, professionalism and resilience.

This report reflects some of the significant work and continued efforts of our work to recover from the pandemic, with a focus on how we have been taking forward the Health and Social Care Partnership's (HSCP) Strategic Priorities aligned to the nine National Health and Wellbeing Outcomes.

This reports evidences some of our key achievements but also acknowledges the challenges Health and Social Care Moray (HSCM) continues to face. Moray still faces the challenge of an increasing older population, and a decline in the working age population, staff recruitment challenges and a lack of available accommodation against a backdrop of significant financial challenge.

We also review our performance in relation to our key strategic performance indicators and highlight areas of success, as well as where we seek to do better over the next 12 months. Performance in relation to the Scottish Government's core suite of national integration indicators, which allows comparisons to be made over time and with Scotland as a whole, is also presented.

This APR can only ever provide a snapshot of our continuing ambition to work with all partners to transform the planning, design and delivery of health and social care services in Moray so that together we can improve the health and wellbeing of the citizens. It provides the opportunity however, to highlight the progress made, set out the challenges we face, and demonstrate some of our work to tackle the issues that matter to the people we serve.

Dennis Robertson	**Cllr Tracy Colyer**	**Simon Bokor-Ingram**
Chair, Moray Integration Joint Board	Vice Chair, Moray Integration Joint Board	Chief Officer, Health & Social Care Moray

2. PURPOSE OF REPORT

The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Boards to publish an Annual Performance Report, setting out an assessment of performance in planning and carrying out those functions for which they are responsible, as set out in the National Guidance . This is the sixth report for the Health and Social Care Moray Integration Joint Board (MIJB) and within it we look back upon the last year (2022/23). We consider progress in delivering the priorities set out in our Strategic Plan, which was approved ******add date (Partners in Care 2022-32), with key service developments

and achievements from the last twelve months highlighted. Therefore, this report will relate to both Moray Partners in Care 2019-2029 and Partners in Care 2022-32. Within this report, we review our performance against agreed local Key Performance Indicators, as well as in relation to the Core Suite of National Integration Indicators (Appendix B) which have been published by the Scottish Government to measure progress in relation to the National Health and Wellbeing Outcomes (Appendix C).

3. INTRODUCTION

4. Board and Partnership overview

Moray Health and Social Care Partnership ("the Partnership" / "HSCM") formed as the Integrated Authority in April 2015, formally bringing together health and care services in Moray. The Partnership includes the full range of community health and care services. The Partnership is a large and complex organization, bringing together a range of partners, services and significant financial resources. It is responsible for achieving local and national objectives, therefore it is important to publicly report on how we are performing against the agreed outcomes we aspire to. The Partnership's work and ambitions align with strategic plan, Partners in Care 2022-32.

Moray Integration Joint Board (MIJB) is a distinct legal entity created by Scottish Ministers and became operational in April 2016. Under the Public Bodies (Joint Working) (Scotland) Act 2014, Moray Council and Grampian NHS Board are legally required to delegate some of their functions to the Integration Joint Board.

These services include:

- Social care services;
- Primary care services, including GPs and community nursing
- Allied health professionals such as occupational therapists, psychologists and physiotherapists
- Community hospitals
- Public health
- Community dental, ophthalmic and pharmaceutical services
- Unscheduled care services;
- Support for unpaid carers.
- Children and Families Social Work and Justice Services are delegated from April 2023 and will be included in this report for the year 2023-2024.

Services hosted by Moray for all of Grampian:

- Primary Care Contractors
- GMED

Children and Families Health Services `hosted` within the Board's Scheme of Integration include: Health Visiting; School Nursing; and Allied Health Professions, i.e. Occupational Therapy, Physiotherapy and Speech and Language Therapy.

The board also has delegated responsibility for the strategic planning of unscheduled care delivered in emergency situations such as A&E, acute medicine and geriatric medicine at Dr Gray's Hospital and Aberdeen Royal Infirmary (ARI). Further information on the health and social care services and functions delegated to the Moray MIJB are set out within the Scheme of Integration.

The MIJB's role is to set the strategic direction for functions delegated to it and to deliver the priorities set out in its Strategic Plan. Moray Council and Grampian Health Board contribute a defined level of financial resource, which together forms the Moray Integration Joint Board's budget to enable delivery of local strategic outcomes for health and social care. The Board gives directions to the council and health board as to how they must carry out their business to secure delivery of the Strategic Plan. The legislation requires the MIJB to appoint a Chief Officer who is responsible for the strategic planning, budgetary management, performance, and governance arrangements for all integrated services. The Chief Officer works collaboratively with the Senior Management Teams of Moray Council and NHS Grampian and provides a single senior point of overall strategic leadership for the employees in the Moray Health and Social Care Partnership. The Chief Officer is supported by the partnership's Senior Management Team and System Leadership Group.

In addition to directly providing services, the Partnership also contracts for health and social care services from a range of partners, including Third and Independent sector organisations. Within primary care services, a range of independent contractors, including GPs, Dentists, Optometrists and Pharmacists, are also contracted for by the Health Board, within the context of a national framework.

5. The Moray area profile is included at Appendix A.

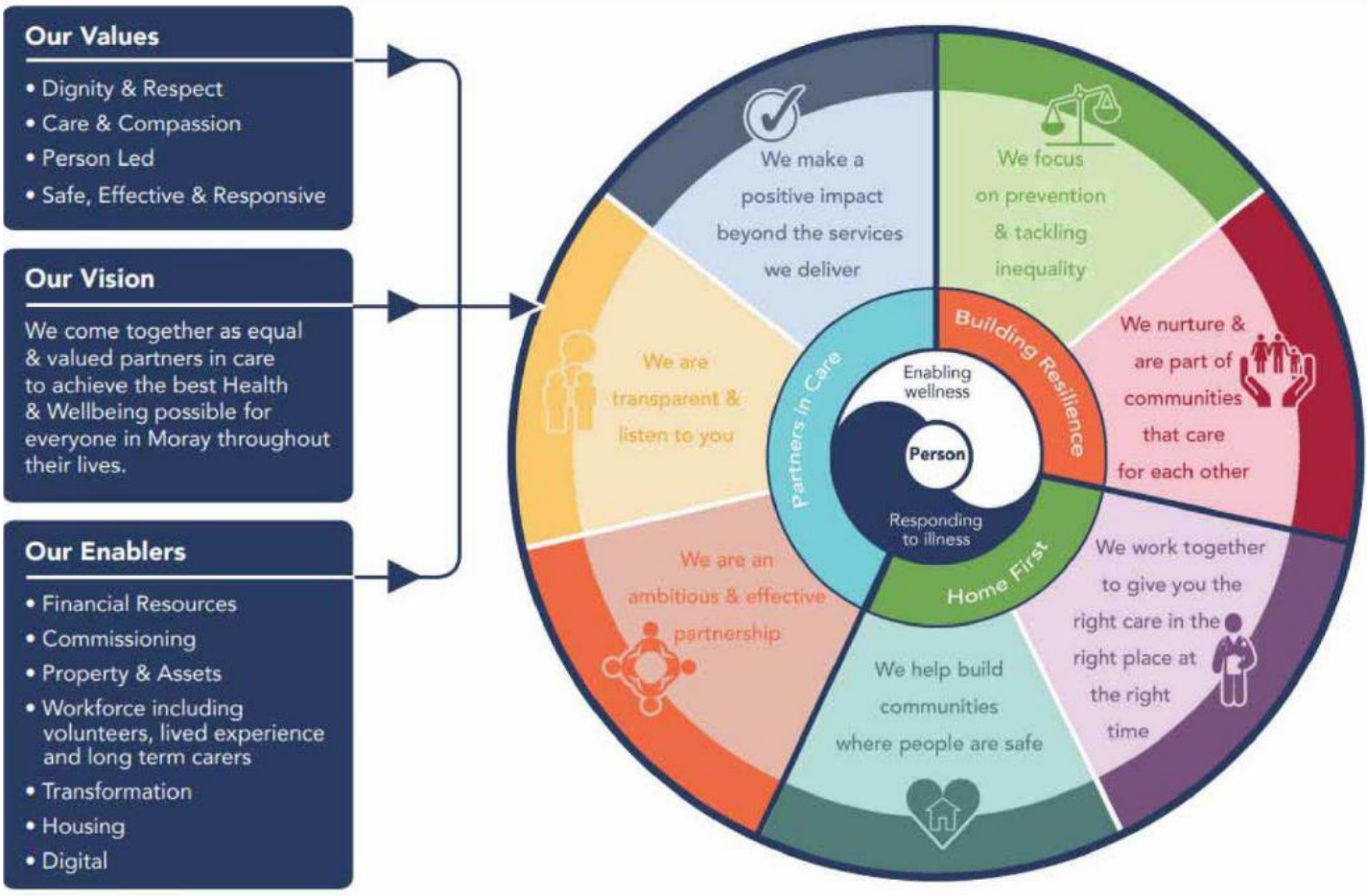
6. Strategic Plan – vision and priorities

The MIJB is required to review their Strategic Plan every three years as per the legislation, with a decision taken on whether to replace the existing Plan. The Strategic Plan 2019-2029 was widely consulted to create an ambitious 10-year Plan for Moray. In preparing to refresh MIJB Strategic Plan, it should be noted that engagement activities have helped inform and gain an understanding of Moray citizen's aspirations. This has been through engagement with citizens as part of locality network events, the development of the NHS Grampian Plan for the Future, Dr Gray's Hospital Strategy. This is in addition to informal citizen feedback from existing networks including the Carers Network and Older People groups.

It was recognised that the health and social care landscape has changed but the 2019 Plan purposefully placed an emphasis on prevention and early intervention with the aim of building resilience for individuals and communities. The Plan identified key aims of the MIJB and directed HSCM to work closely with communities and key partners to reform the system of health and social care in Moray. It was also recognised that progress has been made against the three strategic themes and the review of the Plan focused on what already has been achieved.

Therefore, the MIJB Strategic Plan 2022-2032 is a continuation of the 2019 Plan and the long-term strategic objectives make room for adapting to challenges and developments in health and social care over the coming years. To deliver on these objectives a 12-month Delivery Plan is under development.

Health and social care services are delivered by Health & Social Care Moray and partners as directed by the Board to deliver the ambitions set out in the Strategic Plan. The current Strategic Plan sets out the following vision and priorities for health and social care services in Moray.



Health and Social Care Moray's strategic plan sets out the 3 key themes and the objectives;

Building Resilience – supporting people to take greater responsibility for their health and wellbeing
- focusing on prevention and tacking inequality
- nurturing and an integral part of communities that care for each other.

Home First; supporting people at home or in a homely setting as far as possible.
- working to give citizens of Moray the right care in the right place at the right time
- building communities where people are safe.

Partners in Care – supporting citizens to make choices and take control of their care and support.
- to work in partnership with all.
- listen to what citizens are telling us and be transparent in our decision making and communications.
- ensuring we make a positive impact beyond the services being delivered.

A number of strategic commissioning plans are in place to improve outcomes for supported people who experience additional challenges to their health and wellbeing. These are:

- People who are unpaid carers
- Older people

- People with dementia
- People with autism
- People with physical and sensory disabilities
- People with mental health issues
- People with a learning disability
- People with alcohol and drug issues

MEASURING PERFORMANCE UNDER INTEGRATION

National Indicators are included in APPENDIX B

Since January 2018, HSCM has been working to local objectives and trajectories set out by the Ministerial Strategic Group for Health and Community Care (MSG), for improvement in relation to key performance indicators which aim to provide a whole system overview of performance. Analysis and interpretation regarding our performance against the MSG measures are included within this report. The MSG information incorporates a range of activities under the umbrella of 'unscheduled care', that support people to remain in their own homes, return to their own homes as quickly as possible when hospital treatment is required, prevention of related re-admission to hospital and end-of-life care. Unscheduled care is a core element of the health and social care system and as such, our services require to be responsive to need whilst being transformative in that, where appropriate.

Reports aligned with the MSG indicators are presented quarterly. The reports are scrutinized by HSCM's Performance Management Group, Senior Management Team and Senior Leadership Group before being presented before being presented to the MIJB and Audit, Performance and Risk Committee.

The MIJB, its committees and Senior Management Team also receive regular assurance reports and updates on how the Strategic Plan commitments are being progressed through work streams and individual service plans, as well as detailed financial updates.

The strategic risk register is reviewed regularly by the Senior Management Team as part of a robust risk monitoring framework in order to identify, assess and prioritise risks related to the delivery of services, particularly any which are likely to affect the delivery of the Strategic Plan.

The inherent risks being faced by the Moray MIJB, together with a current assessment on the level of the risks and mitigating actions being taken to reduce the impact of the risks, is reported to each meeting of the Audit Performance and Risk Committee for oversight and assurance.

Management teams and the Care and Clinical Governance Group also review and respond to any reports produced by Audit Scotland, Healthcare Improvement Scotland, the Care Inspectorate, and the Mental Welfare Commission for Scotland and the Ministerial Strategic Group for Health and Care.

Performance within Health and Social Care Moray is reported quarterly to the Moray Integration Joint Board. The table below presents the status of the indicators at year-end for the past 3 years.

It should also be noted that the figures presented below continue to reflect the recovery from the impact of the Covid-19 pandemic. This is also reflected in the performance of other areas throughout Scotland during this period.

RAG scoring based on the following criteria:	
GREEN	If Moray is performing better than target.
AMBER	If Moray is performing worse than target but within agreed tolerance.
RED	If Moray is performing worse than target by more than agreed tolerance.

Indicator	2020/21 (Q4)	2021/22 (Q4)	2022/23 (Q4)	Target
A&E Attendance rate per 1000 population (all ages)	17.8	20.2	20.6	21.7
The number of people presented at A&E in quarter 4 had only slightly increased from the previous year. The trend over the past 6 months has shown a slight decrease and hopefully this downward trend will continue to pre-pandemic levels.				
Number of delayed discharges (Inc. code 9) at census point	17	46	26	10
The number of people waiting to be discharged from hospital has reduced again in quarter 4 to 26. This is the lowest since August 2021 and indications are that this will continue to improve into 2023/24.				
Number of bed days occupied by delayed discharges (incl. code 9) at census point	496	1294	751	304
The number of bed days occupied has reduced again in quarter 4 to 751. This is the lowest since August 2021 and indications are that this will continue to improve into 2023/24.				
Rate of emergency occupied bed days for over 65s per 1000 population	1773	2140	2749	2037
The steady monthly increase in the rate of emergency occupied bed days for over 65s. Since 2021/22 the rate has increased from 2,140 to 2,749, exceeding the target of 2,037 per 1,000 population.				
Emergency admission rate per 1000 population for over 65's	174.8	183.0	185.8	179.9
The emergency admission rate per 1000 population for over 65s has increased slightly from 183 to 185.8, also slightly above the target of 179.9.				
Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	119.3	125.2	129.2	123.4
The number of people over 65 admitted to hospital in an emergency increased slightly from 125.2 to 129.2, slightly above the target figure.				
% Emergency readmissions to hospital within 7 days of discharge	5.0%	3.4%	3.6%	4.2%
The readmissions have increased slightly from 2021/22, however, they still remain less than the target.				

% Emergency readmissions to hospital within 28 days of discharge	9.8%	8.0%	7.5	8.4%
The 28 day readmissions remain improved at 7.5%, and better than target set.				
% of patients commencing Psychological Therapy Treatment within 18 weeks of referral	100%	33%	73%	90%
The number of patients being referred within 18 weeks continues to improve, albeit not yet back to target rates of 90%				
NHS Sickness Absence (%of hours lost)	3.1%	4.7%	5.9%	4%
Staff sickness levels have increased above the target of 4%. It is hoped that with the various staff wellbeing programmes now being in place and as the pandemic recovery continues, that this will now begin to improve.				
Council Sickness Absence (% of calendar days lost)	-	8.9%	9.7%	4%
Staff sickness levels have doubled above the target of 4%. It is hoped that with the various staff wellbeing programmes now being in place and as the pandemic recovery continues, that this will now being to improve.				

Delayed discharges and unmet need for residents requiring support living at home, or residential care, still remain significant challenges for the partnership. The number of people who are clinically safe to leave hospital but are delayed in leaving while appropriate care arrangements are put in place rose to over 50 at the start of the year, but since then the number affected has steadily reduced, although there were still more than double the target of 10 people waiting to be discharged at the end of 2022/23.

Whilst the number of delayed discharge bed days still remains more than double the pre-pandemic period, significant improvement can be recognised. This is due to the significant effort and resource that has been focused on this issue. The Home First and Discharge to Assess plans have played a significant role in this continued improvement.

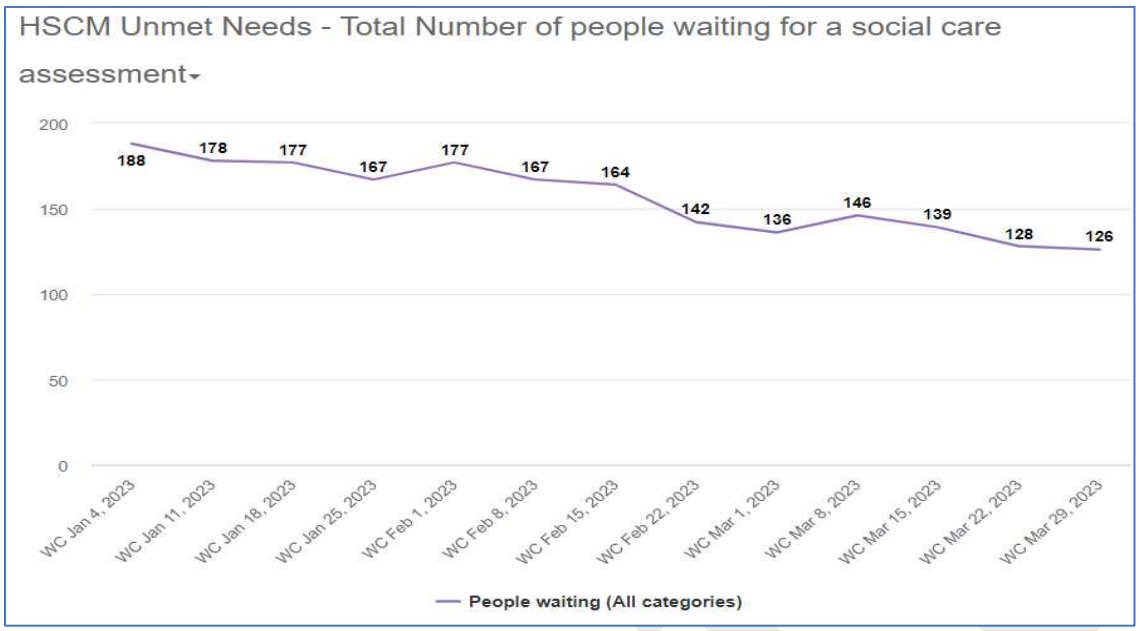
Our performance in 2022-23

We continue to work with our partners across Moray and Grampian to improve services, promote health and wellbeing and prevent ill-health and increase healthy life expectancy.

Key development and achievements

Care home occupancy rates are typically above 99% in Moray, with typically 3 to 5 free beds available on any day, providing few options for people awaiting to be discharged from hospital. This situation is compounded by the lack of care service provision, which has consistently struggled to match demand, even before the impact of the COVID-19 pandemic.

Since January 2023, the number of people waiting for a social care assessment has reduced from 188 to 126 at the end of March 2023. The figures before this date are unreliable, as there was a change in process that resulted in assessments being recorded separately. This has now been resolved and the figures have been corrected back to the start of 2023.


HSCM Unmet Needs - Total Number of people waiting for a social care assessment
200
150
100
50
0
188
178
177
167
177
167
164
142
136
146
139
128
126
WC Jan 4, 2023
WC Jan 11, 2023
WC Jan 18, 2023
WC Jan 25, 2023
WC Feb 1, 2023
WC Feb 8, 2023
WC Feb 15, 2023
WC Feb 22, 2023
WC Mar 1, 2023
WC Mar 8, 2023
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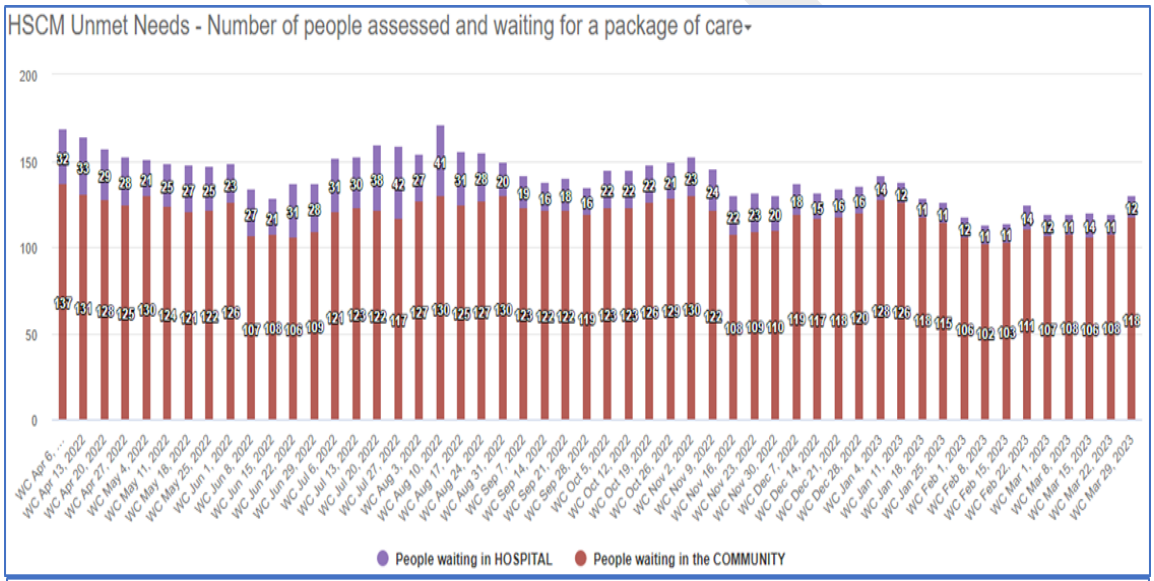
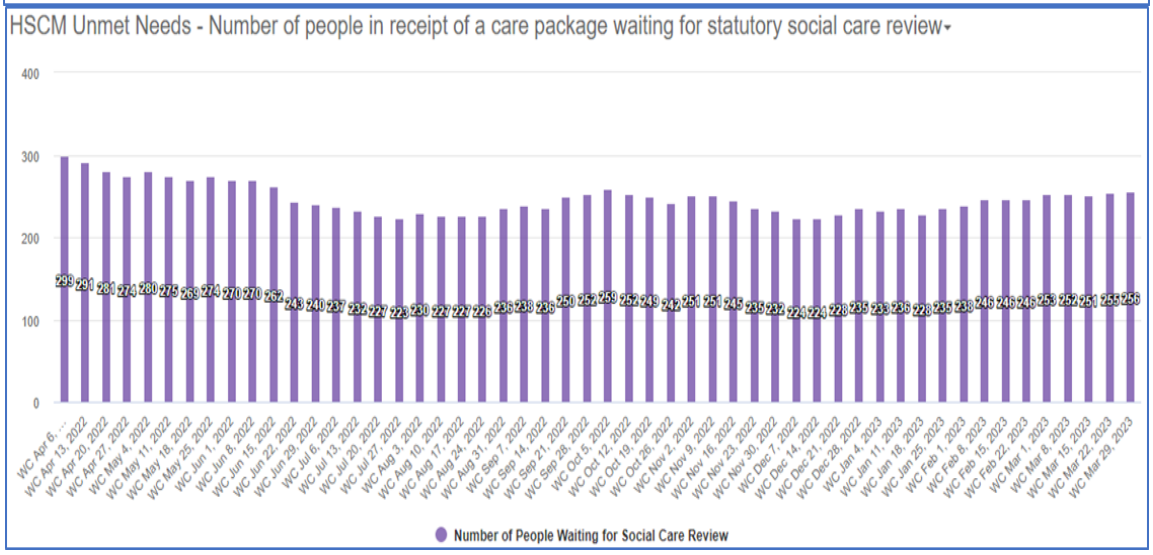
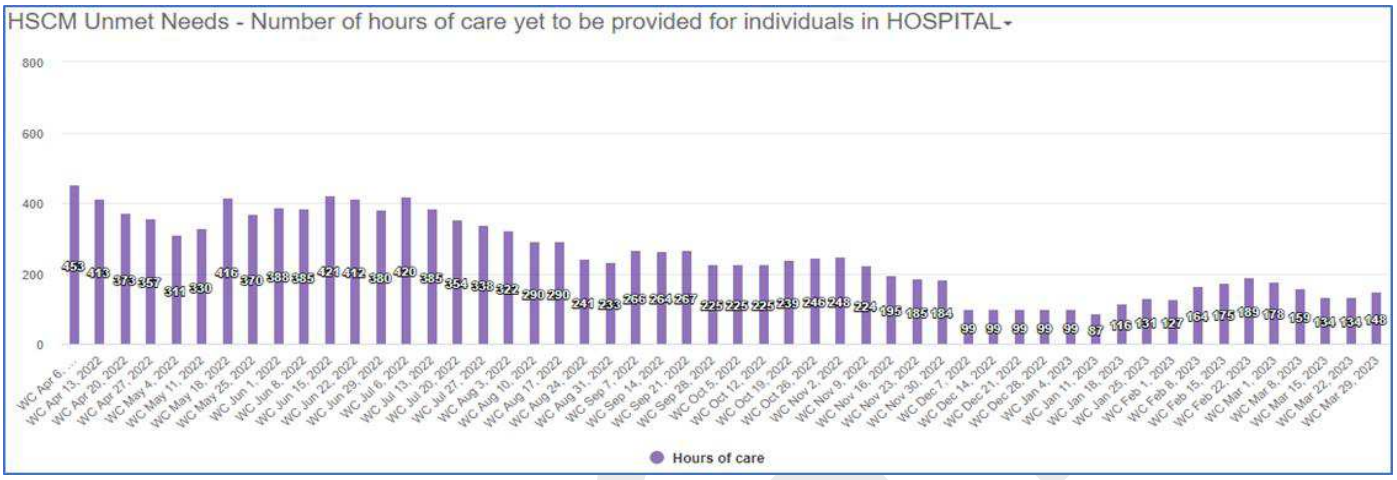
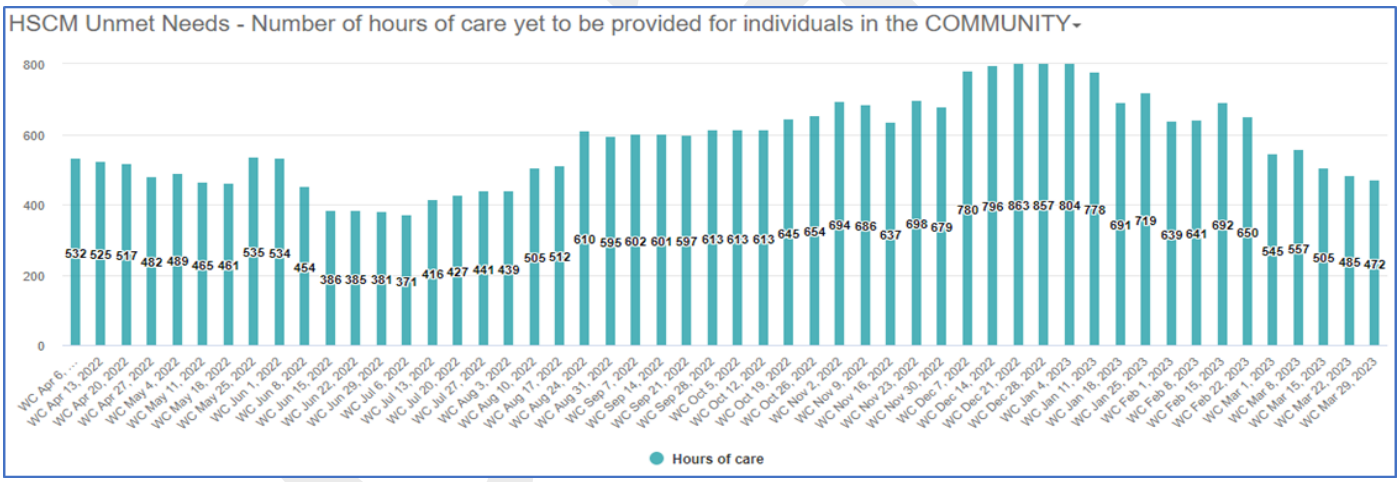
WC Mar 29, 2023
People waiting (All categories)

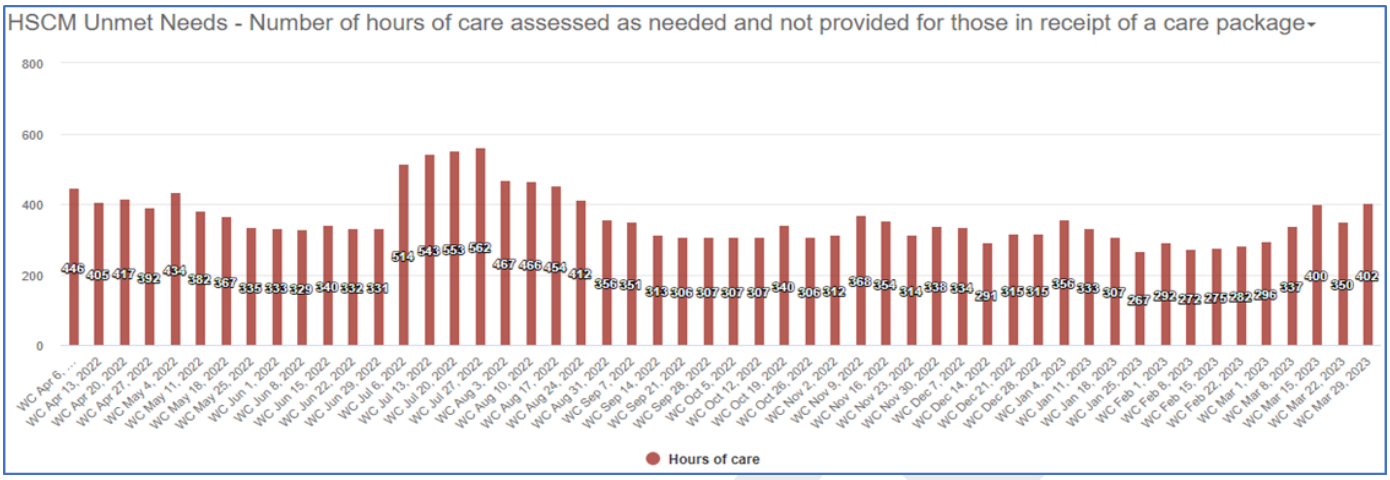

HSCM Unmet Needs - Number of people assessed and waiting for a package of care
200
150
100
50
0
People waiting in HOSPITAL
People waiting in the COMMUNITY


HSCM Unmet Needs - Number of people in receipt of a care package waiting for statutory social care review
400
300
200
100
0
Number of People Waiting for Social Care Review

Unmet needs have a human context. The numbers being reported represent real people whose quality of life is being diminished either through remaining in hospital longer than necessary, or from not receiving the care that they require. The data suggests that at the year-end 126 people were waiting for a social care assessment and around 118 people in the community and 12 people in hospital had been assessed and were waiting for a package of care. Those people who are in receipt of a care package are waiting for a statutory social care review in any week remains constant at 256. For both of these indicators, performance appears to have stabilised at these levels with little sign of improvement or significant worsening.







Since the end of the previous reporting year, there has been a significant reduction in the hours of unmet need for people in hospitals waiting from over 450 hours to 148. The unmet hours have been relatively steady during quarter 4 at between 99 and 189, which is the most consistent, and promising performance since August 2021. Care provision for people living in their communities was difficult to source this winter due to staff shortages and higher than normal absences due to illness. Since then, the hours not provided has almost halved from over 800 to 472 at the end of the reporting period.

For those in receipt of a care package, apart from a problem last summer, there are between 300 and 400 hours not provided each week. This figure was at the higher end of the range towards the end of the year, which may be an indication of the future trend.

WOMEN

Life expectancy 82.4 years (Scotland 80.8 years)

Healthy Life Expectance 62.1 years (Scotland 62.2 years)

76% of life spent in good health (Scotland 76.7%)

MEN

Life expectancy 78.3 years (Scotland 76.5 years)

Healthy life expectancy 62.1 years (Scotland 61.9 years)

78.7% of life spent in good health (Scotland 80.3%)

Over the period between 2001 and 2021 (the most recent published data), female life expectancy at birth in Moray has risen by 2.8%. This is the joint 13th highest percentage change out of all 32 council areas in Scotland and this is higher than the Scotland overall data (+2.4%).

Over the period between 2001 and 2021, male life expectancy at birth in Moray has risen by 5.4%. This is the 6th highest percentage change out of all 32 council areas in Scotland and this is higher than the percentage change for Scotland overall (+4.1%).

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

Early intervention and prevention are key to enabling people to maintain good health and wellbeing and in supporting people to manage existing long term conditions. There is a wide range of initiatives across the Partnership intended to help people improve their own health and wellbeing. These initiatives aim to bring a holistic approach to improving wellbeing, supporting people to improve many aspects of their lifestyles and building their level of personal

93% of people in Moray felt they were able to look after their health "very well" or "quite well", compared to the Scotland average of 91%. However, this is slightly less than reported in previous years.
38.97 per 100,000 people in Moray dies prematurely due to coronary heart disease (<75 years), this is lower than the Scottish figure of 52.59 per 100,000.
97% of people referred for alcohol treatment were seen within 3 weeks, compared to 91.7% in Scotland.
Over a 3 year rolling period, an average of 69.92% of the people invited in Moray participated in the bowel screening programme, compared to the Scottish average of 64.17%
The premature death rate in Moray is 401 per 100, 00 compared to the Scottish average of 466 per 100,000.

Health and Social Care Moray continues to work with its partners across Grampian to improve health and wellbeing, prevent ill-health and increase life expectancy. One of the most significant challenges is reducing the time people have to wait for access to services. This is a driving factor in all of our service planning and we will continue to keep this a priority.

Additional resource was allocated to the local authority Occupational Therapy (OT) waiting list. This has resulted in a continued reduction in the number of people waiting for assessment for major home adaptations. The post has been extended until March 2024 and the expectation is that the improving trend will continue, improving the quality of life of those currently waiting. This test of change has also offered opportunities for a hub approach to community OT, allowing a collaborative approach to getting the right OT to the person reducing delay in assessment and meeting outcomes.

Health Improvement Team

The Health Improvement Team have launched a new Facebook page; a further platform to share health and wellbeing information, page followers are gradually increasing each month. The Health Improvement Team support local partners to access the free Confidence 2 Cook course, aiming to have trainers within each Moray locality. It is a training programme which aims to promote healthy eating messages through practical hands-on cookery sessions, particularly in low-income communities with vulnerable groups.

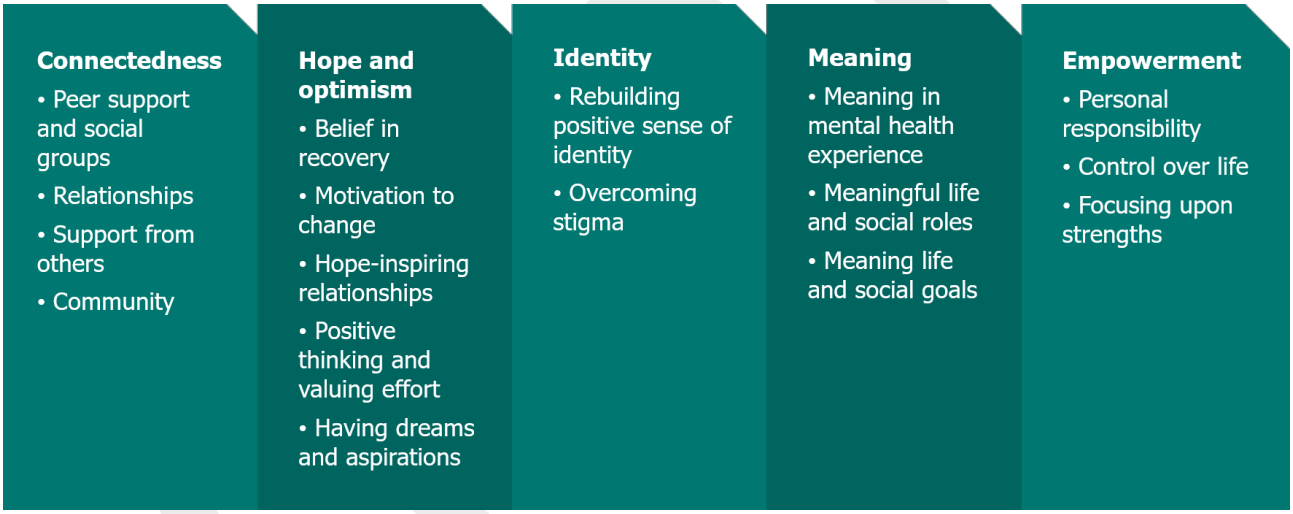
Baby Steps is a multi-agency, midwife led, interactive programme run in Moray. The sessions provide women with the knowledge and skills to improve their Health and Wellbeing. Baby Steps actively supports women to take small steps towards a healthier pregnancy. The programme has supported 14 women since restarting in July 2022.

All care homes in Moray were given the opportunity for supporting services to visit the care home site, using the Mobile Information Bus (MIB) to show case range of services available locally and nationally that staff can access to enable themselves to support their health and wellbeing. The team attended 4 care homes; Parklands, Netherha, Andersons and The Grove. Over 60 staff visited the MIB and are actively engaged with teams. Each session was positively evaluated and interest has now been expressed from other care homes across Moray.

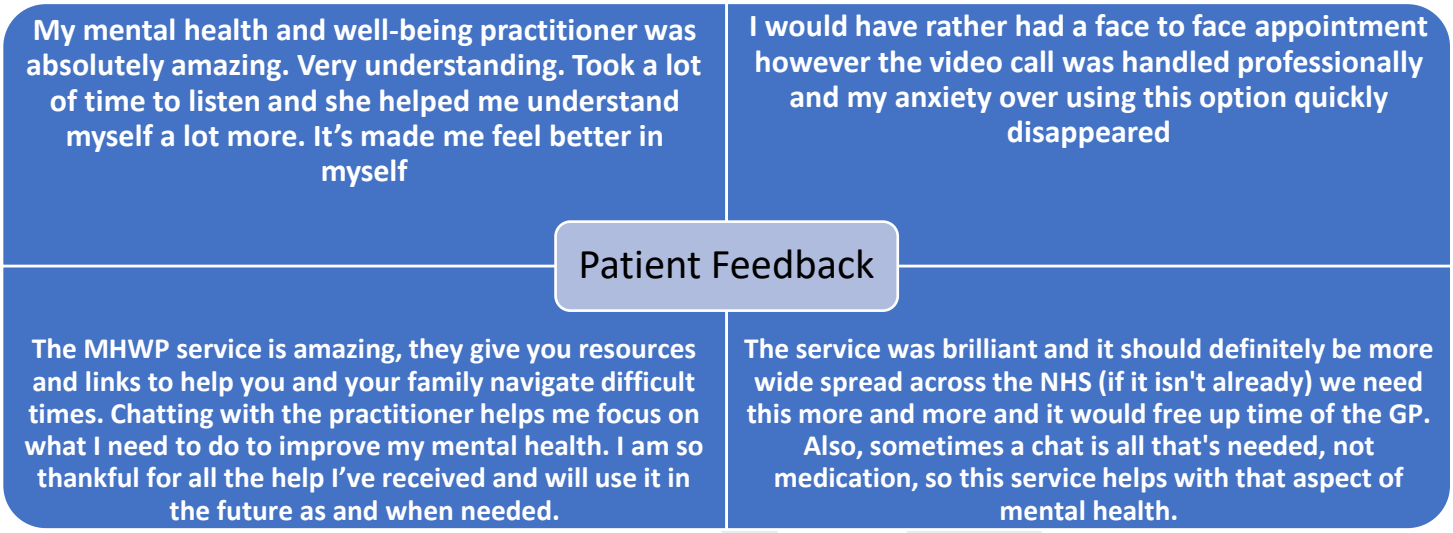
Making every Opportunity Count (MEOC) is a simple approach encouraging service staff to engage in light touch, opportunistic conversations on lifestyle and life circumstances. The brief conversation approach also supports and enables self-management. Twenty seven partner organizations across Moray have attended awareness sessions and embedded the approach within their practice. On average, 100 light touch conversations, signposting people to appropriate support, are recorded each month.

Mental Health and Wellbeing Practitioner Service

At Maryhill surgery there is a new Mental Health and Wellbeing Practitioner. The service has been used to work with individuals suffering with a number of mental health issues, from mood depression, addiction to chronic health conditions. The aim is to use a range of interventions such as reflective listening, mindfulness and teaching coping skills to empower people to meet their needs.



Referrals can be made from a range of people and if a referral is not suited to this service contact will still be made with the patient to connect them with a suitable resource.



Case Study 1 Jane had been seeing her GP for low mood and problems for 30 years, and she was given medication. After talking to the Mental Health and Wellbeing Practitioner and being giving coping strategies and tools to recovery she felt that she had gained so much insight into herself and her mental health. Jane was signposted to primary care who have triaged her and she is getting therapy for the first time in her life. She feels like her whole life has changed since using the service.

Case Study 2 Jane is a survivor of domestic abuse. She was referred to the Mental Health and Wellbeing Service as she was experiencing anxiety and was afraid to go outside, meaning she couldn't get a job to support her family.
One session explored what she might like her recovery to look like; how her life could be. A plan was agreed to reduce her anxiety and relaxation techniques, coupled with on line support for self-compassion and women who were survivors too, so that she didn't feel alone. She also consented for referral to Women's Aid and Rape Crisis so that she could get some specific counselling and support around violence against women and girls. They would also be able to support her family, as well as helping her to access financial, housing, school and food bank support too. She had a new goal for her to eventually get a job so that her self-esteem could recover, too.
3 months later she got back in touch with the service to say she had gone to the Job Centre and was applying for jobs. She was feeling less isolated, more confident and able to get support for her and her family which was helping her to feel like a good mum, a good person, resilient and capable.
This is an example of how the Mental Health and Wellbeing Practitioner service can help patients; we connect the different elements of a person's challenges, and support a journey to recovery.

Current System

Bob contacted his GP because he realised that he was not able to lift himself from the low mood that had been intensifying over the last six months. He now had regular thoughts of suicide and was frightened by these. Bob phoned the GP surgery and an appointment was made for him in 3 weeks' time. In the interim the Receptionist asked if he would like the MH and Wellbeing Practitioner to make contact. He said yes, as he was feeling desperate. The Practitioner contacted Bob 3 days later and offered him a cancellation the following week. Bob attended and with the Practitioner he worked up a plan

- Talk to his wife and adult children about how he was feeling
- With his wife download and populate the StayAlive app
- Talk to his supervisor at work as he had a good relationship with him

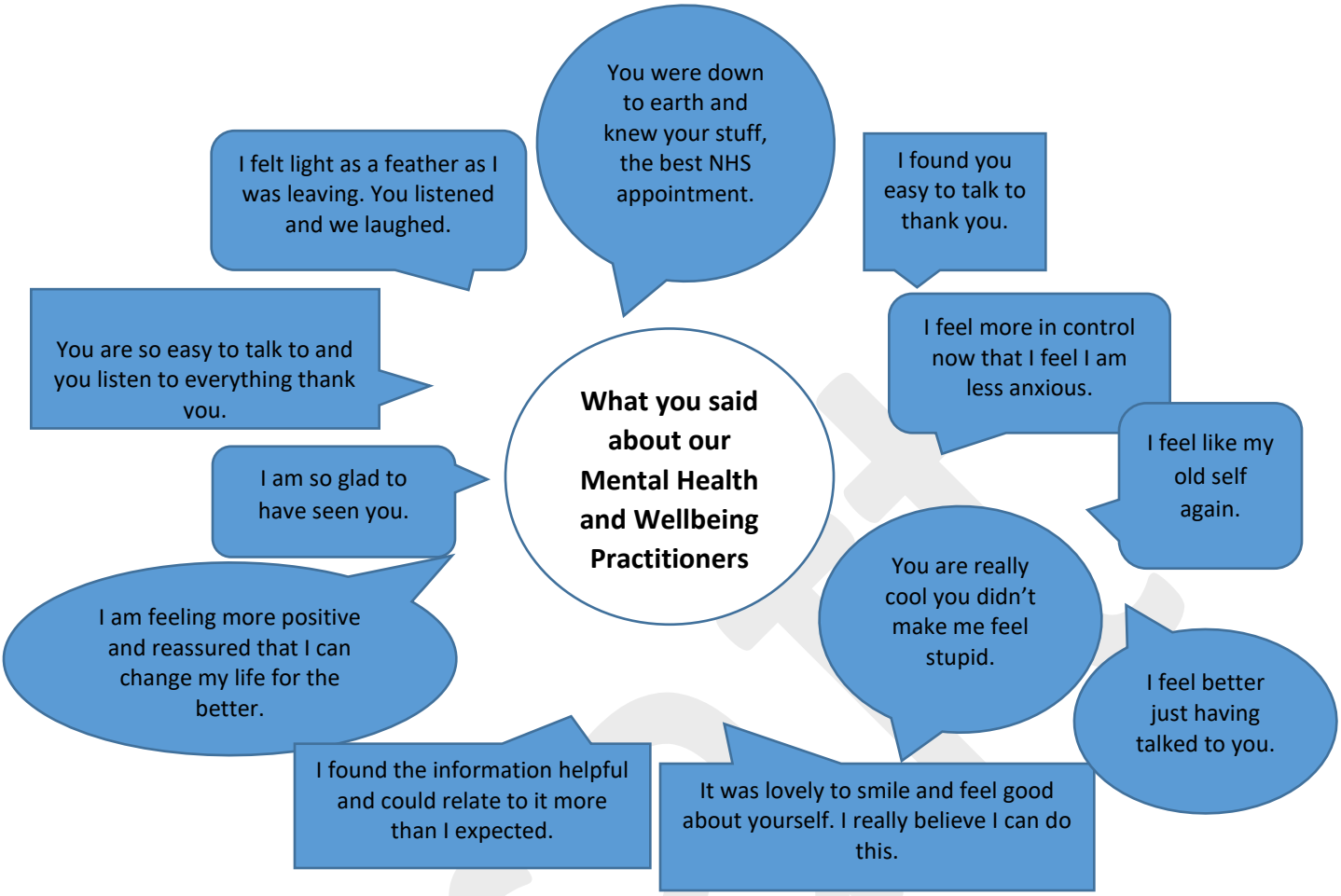
- Read and watch self-help materials that the Practitioner emailed him on the day of his appointment - this built on recommendations that he takes time to get outside and exercise in daylight
- Keep GP appointment and discuss medication
- Consider using mental health support helplines if he was struggling, details of which were emailed to him
- Follow-up appointment in 3 weeks.

Bob found the appointment incredibly helpful. He felt listened to and equipped with some tools to help him understand how he was feeling and feel more in control and, most importantly, safe. Bob had been dreading the upcoming holiday period but he found that getting out each day to walk the dog made a big difference in lifting his mood and providing structure. Although very skeptical about taking antidepressant medication, after talking to the Practitioner and his GP, Bob started on medication. He experienced no side effects and felt his mood lifting.

Bob attended three more appointments with the Practitioner in the GP surgery until he felt he could cope. His knowledge and understanding of himself and how to stay well improved markedly through his own hard work. He was aware of the talking therapies available to him but at this stage felt that the support of his wife and family was all that he needed.

Future System

Bob had an awareness of low mood and anxiety because his friend had been talking about it six months ago after recently being trained to talk about men's mental health. Bob had been given a leaflet before which he had kept and was able to find when he first realised his mood was declining. The leaflet directed Bob to the Moray Pathways website where he was able to complete an interactive self-assessment which guided him to make a self-referral to the Mental Health and Wellbeing Practitioner in his GP surgery and also a local Men's Group. Bob sent a message via Facebook and got an instant reply from Mick, one of the Group facilitators. Mick communicated with Bob for a couple of weeks, encouraging him to talk to his family and make the appointment. He also met him for a walk in the local park. Bob found the informal support on offer really helpful and, as it was connected closely to NHS services, the two together provided an integrated approach to his recovery. Bob plucked up the courage to attend the Men's Group closest to him, which was held in the leisure centre. The Mental Health practitioner and a counsellor worked with the group at the sessions. Men attending the group could also access the gym, pool and sauna as well as participating in the group. Bob felt the experience of being with peers incredibly helpful and through this support, and that of his family and the Mental Health Practitioner he was able to make changes to his life and his low mood lifted. Bob signed up as a volunteer with the Men's Group and became an advocate for mental health and wellbeing in his company and local football club. He had re-joined a local football club with his son, and was training to be a referee to support the junior division. He also took up fishing, which he hadn't done since being a teenager, finding solace in quiet time by the river. Bob's wife attended a Men's Group family event too and found it invaluable to learn more about mental health and wellbeing as well as services on offer. Through this she was able to support Bob even more and help him make and sustain the changes that were keeping him well.


What you said about our Mental Health and Wellbeing Practitioners
You were down to earth and knew your stuff, the best NHS appointment.
I felt light as a feather as I was leaving. You listened and we laughed.
I found you easy to talk to thank you.
You are so easy to talk to and you listen to everything thank you.
I feel more in control now that I feel I am less anxious.
I am so glad to have seen you.
I feel like my old self again.
I am feeling more positive and reassured that I can change my life for the better.
You are really cool you didn't make me feel stupid.
I feel better just having talked to you.
I found the information helpful and could relate to it more than I expected.
It was lovely to smile and feel good about yourself. I really believe I can do this.

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

People's care needs are increasingly being met in the home or in a homely setting in the community. This continues to be at the forefront of service planning and delivery. There are a number of ways that the Partnership is working towards enabling people to live as independently, for as long as possible in a homely setting. This includes providing services that are based in our communities where possible. Moray Council is a Disability Confident employer and holds the Carer Positive award at an engaged level.

4% of respondants don't work due to illness or disability, this is slightly lower than the Scottish average of 5%

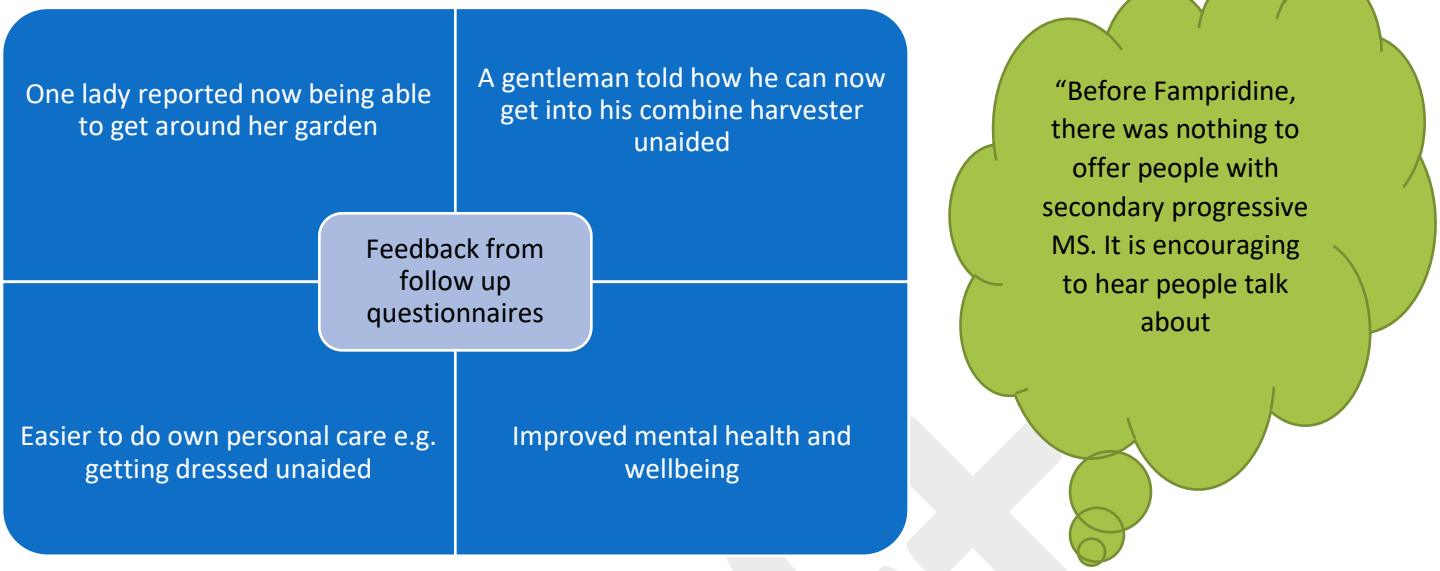
The Learning Disability Service had plans to develop two housing projects. However, due to the increased costs post pandemic, these did not progress as planned. Work is ongoing to try and identify a feasible plan to continue with the project. This remains an important element of service transformation and will allow people to be returned to Moray as per the recent 'Coming Home' report guidance.

A further plan to develop a group of 12 flats in Elgin for adults with a learning disability has also stalled due to similar pressures mentioned above.

Highland Way, Buckie and Greenfield Circle in Elgin both utilised the Just Roaming telecare system. The system permits real time monitoring of service user behaviour and alerts staff to potential risks that require staff support. This has been greatly beneficial in allowing the service users to live with a greater range of independence, with carer support only being provided when required. This system allows for elements of shared care between the people living closely together, resulting in savings due to economies of scale. It also helps to mitigate risks as they can clearly identify patterns of activity within the homes.

Moray Fampridine Clinic – Multiple Sclerosis (MS)

People in Moray with Multiple Sclerosis (MS) are being supported to access a life-changing therapeutic treatment. Following approval of the drug Fampridine, for people with MS with a walking disturbance by the Scottish Medicine Consortium. Gill Alexander, a MS Specialist Nurse for Moray, and her fellow MS Nurses in Grampian began looking at how best to support people to access the treatment. The initiative was to set up a local clinic for those interested in starting the treatment and continues to support them on their journey living with the progressive illness. Since the patients began taking Fampridine, many have reported an improved quality of life, with positive changes in their walking and energy levels leading to greater independence in daily activities with less reliance on others. This involves a multi-disciplinary approach, from the initial referral and pre-assessment, to a timed walk over a measured distance and the issuing of prescriptions. The staff work collaboratively with physiotherapy, neurology and pharmacy colleagues at Dr Gray's Hospital and Aberdeen Royal Infirmary.



Care at Home Teams

Care at Home teams work collaboratively with colleagues across HSCM. The main aim is always to assess individuals and aim to support them in their own homes, where possible. This includes monitoring the situation and reviewing the care needs as appropriate.

ADD AYLSA GOOD STORIES HERE

Community based services based in Fleming Hospital

Following the decision to close Fleming Hospital in Aberlour in 2020 as an inpatient facility, HSCM recognised the need to replace this with community led services. Using the strategic themes as the driver, this identified that repurposing the site could address all three themes; delivering more services locally, enabling collaborative working to support people at or near their own homes and working with partners across health, care and the Third sector. This also resulted in more choice and awareness for communities. The site is now used as a base for a variety of services listed below, and also a number of ad hoc services.

This not only means people in the locality more likely to seek support, but provides services that our teams can signpost into and eventually provide a wider social prescribing facility for patients.

District Nurse Team (DN)	Community Response Team (CRT)	Administration Staff	Leg Clinic (DN Led)	Podiatry
Health Visitor Clinics incl. Baby Massage	Immunisation Clinics	Retinal Screening Clinics	Occupational Therapy (OT)	Tissue Viability Nurse
Aberlour Practice (ad hoc)	Healthpoint - walk in services	NHS Volunteer offices	Community Treatment and Care (CTAC) Hub	Care at Home

The Oaks' in Elgin is undertaking a test of change for Daytime Unscheduled Care. It offers services Monday to Thursday delivered by nursing staff. The range of services provided has been done in collaboration with the people attending, focusing on being person centred through either group or 1:1 provision. Consultant clinics and Multiple Sclerosis and Parkinson's clinics are delivered also from the Oaks. It is developing into a centre of excellence where those on a palliative care journey can access several services and supports during their visits and not having to be "referred on". There is an action plan for the longer term and is being supported by the Clinical Lead for Palliative Care.

Two 'End of Life' (EOL) beds have been commissioned at Spynie care home. The beds are supported through the Community Nursing service. The beds are commissioned to support applicable patents from an acute hospital who cannot, or do not, wish to return home for end-of-life care. Also, patients in the community who require a period of symptom management control, or do not wish to remain at home, for EOL care. It is acknowledged that the use of the beds within the first 3 months was limited, but following the review and actions taken, it is expected that this will increase.

A Social Prescribing test of change is ongoing within the Forres Locality at Forres Health Centre, supported by the Prevention and Self-Management working group. A process is in place which enables all health and social care practitioners to signpost patients to local community supports. Health point, Citizens Advice Bureau, Mental Health & Wellbeing Practitioner and the Listening Service are the main referral services for the test of change, signposting individuals on to local opportunities. A total of 424 referrals have been made to a broad range of community programmes.

Jubilee Cottages continue to provide interim accommodation. There have been developments to allow a further cottage to be made available, giving a total of 6 cottages for interim support. One previously operated as a hub. There have been some notable successes for individuals who have used the cottages to reach independent living as a result. Work is underway to capture these stories and feed back into the system, demonstrating the effectiveness of the resource.

Delivering services differently

Digital
NHS Near Me is a secure web-based service which allows people to have health and social care appointments by video, without having to leave their home and often travel to Aberdeen or Elgin. Many services adopted new ways of working during the pandemic by offering virtual consultations alongside telephone triage and those developments will continue as part of our longer-term planning. This reduces the time and costs associated with attending hospital appointments, whilst also considering the impact on climate change in our planning.

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

It is important that we understand our citizens' experiences of our services. All feedback or complaints are logged and processed to ensure we understand and learn from that information. There are a range of ways that people give feedback about their experiences; HSCM facebook page, email, phone, post, as well as face to face.

Learning from complaints and feedback

Complaints received by the Moray MIJB are reported in line with recommendations from the Complaints Standards Authority and the MIJB's Complaints Handling Procedure. There were no complaints received in 2022-23 relating to the dissatisfaction with the Moray MIJB's policies, decisions or administrative or decision-making processes followed by the Board.

Within Health and Social Care Moray, complaints received by NHS Grampian and Moray Council are corded on two separate systems. Reports for the systems are submitted quarterly to the Clinical and Care Governance Group and Committee annually.

The complaints handling procedure enables us to identify opportunities to improve quality and services across Moray. We record and interrogate the information gathered to identify any learning and share it across the partnership and wider professional groups, if relevant. Learning from complaints is a key part of the Scottish Public Service Ombudsman's (SPSO) criteria in relation to complaints handling

	Total Received Q1	Total Closed Q1	Total Received Q2	Total Closed Q2	Total Received Q3	Total Closed Q3	**Total Received Q4**	**Total Closed Q4**
LA	9	4	7	5	4	6	**9**	**8**
NHS	17	17	25	16	20	30	**16**	**21**
	26	**21**	**32**	**21**	**24**	**35**	**25**	**29**

There was a total of 91 complaints received last financial year. In 2022/23 the number of complaints rose to 107. The slight increase in complaints might be attributed to the increase in use of services. During the pandemic many services were reduced but some services increased in activity, for example GMED activity continues to increase with 2022 being the busiest year on record. This increase in clinical demand could reflect pressures and subsequent complaints. We continue to discuss any learning from each complaint that is received, and we will continue to monitor the increase in 2023/24. The annual report will be published on Health and Social Care Moray's website.

Day Care Services

Artiquins Day Services continually promote life skills to their service users. They held a Health Week in May 2022. Artiquins promoted a wide variety of ways that we service users can improve their Health and Wellbeing. This included, healthy eating, food tasting, cooking sessions and even a fun smoothie making with the use of a smoothie making bike, which also promoted exercise. Different methods of movement and exercise were demonstrated to suit the service user's abilities; Yoga, Bikeability and Cycling Sessions.

Cedarwood and Burnie Learning Disability Day Services

The staff at Cedarwood and Burnie strive to deliver the 9 Health and Wellbeing outcomes for their service users:

- Staff support service users to maintain their health and well-being
- Staff support some of their service users who continue to live at home with family

- Service users who attend day services are supported by trained staff who follow the guidance in place from SSSC and Health and Social Care standards to ensure that dignity and respect is at the forefront of everything we do.
- Service users have individual care plans to ensure that their service remains outcome focused, relevant to their needs
- Good communication with family, residential support and all other agencies involved with the individual is a key element in ensuring reduction in health inequalities
- Day services allow parents who provide care the opportunity from their caring role under the “Carers Scotland Act 2016).
- People who use health and social care services are kept safe from harm and staff are trained in all the relevant requirements.
- Staff that work in health and social care are supported to continuously improve their information, support, care and treatment provided by regular supervisions
- Resources are used effectively and efficiently as the building and equipment are maintained on a regular basis

Keith Resource Centre is part of the
older people's day services /Linburn in Rothes

Greenfingers – Day Services

Service users enjoying Cedarwood Day Services, Elgin

Love to see how happy he is getting on the bus when he knows he is going to Cedarwood. (Residential staff comment)

Cedarwood is such a happy place to come into and you sense it as soon as you walk through the door. (Parent comment)

Enjoying some of the outdoor activities.

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

Quality improvement is the main focus of all services within Health and Social Care. As we look to a different landscape following the pandemic, we are mindful that we need to be innovative with our ideas and listening to our citizen's needs.

73% of adults supported at home agree that their services and support had an impact on improving or maintaining their quality of life. This is lower than the Scottish average of 78%
People spent 755 days in hospital (per 1,000 population) when they are ready to be discharged versus the Scottish average of 748 days. This is slightly higher than the national average.
80% of services were graded 'good' or better compared to the Scottish average of 75.8%

Discharge to Assess (D2A) is one of several initiatives that has been developed within the Operation Home First Programme. The programme aims are: -

- To maintain people safely at home
- To avoid unnecessary hospital attendance or admission
- To support early discharge back home after essential specialist care

D2A aims to impact on the following:

- Avoiding unnecessary admission

- Reducing length of hospital stay
- Lowering re-admission rates
- Reducing the requirement for care packages

The average length of treatment once discharged home with support from the D2A team was 11 days, calculating into a cost per day, per patient of £169, compared with £262-570 a day for a hospital bed.

This shows an increase in early supported discharge from hospital to D2A, resulting in improved flow and capacity of the hospitals. Data collated also shows that over 50% discharged to the D2A team are also less likely to be readmitted at 7 and 28 days.

Prior to D2A the only response to patients requiring support with activities of daily living was a referral to Social Care. By introducing D2A, in 2021, 161 patients had swapped a potentially lengthy wait for a social care package. Since launching, only 4% of D2A patients required assessment for care. More work is being done to analyse this benefit and cost saving.

- Avoiding unnecessary admission: 64 patients were discharged to D2A directly from the Emergency Department at DGH thus avoiding an unnecessary admission.

- Reducing length of hospital stay: D2A continues to provide early supported discharge and therefore reduce length of stay in DGH by an average of one day - this is increased for Moray Community Hospitals and also for those patients from ARI, Woodend etc who would historically have gone to a Moray Community Hospital on discharge.

- Lowering readmission rates: Readmission figures for DGH remain the same i.e. patients who have D2A intervention are 50% less likely to be readmitted at 7 and 28 days.

- Reducing the requirement for care: In the absence of D2A prior to August 2021, 92% of patients seen by D2A would have required a care package for discharge and would therefore require a longer length of hospital stay to await that care. Currently only 6% of D2A patient require onward referral for care.

Patient Outcomes:

- 93% of D2A patients showed an increase in their functional performance in Activities of Daily Living (ADL)
- 89% of patients rated an improvement in their own ADL performance
- 83% of patients rated an improvement in their satisfaction with their activities of daily living (ADL) performance
- 92% of patients improved their functional mobility and gait this reducing their risk of falls and improving their overall ability to maintain ADL
- 87% of patient were rated with improved score for balance, gait and mobility

The success of the D2A programme will likely bring unintended challenges, in that the increase in acuity of the patients being referred, often requiring more input and are slightly more likely to require care now than during the pilot. This is due to the increased complexity and multimorbidities of the patients we are now seeing post pandemic.

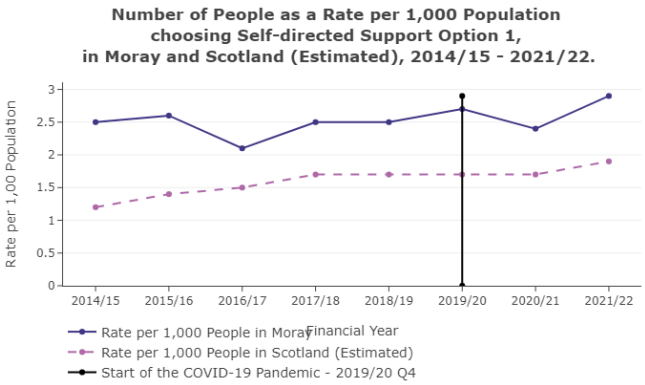
79% of people surveyed said they are supported to live independently at home, this is in line with the Scottish average figure (Pentana)
2.9 per 1,000 people are choosing to arrange their own care at home through Self Directed Support (SDS) compared to the Scottish average of 1.9
Only 86 per 100,000 peole are readmissed to hospital as an emergency within 28 days of discharge. This is significantly lower than the Scottish figure of 107 per 100,000
65% of people asked stated that their experience of social care made them feel safe. This is slightly lower than the scottish average of 67%
We'll need to include something around NI-17 (Although 18 on our pentana dashboard Bruce?) - percentage of adults with intensive care needs receiving care at home, which I can't see mentioned on the draft, but maybe I'm missing it. This has already been published by PHS in the balance of care tables, which I have attached. This also would come under MSG indicator 6.

Self-Directed Support

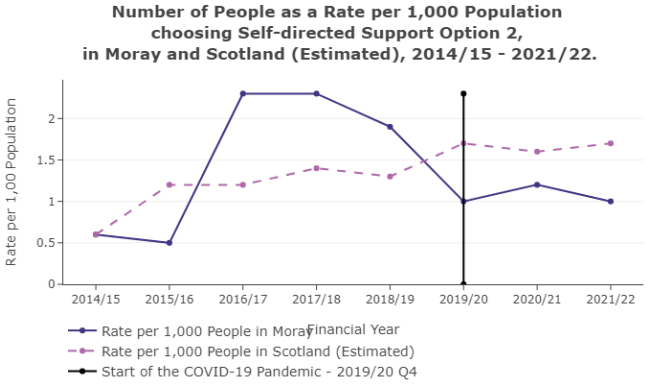
Self-directed Support Options

The chart below shows the trend in the rate per 1,000 population choosing self-directed support options from 2014/15 to 2021/22. The most popular option in Moray is Option 3, choosing Moray Council to provide care.

Option 1: Taken as a Direct Payment.

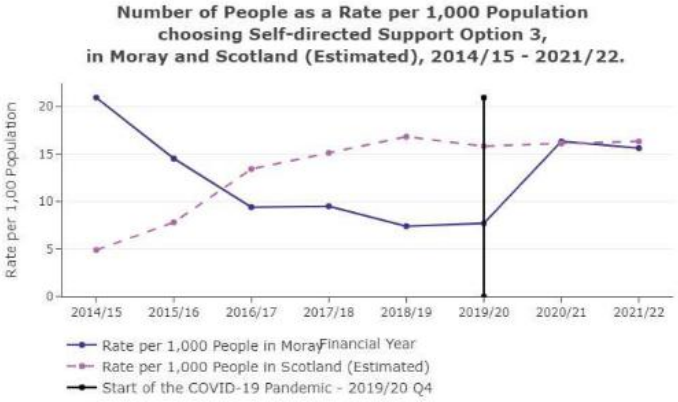


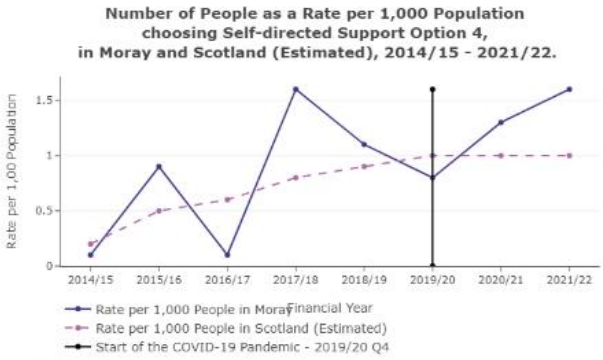
Option 2: Allocated to an organisation that the person chooses and the person chooses how it is spent.



Option 3: The person chooses to allow the council to arrange and determine their services

Option 4: The person can choose a mix of these options for different types of support.





The most commonly assessed need in Moray is for Personal Care, it represents 88% of support required (2021/22)

The Self-Directed Support (SDS) team within Health and Social Care Moray currently support 288 individuals who are in receipt of a Direct Payment (Option 1) to meet their care and support needs. The majority of those in receipt of a Direct Payment opt to use their budget to employ their own team of carers (Personal Assistants). Currently there are approximately 380 Personal Assisitants (PA's) working in Moray. In order for the PA profession to be more visible, work is underway at a national level through a PA Programme Board.

Day Opportunities

Health and Social Care Moray embarked on a jounrney of transformational change due to the challenges presented by the COVID -19 pandemic. The Day Opportunities team implemented an innovative approach to delivering care and short breaks to both the cared for person and their unpaid carer through thinking differently to achieve good outcomes for them. During the test of change which ran for 6 months, the SDS Enablers supported over 100 carers and cared for people to access the right support for them. Just over half of the referrals undertaken by the team were to support unpaid carers in their role. The test of change became embeded into mainstream practice in July 2022 allowing for a team of five SDS Enablers to be recruited on a permanent basis.

The team have bee recognised for their innovative approach with an Impact story being developed by Health Improvement Scotland.

The ethos of the team is to take a strength and asset based approach when exploring personal outcomes: *"Committed to delivering supports that strengthen communities and empower individuals"*

Continuous Quality Improvement

Maryhill and Linkwood GP Practices have established Multi-Disciplinary Teams (MDT's). This has improved team communication and allowed the sharing of concerns for certain patients. This has proved a valuable outcome for these MDT's. It is also noted that the engagement of an Old Age Psychiatrist within the MDT has also further enhanced positive outcomes for both staff who feel more supported with the level of expertise brought to the discussions and outcomes for patients. Co-

location has also enhanced the MDT's. Planning is underway to host its first Oversight group, which will focus on the key priorities for the locality and further populating the action plan.

Day of Care Survey

As part of the System Pressures "two-week challenge" as a Scottish Government Initiative, Health and Social Care Moray undertook the Day of Care Survey for all in-patients in Moray. As well as performing the Day of Care Survey, the team took the opportunity to carry out qualitative interviews with staff to understand from an operational perspective, the pressure teams are under and to understand barriers and possible solutions to the flow of patients through our systems in Moray and Grampian wide.

The Day of Care Survey is a National Tool which is usually completed once a year throughout Scotland. The tool can be used at any time by teams who feel it would be beneficial to know their in-patient profile. The tool pays particular attention to those who could be discharged but there is a delay in their journey. This allows understanding of issues preventing discharge and provides data to support change.

A senior team of auditors spent two days carrying out the Day of Care Survey and Qualitative Interviewing in both Moray Community Hospitals (25 January 2023) and Dr Gray's Hospital (26 January 2023). Further work is now being progressed to identify and implement learning from the results.

Woodview Development

Woodview was developed in partnership with Grampian Housing Association. These properties were built to accommodate those with the most complex and challenging behaviours. Many of the residents were supported out of area, this enabled them to be rehoused in Moray.

Testimonial from David Hurst about the difference Woodview has made to his son Michaels life.

"My son's life has improved beyond recognition from where we were when he was in his 20's and I'm so proud to say that we all contributed to making that happen. To me, this photo shows determination, drive and teamwork and sums up everything we've dealt with throughout Michael's life."

After many challenging years living hundreds of miles away from family, Michael now has his own home in Woodview.

David tells us how he feels the staff at Woodview meets some of Michael's needs:

- Michael has freshly prepared healthy option meals provided for him daily.
- Michael's house is his home. Staff support him in his home.
- Michael is constantly offered new experiences. Positive experiences are reinforced when possible.
- Michael's team are "willing to go the extra mile" both personally and as a group. As a family we are offered the opportunity to do the things we would like, from a pub lunch to a family holiday

We appreciate beyond words that the team will help us meet what we want to do but are also willing to state this is "not a good idea – at the moment" we know this is always said with Michael at the heart of a decision. The care team feels like an extension of the family.

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

As we recover from the pandemic, it is essential that we keep a focus on reducing health inequalities. These inequalities often arise from circumstances in an individual's daily life. As we have seen recently, broader social issues can also affect us e.g., increased food prices, increased fuel prices. HSCM continues to understand and strive to reduce how these broader social issues can affect a person's health and wellbeing, including education, housing, loneliness and isolation, employment, income and poverty. People from minority communities or with protected characteristics (such as religion or belief, race or disability) are known to be more likely to experience health inequalities. We will continue to prioritise those who are most vulnerable in our society, to ensure that we stop the level of inequality from increasing.

The Moray Health Improvement Team works in partnership with the Moray Community Justice teams to enhance health and wellbeing. The National Strategy recognizes that health needs should be supported to ensure successful reintegration, where people do not experience stigma and discrimination upon accessing services. The team has successfully delivered interactive workshops on a range of health and wellbeing topics including cancer screening, utilizing interactive resources, sexual health as well as offering mini lifestyle checks. These drop-in sessions were delivered in a Polytunnel within an industrial estate demonstrating innovation to overcome the challenges this unconventional environment can bring. The workshops supported 12 service users and evaluated positively. The next steps will be to plan and support a sustainable, holistic program of health and wellbeing to encourage access to services.

Let's talk 'Health, Wellbeing and Communities' event in Keith

HSCM hosted a 'Let's talk Health, Wellbeing and Community' event in Keith in August 2022, it was attended by over 40 exhibitors from across the HSCM services, local and national charities, community groups and public sector including the Police, Scottish Fire Service and the Department of Work and Pensions (DWP).

The aim of the event was to raise awareness of the services and support available in and around the Keith area, offer advice and signpost members of the community and to gather feedback to support plans in the Keith area and for the Keith and East Locality Planning (KELP) project.

The Community Learning and Development (CLD) team played an important role in planning the event, including a joint questionnaire that was produced to try and capture everything around what matters to the people living in and around Keith, from health through to the place itself.

The feedback from the event has been tremendous, with new opportunities created for services to work together and refer into one another, people from in and around the Keith area being more aware of services and support available and requests coming in from across Moray for similar events to be run elsewhere.

A massive thank you to Tesco in Keith who provided refreshments and a member of their team to support the day!

Digital Access
Moray was reported as having 59.7% of households with access to broadband at minimum speed of 30mb/second, this is considerably higher than the national average figure of 43.1%

Screening

Women over 70 are once again being offered the opportunity to self-refer for breast cancer screening. This service was suspended during the early stages of the COVID-19 pandemic. However, data suggests that screening has now recovered, and 53% of breast cancers diagnosed via screening has recovered to its pre-pandemic detection rate.

Outcome 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.

A Carer is generally defined as someone, irrespective of age, who provides unpaid help and support to someone who cannot live independently without the help. This can be due to frailty, illness, disability or addiction. Unpaid Carers are the largest group of care providers in Scotland, providing more care than health and social care services combined. HSCM understands that supporting Carers must to be a priority for HSCM, and have invested in the Carers Strategy (ADD LINK) and we will now focus on the delivery plan to continue to ensure the sustainability of the Carers role.

Moray Carers Strategy 2023-2026 – (add hyperlink)

32% of people surveyed in Moray felt supported to continue caring compared to 30% of people across Scotland. However 31% gave a negative response compared to the Scottish figure of 28%.
60% reported having a good balance between caring and other things in their lives, this was slightly lower than the Scottish figure of 63%
44% of people surveyed felt that they had a say in the services provided for the person they looked after, compared to 39% across Scotland
NHS Grampian were recoginised with a Carer Positive award for supporting staff in the workplace who are also carers.
Source: ScotPHO profiles (shinyapps.io) HACE survey

Health and Social Care Moray recognise the vital support unpaid carers provide to the person they care for. It is vital that unpaid carers have a life outside of their caring role and are supported to carry

on caring as long as they wish to do so. In recognition of his Health and Social Care Moray has recently published the new local Moray Carers Strategy, Recognised, Valued and Supported following engagement with unpaid carers. A local implementation plan has recently been developed to deliver on the key themes and objectives of the strategy with the three strategic priorities being:

Health and Social Care Moray commission Quarriers; our carer support service.

- As of 31st March 2023, there were 1220 adult carers registered.
- There are 171 young carers, of which 156 are being directly supported by Quarriers during the reporting period January to March 2023.
- Of the 171 carers registered with Quarriers, 17 are classed as very young carers (under the age of 8).

At the most recent Carers United meeting, young carers in Moray had the opportunity speak with the Young Carers Scottish Youth Parliament representative. Members of Carers Unite, the young cares focus group in Moray, produced a video for Young Carers Action Day which can be widely shared throughout Moray. Quarriers 2023.mp4

Extract from Carer Representative, MIJB*: Our new strategy, Recognised, Valued and Supported, is grounded in the lived experience of unpaid carers and my thanks goes to everyone who has been involved. It reflects what carers say matters to them. It recognises where we are now and where we want to get to over the next three years to improve the experiences of carers. The strategy and supporting implementation plan will guide the work of health, social care and community partners towards a better Moray, where carers of all ages are recognised, valued and supported to enjoy healthier and more fulfilled lives.*

Communities & Volunteering Team (Moray)

During the previous year, the Volunteer Team underwent some positive changes that resulted in a rebranding and restructuring of the service. By collaborating with the Community Wellbeing and Development Team, the service was renamed as the Communities and Volunteering Team.

The Community Wellbeing and Development Team continues to support older people to move from crisis to confidence with the facilitation of all the Be Active Life Long BALL groups.

The joint objectives of the teams are to prevent, reduce and delay the need for formal care services by enabling everyone to maintain their independence and lead healthy, active lives in their own community, for as long as possible.

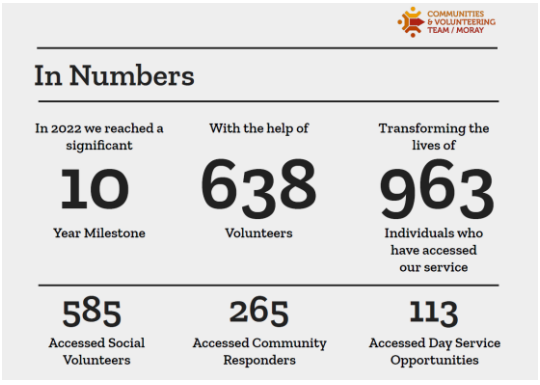
- The volunteer team continue to expand one of their services (Moray Caller) to reach rising demand in referrals.
- Launched a new initiative in collaboration with The British Lions for providing ICE (in case of emergency) boxes, where essential information can be accessed if needed by the emergency services, bringing peace of mind to those who access their service and added support for the volunteers
- Launched a new Facebook page to promote volunteer opportunities and celebrate the positive impact of volunteering.

The team's aim is to ensure that no one is left behind in our community and they are committed to reducing social isolation and re- connecting people back into their communities. The team continues to develop and now offers a wide range of roles and support.

Volunteer Roles

Community Responder	Volunteers connect to people who are socially isolated in their home setting (Community Alarm / Telecare). Community Responders are dedicated volunteers who offer initial support to people at risk of falls or illness, especially those who may not have nearby family or friends. By offering comfort and reassurance, volunteers can help individuals stay safe, secure, and independent in their own homes.
Social Volunteer	Volunteers offering friendship to social isolate people supporting reengagement back into their communities (befriender). Social Volunteers play a vital role in connecting with people who may be socially isolated in their communities. By being matched with someone and making regular home visits, volunteers provide companionship, shared interests, stories, and experiences.
Moray Caller	Volunteers who connect to people who are socially isolated in their home setting (Telephone Befriender). Moray Calls volunteers play a vital role in reaching out to individuals who may be socially isolated in their community. By making regular phone calls, volunteers can share interests, stories, and experiences, helping to brighten someone's day and foster connections.
Flexible Volunteer	Being available to call upon if there is an urgent need in and around the local community Finding time for volunteering can be a daunting task, given the many commitments people face, such as work, family, or studies. Flexible volunteering offers a diverse range of roles, giving volunteers the freedom to choose activities they enjoy in the time they have available

This invaluable volunteer service supports services delivered by the Health and Social Care Partnership, improves patients discharge pathway, connects people with their communities, builds personal and community resilience and provides clear signposting and supports those connections.



This can also be very rewarding for the Volunteers; they are also connected with their communities, and this promotes improvement in their own health and wellbeing. Volunteering also provides opportunities for people to develop a range of skills and experiences than can be transferred into a workplace setting.

We are committed to ensuring that service users and their carers are supported and empowered to make their own choices about how they will live their lives and what outcomes they want to achieve.

Case Study

After retiring and then moving away from the area Terri suffered a double bereavement. Her husband was still working, and even after returning to the area she felt lonely and isolated. She started to lose my confidence and self-worth. She decided to join the group. Terri is now a Social Volunteer (befriender) and has dedicated 1 year of her time to visiting her client, a 99-year-old individual who has dementia. On a weekly basis, Terri spends one hour and spends time with her client, talking about their shared interests in sewing and knitting.	
Benefits	**Benefits**
Volunteer	Gained confidence Met new people Improved her health and wellbeing Helped recovery from bereavement – renewed sense of purpose
Client	Companion and social interaction Supported ability to remain at home and independent with support network
Feedback from Terri "I look forward to my visits, I think I get as much out of it as the client gets from me. I know I am making a difference to someone else. A family member recently told me that her parent had said how much she enjoys my visits. Volunteering means a lot to me, volunteering has given me a social life and I have met new people and get out the house more"	

NHS Grampian are working towards achieving the Engaged level of the Carers Positive Award for supporting carers in the workplace. Carers Scotland, on behalf of the Scottish Government, operates an award scheme to recognise employers in Scotland who support carers in their workforce. It aims to raise awareness of the growing numbers of people who juggle work and caring responsibilities.

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

The Adult Support and Protection (Scotland) Act 2007, states that public sector staff have a duty to report concerns relating to adults at risk and the local authority must take action to find out about and, where necessary, intervene to make sure vulnerable adults are protected.
This duty also includes ensuring services are maintaining safe, high-quality care and protecting vulnerable people.

During the pandemic, and specifically during lockdown, vulnerable people had limited access to their support networks. This reinforced the importance of child and adult protection, and HSCM has prioritised resources to ensure this remains a priority. New teams and processes have been introduced to allow us to identify and protect those identified as most vulnerable in our communities.

Adult Support and Protection

The joint inspection of HSCM took place between March and May 2022. The Care Inspectorate reported that there were 'some clear strengths in ensuring adults at risk of harm were safe, protected and supported'.

The Care Inspectorate asked the partnership to develop an improvement plan to address the priority areas for improvement identified. The Care Inspectorate will monitor progress implementing the

plan. The Multi-agency Improvement Plan builds upon Moray's original improvement action plan formulated in 2019 following a series of engagement and consultation events and multi-agency workshops with the purpose of giving a clear foundation and oversight to Adult Support and Protection activities in Moray.

This plan is a multi-agency plan and is the tool used within the Moray Adult Protection Committee to provide assurance to all partners of progression and development in the work carried out. Updates on the delivery of the plan are presented to the Clinical and Care Governance Group and the MIJB Clinical and Care Governance Committee. It is also presented at a multi-agency committee which has an independent chair.

The Moray Health Improvement Team has delivered alcohol brief intervention (ABI) training to 85 colleagues, Local Authority and Third Sector partners.

The Health Improvement Team supported Operation Protector: 2 days covering Elgin, Buckie and Keith. Engagement with over 100 people sharing information on how to protect vulnerable people in the community and report any concerns of organised crime activity

Resettlement and Refugee Team - Ukraine Displaced Persons Scheme

The Resettlement and Refugee Team have provided support to a total of 133 people (84 adults and 49 children) from Ukraine across Moray. The families were helped to integrate into their communities and also supported into education and employment, with 58% currently employed or in college education.

The support received from the Department of Work and Pensions (DWP) Employability Team, Income Maximization Team, NHS, Education and Social Security Team at the Drop-in Sessions when families arrived was instrumental to the resettlement success. Support from wider partners has also been exceptional; the University of Highlands and Islands for English for Speakers of Other Languages (ESOL), Moray Food bank, Moray Clothing Bank, and Tesco's significantly contributed towards the successful integration of the Ukrainian citizens into the wider Moray community.

PREVENTION
Vaccination programme in Moray

The Vaccination team continue to work hard to ensure the safe and effective delivery of the Vaccination Transformation Programme across Moray. The Spring Booster campaign commenced in March 2023 with a good update across Care Home residents and with the lowered age of 75+ from 80+, increased outreach clinics have been implemented across Moray, delivering vaccines closer to the communities resulting in positive feedback.

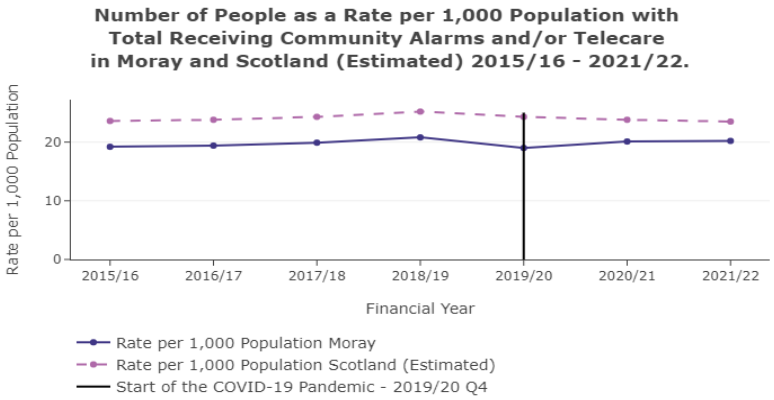
Pre School-Vaccination (below data shows Moray update is above the Grampian rates)

CHILDHOOD VACCINATIONS UPTAKE 2022	**% MORAY**	**% GRAMPIAN**
Immunisation	**Year ended 31/12/22**	**Year ended 31/12/22**
Uptake by 12 months		
6-in-1 primary course	97	95.4

PCV primary course	96.8	95.5
Rotavirus primary course	95.5	92.5
MenB primary course	96.4	93.7
Uptake by 24 months		
Hib/MenC	95.3	92.9
PCV Booster	95.2	91.4
MenB Booster	95.6	92.5
MMR1 (first dose of MMR)	95.3	93.6
Uptake by 5 years		
DTaP/IPV	92.1	89.0
MMR2 (second dose of MMR)	91.2	88.2

Technology enabled care

We are continually working with partners to identify where technology can be used to improve care and allow people to live independently and safely. Telecare is a system that includes alarms and sensors that can be placed in a citizen's home, linked to a response centre using the telephone line.



29.7% of people using Telecare also receive Care at Home in Moray (2021/22).

Outcome 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

Although MIJB does not directly employ people who deliver health and social care services, the MIJB influences the services which are commissioned and therefore has a role in influencing the workplace culture. This includes influencing how well services are integrated and approving strategies that set the direction of travel.

Health and wellbeing initiatives

We Care is a staff health and wellbeing programme established to deliver, coordinate and enhance staff wellbeing across NHS Grampian and Health and Social Care Partnerships. The 'We Care'

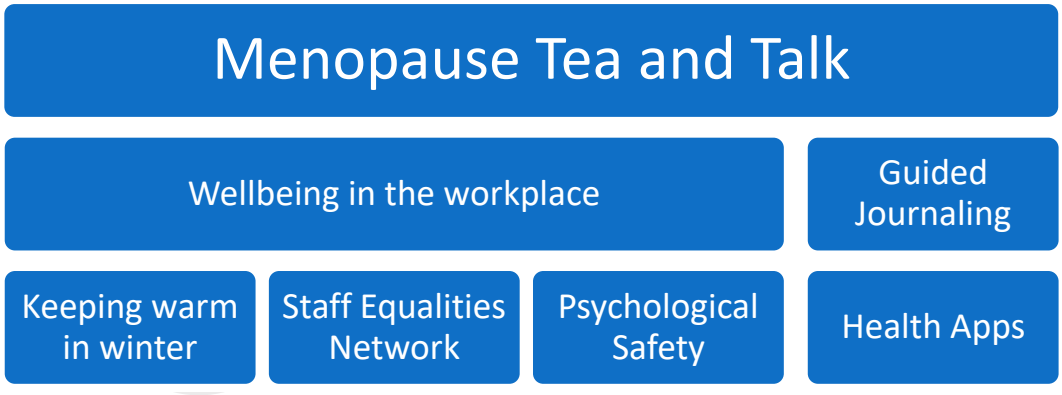
website is a hub where staff can access information, help and advice related to individuals and their teams' wellbeing.

Specific examples of support that has been provided:

- Values based reflective practice has been taken up by a number of front-line teams across Moray as has the opportunity for team resilience training.
- Trauma risk management support has been provided to staff who have faced a significant traumatic event in their day-to-day work.
- Moray staff have participated in mindfulness courses and online yoga for menopause is available

Sports classes have been identified to promote free healthy exercise classes a week are run by the Moray Sports Centre. These classes are exclusively for Moray HSCP staff and funded by the NHS Grampian Charity.

- Staff sessions run by Horseback UK to relieve stress and anxiety
- Staff have linked into many activities run by Moray Health and wellbeing Hub including managing their own mental health and wellbeing
- A 12-week programme was run by the health improvement team to support staff through a variety of initiatives such as weight loss, smoking cessation, safe drinking and financial crisis support.



The Health Improvement Team also leads on a number of staff wellbeing initiatives, such as healthy weight, mental health and smoking cessation. They also provide onsite and outreach sessions to staff teams on request.

Moray Council became a Living Wage Accredited employer in September 2022. Additionally, the council holds the Armed Forces Covenant Silver award and are awaiting the outcome of their gold award application. Additionally, to support the age profile and in line with good practice, a Menopause Policy was introduced in April 2023.

Hybrid working
The pandemic required HSCM to rapidly embrace new ways of working. This resulted in some staff suddenly working from home on a full-time basis. HSCM faced a huge challenge to ensure all staff had the appropriate equipment to allow this to happen, whilst still supporting staff remotely. A huge benefit from this is the progress we have made in digital technology and skills in a very short time. However, we appreciate the staff can feel isolated and less supported working from home, so we are now concentrating on how we work towards a true hybrid model, where appropriate. With an ageing building estate and higher specifications for patient spaces, this will be planned by the newly formed Moray Transformation Board with a wider lens of the health and social care partnership and Dr Grays Hospital.

Moray Council updated their Flexible Working policy in 2022 to reflect the new ways of working and promotes a high number of flexible working options to help employees balance their work life commitments which supports health and wellbeing

iMatter (Data to be added)

iMatter is an annual survey tool that allows for staff feedback across the system. It is used across health and social care teams. iMatter also includes the development of team action plans to reinforce the importance of feedback and creating a positive workplace.

The response rate in 2022 was (add data) overall, compared to (data)

The employee engagement index has gone up from %% to %%

The overall experience of working within the partnership has risen from &&& in 2021 to &&& in 2022.

'Trickle' is an online ideas platform that allows everyone in NHS Grampian a place to be heard. People can make suggestions, challenges and highlight hot topics. This then allows leaders to understand what matters most to staff and encourages the sharing of ideas which may improve patient experiences or even drive financial savings.

Development and Training

Turas is the NHS system for annual appraisals. This includes planning for staff to identify growth areas and goal setting. In 2022/23 *** appraisals were completed on Turas. This is approximately **% of people employed by NHS Grampian. The number of annual appraisals is discussed at various staff and partnership forums and is monitored by the NHS Staff Governance Committee.

Recruitment

It is widely recognized that there is a significant challenge in recruiting too many roles within the health and social care partnership. This is not isolated to Moray. However, Moray has the added issue of lack of affordable housing. We continue to work across professional organizations to attract people to work in Moray. Furthermore, there are significant numbers of people leaving the organization or taking early retirement, leaving a vacuum in knowledge and skills to be passed on.

Third sector organisations

The pandemic and adverse weather events have contributed to the creation of Community Resilience Groups, some of which grew from existing organisations such as community councils, others were completely new. HSCM recognizes the value these groups bring, not only to their communities but as vital links between their communities, local authority and health and social care partnerships. It is hoped that this collaborative relationship will continue to grow and develop even stronger links in the future.

Staffing

Moray Resource Centre Staff – finalists at Moray & Banffshire Heroes 2023 Award Ceremony

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

HSCM continuously seeks to ensure that resources are used effectively and efficiently. We continue to focus on improving quality and efficiency by making the best use of technology and new ways of working, improving consistency and removing duplication. The Partnership is also committed to using its buildings and land in the most efficient and effective way.

The 'Health Point' based within Dr Grays Hospital, offers free information, support and advice on a range of health and wellbeing concerns, including smoking cessation, weight management. A total of 2028 enquires were received by the team. Health point also offers an outreach service, in both clinical and non-clinical settings, within each locality in Moray providing an accessible health and wellbeing support service. Staff have also attended several events alongside partners, such as Moray Pride, DWP Job Fairs and community lunches, offering health and wellbeing advice and guidance in a rage of settings.

Moray Daytime Unscheduled Care Service (DUCS)

There is considerable pressure across the health and care system in Grampian. This pressure is particularly felt within General Practice. The unpredictability of the demand for unscheduled home visits during the day is becoming increasingly disruptive on an already stretched workforce. Therefore, it was felt there is a need to find further initiatives that supports Practices with this demand, and as such the DUCS test of change was developed.

The Moray Daytime Unscheduled Care Service (DUCS) was a test of change that comprised of an in-hours urgent care team (1 x GP and 2 x Advanced Nurse Practitioners (ANP), operating from a Monday-Friday. Referrals were professional to professional with Practices calling a dedicated number. The GP/ANP would then triage the call and the call would then be assigned appropriately.

The service provided 131 visits to patients during the 9-week period. A full evaluation process has now been completed and the information will be presented, and any recommendations will be considered by the senior management team.

Localities

While the Strategic Plan is a Moray-wide document, Moray has been divided into four areas, known as localities, to enable planning to be responsive to local needs and to support operational service delivery. These localities are:

- Buckie, Cullen and Fochabers
- Elgin
- Forres and Lossiemouth
- Keith and Speyside

Each locality has a locality manager who leads on putting locality oversight arrangements in place and taking forward engagement with partners, including the third sector, service users, and carers, to develop locality plans to improve health and wellbeing. Locality plans can be found on our website.

Community Planning

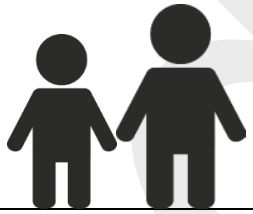
Links with Community Planning partners are maintained at a strategic level through the Chief Officers Group and the Community Planning Partnership Board. This supports joint working on multi-agency plans such as the Children's Services Plan, Drug and Alcohol Strategy and Public Protection Plans.

The health board area for NHS Grampian covers not only the health and social care partnership for Moray but also Aberdeenshire and Aberdeen City. We work closely with colleagues across Grampian to support the delivery of NHS Grampian's Plan for the Future.

APPENDIX A

Moray Area Profile

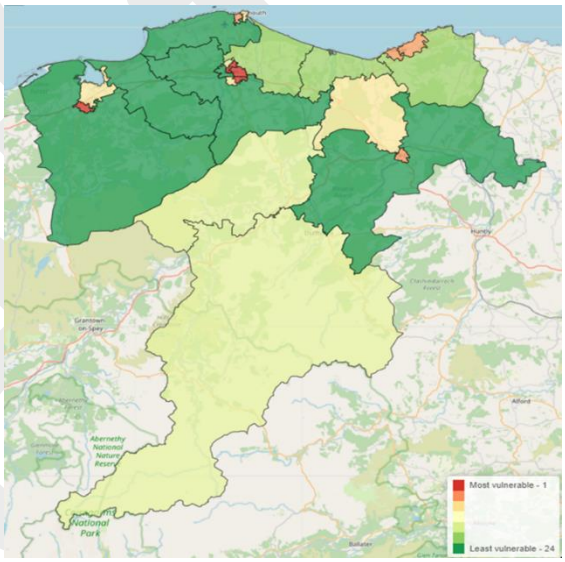
- Moray spans 864 square miles in North East Scotland
- Comprising mainly coastal and rural communities
- Population 96,410 (2021 estimate) - 1.76% of Scotland's total population
- Population predicted to fall by 1.04% by 2028

Moray Age Profile		
(latest NRS data based on mid-year estimates 2021, used for population projections using 2018 as baseline)		
		
0-15 year olds	16-64 year olds	People aged 65+
16,173	**58,924**	**20,423**
16.9% of population	61.7% of population	22.3% of population
(Scotland 16.9%)	(Scotland 64.2%)	(Scotland 19.6%)
Males: 487,733, Females: 48,677 which is comparable to Scottish average		

Expected to fall to 14.6% of the population by 2028	Expected to fall to 59.3% of the population by 2028	Expected to rise to 26.2% of the population by 2028 (Scotland 22.1%)

Deprivation

2.7% of Moray population live within the most deprived quintile, whilst 13.3% live in the least deprived quintile (SIMD2020 &NRS)



Economic status sources:

https://www.gov.scot/publications/scottish-index-multiple-deprivation-2020/pages/5/
https://www.nomisweb.co.uk/reports/lmp/la/1946157424/report.aspx#workless
https://www.gov.uk/government/statistics/children-in-low-income-families-local-area-statistics-2014-to-2022
https://www.gov.uk/government/statistics/children-in-low-income-families-local-area-statistics-2014-to-2022

APPENDIX B

The 9 National Health and Wellbeing Outcomes

The Scottish Government has set out 9 national health and wellbeing outcomes for the people of Scotland. The 9 national health and wellbeing outcomes set the direction of travel for all partnerships services in the Health and Social Care Partnership, and are the benchmark against which progress is measured.

	Outcome	What people can expect
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	• I am supported to look after my own health and wellbeing • I am able to live a healthy life for as long as possible • I am able to access information
2	People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently at home or in a homely setting in their community.	• I am able to live as independently as possible for as long as I wish • Community based services are available to me • I can engage and participate in my community
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	• I have my privacy respected • I have positive experiences of services • I feel that my views are listened to • I feel that I am treated as a person by the people doing the work – we develop a relationship that helps us to work well together • Services and support are reliable and respond to what I say
4	Health and social care services are centered on helping to maintain or improve the quality of life of people who use those services	• I'm supported to do the things that matter most to me • Services and support help me to reduce the symptoms that I am concerned about • I feel that the services I am using are continuously improving • The services I use improve my quality-of-life Health and social care services contribute to reducing health inequalities
5	Health and social care services contribute to reducing health inequalities.	• My local community gets the support and information it needs to be a safe and healthy place to be Annual Performance Report 2021-22 48 Health & Social Care Moray Outcome What people can expect • Support and services are available to me • My individual circumstances are taken into account
6	People who provide unpaid care are supported to look after their own health and well-being, including to reduce any	• I feel I get the support I need to keep on with my caring role for as long as I want to do that • I am happy with the quality of my life and the life of the person I care for

	negative impact of their caring role on their own health and well-being.	• I can look after my own health and wellbeing
7	People using health and social care services are safe from harm	• I feel safe and am protected from abuse and harm • Support and services I use protect me from harm • My choices are respected in making decisions about keeping me 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. decisions	• I feel that the outcomes that matter to me are taken account of in my work • I feel that I get the support and resources I need to do my job well • I feel my views are taken into account in decisions
9	Resources are used effectively and efficiently in the provision of health and social care services.	• I feel resources are used appropriately • Services and support are available to me when I need them • The right care for me is delivered at the right time

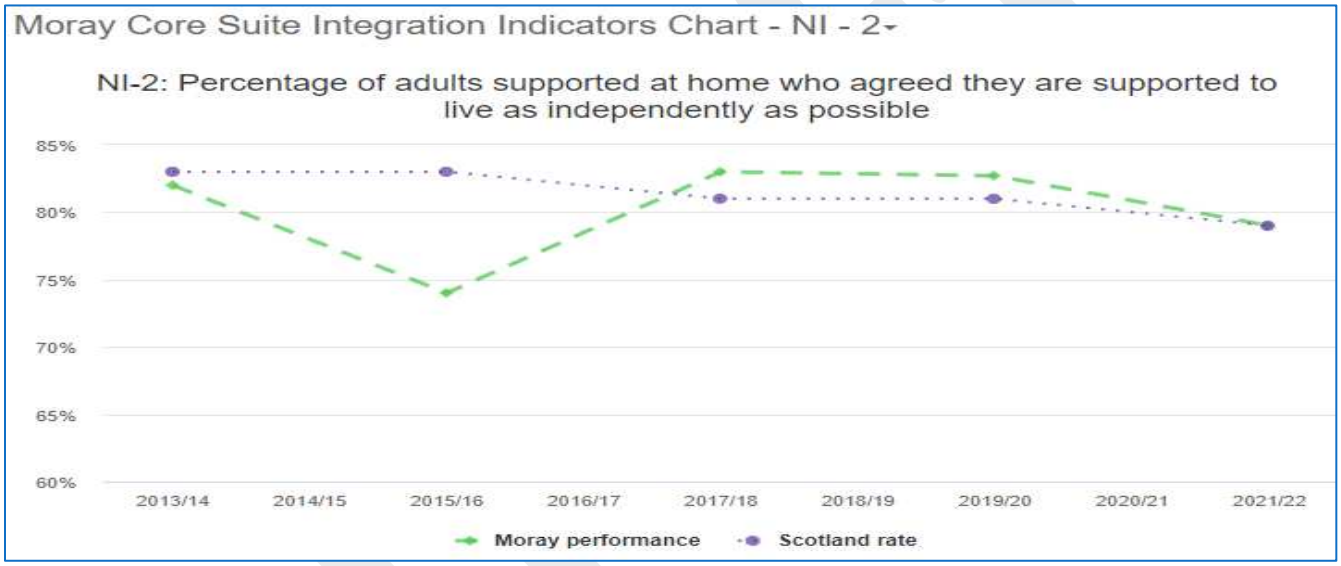
APPENDIX C

National Indicators (**DATA TO BE UPDATED WITH JUNE FIGURES**)

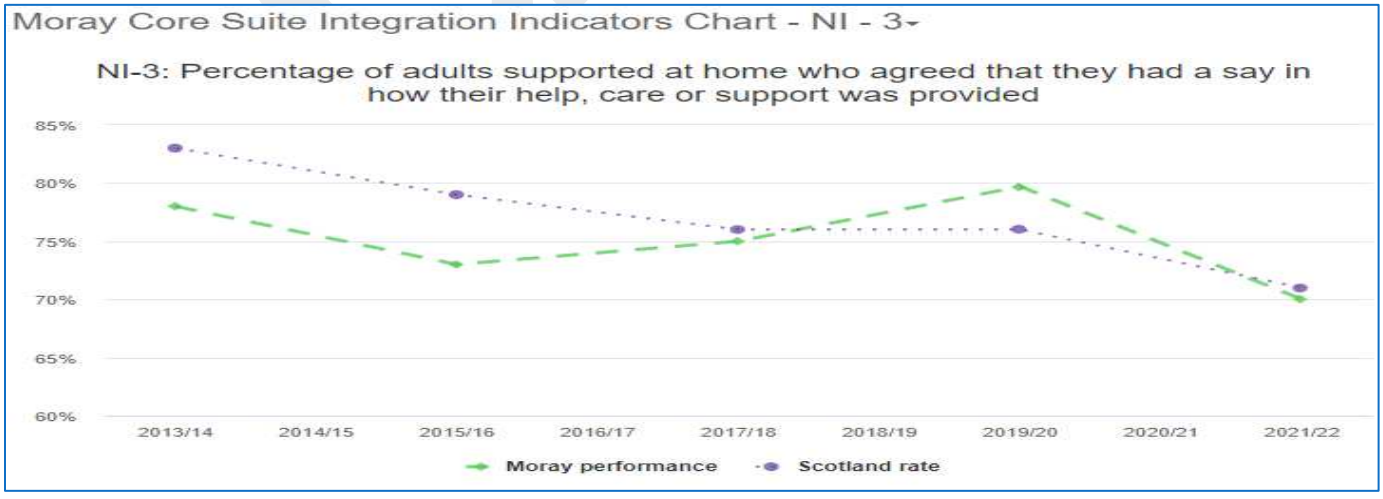
Performance issues and actions to improve performance

The measures in the survey that are used to track the performance of the person-centered approach to independent living all show reducing trend since 2013/14. In addition, there hasn't been a noticeable reduction in health inequality between the least and most deprived areas in Moray since 2010 for early mortality and emergency hospital admissions. However, Moray has lower levels of inequality compared to Scotland as a whole.

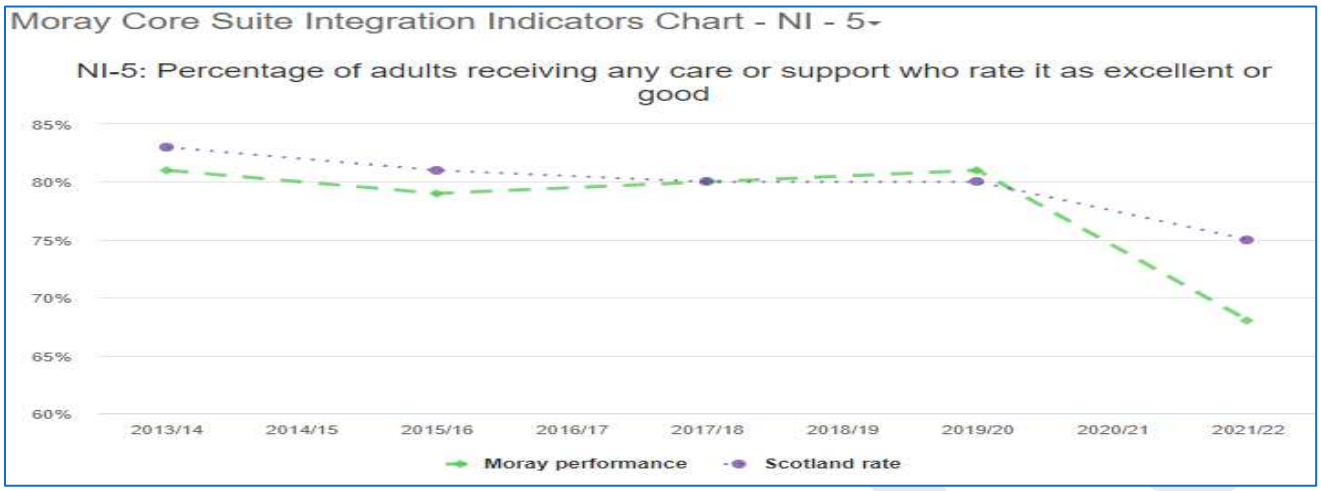
The trend in the proportion of people who agree they are being supported to live as independently as possible has reduced marginally for both Scotland and Moray in the past 3 year. However, around four-fifths (79%) of respondents agreed with this statement in the most recent survey.



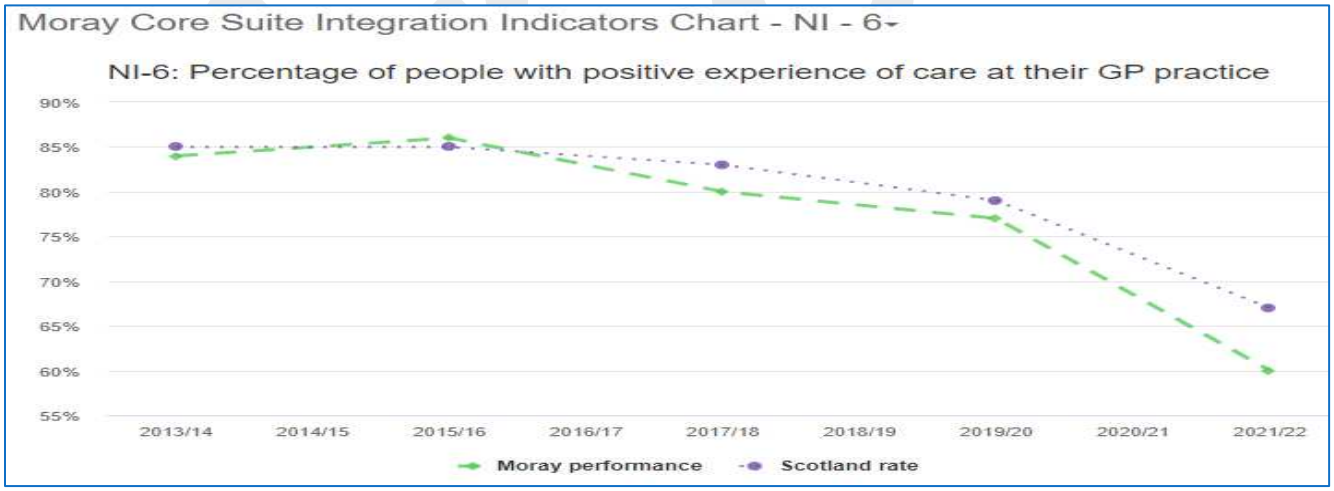
A smaller proportion of Moray respondents agreed they had a say in their care provision in the latest survey compared to previous years. With a positive response of 70%, Moray is similar to the Scottish average of 71%, but is down 10% from the previous survey.



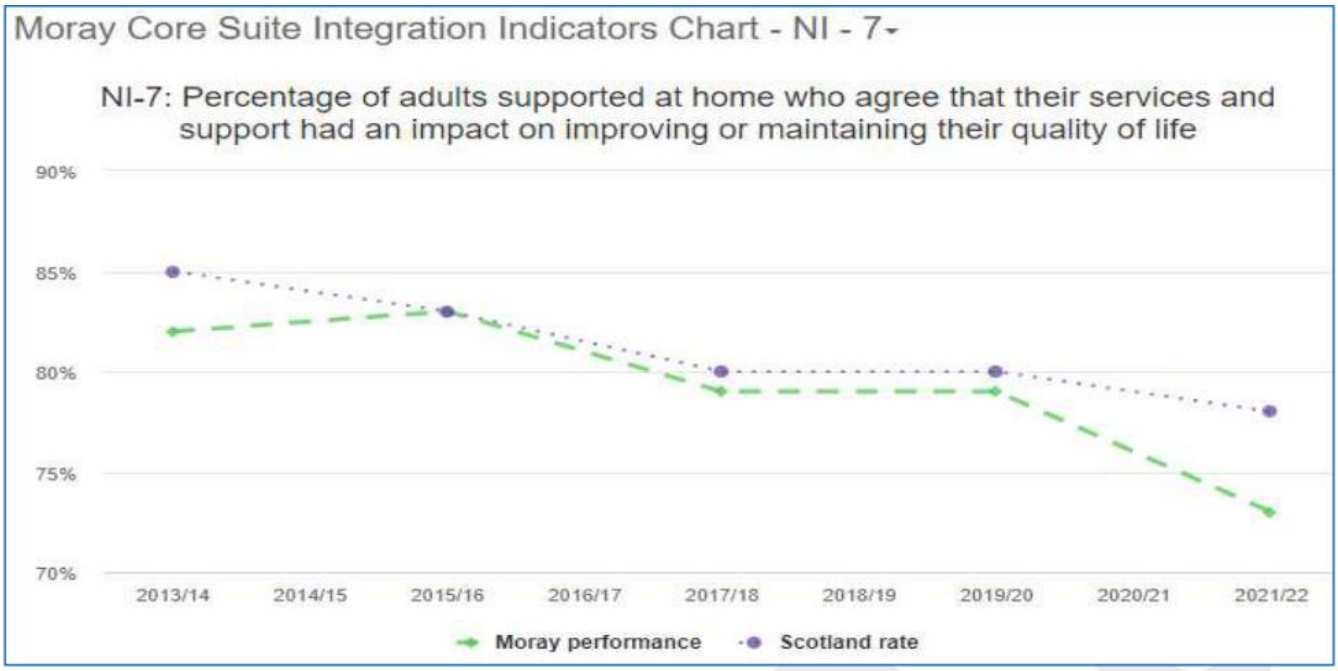
In previous surveys around 80% of Moray respondents have rated their care as excellent or good. That proportion reduced to 68%, below the Scottish average of 75%, in the latest survey.



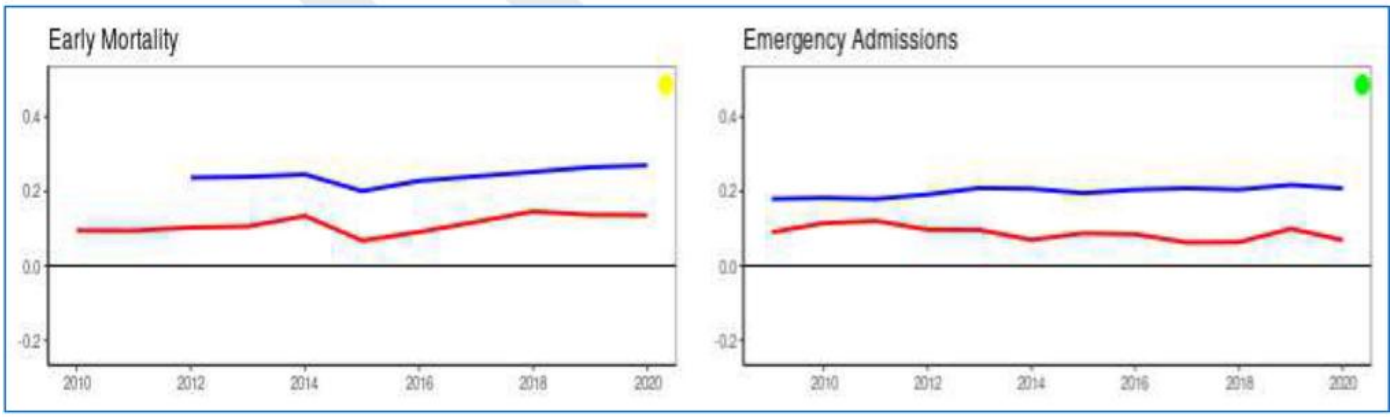
Just 6 out of 10 respondents in the latest survey had a positive experience of care at their GP practice, down from 85% in previous surveys. This deterioration in experience mirrors the decline across Scotland.



Similarly, a smaller proportion of Moray respondents agree that the care they received has had an impact on improving or maintaining their quality of life than in previous years. In the latest survey the proportion agreeing with this statement was 73%, below the Scottish proportion of 78%.

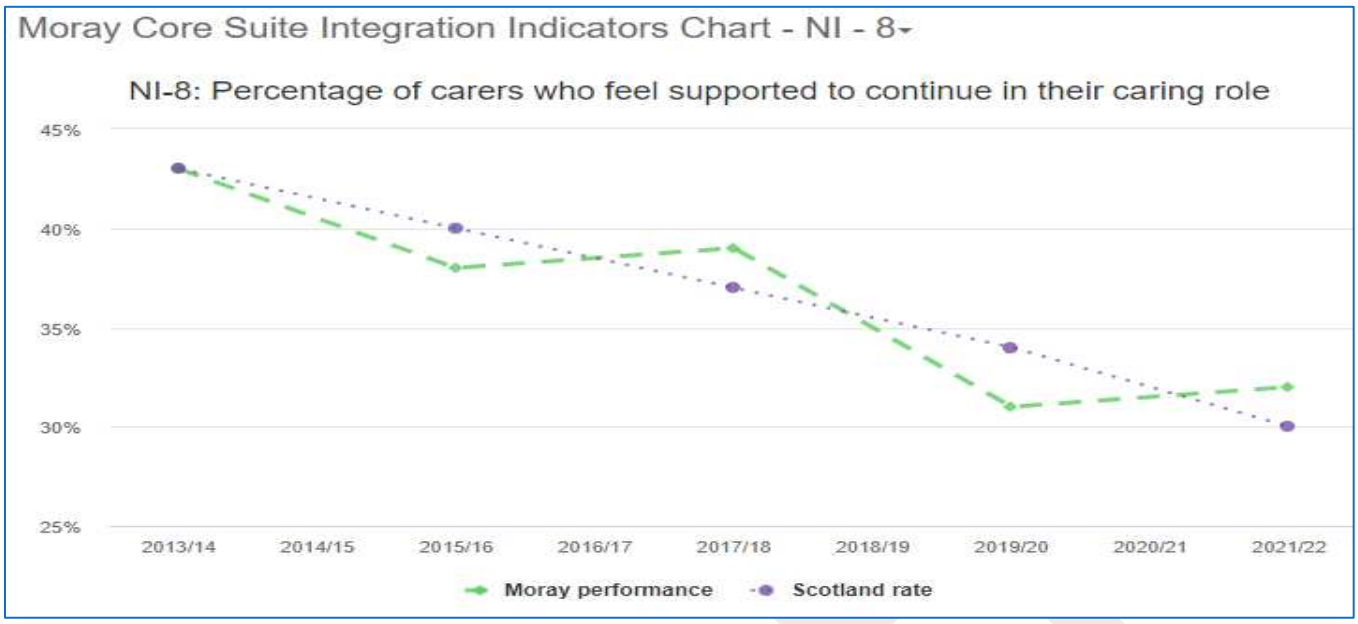


The Improvement Service's Community Planning Outcomes Profile tool[1] contains 2 measures that indicate the level of inequality between the least deprived and most deprived areas in Moray (the most recent data is for 2020). Inequality in the early mortality rate has consistently been below the Scottish level since 2012. The figure has remained stable over the past 2 years after 3 years of gradually rising, indicating that inequality has stopped widening, but is not reducing. Similarly, the inequality in emergency hospital admissions has been less than the Scottish level since 2010 and showed an improvement in 2020.

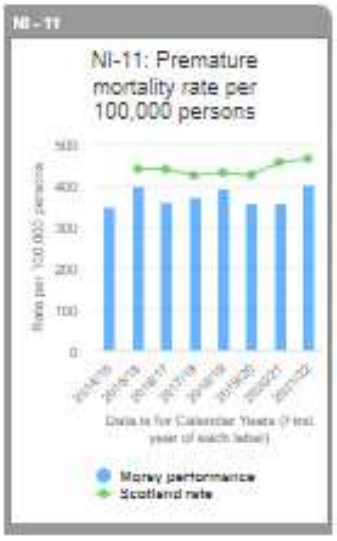


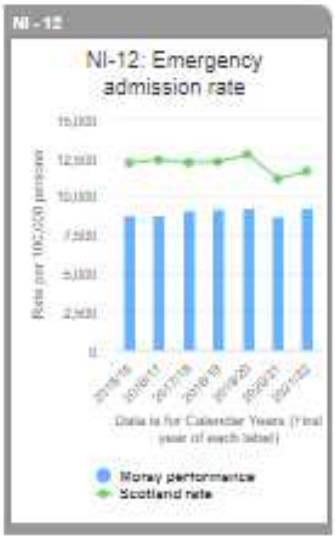
The percentage of carers in both Moray and across Scotland who feel supported has never been high, but has gradually reduced over the years from 43% to fewer than one in three (32% in Moray and 30% in Scotland).

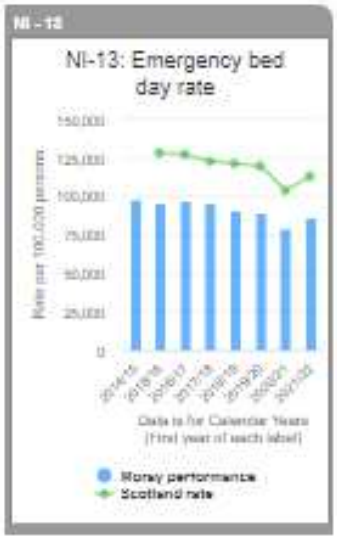
[1] Scottish Government Improvement Service – Community Planning Outcomes Profile Tool - https://scotland.shinyapps.io/is-community-planning-outcomes-profile/

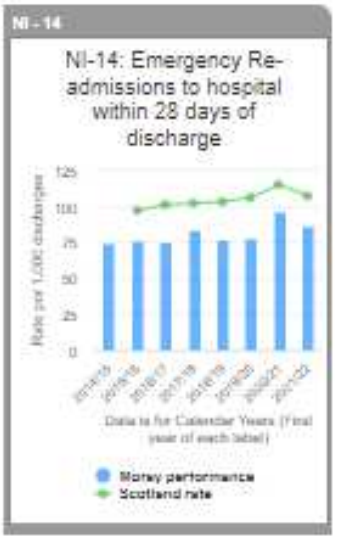

Moray Core Suite Integration Indicators Chart - NI - 8
NI-8: Percentage of carers who feel supported to continue in their caring role
45%
40%
35%
30%
25%
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20
2020/21
2021/22
Moray performance
Scotland rate

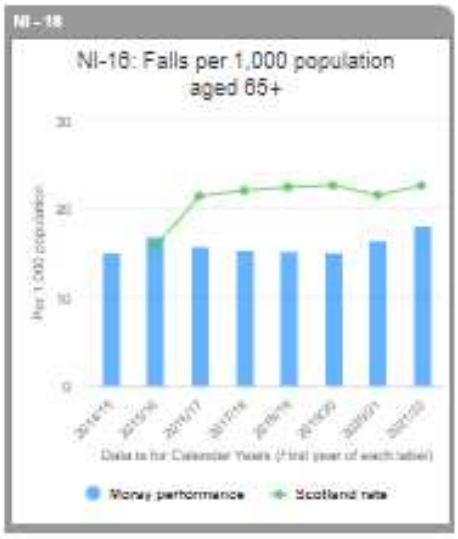
APPENDIX D Operational Indicators –(updates not available till mid June REPORT TO COMMITTEE WILL NEED TO SHOW OLD INDICATORS FOR REFERENCE ONLY, TO BE UPDATED PRIOR TO PUBLISHING.)

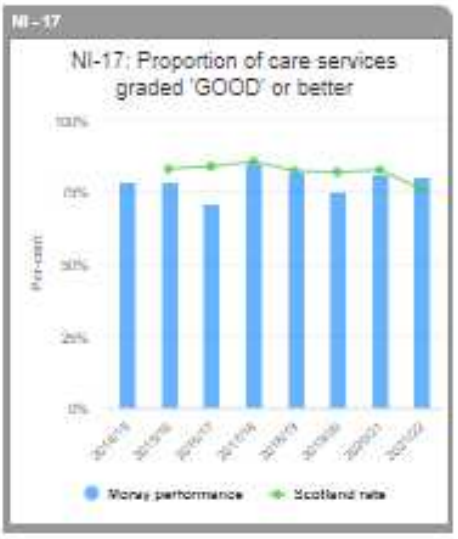


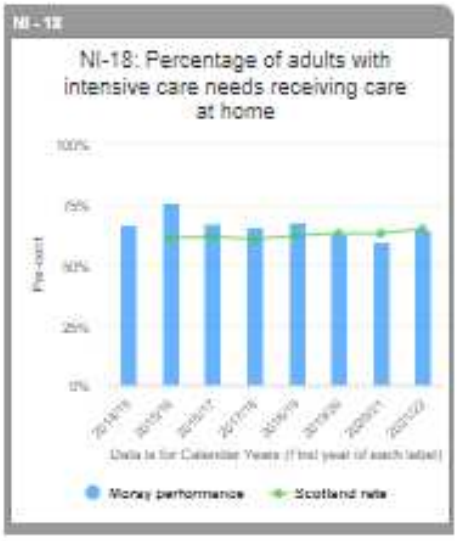


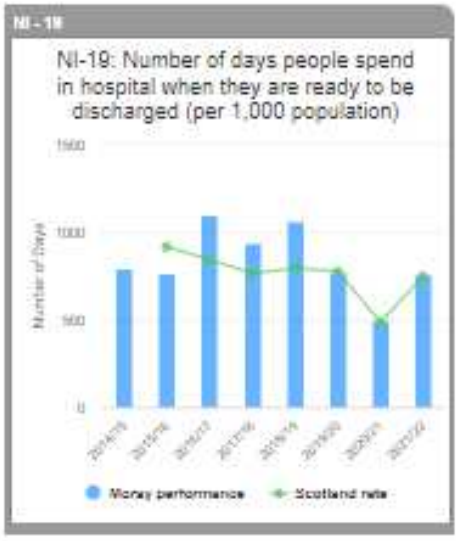


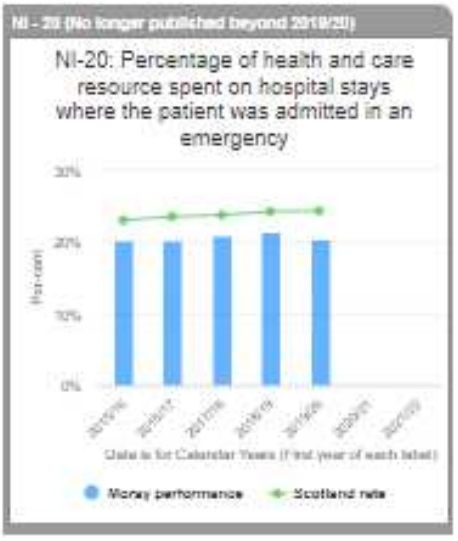












APPENDIX E – MORAY INTEGRATION JOINT BOARD SIGNIFICANT DECISIONS

Annual Performance Report 2022/23

Decisions taken by the Board during the year included:

May 2022	• Approved the continued closure of the Burghead and Hopeman branch surgery buildings and noted the continuation of interim measure to support patients in vulnerable groupings to travel to the Lossiemouth surgery. • Approved a formal consultation with patients of Moray Coast on the future model. • Agreed future meetings of the Moray Integration Joint Board would be held as hybrid meetings.
June 2022	• Approved the Business Case for delegation of Children's and Families and Justice Social Work Services to MIJB and noted that the Business Case has been submitted to Moray Council and NHS Grampian for their respective approvals. The Board also noted that financial accountability for the service remains with the Council for a period of 18 months up to 31 March 2024.
September 2022	• Agreed to make an application to the various national performance bodies so that future data sets are provided on a locality level where possible. • Approved the expenditure of £63,854 for the provision of initial health assessment for Ukrainian Refugees (as part of a pan Grampian response) and noted current spend to date circa £43,000, with Moray's proportion to be £8,649.87. • Approved in principle the Draft Integrated Workforce Plan content and structure.
November 2022	• Approved the publication of the Draft HSCM Carers Strategy 2023-26 for consultation in January 2023. • Approved the draft submission to Sustainable Scotland Network for the reporting year 2021/22 in line with Public Sectors Climate Change Duties Reporting. • Agreed the revised MIJB Strategic Plan 2022-32. • Approved for publication the HSCM Annual Complaints Report for 2021/22.
January 2023	• Approved reports to those charged with governance from the Board's External Auditor for the year ended 31 March 2022.

	• Approved the Audited Annual Accounts for the financial year 2021/22. • Approved the amendments to the Integration Scheme, which reflect the decision to delegate Children and Families and Justice Social Work Services to Moray Integration Joint Board and agreed its submission to the Scottish Government for final approval subject to approval by Moray Council and NHS Grampian at their meetings on 2 February 2023. • Approved a model of health and care provision that maintains a local focus on Burghead and Hopeman and ensures that services respond to local need, utilising the opportunities of a multi-disciplinary community team, supported by primary care. Use of existing and emerging technology must be promoted within the locality, using the opportunity afforded by the Digital Health Innovation strand of the Moray Growth Deal.
March 2023	• Approved the 2023/24 proposed savings plan • Approved the uplift to social care providers as part of the continued policy commitment made by Scottish Government in November 2021 • Approved the updated medium term financial framework, noting a full review will be carried out and presented to the MIJB before 30 September 2023. • Approved the revenue budget for 2023/24. • Approved the launch of Unpaid Carers strategy in April 2023.