[HEALTH AND SOCIAL CARE MORAY logo]

[Suitable picture demonstrating health and care]

Annual Performance Report 2018-19

CONTENTS

WELCOME FROM CHAIR AND CHIEF OFFICER, MORAY INTEGRATION JOINT BOARD

Health and Social Care Moray ("the partnership") formed in April 2016, bringing together health and care services across the area under the direction of a new public body the Moray Integration Joint Board.

Welcome to the 3rd Annual Performance Report 2018-19 for Health and Social Care Moray. The last year has continued to demonstrate significant work across the partnership as we strive to deliver better outcomes for the people of Moray. As a relatively new organisation we have worked hard to understand the potential of these new arrangements and had some significant changes emerge in the way in which we deliver support particularly in the area of mental wellbeing. We see this aspect of care as critical on many levels in achieving better outcomes. The approaches range from engagement with community led activities through to how we deliver formal services.

This report sets out progress in a number of areas and is set out in the context of the 9 national health and wellbeing outcomes, those outcomes by which we are measured on a alongside other partnerships across Scotland.

Our workforce is made up of those working in the public services and those working for the third and independent sector. We are continually impressed by the commitment they demonstrate on a daily basis in what can be extremely challenging circumstances. We are thankful for all that they do. We remain committed to supporting teams to work collaboratively together for the good of the people in all of our communities. Our services will continue to strive to be of high quality, accessible for those most in need and sustainable for the future.

The people of Moray continue to be fantastic allies by challenging us, holding us to account and enlightening us to the power of community. We are ever grateful for this. Whilst we still have a lot of learning to experience although we have made some headway in working positively with communities towards positive outcomes whilst recognising we have a way to go in this.

We are committed in these challenging times to deliver the best services possible for the people of Moray whilst supporting communities and individuals to be resilient in a way that enables them to have choice and control of their lives, feeling equipped to reach their true potential.

[Photo 2 Pam Gowans]

[Photo 2a Shona Morrison]

INTRODUCTION

The Public Bodies (Joint Working) (Scotland) Act 2014 is the legal framework underpinning health and social care integration in Scotland. This legislation requires the Integration Joint Boards (IJB) to produce annual performance reports that assesses their performance in planning and carrying out their functions in respect of the delivery of health and social care services locally, improving outcomes for the people of Moray. This report is the third Annual Performance Report of MIJB and is produced to meet these obligations and to provide an opportunity for our local community to have an overview of the progress being made during the year.

The Moray Integration Joint Board (MIJB) was established 1 April 2019. MIJB has the responsibility for the planning and delivery of all community based adult health and social care services in the area. It also has the strategic planning responsibilities in respect of emergency care required by people often ending in admission to the acute hospital locally, Dr Grays or in Aberdeen Royal Infirmary. The MIJB also manages (referred to as hosting) on behalf of Aberdeenshire and Aberdeen City IJB, the pan-Grampian services relating to GMED, the service that provides out of hours general medical care and Primary Care Contracts the team who service all the contracts for General Practice, Community Pharmacies, Optometrists and Dentists.
In-line with the expectations explicit in the legislation and Scottish Government guidance, the report considers our performance from several different perspectives:

- The progress we have made in achieving the nine National Health and Wellbeing Outcomes and the related key priorities of the MIJB;
- Making our Strategic Plan a reality;
- The views of other people based on service user feedback, carers and external organisations who inspect and regulate our services;
- The way in which we have managed our finances and delivered best value

STRATEGIC CONTENT

Scottish Government's strategic vision "**by 2020 everyone is able to live longer healthier lives at home, or in a homely setting**" and that we will have a healthcare system where:

- We have integrated health and social care
- There is a focus on prevention, anticipation and supported self- management.
- Hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm.
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.
- There will be a focus on ensuring that people get back to their home or community environment as soon as appropriate with minimal risk of re-admission.

The MIJB Strategic Plan 2016-2019 is currently under review, this plan set out the local context in response to the national strategic direction with a vision seeking to enable the people of Moray to lead independent, healthy and fulfilling lives in active and inclusive communities where everyone is valued, respected and supported to achieve their own goals. The strategic outcomes set out in this plan were that:

This strategic approach is supported by an ambition to encourage a more mutual relationship between those who deliver services and those in receipt of services as well as working with local communities. We are keen to ensure a better integration with those assets and activities in neighbourhoods that can support positive health and wellbeing. We have also set up a mechanism referred to as the Moray Alliance; this planning mechanism will have a focus on improvement and redesign of services, bringing together key stakeholders in the pathways of care to do so. The aim here is for an ethos of collaboration, planning together to ensure best fit for the people of Moray.

All of this direction is underpinned by the findings of a report published in 2011 referred to as the Christie Commission after the author. This report set out the case for change and the urgent requirement for the delivery of health and social care to change in order to respond to the growing demand for services as a result of the population changes, the reduction in the working age population, the economic landscape and the need to prioritise those most in need.

WHAT DO WE KNOW ABOUT THE MORAY POPULATION IN RELATION TO HEALTH AND WELLBEING?

Historically Moray tends to have a health profile that is better than the Scottish national average.

Overall Moray has:

- above average educational attainment at S4 level, smoking rates
- average levels of employment (albeit below average income), alcohol-related mortality,
- below average levels of crime, homelessness, alcohol-related hospital admissions,
- significantly better health condition prevalence rates than the average across Scotland regarding – emergency admissions, over 65s multiple emergency admissions, new cancer registrations and admissions for Chronic Obstructive Airways Disease (COPD), Chronic Heart Disease (CHD) and asthma.
- average incidents of traffic accident casualties, and worsening access to services overall.
- the population of Moray is ageing with a significant increase in the proportion of over 50 year olds and a reduction in 29 to 40 year olds predicted in the next 10 years.

WHAT HAVE WE ACHIEVED SO FAR?

The Strategic Plan outlines the key strategic outcomes to achieve the shared vision for change.

This report is a summary of progress during 2018/19 in achieving the principles outlined above. In also reviews and analyses performance in relation to the 9 National Outcomes for health and social care whilst highlighting some of the specific project work undertaken.

Key areas of focus during 2018/19:

- Transformation Programme in Learning Disabilities Services through the application of the progression model.
- Transforming Primary Care including the implementation of the new General Practice Contract for Scotland and Out of Hours care
- Developing Acute Care for the Elderly in the context of our wider older peoples pathways of care
- Implementing the new Carers Act 2018
- Continued developing on housing based initiatives supporting people to live independently with a range of personal challenges or health and care needs.
- Continued focus on Health Improvement and active communities
- Continued implementation of our Good Mental Health for All strategy
- Continued implementation of enabling approaches such as Self-Directed Support, and Shared Lives

PROGRESS

Across the outcomes of wellbeing there are areas of notable progress in the provisional figures for 2018/19:

- The number of total emergency acute hospital admissions remain well below the Scottish rate.
- Readmission rates although slightly increasing are below Scottish rates.
- The Falls rate (per 1,000 population) has been maintained despite an increase in 65+ population for Moray, and remains below the Scottish rate..
- Continued improvement in the proportion of care services graded “good” or above.

CHALLENGES

Where we have more challenging areas of performance these relate to:

- Whilst there is a shift in the balance of care of older people into community settings, demand for services is increasing due to the increase in the proportion of 65+ population overall, and people living longer with complex conditions.
- The national trend shows an increase in the number of suicides, in particular those of young men taking their own lives that are not known to services. In our new strategic plan we will be considering the wider Community Planning Board collaborative effort with communities, as we implement the new Suicide Strategy for Scotland, assessing the position in Moray and what action is required above what is already on offer.
- The growth in the levels people, who live with a learning disability, transitioning from children’s services into adult services. This provides challenges in the form of supply and demand of services, for staffing and accommodation, alongside the costs associated with the packages of care required to deliver the positive outcomes of living well and living longer.
- The number of delayed discharges from hospital continues to be volatile, however there has been progress in reducing the number of days delayed over the past year and it is anticipated that this trend will continue.
- Finances continue to be challenging with a picture of increasing pressures against a decreasing budget.
- Workforce supply, recruitment and retention continue are of ongoing concern with a reducing number in the working age population, outward migration of young people in Moray and low unemployment locally. This is compounded by the fact that nationally there a shortages in key professional groupings.

NATIONAL OUTCOMES

The National Health and Wellbeing Outcomes are the Scottish Government's high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care. These outcomes provide a strategic framework for the planning and delivery of health and social care services and they focus on the experiences and quality of services for people using these services, carers and their families. We have used this framework as the basis for our performance report and further detail is provided in pages X – Y

Health and Wellbeing Outcomes	
1.	People are able to look after and improve their own health and wellbeing and live in good health for longer.
2.	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3.	People who use health and social care services have positive experiences of those services, and have their dignity respected.
4.	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5.	Health and social care services contribute to reducing health inequalities.
6.	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
7.	People using health and social care services are safe from harm.
8.	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9.	Resources are used effectively and efficiently in the provision of health and social care services.

National indicators have been developed to underpin each outcome and performance is highlighted in the pages that follow. The information for indicators 11 to 20 are to be updated, however information for 2018/19 has not been released by Information Services Division (ISD) for publishing, with the exception of indicators 15, 16 and 19. Scotland comparator information is also not yet available for publishing for 2018/19.

Health and Care Experience (HACE) survey, a survey issued to a random sample of patients registered with a GP in Scotland, is undertaken nationally every two years. Therefore information for indicators 1 -10 for 2014/15, 2016/17 and 2018/19 is not available.

Please note * *RAG = Green performance is better than Scottish average, Amber performance is worse that Scottish average but within 5% tolerance, Red performance is worse that Scottish average by 5%.*

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

This national outcome is truly incorporated in our vision “to enable the people of Moray lead independent healthy and fulfilling lives…”

We are working together with partners to facilitate people being independent and leading the lives they choose, maintaining good health and wellbeing.

No.	National Indicator	2015/ 16	2016/ 17	2017/ 18	Scotland 2017/18	2018/ 19	RAG*
1	Percentage of adults able to look after their health very well or quite well **	96%	N/A	93%	93%	N/A	G
11	Premature mortality rate	399	360	372	440	N/A	G
12	Emergency Admission Rate per 100,000 population for adults	8,673	8,775	9,269	12,192	not yet available	G

HOW DID WE DO?

93% of adults surveyed in Moray believe they are well able to look after themselves, which is in line with the Scottish average.

The premature mortality rates remains significantly lower than the Scottish average. The emergency admission rate is among the lowest rates for Scotland and is well below the Scottish average.

Reducing drug related harms through training and promotion of Naloxone has been a focus in 2018/19. 120 people were trained in use of Naloxone kits, an increase of 74% against a target of 5%. 120 kits were subsequently supplied, of which 60 were new, an extremely positive increase.

WHAT DID WE DO?

Residents of Moray are provided with a wide range of support options to enable them to look after their own wellbeing with a number of projects and initiatives undertaken during 2018/19.

In 2018 to maximise opportunities, increase reach and provide a flexible, holistic, person centred approach, the **healthpoint** and **Smoking Advice Service** merged. **The new merged service provides access to:**

- Specialist Smoking Cessation Support
- Practical ways to improve health and health concerns
- Support groups and organisations
- Self-care/self-management, through National Campaigns such as the 'Winter Chest' campaign which provided information on early warning signs of 'flare ups' for those with existing chest conditions, how to manage and access treatment to avoid exacerbations.
- NHS services
- Long term conditions e.g. Diabetes & Asthma
- Free condoms

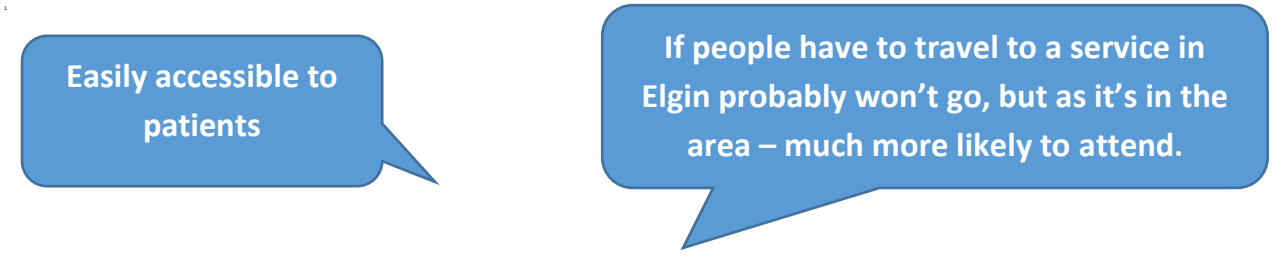
The new merged healthpoint service is available within the community, GP practices throughout Moray and Dr Gray's Hospital.

Since the merger in 2018 we have increased delivery of our community healthpoint outreach service by 24% reaching local communities and workplaces, with 89% of those accessing the service being of working age and older people.
Outreach enquires relate to:

- nutrition and physical activity 43%;
- alcohol and smoking 30% and
- Healthpoint/NHS services 27%.

The 1:1 service is a very welcome addition to the community, for our partners and population, complementing the existing helpline and text service.

Feedback includes:



To deliver the community outreach service we work in partnership. One of our key partners is the Department of Work and Pensions, who utilise our Mobile Information Bus to reach rural communities such as Tomintoul to provide advice on health and wellbeing, employment and income/fuel maximisation.

Case Study 1

Carol has a chronic chest condition and was referred for smoking cessation support. Carol found the service to be flexible and easy to access, bringing along her husband. The couple have now reached their '12 week' quit and are now accessing the service for weight management.

Case Study

Sharon is accessing the outreach heath point service in her GP practice for smoking cessation support. Sharon is a carer for elderly parents who both have dementia which has had an impact on her financial situation. With healthpoint advisor support, Sharon has been referred to Quarriers and the income maximisation team and now has the confidence to access these services that she was previously unaware of. Sharon continues to cope with her smoking cessation journey.

Case Study 3

To enhance Kevin's journey to independent living, his carer accompanied and supported him to access the healthpoint service for weight management advice.

Kevin has now successfully lost 25% of his body weight, attends the gym and has learned to cook from scratch.

Kevin's confidence has soared, he used to lie in bed and worry what problems the day would bring, but now he sees 'everyday as an adventure'.

[Mobile bus photos]

MORAY WELLBEING HUB CIC ACTIVITY FOR HSCM

In 2018-19 Moray Wellbeing Hub Community Interest Company (CIC), worked as a resource to support local services delivering health and social care.

The organisation is a Moray based social movement and enterprise that looks to harness lived experience of life challenges to create change. Empowering community members as active citizens and connecting partners in health and social care, and wider, for values focused collaboration to make Moray more mentally wealthy.

Projects co-designed and delivered in partnership include:

- **Mental Health Pathways in Moray**:
  Creation of a new tool to help GPs and community members understand and discuss their options in mental health in Moray, both with support and alone. Co-designed by a majority of people with lived experience of mental health challenges (survey showed 77%). Our training around this tool is becoming a key component to how we can support community members to self-manage and help others. Partners involved – HSCM Public Health and Mental Health teams, Moray Coast Medical Practice, tsiMORAY, Scottish Recovery Network, Health & Social Care ALLIANCE. Further developments underway are a children, young people

and families version, with other versions such as around drug and alcohol issues to be created in 2019.

- **'Wellness College' brand**:
  Peer-led self-management courses 2018 - over 120 over 16s attended, results show increased self-management ability and decreased self-stigma.
  Qualitative feedback includes "(I gained) more understanding of my feelings, emotions - feel in a better place to deal with, and achieve things."

  Training for Trainers - 15 peers completed Peer2Peer course enabling them to run support groups and provide mentoring

- **Social movement**:
  29 Champions joined in 2018 so there are now 176 people actively involved. Evaluation shows increased connection, hope, ability to give and receive support for those involved.
  "Hopefully sharing my own experiences with mental health in the past contributes to the creation of a growing openness to speak about issues, and inspire others to accept that it is ok to talk."

- **Supporting the workforce with training for HSCM staff**:
  52 dental and GP admin staff trained by peer-trainers. Feedback received identified an increase in confidence, hope, knowledge and willingness to share own experiences.
  "(I will) talk more to those around about my own and their mental health… to not be afraid to talk" Participant, Dental Training.

- **Adding value to HSCM services and events**:
  Supporting partnership and coproduction through pop-up cafes at events (House of Care GP community events / Scottish Services Directory event), sharing volunteers and facilitators for strategic engagement.

NEW SAMH SERVICE

The new SAMH contract was launched with the adult mental health service as of the 1st of April 2019 integrating SAMH as third sector partners with the Integrated Mental Health Service.

Prior to the commencement of the new contract we had the commissioning process (going out to tender to engage a service in a contract) we worked with SAMH as the existing providers engaged in testing out new ways of working, thus assisting us to understand what a new and improved service needed to look like. This involved listening to feedback from the community and partner agencies working collaboratively with the hospital and community mental health teams capturing the highlights of "what matters?" through the Making Recovery Real Conversation Café events. This feedback included insights such as people wanting to be supported in their own homes as much as possible, for any necessary inpatient stays to be as brief as possible and to have support to access their local communities and the resources within them more successfully.

Initial feedback is very positive and the service is facilitating more timely discharge and helping to prevent admissions to inpatient care by providing alternative options of intensive support.

DISTRESS BRIEF INTERVENTION LAUNCH

Joint work with Penumbra continues in regards to the Distress Brief Intervention (DBI) project. The DBI initiative emerged from the Scottish Governments work on suicide prevention as a component of the national mental health strategy showing that people in distress require improved co-ordination across agencies and quicker access to support with an emphasis on more consistency in the compassion they receive.

Associated Partnership has been awarded from the Scottish Government Initiative run in Aberdeen with Penumbra and this is a huge boost to Moray in terms of having access to already developed and effective resources. 1st Response Moray training is underway and will launch operationally in July 2019.

MAKING RECOVERY REAL PARTNERSHIP REBRAND

The Making Recovery Real Partnership in Moray continues with representation from the community, third sector, NHS and Local Authority colleagues. A celebration event was held in the spring to mark the works undertaken so far and to invite a greater representation from community members in how we take forward our strategic goals in Moray.

[Possible **Photo** moray well being hub page and search up - Reflection: Making Recovery Real in Moray – A Celebration, 17th April 2018]

To support and promote independence, positive health and wellbeing for older people in Moray, a range of community initiatives and programmes continue to be developed with the aim of promoting; independence, choice, reducing social isolation by increasing community connections and promoting the use of local assets.

The success of our staff and the partnerships created in Moray have been recognised nationally.

BOOGIE IN THE BAR – SUCCESSFUL PARTNERSHIP

The glitter ball has been shining brightly again during 2019 for the award winning day time Boogie in the Bar. To date there have been 5 discos with 640 participants with £1,100 funds raised being reinvested into local community groups.

Boogie in the Bar has been recognised nationally through the "**Age Scotland Patrick Brooks Award for the Best Partnership Work 2019"**
[PHOTO]

This award is for partnership working that has made an outstanding contribution to addressing the needs of older people.

Partners included: Moray Council, NHS, Scottish Ambulance, Scottish Fire and Rescue, Joanna's Night club, Quarriers, Alzheimer's Scotland, Brivic plc, Moray Care Homes, community groups.

https://www.youtube.com/watch?v=pbk_6NIrBv4

These events continue to support the older people in Moray to increase their physical activity whilst enjoying a 'boogie'. Health and Wellbeing campaigns are promoted at each disco and featured topics have ranged from Falls Prevention, Dementia awareness, role of the unpaid carers, sexual health, Making Every Opportunity Count (MEOC).

COMMUNITY CAPACITY BUILDING

The Community Development Team use the asset based community development approach focusing on people as their biggest assets as community connectors

- **Assets** – getting to know people in their own communities
- **Building** – build positive and trusted relationships with one another over time
- **Communication** – encourage and support through positive conversations
- **Developing** – support the development and confidence of people in their community as they become skilled and effective community champions

Testimonials regrading personal outcomes and benefits to service are collected and demonstrate real positive impacts for participants.

In 2018-19 CWDT supported **32** independent groups including

- 21 BALL groups

- 12 Social groups including Men's Sheds,
- 3 specialised health and wellbeing groups

This equates to over 1178 people each week accessing community resources

Year	No. of Groups	No. of People
2015-16	41	820
2016-17	49	1160
2017-18	52	1230
2018-19	**36**	**1178**

During this year the number of groups that could be directly supported by CWDT reduced due to available capacity. However CWDT worked with Hanover Sheltered Housing staff, take forward developing social contacts and connections for their residents. CWDT supported the Hanover staff with building links with external support by providing contacts and connections, to integrate tenants with groups that already exist in the community.

CASE STUDY

Charlene is a tenant at Linkwood View. For the last 3 months, Charlene has been attending Elgin Duellist Fencing Club members for an extra night of fencing we hold at Linkwood View. Although Charlene has a learning disability she's achieved a lot and will be looking to join our main club night on Thursdays.

[photo 5 Charlene]

SOCIAL RETURN ON INVESTMENT (SROI)

Increasing Mens sheds has been a key focus for 2018-19 for the CWDT

A study has proven that a community Men's Shed project yields a 10:1 return on investment. For every £1 spent an equivalent £10 is saved. It is fair to say that the outcomes of a Men's shed mirrors the community groups developed throughout Moray.

Additional savings occur as the CWDT support those who require community transport (Dial M) and collaborate with third sector organisations to support individuals through befriending and volunteering, incurring no additional transport costs.

The CDWT works differently across boundaries and is currently collaborating with a third sector organisation to secure funds to increase growth of groups across Moray. A recent report in the Press & Journal identified that there was a boogie in the bar in BUCKIE….this demonstrates community capacity building and self-care self-management in practice!

SINGING EXERCISE & TEA GROUP

Working in partnership with Dance North has allowed the 3 SET groups to continue to grow in Moray. With funding being awarded from the NHS Grampian Endowment Fund the partnership allows trained dance facilitators to deliver gentle seated exercise to music for 34 people weekly.

The 3 groups offer a safe place to develop new friends whilst exercising and sharing memories, reducing social isolation and creating connected communities.

SET group participate quotes "this group is better than any medicine"

[Poster 1]

BE ACTIVE LIFE LONG (BALL) GROUPS

BALL Groups are unique to Moray and originated in 2005. They were created out of the need to improve mental and physical activity amongst the over 60s in order to keep them connected to their communities and to prevent, reduce or significantly delay the need for formal care services. The growth of participants in Moray continues to grow year on year with over 780 people attending BAKLL groups through Moray on a weekly basis.

The Institute for Research and Innovation in Social Services (IRISS) documented the value of the BALL group's by studying the methodology, interviewing BALL group's participants and providers as well as showcasing Moray as a positive example of community social Work. **[Poster 2]**

As a result of the report, Kirkwall now has 3 BALL groups established due to shared learnings and telephone support from the CWDT to Voluntary Action Orkney.

[Photo 4 - Duffus BALL group participating in indoor activities]

DOT BALL GROUP PROVIDER [photo 3 of Dot]

"*It's just wonderful – you see them coming in kind of timid and shrunken and after three or four weeks they're striding along. You wouldn't believe the difference it makes and it can spread into all areas of their life. It's as though someone has lit a light inside them*."

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

One of our strategic outcomes is "Supporting people to live independently at home or in a homely setting for as long as possible will always be our default position" and the work that has been carried out with partners under Strategic Housing Implementation Plan (SHIP) for Moray demonstrates that commitment.

The SHIP has been developed from an assessment of forecasts of future needs for Moray in terms of accommodation requirements, and Moray Council, HSCM and partners are working to build appropriately to meet these requirements. We have also established a strong partnership with a housing association and this has enabled the delivery of extra care facilities that allow people to live independently in their own tenancy with the care on site. More detail of these initiatives are in the examples further on in this report.

In the event of people finding themselves in hospital our aim is to get you back home as soon as you are medically fit, particularly for the older population. The evidence is clear that extended hospital stays often lead to people losing their confidence, mobility and as such their independence. Preventing delays in discharge remains a focus in Moray and new initiatives are showing encouraging signs of positive impact for future.

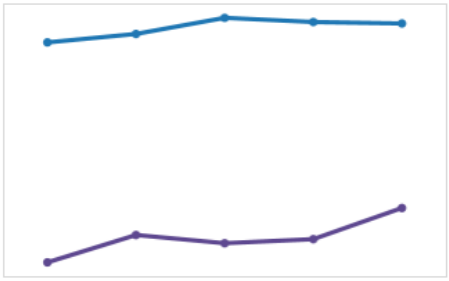
No.	National Indicator	2015/16	2016/17	2017/18	Scotland 2017/18	2018/19	RAG*
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible**	74%	N/A	83%	81%	N/A	Gu
3	Percentage of adults supported at home who agreed that they had a say in how their help, care or support was provided	73%	N/A	75%	76%	N/A	Au
5	Total % of adults receiving any care or support who rated it as excellent or good	79%	N/A	80%	80%	N/A	Gu
12	Emergency admission rate (per 100,000 population)	8,711	8,775	9,269	12,192	not yet available	Gd
13	Emergency Bed day rate (per 100,000 population)	96,114	97,461	96,050	123,160	not yet available	Gd
14	Readmission to hospital within 28 days (per 1,000 population)	76	74	84	103	not yet available	Gd
15	Proportion of last 6 months of life spent at home or in a community setting	90%	90%	89%	88%	90%	Gu
19	Delayed discharge bed days	764	1,095	936	762	1,093	Ru

HOW DID WE DO?

Moray has performed well in terms of low emergency admissions and is well below the Scotland average.

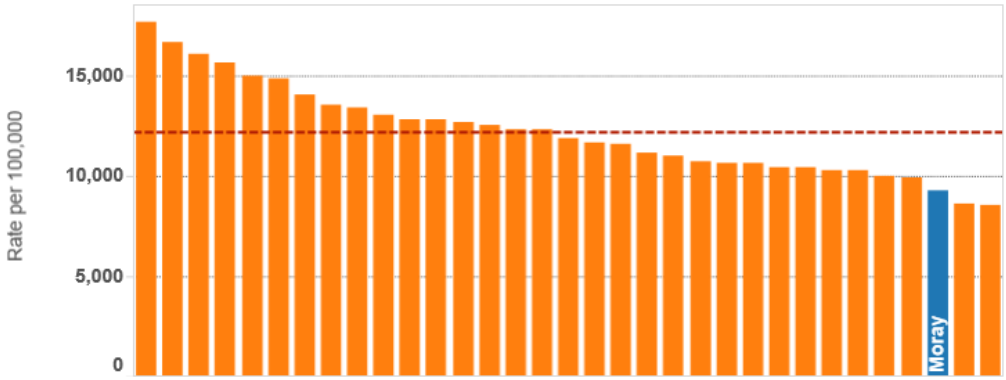
Emergency admission rate for adults (per 100,000 population).

	2013/14	2014/15	2015/16	2016/17	2017/18
Moray	8,408	8,841	8,711	8,775	9,269
Scotland	11,892	12,026	12,281	12,215	12,192



Scotland Moray

Bar graph shows data for **2017/18:**



Additional Information for 2017/18:

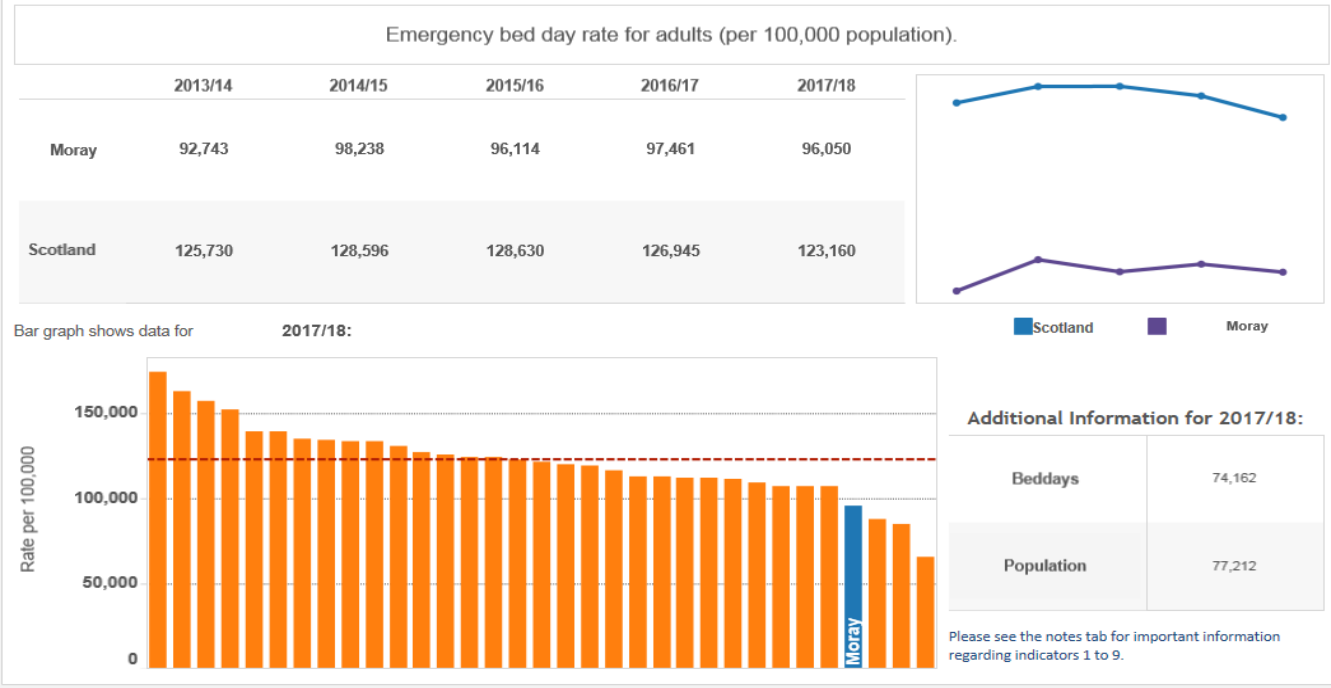
Admissions	7,157
Population	77,212

Please see the notes tab for important information regarding indicators 1 to 9.

Emergency Admission to hospital rates are well below the average at National and Grampian level, and whilst there was an increase during 2017/18 provisional figures for 2018/19 show a promising reduction.

This is an area of work that is monitored closely by Moray IJB and Health and Social Care Moray as an indication of the progress in preventing unscheduled admissions to hospital.

In addition the length of time those emergency admissions stay in hospital is monitored via the Emergency bed day rate. As shown below Moray has continued to maintain its position nationally and 2018/19 provisional figures indicate a notable decrease.



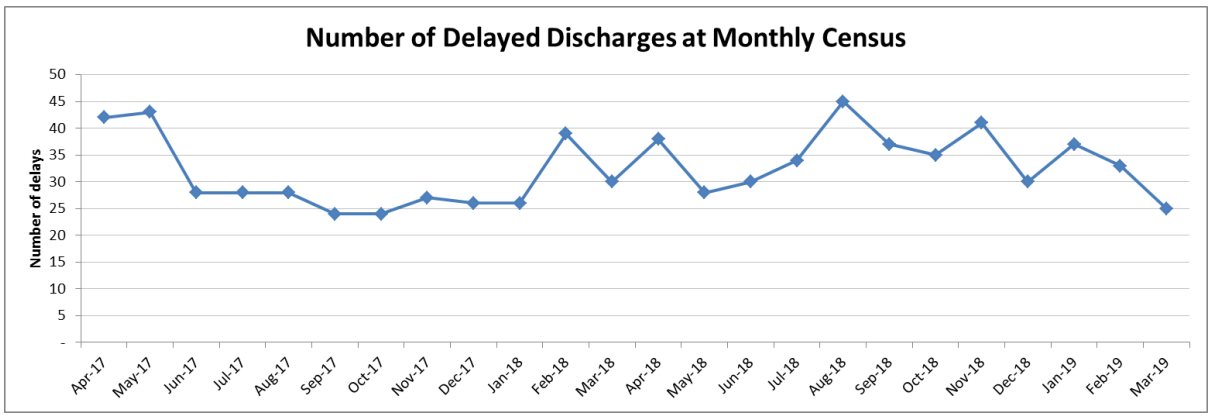
The rate of emergency occupied bed days for over 65's per 1000 population continues to reduce from previous years as shown below:

Year	Apr – Jun	Jul – Sept	Oct – Dec	Jan – Mar
2017-18	2558	2531	2495	2444
2018-19	2381	2375	2344	2274

DELAYED DISCHARGES

A key target for MIJB is to reduce the number of Moray residents that are ready to be sent home from hospital but have been delayed in this process. This is often referred to as a 'delayed discharge'. Historically the number of people affected by delayed discharge in Moray ranges between 22 and 32 in a year. Delays can occur due to a number of factors that can be complex in nature. There has been continued focus from teams across the health and care system to ensure that people can leave hospital with appropriate support when they are fit to do so. The monthly census figures are showing a reduction from a highest point of 45 in August last year to a low of 25 in March this year.

Overall there was an increase in 2018 in the number of delays from a monthly average of 30 in 2017/18 to 34 in 2018/19. The reason for delay increased in relation to "waiting for care arrangements" and decreased in relation to "waiting for assessment". The majority of delays were between 3 days and two weeks and whilst the number of delays for Dr Grays and beds in the community halved in 2018/19 compared to 2017/18, delays in Community hospitals increased by 15% over the same period.



WHAT DID WE DO?

Acute Care of the Elderly Unit, Dr Grays Hospital ACE Unit

Part of our approach to improving how we work with frailty in older people has been championed by the Geriatricians and the wider team in Dr Grays. This successful approach is being looked at in terms of spread across the community hospitals and in the planning how our integrated multi-disciplinary teams will work at a neighbourhood level moving forward.

In the 18 months that this 10 bedded ward has been in place 640 patients have been treated with an average length of stay of 7.4 days. There is a daily Geriatrician led ward round and daily access to Physiotherapy, Occupational Therapy and Social Work staff, with referrals to other services such as dietician or pain team as required. There is a weekly “relative’s clinic” and 85% of families meet a consultant. A Frailty Assessment Tool is used to identify appropriate patients and Physicians, Site Nurses, Site & Capacity team have been trained in identifying frailty.

Currently 66% patients are discharged home, with 24% to a community hospital. Links in the community have been strengthened with monthly hour long meetings with GP practices focussing on ACE Unit discharges and Frailty identification. The Geriatricians lead case conferences with the multi-disciplinary teams in community hospitals and undertaken scheduled ward rounds with GPs.

Delayed discharges remain a challenge with 32.5% of patients experiencing a delay awaiting care or transfer to community hospital and the 28 day readmission rate is currently about 10%. These are areas of close scrutiny and actions will continue to reduce these figures.

6 essential actions for improving unscheduled care in Grampian

This programme of work seeks to support the overall functioning of the hospital in terms of “flow”. This means how people travel through the hospital from home and back again. The actions contained within this programme seek to optimise all of the different parts of the pathway to ensure the quality of the journey for the person is high and the efficiency of the system is optimised. The Scottish Government team associated with this programme undertook a site visit to Dr Grays Hospital on 8 February 2019. They were very impressed with the work that has been progressed by the Unscheduled Care Group (the integrated team who support this activity). The

daily safety huddle and the defined improvement programme set out clear plans for the patient. This process relates to both general emergency and discharge processes as well as delayed discharges.

Caring delivered at home, or homely environment

One of our strategic priorities is to facilitate clients being able to remain in their own homes and be supported in the community. When clients are supported at home this increases the potential for client satisfaction and reduces the use of care home places, so saving associated costs.

During 2018 there was a review of operational efficiency through the analysis of data to monitor quality and performance at various stages through the process of service delivery. Through this review Services now have a greater understanding of their information and how it relates to operational efficiency and performance improvement. As a result of the review:-

- Closer monitoring of over or under delivery has led to practitioners reviewing packages
- Increased turnaround in identifying individuals requiring more or less support
- Improved communication from front line staff to care officers and senior managers.

Customer satisfaction surveys are issued to service users annually and any areas form improvement are identified and acted upon. Of the 497 questionnaires issued, 180 were received giving a response rate of 36%.

99% of people had confidence in the staff that support and care for them, with 97% rating the quality of care and 95% rating the experience of the service as excellent or good. These results show maintenance of the high standards established in previous years.

Feedback showed that support to enable people to meet their health and wellbeing **outcomes**, such as being able to live at home as **independently** as possible and improving their **quality of life**, was valued.

How well does the service help you?	**% positive**			
	Aug 2016	**May 2017**	**Sept 2017**	**July 2018**
The service supports me to live as independently as possible	93%	89%	94%	98%
The service helps me to maintain/improve my quality of life	89%	93%	100%	98%
The service meets my care and support needs	91%	91%	98%	96%
I have a say in how my care and support is provided	82%	82%	89%	88%
The service helps me feel more safe and secure	85%	86%	92%	93%
I am confident the quality of the service is being monitored	85%	95%	81%	93%

I am satisfied with how the service is run	83%	87%	92%	90%

Overall **satisfaction** with the service has continued and many people indicated they could not identify areas for improvement. However issues were identified in relation to time pressures for staff, at times poor continuity of care a variation in the quality of care dependant on who their carer was. These issues have been considered by the management team and actions have been implemented to address them.

A core principle of the **Moray Drug and Alcohol Partnership (MADP)** is to enable engagement into treatment, care and support ensuring consistency of access to alcohol and drug service provision across Moray. Supporting community services in meeting the needs of those using services where alcohol or drug use is a factor.

An example of what can be achieved was demonstrated at the **Moray Connect More event.** This event was co-produced by a team of people with lived/living experience volunteers, and. agency staff.
Circa 100 delegates from across Moray attended the event to celebrate and promote partnership working across statutory, third sector and community projects; enabling a range of easily accessible services and supported, aimed at reducing harms and promoting recovery to link up, share idea and support those with lived and living experience to engage in and be part of service design and delivery.

Technology Enabled Care (TEC)

We have an established, mainstream Telecare service that is very much part of the care planning process.

In our **extra care facilities** various TEC items have been introduced. Internal door alarms alert staff when someone leaves their room at night thus reducing the need for staff to actually be in the property overnight, providing more independence for tenants whilst keeping them safe;

- For people who have Epilepsy audio and visual monitors are used to check for seizure activity so that staff do not have to be present all the time.

- A staff call system is in place, to help staff call for assistance when required, reduces the requirement for large number of staff to be permanently present in people houses.

A project is underway to assess the most effective way to make use of **Attend Anywhere** to improve access to services in GP Practices. Working with a small number of GP practices opportunities to implement use of video consultations into everyday business are being identified. The outcomes of the project will be evaluated and adoption of agreed developments will be rolled out across all GP practices. Opportunities for use of this technology are also being tested outside of Primary Care for example in Quarriers Drug & Alcohol Service. Developments are also underway in secondary care, to include VC links to appropriate consultant/out-patient appointments at major hospitals in the future.

As part of a pan-Grampian project funding has been secured for use of “Florence” which is an assistive technology for self- care of blood pressure monitoring. A plan

is being developed for making this technology available across all 73 GP practices in Grampian.

SUPPORTED ACCOMMODATION

Woodview

Previous annual performance reports have featured the construction of the £2.5m new build of 8 bungalows for people with autism and challenging behaviour at Urquhart Place, Lhanbryde. This project was a "first" because HSCM provides the landlord function for these properties and we were able to tailor the accommodation to the needs of the tenant whilst ensuring the accommodation is sustainable for future use.

All the units were occupied by June 2018 and initial results have been extremely positive with a stable workforce, significant reduction in medication required and number and level of incidents. Before the move to the new accommodation, in 2016, there were on average 85 incidents per service user. In the first full year at Woodview the average number of incidents has reduced by 70% to 24 incidents per user.

In September 2018 the Care Inspectorate completed its first inspection of this housing support service and the report findings were very positive, with no requirements or recommendations.

Care Inspectorate Findings- September 2018	
Quality of Care & Support	5 – Very Good
Quality of Staffing	4 - Good
Quality of Management and Leadership	4 - Good

Extracted from a letter from a family to Woodview staff:-

"His house was a close to perfect as we could get it. We didn't replicate the hospital but we had taken all the important parts. I know some staff looked at the house and were unsure that parts of it were the right thing to do, I knew the first time I walked in on the 27th before Michael even arrived that he would be safe and enjoy his space. I think now everyone recognises how much we all got right in his house and how much it was designed with Michael at its heart.

Such a year for us as a family, visiting on our birthdays, a family picnic at Duffus Castle, sitting, spending the day with Michael in ***HIS*** *kitchen around* ***HIS*** *table.*

Brunch club, Halloween, Christmas parties, taking Michael out as a family on our own, a family Christmas, Alison being able to just jump on a bus and spend a day with Michael.

We stepped into the unknown a year ago. The unknown has been so positive. If we could have wished on New Years day 2018 for a perfect year and a perfect move, our dreams of what that would look like would not been as good as the year we have had. The most important highlight of the year is seeing Michael growing as a young man in his house we have never seen such a marked positive change in Michael as we have in the last year.

Every member of staff should share that pride for a job that goes beyond "well done", words cannot express that well enough".

Loxa Court

On 9th July 2018, building work started on a new Hanover (Scotland) Housing Association Ltd extra care housing development at Spynie, Elgin. Following suggestions put forward by the local community, this development has been named Loxa Court.

Commissioned by Health & Social Care Moray, Loxa Court is divided into a main three storey building, currently designated for extra care, and in the grounds two cottages and a further six two storey blocks.

Working in partnership with Health & Social Care Moray, Hanover Housing colleagues have designed the building primarily to support older people. However, the design of the building will also offer supported accommodation for people with a range of other health or social care needs.

The start of building work on this 44 unit new build follows the completion of the highly acclaimed Varis Court (Forres) and Linkwood View (Elgin) developments by Hanover (Scotland) Housing Association Ltd.

While Health & Social Care Moray have commissioned the development and Hanover Housing will be the landlords, Allied Health Care were awarded the contract to provide care and support.

Loxa Court will receive its first tenants in the Autumn of 2019.

Development of Multi-Disciplinary Team (MDT) in Forres

The partnership approach Hanover (Scotland) Housing ltd, to lease 5 of the 33 extra care units at the development in Varis Court has continued, with the Moray Integration Joint Board (MIJB) agreeing to fund the units for another year to November 2019. This is to continue with the purpose of testing new models of delivering health and care interventions and informing how health and social care services could be redesigned in the future for the Forres locality area. The nursing team providing 24 hours of care, 7 days a week at Varis Court with a strong re-ablement and recovery focus and they also provide support for people in their own homes in the community.

The nursing team are part of the multi-disciplinary team working with the two GP practices in Forres to prevent people requiring to be admitted to hospital by providing early interventions, or to support people in their own homes when they come out of hospital. During 2018 the MDT were co-located in Forres Health Centre to enable them to work closer together to support older peoples care at a local level.
They have become a key component in health and care system in Forres and it has proved popular with patients who have experienced them.

Positive benefits have been noted and a full evaluation and the longer term clarity on how this integrated model fits into the wider system will be assessed and reported to MIJB by December 2019.

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

We work alongside those people who use our services, those who deliver our services, carers, families and the wider public, to ensure that the way in which we conduct our business is from a basis of mutual respect.

We have a number of mechanisms for recording feedback including; direct feedback from those using our services, complaints, compliments, investigations and feedback through community councils, local elected members and the public through community engagement events held by ourselves and other partners. We are keen to ensure that the services we shape, have an human rights based approach, ensuring choice and control that in itself should result in a positive experience, where dignity and respect prevail.

No.	National Indicator	2015/ 16	2016/ 17	2017/ 18	Scotland 2017/18	2018/ 19	RAG*
4	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	71%	N/A	73%	74%	N/A	G▼
6	Percentage of people with positive experience of accessing their GP practice	86%	N/A	80%	83%	N/A	Ad
15	Proportion of last 6 months of life spent at home or in a community setting	90%	90%	89%	88%	90%	G −
17	Proportion of care services graded “good” or above in Care inspectorate inspections	78%	71%	85%	85%	87%	G ▲

The national GP survey is only carried out every two years so figures are not available for 2018/19

HOW DID WE DO?

93% of people surveyed considered they were able to look after their own health very well or quite well, which is in line with the Scottish average.

There was a slight reduction from previous years to 73% of people who felt that their services were well co-ordinated, however there was an increase to 80% of those who felt that the services provided were excellent or good.

In addition the majority of people surveyed and supported at home (84%) advised that they felt safe, which is just above the national average.

There has been a continued increase in “care services graded good or above” with the majority of our in house services averaging a score of 5 across all elements.

Complaints and compliments

The number of complaints received are very small in comparison to the level of contacts that are carried out every day with 24 complaints for health related services and 25 for Social care services being received during the year. Whilst the number is relatively small, the time taken to respond is an issue for health related complaints, with 54% being responded to within the target of 20 days. This can related to the complexity of the complaint however the process will be reviewed to establish any improvements that can be made. Any feedback from those experiencing our services is important and is monitored closely to strive to achieve the levels of care and standards required.

There were 3 complaints referred to the Ombudsman, 1 was not investigated by the ombudsman and 2 were not upheld. For one of these complaints a member of staff had reflected on the assessment of patients presenting with such symptoms and the Ombudsman advisor had identified this as clear evidence of ongoing learning and reflection to inform future practice.

Currently there is no formal mechanism to record compliments but this is an area under consideration for future.

WHAT DID WE DO?

As we strive to be a learning organisation seeking customer feedback and engagement is an integral part of service delivery.

Feedback from those receiving services is actively sought through a variety of media including annual customer satisfaction surveys, or when carrying out assessments or reviews. The information is then used to prepare action and development plans that are produced collaboratively with service users;

Cedarwood is a day centre for adults with learning disability. They issue service user and carer questionnaires annually with the most recent having a 71% and 57% respective response rate. Of the responses from service users 100% liked attending and enjoyed the activities. Of the responses from Carers 90% rated the service good or above and were happy with communication and relationships with keyworkers. Comments for improvements related to written communication and welcoming in the morning. These results are discussed at team meetings and group sessions.

Greenfingers is part of our Employment Support Services team, providing training and work experience for people with a learning disability, on the autistic spectrum or in recovery of a mental health condition, using the therapeutic benefits of horticulture and Green spaces. The service gather information from trainee reviews which is fed into their monthly comments and complaints discussions. They engage with the public via open days and pop up sales, gathering feedback from trainees, staff, visitors and volunteers on what they do and how they could improve. They have also been involved in forestry-based tasks over the past year and received very positive feedback from the Forestry Commission, who have committed to a further two years of financial support as a result.

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

Improving people's quality of life by reducing social isolation and connecting people to their communities is an area of focus, given the emphasis based on evidence of the impact of positive mental wellbeing on people's health overall. Supporting those with long term conditions by developing a variety of approaches to self-care and self- management ensuring people and their families/carers are able to develop confidence in managing their conditions. This can result in people not having unnecessary admissions to hospital and importantly being able to live their life to the full regardless of their condition.

No.	National Indicator	2015/ 16	2016/ 17	2017/ 18	Scotland 2017/18	2018/ 19	RAG*
6	Percentage of people with positive experience of the care provided by their GP practice	86%	N/A**	80%	83%	N/A	**A ▼**
7	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	83%	N/A**	79%	80%	N/A	**A ▼**
12	Emergency admission rate (per 100,000 population)	8,673	8,734	9,269	12,192	Not yet available	**G ▼**
14	Readmission to hospital within 28 days (per 1,000 population)	76	74	84	103	Not yet available	**G ▼**
19	Delayed discharge bed days	764	1,095	936	762	1,093	**R▲**

HOW DID WE DO?

National GP survey results for people's feelings of a positive experience in relation to services provided have shown decreases on previous years' results and are below the Scottish average.

However survey results collated for clients, who have support plans and who are requested to provide feedback on their experience, demonstrate that there is a high level of satisfaction with their involvement.

Year	2017	2018
No. of Clients surveyed	1,463	1,155
Reponses received	59%	64%
Agree they feel satisfied with their level of involvement	99.6%	99.45%

Note -The reduction in the number of clients surveyed is due to a redesign of process in Learning Disabilities.

WHAT DID WE DO?

New GP Contract and the Primary Care Improvement plan (PCIP)

The new contract has gone through its first year of a 3 year programme of implementation in Moray. We have a PCIP that sets out the actions and stages of implementation to support the changes initiated through this new national contract.

Our PCIP has key priority areas to be considered and delivered against, as part of the national process. For the people of Moray the aim is to improve the way in which people access and receive those services traditionally contained within the GP Practice setting. We have many professionals trained to high levels of expertise and we are building on the idea of a much broader multi-disciplinary team with a range of skills. This means that where people may have traditionally expected to a Doctor they may now see other professionals, supporting our ability to disperse the workload and improve access to the right care, at the right time by the right person.

Progress in the 6 priority areas of the PCIP are;

- Vaccination Transformation Programme – Short life working group established to develop Moray's model of delivery, this is now agreed and a full business case from Vaccination transformation Programme Board and funding for future years is currently being considered.

- Pharmacotherapy services – all practices have received additional Pharmacy input and are currently recruiting to new posts.

- Community Treatment and Care Services – review of work loads of Primary Care Nursing services, development of a new phlebotomy service, identifying links with NHS Grampian's Elective Care Project

- Urgent Care (advanced practitioners) – work is progressing regarding understanding of existing workloads and skill mix required for multi-disciplinary teams, tests of change in localities re response to urgent care needs at home and responses to emergency unscheduled care needs in the community.

- Additional Professional roles – Current evidence that musculoskeletal (MSK) health issues are the most common cause of repeat GP appointments and account for 20-30% of demand in general practice. Moray model has been developed to have physiotherapists working collaboratively with primary care multi-disciplinary teams to embed a MSK service in practice teams and will be

tested over 12 months. The subsequent evaluation will inform implementation for a Moray-wide service.

- Health and Wellbeing Workers- each GP practice has direct access to a Mental Health Link worker for Distress Brief Interventions. Dementia/Frailty co-ordinators are in place in 2 GP practises and further are planned for recruitment.

Considerable progress has been made during 2018-19 to establish the framework and governance requirements to deliver key objectives of Health & Social Care's PCIP, allowing for flexibility whilst ensuring adherence to the core aims and principles of the new contract. Within Moray we are well engaged with the local GP practices in planning and prioritising our planned activity**.**

- The PCIP Core group has close working relationships with the Moray GP Practice managers group and produces monthly newsletters providing updates that are circulated to the wider Primary Care teams.

- Workshops have taken place on MSK, Mental Health/Action 15 and further workshops are planned for the remaining priorities.

- Public engagement around developments associated with the PCIP has taken place with members of the PCIP core group attending local community groups. There is however a requirement and plans to increase the activity in this area.

Transformational Change in Learning Disabilities

A key project underway continues to focus on delivery of transformational change in Learning Disabilities, in relation to increasing levels of independence in the community with the intention to further improve people's quality of life.

The Progression Model: a person-centred developmental approach that seeks to support each adult with a learning disability to achieve their aspirations for independence though focusing on outcomes over time. It is a relational change from traditional care management approaches by focussing on the individuals' hopes and choices, using these as the basis to co-develop care and support plans that enable each person to reach their potential. This requires a different model of integrated assessment; risk enablement; commissioning; contract modelling; social care and housing market development.

Progression Model in practice - Case study

Leaving home is a big step for anyone and for adults with a learning disability it brings many additional challenges.

The Community Learning Disability Team works closely with both internal and external service providers to embrace the ethos of progression and enable people to learn the skills needed to have greater choice and control over how they live their lives.

The team supported Kyle and his mum when a tenancy became available in a shared living arrangement where all tenants receive support from Cornerstone. He moved in with an agreed progression-focused Support Plan designed to provide him with opportunities to develop his independent living skills as he works towards his long term goal of living independently.

Over the past 18 months Kyle has been supported to develop his cooking, housekeeping and independent travel skills. People who know him have noticed real changes in his confidence and decision making and his achievements were crowned when he won the Skills and Learning Award at this year's Learning Disability Awards held in Glasgow.

[Photo 10 of Kyle with award]

Self-Directed Support

The ethos of SDS is intertwined within the Health and Social Care Standards, My Support, My Life to ensure that individuals experience high quality care and support right for them, that they are fully involved in all decisions about their care and support and have confidence in the people who care and support for them.

The Self-Directed Support (SDS) team provide support and advice both internally and externally as to the functions of SDS in line with the legislation. This includes the delivery of training, information and advice to frontline staff, other internal staff; including Integrated Children's Services (ICS) and advice to external organisations. Information and briefing sessions are delivered to local community and user groups on the key aspects of SDS.

The current demand of the service has been steadily increasing over the years, this is in line with the requirement for practitioners to explain the nature and effect of all of the options of SDS. This has directly contributed to the increase of Direct Payment recipients and the increase in demand for support and financial monitoring. The expected trend is for a steady increase over the next 3-5 years especially with the development of the Carers SDS with an unknown prediction as to the number of carers who may be eligible. This is due to there being many unpaid carers who have not referred themselves to the Quarriers service and identified as an unpaid carer.

Financial Year	Total Number of DP recipients Supported by SDS team
2015/16	171
2016/17	199
2017/18	212
2018/2019	219 + 6 carers
Present (June 2019)	229 + 15 carers

The SDS team carry out an annual service user evaluation as to their experience of the team which allows for the success of the team to be monitored and areas of improvement to be identified from a service user perspective
A Thematic Review of SDS was undertaken by the Care Inspectorate in October 2018 and the final reports of the local (6 partnerships were part of the thematic

review of which we were one) and national reports published on the Care Inspectorate and Healthcare Improvement Scotland website on 27th June. The evaluation identifies that the Moray partnership has been working consistently since 2010 to understand, develop and implement self-directed support and had demonstrated commitment and innovation in seeking to provide and delivery flexibility, choice and control form supported people.

Moray has made significant progress implementing self-directed support with supported people experiencing choice and control in how they used personalised budgets and that there were established approaches for collecting feedback about their outcomes. There was evidence there was good public access to information and social supports and services, with effective signposting and early intervention and prevention. Social Work staff understood the values and principles of SDS and were motivated and supported in their delivery of these principles. The 3 tier model adopted by Moray partners in care provides a good structure for responding to needs. Its approach to stimulating market activity had resulted in a more varied range of services and micro-providers providing support in communities.

Recommendations for improvement were made relating principally to developing performance management information and evaluation, provision of independent advocacy, developing Health staff knowledge to support delivery, ensuring regular reviews are undertaken to maximise opportunities for ongoing choice and control and to develop ongoing training and learning development opportunities for staff on SDS. These will be taken forward in an action plan.

Shared Lives

Providing individual tailored support, to meet assessed needs, in a home environment setting is the aim of our Moray Shared Lives Service.
The service supports adults over the age of 18 years with:

- Dementia;
- Physical Disabilities;
- Mental Ill Health;
- Learning Disabilities; and
- Social Isolation.

The service provides:

- Day Support;
- Respite & Short Breaks; and
- Long Term Placements.

Moray has a well-developed bespoke Day Care service where Shared Lives carers support one or two people and will tailor activities according to their interests. A respite service is offered to unpaid carers of family members for periods of 24hrs and developments are underway to provide Long Term Placements that involve people living in the Shared Lives carer's home and being considered a family member.
136 service users are supported in a Shared Lives setting each week however there are 32 referrals outstanding at present. The waiting times can vary as they depend

on various elements such as individual client's needs, carer availability, geography, carer skills and home setting.

The service has membership with Shared Lives Plus, who support partnerships to implement or develop Shared Lives. Shared Lives Plus undertook an audit during 2018 and determined that Shared Lives provided a positive impact for people living with Dementia in Moray.

This is an area for future development over the next 5 years with the aim to redirect resources from traditional Day Care services and enable the provision of more bespoke services.

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

Access to key services, public spaces and retail centres is much poorer in Moray than Scotland generally, recognised locally as a result of limited public transport connections across a very rural area. There is also a profile of "in-work" poverty resulting from predominantly low wage economy placing additional pressures on families in general. Ability to access health and care services is a key area of focus, not just in terms of Moray services, but also for those where people have to travel further for services delivered from Aberdeen Royal Infirmary and beyond where very specialist services are required but not available within this Health Board. Innovative solutions are actively being sought through the use of technology to ensure clients have access to the services they require when they require it, this is a shift in how we do business and requires support both for those delivering services and those in receipt to adjust to a new way of working.

Alcohol and drug use can have an extremely harmful impact on individuals and their families. The objective for Alcohol & Drug Partnership's (ADP- a group of key partners working to support change and improvement in this arena) in the Local Outcome Improvement Plan (LOIP), which underpins community planning arrangements in Moray, is to look at the population's relationship with Alcohol. A broad based public health approach is adopted to understand what the evidence tells us in terms of positive interventions at a community level. To take this work forward the ADP are undertaking an exercise of mapping the landscape of Moray with the aim of coming up with some key actions to support responsible use of alcohol. This seeks to understand the broad population profile and general health as well as those most in need, where alcohol can be a prominent feature alongside other health behaviours which are harmful. The community planning partners offer an opportunity for wider service support across the public, private and third sector in tackling a range of issues that require approaches beyond traditional health and social care interventions, with more of a focus on prevention.

No.	National Indicator	**2015/16**	**2016/17**	**2017/18**	**Scotland 2017/18**	**2018/19**	**RAG***
11	Premature mortality rate	399	N/A	360	440	372	G u

Local Indicators	**2018/19 Qtr 1**	**2018/19 Qtr 2**	**2018/19 Qtr 3**	**2018/19 Qtr 4**	**Target**	**RAG**
L16 percentage of clients receiving alcohol treatment within 3 weeks of referral	98%	100%	100%	100%	90%	G
L17 Percentage of clients receiving drug treatment within 3 weeks of referral	100%	100%	100%	100%	90%	G

HOW DID WE DO?

Access to Psychological Therapies: Moray Mental Health have met the 18 week Referral to Treatment Time Standard 100%

The target for treatment within 3 weeks following referrals for Drug and for Alcohol patients is being met and exceeded.

WHAT HAVE WE DONE?

We recognise the challenges of service delivery in rural locations and are taking forward project to allow clients to receive services in their local areas. Further work will be taken forward to understand the opportunities of Attend Anywhere – econsult as a means of addressing remote access to services. This technology is currently being rolled out and work is underway to consider how this become part of normal business in health and care and potentially beyond eg. Welfare.

BABY STEPS

Baby Steps Health and Wellbeing programme for pregnant women with a BMI ≥ 30 is now in its second year, with 12 cycles of the 8 week midwife led programme being delivered. Baby Steps is a fun, free interactive programme that aims to support women take small steps towards a healthier pregnancy, which includes gentle exercise and practical food skills.
[photo 6]

To evaluate the impact on the women's health and wellbeing; the wellbeing wheel is used, which is completed by the women on week, 1, 4 , 8 and in the post-natal period,

The data collated clearly demonstrates a 100% of women who attended reported:

- An increased awareness of the risks of having a BMI and how to reduce these risks
- An increase in knowledge and confidence and how to take steps to improve health and wellbeing
- An increase in awareness of support available within the community
- Feeling healthier and more active
- A clearer understanding of how to interpret food labels.

BABY STEPS has been recognised on a National and Local level winning the following awards:

Baby Steps secured best poster at the **Faculty of Public Health Conference** (2018) in category 1 for 'visual impact, clarity of content and contribution to public health'.

Laura Sutherland (Acting Health & Wellbeing lead), Kirsteen Carmichael (Baby Steps Midwife) and Dr Catherine Calderwood (Chief Medical Officer for Scotland).

Children and Young Peoples Improvement Collaborative Quality Improvement award for excellence in the Early Years 2018.

*The Baby Steps Team collecting the **CPIC award** from John Swinney (Deputy First Minister)*

Celebrating Excellence: Kirsteen Carmichael (midwife) has also been recognised for her role in Baby Steps receiving the inspiring **NMAHP award** (2019).

I**nkwell Choice Award** in 2019 for community engagement and partnership working.

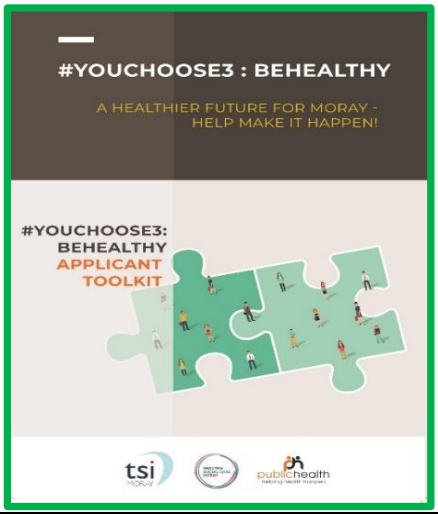
#YOUCHOOSE3- BEHEALTHY: A "FRESH" APPROACH

By exploring new and innovative ways to improve health and wellbeing we aim to engage, work with and support communities. Through participatory budgeting communities can access small grants.

In collaboration with tsi MORAY #YouChoose 3: BeHealthy invited applications for funding between £200 and £2000 which focused on the outcomes and vision of 'A Healthier Future – Scotland's Diet & Healthy Weight Delivery Plan'.
BeHealthy aimed to create a healthier Moray through supporting projects that promote healthier food choices, access to healthy, affordable, local foods, and give opportunities to gain practical cooking skills.

The impact of this piece of work has been wide ranging. The 9 projects that were funded not only promoted healthier food choices but also wider health issues e.g. general wellbeing, mental health, isolation, ACE's, making recovery real, self-management and reducing health inequalities. The projects represented all life stages from children to older adults and also intergenerational work.

BeHealthy has given the opportunity for the local communities to have an active say and to play an active part in decisions affecting their health but also projects that are meaningful. Moreover these projects have been community led promoting local connections, skill development and peer learning.



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 well-being.**

A key strategic objective for Health and Social Care Moray (HSCM) is to have people cared for at home, if they wish, for as long as possible. HSCM recognise the significant input that families and carers contribute in supporting people to live at home. As the proportion of older people increases there will be increasing demand for carers so engagement to establish what carers need to support them in their caring role has been, and will remain a key focus with the learning informing actions taken forward.

No.	National Indicator	2015/16	2016/17	2017/18	Scotland 2017/18	2018/19	RAG*
8	Percentage of carers who feel supported to continue in their caring role	38%	N/A	39%	37%	N/A	G ▼
18	Percentage of adults with intensive care needs receiving care at home		67%	65%	61%	Not yet available	G ▼

HOW DID WE DO?

Despite a slight reduction from 67% to 65%, Moray continues to perform above the Scottish average (61%) in the measure relating to adult with intensive care needs receiving care at home. In the survey conducted nationally the percentage of carers who feel supported has dropped in the last two years, although the rate at 39% is above the national average.

The number of referrals for adult carers remains above the average from previous years and there was an 8% increase in the number of registered adult carers from last year taking the number to 1,526. Of these new referrals 36% were self-referrals and 64% were identified via support from health professionals.

An annual survey was sent to all carers registered with Quarriers Carer Support Service in Moray andthe response rate was slightly higher than last year at 4% but still lower than we would like . Of the 65 responses received 94% rated overall support as good/excellent. The service was recognised as responsive, providing relevant information and having staff who were knowledgeable, supportive, helpful and respectful.

WHAT DID WE DO?

Accessibility to Carers support services in local areas is a challenge due to the rurality of Moray, however progress is being made and respondents rating local area provision as “good” increased from 48% to 56%. More use is being made of digital communication methods, including text, and this will be developed to make further inroads to improve accessibility.
In the last quarter of 2018/19 there were fewer carers identified as requiring;
Intensive support – those carers in complex situations requiring frequent contact for

a 12- week period with a named worker to support them to identify outcomes and take action to achieve them; **Active support** – those carers with significant caring roles requiring short term targeted support and more carers identified as requiring **Low** or **information** support.

All registered carers are being built into a scheduled review programme to ensure that Adult Carer Support Plans are completed within the next three years. The level of support required is reassessed as part of this process.

Consistency of processing timescales for final assessment of Adult Carer Support plans submitted from Quarriers to HSCM are proving unpredictable, with carers experiencing delays of 6 months or more in receiving decisions about their eligibility for additional support. This is an area for improvement and a review of the referral process has been undertaken with an implementation plan to ensure achievement of the outcomes of the Carers Act being defined. The intention is to have a dedicated worker to take this forward.

Attendance at Carer peer support cafés is increasing and text reminder to café sessions are proving successful in encouraging carers to attend where they receive support and information in an informal setting on subjects ranging from dental hygiene to emergency planning.

Poster Carer peer support café

Training courses in First Aid and manual handling have been provided and staff are undertaking training to deliver “Before I Go”, a workshop programme that has proven beneficial in helping individuals and families to prepare for their own death and that of their loved ones.

Young Carers

The documents and processes linked to introducing a Young Carer Statement (YCS) for Moray were finalised by March 2018. Two temporary Family Wellbeing Workers (Young Carers) have been appointed to conduct a Test of Change in two specific shool areas, leading ultimately to the rollout of the Young Carers Statement in Moray.

Referrals for young carers remain low however with the introduction of the YCS, and the increased profile in the Test of Change areas is it anticipated that there will be an increase in the coming year.

POSTER Cafes for Unpaid Carers

Volunteer Development

The Scottish Government vision for Scotland is one where every one of its people can contribute towards, and benefit from, making Scotland a better place to live and work; where volunteering is an integral element of this and is valued and recognised across all sectors as an expression of an empowered people and a force for change; and where anyone who wants to volunteer can do so readily. In Moray, with limited workforce and finance, we have managed to address the number of requests for volunteers at a steady rate. When the service started in 2012 there had been 88 requests for volunteers over an 8 month period. By 2018, this had expanded to 168

requests over an 11 month period. Currently we support 223 clients, with 77 alarm responders and 146 in a "Buddy" role.

To celebrate 'Volunteers Week' a Tea Party was held in Elgin Town Hall in June 2018 where 100 people attended. The success of the service is celebrated each year through an annual event and the service provided by volunteers is recognised and acknowledged.

Celebrating Volunteers Week at a Tea Party in Elgin Town Hall attended by 100 people. Thanks was expressed by the Convener of Moray Council

[Volunteer Development Photo 1]

Quotes form clients and volunteers
Home Buddy

Volunteer - "It has saved my sanity and given me purpose"

Client – ' it's great having someone come for a chat each week, it would be wonderful if everyone had someone to talk to'

Social Buddy for Lady in Care Home

Client - I am thoroughly enjoying the company, it is nice to get out of the care home. We have been up to the shops. It is really beneficial. She is a lovely person

Exercise Buddy

Client – 'its great having a buddy to do exercise with. We go for walks in the park and swimming and sometimes the gym. I feel more fitter, healthier and motivated'

Volunteer for Gentleman in Care Home (First Outing)

"Just to let you know that the trip out went well, he met up with his old snooker pals, wasn't fit for snooker but he managed a game of pool with me and we had a few games of dominoes. It was a good day out. He won't remember it tomorrow bless but fresh air and time out is a good thing"

Shopping Buddy

Client – 'she isn't just a buddy, she is a friend and a lifeline. She helps me to make good choices when we are out shopping'.

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

We aim to ensure that people are protected, safe and secure in which ever environment they are, be it at home, hospital or other care accommodation. We develop and carry out our working practices support this aim often referred to as our governance arrangements.

No.	National Indicator	2015/ 16	2016/ 17	2017/ 18	Scotland 2017/18	2018/ 19	RAG*
9	Percentage of adults supported at home who agree they felt safe	79%	N/A	84%	8 3%	N/A	G ▲
11	Premature mortality rate per 100,000 persons (people aged under 75)	399	360	Not yet available	(2016/17) 425	Not yet available	G ▼
14	Readmission to hospital within 28 days (per 1,000 population)	76	74	84	103	Not yet available	G ▼
16	Falls (rate per 1,000 population aged 65+)	17	16	15	23	Not yet available	G -

HOW DID WE DO?

The national survey records 84% adults agreeing they felt safe, an increase from 2015/16. According to locally collated information 98% of people with support plans feel safety needs are completely or partially met which is in line with previous year's performance.

The total number of Adult at Risk referrals to Moray Council from April 2018 to March 2019 was 968 (an increase of 40% on referrals compared to 2016/17). Following screening 220 referrals were passed to the Adult Protection Unit for further scrutiny.

WHAT DID WE DO?

We address this outcome through our governance arrangements, which highlight areas where additional attention is required to help people remain safe from harm.

Clinical care and governance Committee

The Clinical and Care Governance Committee (C&CGC) of the MIJB is responsible for quality assurance of care, demonstrating compliance with statutory requirements and providing the mechanism of assurance that systems are safe.

Clinical Governance Group and Practice Governance Group have been developed to provide surveillance of the operational system, informing the C&CGC of any issues or areas of concern. All risks, complaints and compliments are reviewed at the weekly Clinical Risk meeting to ensure processes are followed accurately and consistently and opportunities for shared learning are identified. Significant reviews are undertaken for any Adverse Events and Duty of candour incidents are reported in a separate annual report. (web address)

Adult support and protection

Effective partnership and collaborative working is essential in protecting adults at risk of harm. Work in this area is overseen by the Moray Adult Protection Committee (MAPC) until recently had the NHS Grampian Adult Protection lead as interim Convenor however appointment of a permanent independent Convenor is underway.

During 2018/19 enhanced governance support was provided from the Moray Chief Officers Group. This group consists of the local Police Commander and Chief Executives of NHS Grampian and Moray Council and provides additional leadership, direction and scrutiny of local adult protection services. They undertook a review of the Terms of Reference of the MAPC as part of a review of the governance support.

Although Moray was not one of the areas subject of the Thematic Inspection of Adult support and Protection, the subsequent report recommendations, examples of good practice and areas of improvement are being considered along with the output of a self-evaluation exercise undertaken in early April 2019. These areas will be the basis for a reviewed Improvement Action Plan, to be enacted prior to the forthcoming Care Inspectorate Inspection.

National Mental Health Strategy

Action 15 of the National Mental Health Strategy has enabled funding of the Distress Brief Intervention Service run by Penumbra, extra mental health workers in A&E and new roles of Dementia / Frailty Co-coordinators to be rolled out across all GP practices in Moray.

Suicide - local action plan.

In Moray the number of suicides is low, however every occurrence is considered so that understanding of individual circumstances assists thoughtful learning and application of retrospective suicide prevention strategies. Suicide prevention work has been taken forward through the multi-agency mental health and wellbeing partnership "Making Recovery Real Moray Partnership" with a focus on delivery of the Moray Mental Health Strategy "Good Mental Health for All 2016-26) and examples of this work are:-

- A H&SC Moray Suicide Prevention Group meets regularly to implement the identified suicide prevention work.

- Moray Wellbeing Hub hosted a partnership project that has developed an interactive online tool aimed at empowering adults in Moray and those that support them, including GPs, to better communicate and navigate the services and supports that help mental health locally. This includes how to access services quickly; also rapid signposting to crisis and suicide prevention services – 'ask once and get the right help fast'. The tool can be found on the Hub home page here: http://moraywellbeinghub.org.uk/mhpathways/

- A male suicide worker has been appointed in the mental health commissioned service (Penumbra) and works as part of the Mental Health and Wellness Centre.

- A Mens Shed project is being delivered by Moray Wellbeing Hub that focusses specifically on men's mental health and wellbeing.

Occupational therapy falls pathway

Following successful bids to 6 Essential Actions for Improving Unscheduled Care initiatives during 20-16/17 and 2017/18 permanent funding has now been allocated by HSCM to continue with Occupational Therapy (OT) in the emergency department (ED) at Dr Grays Hospital.

Some of the project key aims were to prevent unnecessary admissions, provide multi factorial assessment in the ED over 7 days, establish an integrated falls pathway to prevent falls-related hospital admissions and maximise the OT contribution to reduce overall lengths of stay in hospital.

Results have been significant:-

In 2015 there were:

- 5 referrals to OT from ED. During the project November 2016 to November 2018 there were 1,203 referrals of which; 445 (37%) were discharged directly home,

- 142 (12%) were in ED "Out of Hours" and were assessed and referred for follow up telephone assessment, and

- 430 (36%) were referred as a result of a fall. A self-management falls prevention group has been piloted and is to be rolled out across Moray.

The OT in ED has contributed to reduction in admissions, positively impacting on bed availability and providing significant cost savings, and enabling many patients to get back to their own homes, staying mobile and independent.

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.**

Health and Social care services are continually developing in line with the strategic vision of the IJB. Staff are required to maintain existing services whilst implementing significant changes, which presents real challenges that need to be recognised and supported. We aim to actively support the wellbeing of our staff to ensure they feel confident, competent and be professional whilst performing the job they care about.

Local Indicators	**Q1 (Apr-Jun 18)**	**Q2 (Jul-Sep 18)**	**Q3 (Oct-Dec 18)**	**Q4 (Jan-Mar 19)**	Target	RAG
Number of complaints received and % responded to within 20 working days - NHS	4.9%	4.6%	4.7%	**3.8%**	4.0%	G▼
Number of complaints received and % responded to within 20 working days - Council	7.9%	8.1%	8.3%	**7.4%**	5.9%	R▼

HOW DID WE DO?

There is currently no national information to benchmark against.
The rate of sickness absence for NHS staff has reduced and is now in line with the national target of 4%. However rates of absence in Council staff remain high and this is due to a number of factors that are being addressed by service managers. These figures will continue to be monitored closely with the aim of reducing the rate over the coming year.

IMATTER

NHS Grampian conducted a staff survey during 2018/19 that included 1738 Health and Social Care Moray staff. The response rate was 62% which was a slight increase on the survey conducted previously. Analysis of the responses showed 24 of the 28 measures were green status, “strive and celebrate”, with the remaining 4 amber status “monitor to further improve”. Highest scores were returned indicating staff felt clear about duties and responsibilities, their work gave them a sense of achievement, that line managers were approachable and that they would be happy to recommend their team as a good one to be part of. Areas that had least positive feedback related to communication, involvement in decisions relating to the organisation, visibility of senior management and confidence that performance was managed well. These aspects which will the focus for improvement in the organisation development plan for 2019 and beyond.

MERIT award

Our first Staff MERIT Awards to recognise the achievements and celebrate the inspirational and innovative work of staff in the Health & Social Care Moray partnership, took place on Tuesday 26th March 2019 at the Alexander

Graham Bell Conference Centre in Elgin.
Huge congratulations to all nominees and to the overall winners. The judging panel had a very difficult task such was the quality of the entries. Information on all the nominees was included in the awards brochure which can be found online address.
[merit award photo]

[names of award winners by photo]

Services were also invited to join the event by participating in the learning event – an opportunity to showcase areas they felt were of interest to the wider organisation. Feedback from participants and those attending was very positive so it will be back next year!

WHAT DID WE DO?

Healthy Working Lives

Health and Social Care Moray continued to maintain the Gold Healthy Working Lives (HWL) award for the 8th consecutive year. Moray was the first sector within NHS Grampian to achieve Gold status in 2010 and is seen as an exemplar HWL client. In recognition of this achievement Moray has been awarded gold plus status since 2013.

The accolade from Health Scotland recognises Health and Social Care Moray as an employer who strives to improve the health, well-being and safety of employees.

Many activities and initiatives were undertaken in 2018 including:
The Pedometer Challenge

The Healthy Working Lives pedometer challenge began in June 2018 with the aim of supporting staff to take part in a fun challenge to increase physical activity, which has a positive impact of health and wellbeing.

Teams took part from all sectors across Moray, with over 290 staff taking part. Over the 10 weeks of the competition over 262 million steps were taken by staff- equivalent to over 97 thousand miles - Or around the world almost 4 times!

Additionally the pedometer challenge also created an opportunity to undertake staff 'Making every opportunity Count' DIY self-checks. The self-checks helped staff to identify any health and wellbeing concerns, where upon a healthpoint advisor could signpost the staff to support services that could help.

Cycling Scotland Employee Friendly Award

In 2018 Health and Social Care Moray registered for the Cycling Scotland Employee Friendly Award as part of The Healthy Working Lives. The nationally recognised

Cycling Friendly Employer programme supports organisations to encourage cycling as a healthy, sustainable and accessible way to commute.

As part of this Health and social Care Moray actively promoted the benefits of cycling to staff, community cycling initiatives, charity cycling opportunities, and promoted active travel, including the cycle to work scheme. A successful electric bike pilot was undertaken where by staff where encouraged to use an ebike for commuting and leisure purposes; this was received well with staff keen to use the bikes again.

Building Staff Capacity

Throughout 2018 we have supported Community Planning Partners to build capacity through the provision of training that addresses key strategic objectives capacity building has had a focus on:

Alcohol Brief Intervention (ABI):

We have increased the number of trainers (including a partner from Sacro). The ABI training is delivered to a range of Community Planning Partners and has resulted in an increase in Alcohol Brief Intervention Delivery, with some areas exceeding projected targets by an additional 25%.

Helping People Change for Health (HPCH):

HPHC training has been developed by an NHS Grampian health psychologist. The training is delivered a bi-annual basis. The courses evaluated extremely well with participants demonstrating how they embed the training in their day to day practice – enhancing their skills.

Making Every Opportunity Count (MeOC):

MeOC principles and practice are embedded within Health & Social Care as part of core business. The transformative 3-tired approach is designed to support a common way of preventative working. Through this simple, flexible approach, practitioners can use the tools available; such as the DIY MOT self-check, which provides a framework for practitioners to support clients to identify any health and wellbeing concerns they may have. Once identified practitioners can signpost clients to the most appropriate support service. Working in partnership we have built on our success to date and increased the number of MeOC champions throughout Moray and with a wide range of partners.

Moray Alcohol & Drug Partnership (MADP)

With an increased focus on supporting the wider workforce across the statutory, third sector and community groups MADP put on 25 workforce development events with over 410 delegates.

We collate feedback from all seminars/conferences and workshops and use the material as part of future planning e.g. Budget planning conference in October 2018, supported the 2019/20 commissioning decisions, Licensing matters conference supports the rollout of the new licensing policy; feeding into service review and commissioning; all linked to agreed or emerging priorities.

Investing in Leadership development

Leadership development has happened at a senior management level in both the NHS and Moray Council via various programmes, in house and externally. National leadership programmes are regularly considered throughout the organisation and individuals are supported to participate. During 2018/19 there were 18 members of staff who participated in the Kings Fund 2 day System Leadership programme.

The focus of leadership development has been very much around the promotion of integration and collaborations. The expectation is to skill people up to be able to work in a different way as leaders, seeing their leadership role as going beyond their individual departments with the aim of working collaboratively with key care partnership to deliver outcomes for people. This requires much more thought on what other departments/services/partners have to offer and considering how the relationships are such that they maximise the opportunities that arise.

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

Given the financial pressures that are being experienced in the public sector it is imperative that every effort is made to ensure that within HSCM resources are targeted appropriately. There are huge costs associated with hospital stays and out of area placements and we need to consider the balance between impact and consequences of our prevention activity. We have finite resource, mainly of staff and we are keen to ensure that they are utilised well where they are absolutely required and that we interact with wider services and resources at community levels to ensure individuals and families have resilience to cope with the many pressures of everyday life.

In addition technology is required to support staff in delivering an increasing demand for services. Many of our buildings are old and do not reflect a modern health and care facility. We are working with other partners across the public and private sector exploring opportunities to come together and reduce costs, whilst benefiting from the opportunity that collaboration might bring in finance and resource terms.

No.	National Indicator	2015/ 16	2016/ 17	2017/ 18	Scotland 2017/18	2018/ 19	RAG*
14	Readmission to hospital within 28 days (per 1,000 population)	76	74	84	103	Not yet available	G ▼
19	Delayed discharge bed days	764	1,095	936	762	1,093	R ▲
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	22%	21%	22%	25%	19%	G ▼

HOW DID WE DO?

The number of people waiting to be discharged from hospital when they are ready (Delayed Discharges) peaked within 2016/17 and although the figure reduced in 2017/18 it has shown an increase during 2018/19.

Local information relation to readmission rates show that there has been a slight increase in the 7 day rate however the duration is significantly reduced at 1-3 days.

The rate of emergency admissions resulting in a stay in hospital is showing a reduction on previous years, which is positive.

WHAT DID WE DO?

As well as the work that has been undertaken to improve efficiency and effectiveness of allocation of resources for direct services delivery, there are other projects being progressed that will help direct resources appropriately.

Office accommodation requirements are being reviewed in relation to development of localities, multi-disciplinary teams and their future requirements. In addition work

will be undertaken to expand the introduction of SMART working and flexible working to facilitate reduction in desk and office space requirements across all locations.

The continuation of work to review accommodation for **Day Services** identified there were alternative options for care provided from Towerview with alternative methods of meeting individual outcomes being identified through close working with individuals and their families. Individuals now receive their care in more tailored ways in a better environment for them and the building is no longer required.

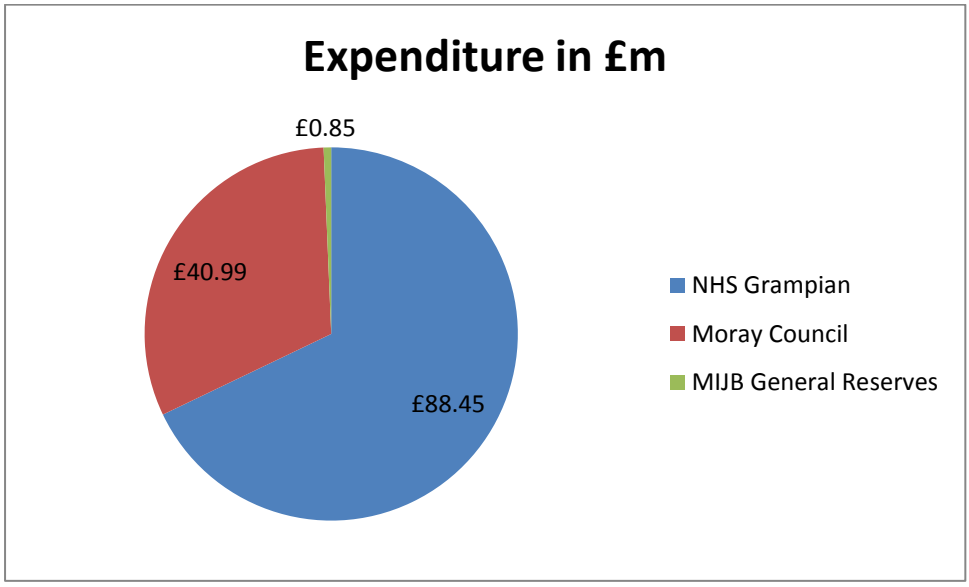
We continually through our planning and operational process consider how we utilise the resources we have and through audit processes both internal and external are scrutinised on our use of public money. We have recently instigated further a collaboration across the local health and social care system including Dr Grays, a "**one system, one budget"** approach aimed at maximising the use of our collective resources through a joint approach to planning for the future. We are hopeful that this will assist further in us achieving both the right shape of services within the resources available that are able to respond to future demand.

Moray Digital Transformation Oversight Group continues to provide a focus on assessing needs and finding assistive technologies for implementation to streamline and support delivery of services. In addition to the projects currently underway we are keen to consider the broader application of "**attend anywhere"** in the context of access to welfare support.

Finance Planning and Performance

Financial Governance

The Moray Integration Joint Board (MIJB) has a responsibility under the Public Bodies (Joint Working) (Scotland) Act 2014 to set a revenue budget each financial year. The funding of the MIJB revenue budget in support of the delivery of the Strategic Plan is delegated from NHS Grampian and Moray Council. The total level of funding delegated to the MIJB for the 2018/19 financial year was £129 million. In addition, the MIJB had remaining reserves of £0.847m which have been utilised to support the existing funding shortfall. Funding can be analysed as follows:



	£m
NHS Grampian	**88.453**
Moray Council	**40.99**
MIJB General Reserves	**0.847**

Financial Performance

Financial performance forms part of the regular reporting cycle to the MIJB. Throughout the year the Board, through the reports it receives is asked to consider the financial position at a given point and any management action deemed as necessary to ensure delivery of services within the designated financial framework. From the mid-point in the financial year, the Board are presented with financial information that includes a forecast on the likely financial outturn at the end of the financial year.

In March 2018 the 2018/19 revenue budget was presented to the MIJB displaying a shortfall in funding to deliver the delegated services of £4.596m. In response to this, further work was carried out to identify additional efficiencies, resulting in an increased savings target of £1.516m. In addition, the 2017/18 financial out-turn produced non-recurring savings at a level of £0.847m, creating a general reserve

and in accordance with the Integration Scheme, this was utilised to support the 2018/19 budget position.

During the year, Scottish Government allocated funding in respect of the Primary Care Improvement Fund, to be used by integration authorities to commission primary care services and support the Government's Mental Health Strategy. The Scottish Government made a commitment to ensuring full sums would be invested and spent on the priorities identified and in support of this and to assist planning a guarantee was made that any in-year slippage would be made available in full in subsequent years and that any allocations made during the year should be considered as earmarked recurring funding and as part of this funding that any underspend was required to be earmarked and used for these specific purposes in future years. The result of which has meant the MIJB is required to retain a general reserve for the purposes of earmarking these funds at a level of £0.257m. The result of which is a movement in total MIJB reserves with a reduction from £0.590 from £0.847m. After consideration of earmarked reserves and application of slippage on Strategic Funds, the MIJB financial position resulted in an overspend of £1.193m which, in accordance with the Integration Scheme was to be met by additional funding from the NHS Grampian and Moray Council proportionate to the original investment, regardless of which arm of the budget the overspend occurred. This translates to £0.752m NHS Grampian and £0.441m Moray Council. An expenditure summary is provided below:

Service Area	2016/17 Actual	2017/18 Actual		2018/19 Budget	2018/19 Actual	Variance Fav/ (Adverse)
Community Hospitals	5,520	5,475		5,349	5,383	(34)
Community Nursing	3,653	3,555		3,640	3,689	(49)
Learning Disabilities	5,288	6,025		6,257	6,749	(492)
Mental Health	7,405	7,447		7,286	7,720	(434)
Addictions	823	1,003		1,127	1,066	61
Adult Protection & Health Improvement	165	144		148	142	6
Care Provided In-House	13,047	13,427		15,197	14,427	770
Older People's Services	16,267	16,945		16,332	18,038	(1,706)
Intermediate Care & Occupational Therapy	1,629	1,508		1,908	2,197	(289)
Externally Provided Care	9,945	11,024		9,526	9,597	(71)
Community Services	7,169	7,143		7,178	7,110	68
Administration and Management	2,703	2,569		2,854	2,467	387
Primary Care Prescribing	17,304	17,844		16,360	17,354	(994)
Primary Care Services	14,890	15,085		15,759	15,498	261
Hosted Services	3,681	4,061		3,978	4,175	(197)
Out of Area Placements	525	658		669	650	19
Improvement Grants	930	787		924	795	129
Total Core Services	**110,944**	**114,700**		**114,492**	**117,057**	**(2,565)**
Strategic Funds	877	1,526		2,583	1,211	1,372
Set Aside	10,163	10,593		11,765	11,765	0
Total Net Expenditure	**121,984**	**126,819**		**128,840**	**130,033**	**(1,193)**

Main Reasons for Variances Against Budget 2018/19

Overall, the MIJB core services resulted in an overspend of £1.193m. Explanations of the major variances have been provided:

Prescribing – remains a significant financial pressure facing the MIJB which gave rise to an overspend in year of £0.994m. There was a low volume increase of less than 1%. The overspend reflects the more material impact of volatile external factors affecting prices. National factors include, variance in prices arising from shortage in supply and the timing and impact of generic medicines introduction following national negotiations. Locally, medicines management practices are applied on an ongoing basis to mitigate the impact of external factors as far as possible and to improve efficiency of prescribing both from a clinical and financial perspective.

Older Peoples Services & Physical and Sensory Disability – services were overspent by £1.706m as at 31 March 2019. There are variances within this overall budget including an overspend on domiciliary care and client transport. Primarily the overspend can be attributed to a continuing increased demand on services through the ageing population that exists in Moray. The adverse variance within this overall budget heading reflects the shift in the balance of care to enable people to remain in their homes for longer.

Learning Disabilities - the Learning Disability service was overspent by £0.492m at the year-end. The overspend is primarily due to the purchase of care for people with complex needs, including young people transferring from Children's services, people being supported to leave hospital and for property adaptations to enable service users to remain in their own homes. Demographics suggest that the number of people with a learning disability will continue to increase, and whilst these people will live longer with more complex needs this creates additional financial pressure in the system.

Mental Health – services were overspent at the end of the year by £0.434m. In the main this was due to senior medical staff costs including locums, nursing and other staff. As a result of redesign and efficiency there is an anticipated reduced overspend as the number of medical sessions reduce and the mental health strategy is further implemented

Care Services Provided In-House – were significantly underspent in year at £0.770m. This primarily relates to staffing costs in the Care at Home service, Community Support workers and the challenging behaviour unit. There have been difficulties during the year in staff recruitment, however, the level underspend is not set to continue into the next financial year at the same level.

Financial Outlook and Best Value

One of the major risks facing the MIJB and its ability to deliver the services delegated to it within the context of the Strategic Plan is the uncertainty around the funding being made available from the partners and the Scottish Government. This is set against a back-drop of a changing demography which increases the demand and complexity for our health and social care services. The reduced funding levels, combined with the demographic challenges we are facing in a period of ambitious reform present defined

risks and uncertainties that require monitoring and managing on an ongoing basis. The ageing population and increasing numbers of people living with long term conditions and complex needs will generate demands which cannot be met unless alternative service delivery models are generated. There is an on-going commitment to provide care to those in the greatest need while providing those services within the resource available.

The MIJB governance framework comprises the systems of internal control and the processes, culture and values, by which the MIJB is directed and controlled. It demonstrates how the MIJB conducts its affairs and enables the MIJB to monitor progress towards the achievement of its strategic priorities and to consider whether those priorities have led to the delivery of cost-effective services.

The MIJB ensures proper administration of its financial affairs through the appointment to the Board of a Chief Financial Officer, in line with Section 95 of the Local Government (Scotland) Act 1973.

Financial Reporting on Localities

The financial reporting for 2018/19 is not currently reported at locality level. This continues to be a work in progress and remains a priority for development. At the end of 2018/19, the MIJB approved a revised a management structure that will support the work and progress surrounding locality planning.

LOCALITIES AND WORKING WITH COMMUNITIES

Working with Communities

Asking what matters, listening to what matters and doing what matters are key to the commitment the Moray Integration Joint Board and Health & Social Care Moray have to working in partnership with the people of Moray.

Engagement happens at every level, from daily person-centred conversations between people with lived experience and those who support them, to active participation in service transformation and improvement.

Among the broad range of engagement undertaken this year are:

Participatory budgeting has been supported through the #YouChoose3 funding for community projects.

Social media has been used to provide updates on a variety of topics. Our Facebook page has over 750 followers.

The website www.hscmoray.co.uk provides information on who we are, what we do and how we perform. It is also used to report on past engagement activities, promote current opportunities and enable people to provide feedback.

Workshops have been used as a forum to bring people together to share their skills, knowledge and lived experience as they work to identify solutions to key challenges. Areas for discussion have included the development of the Primary Care Improvement Plan, redesign of mental health services and the launch of the market shaping strategy for learning disability services.

A recruitment **film** to address Moray's skills shortage across a wide range of professions has been viewed more than 3,000 times and attracted world-wide interest. The six minute video, funded by Health & Social Care Moray, showed off some of the best aspects of living and working in Moray and featured professionals who have already made the move.

Open space technology has been used as a method to engage with people with a learning disability to explore the opportunities and challenges they experience in people active citizens in their communities.

Experience surveys are an opportunity to gain qualitative data from survey users on how well internal and commissioned services are performing. Results are used to support improvement work and inform commissioning decisions.

The **reference group** for strategic planning and commissioning worked through a series of workshops to review the first strategic plan and lay the foundations for the development of the new plan.

Locality Planning

Moray is considered as 2 localities, East and West as noted in the integration legislation. We have identified 4 delivery arms of service at neighbourhood level.

Work has continued to be embedded in Forres with the community and health and care professionals taking an active role in, and provide leadership for, local planning of service provision. A new model of “home first” care and support continues to evolve and led to the decommissioning of services at Leanchoil Hospital. Ongoing work thereafter with the community has presented an opportunity for a Community Asset Transfer, the first of it’s kind for NHS Grampian.

A key focus for 2019/20 will be to deliver the Initial Agreement for the new Health Centre at Keith. Following on from the Keith and Speyside Strategic Needs Assessment we have put in place a process to work with the local communities and those surrounding communities affected to specify the requirements to meet the needs of the communities,, noting a much wider ambition to consolidate local public and partners services on a campus basis.

We have also worked with the management team to:-

- agree a structure that secures local leadership,
- ensure care co-ordination of the key services at a local level, and
- provide consistent and sustained engagement with local neighbourhoods.

Establishing a leader at a local level will provide the clarity for communications and the glue between the neighbourhood and the health and care system. This will be implemented during 2019.

Pop-up stalls and the **mobile information bus** are utilised at community events and in key locations such as supermarkets and town centres to promote health improvement and self-management messages, raise awareness of services and support and promote volunteering opportunities.

Face-to-face attendance at community forums such as community council meetings provide opportunities to engage on any issues of local concern and respond directly to questions.

Inspection of Services

Our services are subject to independent scrutiny by external agencies. These inspections are against national standards and check that the services that are being delivered meet the standards, the needs of those receiving the service and they provide value for money.

Commissioned Services

The Commissioning Team collates information from various areas and uses various tools to assess the quality and effectiveness of the services Health and Social Care commission. Examples of information collated and tools used are as follows:

- Monthly collection of comments, complaints and incidents
- Quarterly contract returns – staffing levels, training, client numbers etc.
- Annual formal contract meetings (including budget discussion)
- Quarterly provider group meetings (Care Home Owners, Care Home Managers etc.)

- On-site monitoring visits (at least annually)
- Outcome monitoring – personal outcomes for clients (via collection of evidence, on-site visits, meeting with stakeholders, meeting with clients)
- Collection of Care Inspectorate grades, complaints and enforcements (in area and out of area)
- Attendance at Care Inspectorate inspection feedback sessions with providers
- Development and continual monitoring of improvement action plans with the providers
- Working with Adult Support and Protection Team on protection issues and investigations
- Full reviews and audits of contracts prior to contract end
- Six weekly reporting of contract compliance and quality to the Social Care Practice Governance Board

In Moray we now have 37 services registered with the Care Inspectorate on the commissioning database. Care Inspectorate score these services from 1 (lowest) to 6 (excellent). Comparisons with previous years scores is not possible due to a change in the scoring mechanism last year.

There is only one commissioned service in Moray sitting lower than 3 (satisfactory) across the inspection areas. An improvement action plan is in place with the provider and regular progress updates are received. The majority of services are graded 4 and above.

Provider Services

Our internally provided services for Provider services are averaging a score of 5, demonstrating a good level of care.

Establishment	**Quality of Care and support**	**Quality of Environment**	**Quality of staffing**	**Quality of management and leadership**
Shared Lives	6	Not assessed	Not assessed	6
Cala House	4	Not assessed	Not assessed	4
CSS	3	Not assessed	3	4
Home Care	4	Not assessed	4	4
Cedarwood	4	5	5	4
Moray Resource Centre	5	5	5	5
Gurness Circle	5	Not assessed	5	Not assessed
Barlink	5	Not assessed	Not assessed	5
Towerview	5	Not assessed	5	Not assessed
Woodview	5	Not assessed	4	4

There were no enforcement actions received but there were some recommendations for improvements, so working in partnership with providers, action plans are established and performance and improvements are monitored by the commissioning team.

Review of Strategic Plan

A programme of workshops and engagement sessions with stakeholders has been undertaken and a revised draft Strategic Plan to be presented to MIJB for consideration in October 2019. Work is underway to interpret all the information known about Moray, the services and the people who live here with a view to launching a new strategy for 2019 and beyond. Our existing strategy remains live for now and engagement and consultation on the new strategy will happen throughout the autumn of 2019.