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# Annual Performance Report

## 2019-20

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# Welcome from Chair and Chief Officer, Moray Integration Joint Board

Welcome to the 4th Annual Performance Report 2019 -20 for Health and Social care Moray. We have continued to demonstrate significant developments in services across the partnership in an environment of increasing demand and of significant resource challenges.

We have launched our new Strategic Plan (Moray Partners in Care) for 2019-29, which outlines a strong emphasis on prevention and early intervention with the aim of building resilience for individuals within communities, supporting people to stay well and maintain independence and a clear intention to work to a Home First model of care.The emerging lessons from the ongoing covid-19 pandemic are reinforcing the aspirations of that plan and potentially accelerating implementation in some areas.

TheStrategic Plan is underpinned by the Transformation Plan and other related plans that will allow us to work towards our shared Vision and support us through the decisions that are required to deliver on that Vision. The Moray Partners in Care Strategic Plan was approved in October 2019 and the Plan was then formally launched in December 2019.

This is the IJB's second strategic plan which has been developed collaboratively with our partners in care, following engagement and consultation.

The Strategic Plan will drive everything we do as a health and social care partnership in line with the aspirations and priorities of people living and working in Moray.

The Plan sets out the vision of the IJB and the key themes we will focus on over the coming years to deliver integrated health and social care services which ensure people get the best possible experience and which enable them to achieve improved outcomes.

We continue to place immense importance on building relationships and working alongside our workforce, our partners in the Local Authority, NHS Grampian, the Third Sector, and Independent sectors. We are committed to supporting our workforce and their teams in working together to deliver high quality services within the Moray community.

The people of Moray continue to be our partners in the development of services, holding us accountable for the range and quality of services we provide.

This Annual Performance Report outlines progress made in many of our services, building on the work undertaken throughout the previous 4 years since the inception of the Partnership, and is set out in the context of the nine national health and wellbeing measures. We have lived beyond our means in 2019/20, and the mis-match between expenditure and available resources is now a significant concern. This will need addressing during 2020/21 and future years. We also know that high quality can be achieved by efficient services, and quality and safety will continue to be a primary focus as we commission services into the future.

The response to covid-19 in the latter part of the year used a significant portion of our capacity, but nonetheless teams planned on how best to meet the needs of those most at risk, and that should be commended.

**Jonathan Passmore**
Chair, Moray Integration Joint Board

**Simon Bokor-Ingram**
Interim Chief Officer, Moray Integration Joint Board

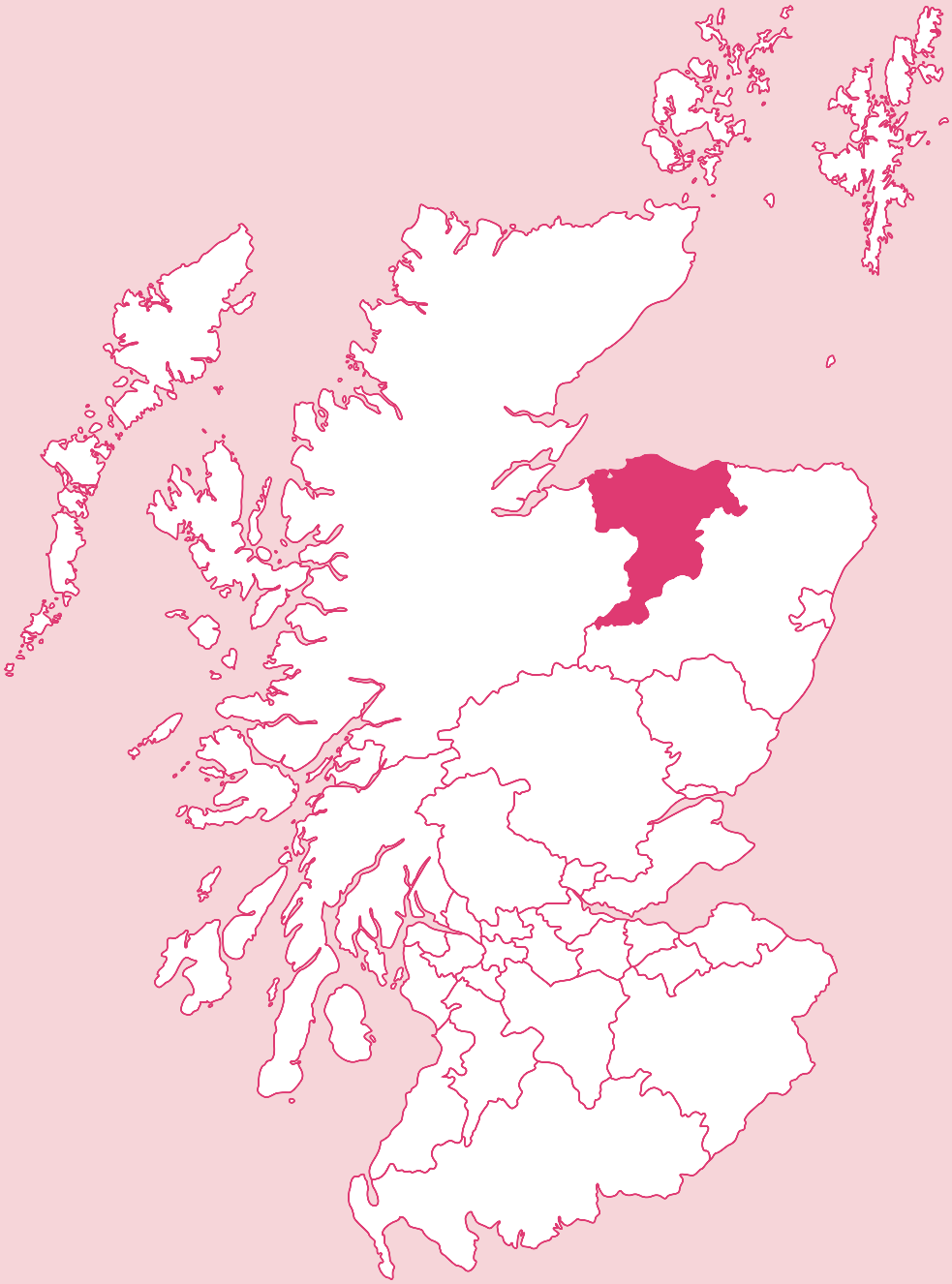
# Introduction

This is the fourth annual performance report for Moray Integration Joint Board (MIJB), which completes the 3 year period of the first Strategic Plan

Moray Integration Joint Board (MIJB) was established in February 2016 and became operational as of 1 April 2016. It has responsibility for the planning and delivery of all community based adult health, and social care services within Moray. In addition MIJB has strategic planning responsibilities in respect of emergency care and it also hosts those pan Grampian services relating to the out of hours, Grampian Medical Emergency Services (GMED) and Primary Care Contracts who are responsible for all contractual arrangements for the 4 Contracted Services (General Practice, Community Pharmacy, Optometrists and Dentists).

As required by the Act, MIJB has a Strategic Plan. In October 2019, the IJB approved a revised Strategic Plan 2019-29 'Partners in Care' which was formally launched in December 2019. The MIJB strategic plan 2019 – 2029 builds on the first 3 year plan foundations and successes since the Board came into existence and has been developed through close cooperation with our partners in the Local Authority, NHS Grampian, the third and independent sectors and of course our staff and the population of Moray.

In this report, we will highlight the progress of Health & Social Care Moray (HSCM) regarding those commitments made within the Strategic Plan and against the 9 national health and wellbeing outcomes. We will look back on the progress we have made, share some of our successes and reflect on some areas that have proved challenging.



# Our Vision

***'We come together as equal and valued partners in care to achieve the best health and wellbeing possible for everyone in Moray throughout their lives.'***

**This vision and all that we undertake as a Partnership underpinned by our values of:**

I. Dignity and respect
II. Person Centered
III. Care and compassion
IV. Safe, effective and responsive

**With our Vision, we strive to achieve our outcomes of:**

- Lives are healthier
- People live more independently
- Experience of services are positive
- Quality of life is improved
- Health inequalities are reduced Carers are supported
- People are safe
- The workforce continually improves
- Resources are used effectively and efficiently

## Strategic Context

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(Moray Partners in Care) 2019-2029,sets 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.

To enable the Partnership to fulfill this Vision we have built on what we know, and as such have identified three strategic themes where we will direct effort; in effect, we wish to major on health and wellbeing by;

I. Building resilience
   taking greater responsibility for our health and wellbeing

II. Homefirst
   being supported at home or in a homely setting as far as possible

III. Partners in Care
   making choices and taking control over decisions affecting our care and support

The Moray Integration Joint Board Transformation Plan 2019-2024 evidences the links between our intended outcomes and related themes, and the national health & wellbeing outcome (1-9)

hscmoray.co.uk/uploads/1/0/8/1/108104703/HSCM_transformation_plan.pdf

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 neighborhoods that can support positive health and well being. 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

**What do we know about the Moray population in relation to health and wellbeing?**

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

**Overall Moray has:**

- average school leavers with 1 or more qualification at SCQF level 4
- above average levels of employment, less of the population who are income deprived and less children in low income families
- below average levels of violent crime, domestic abuse and drug and alcohol-related hospital admissions
- significantly better health condition admission rates than the average across Scotland regarding – emergency admissions, over 65s multiple emergency admissions, admissions for Chronic obstructive pulmonary disease (COPD), Coronary heart disease (CHD) and asthma hospitalisations
- average smoking rates and alcohol specific deaths and above average road traffic accident casualties and people living in the 15% most access deprived areas
- 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?**

Moray Partners in Care worked to develop the new Strategic Plan. They shared their experiences of challenges facing today's system and ideas for what a better future system could look like. We found many examples of great practice and good progress that we can build on as well as a range of things we need to do better or differently. We recognise that to move forward we need to:

- Help people understand the need for change and provide opportunities to become involved in defining the change and making it happen.
- Strengthen relationships through trust, value and equality to make best use of our collective assets and resources.
- Embrace new ways of integrated working.
- Build on existing good practice and ensure services are safe, effective and sustainable.
- Balance what is achievable with what is affordable.

www.yourmoray.org.uk/downloads/file118306.pdf

We reviewed our performance in delivering our first strategic plan, launched in 2016; financial services and workforce pressures; national legislation and policy; and directions from the Moray Community Planning Partnership as set out in the Local Outcomes Improvement Plan (LOIP).

We work as part of the wider group of partners who make up the Community Planning Partnership (CPP) in Moray ensuring alignment to the LOIP, which has four main priorities:

- Growing diverse and sustainable economy
- Building a better future for our children and young people in Moray
- Empowering and connecting communities
- Changing our relationship with alcohol.

All of these areas of priority have significant impact on outcome for people, families and communities.

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

This report is a summary of progress during 2019/20in achieving the principles outlined above. It 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.

## Celebrating success

There was widespread recognition of a progressive housing partnership project that supported four men with learning disabilities to move into their own homes in the heart of their community.

The men, aged from 31 to 60, had previously been living in shared homes in Fochabers with communal dining and living areas. It was identified that this was no longer fit for purpose, with the buildings needing extensive work in order to provide an environment in which the men would flourish.

Through our collaboration and partnership with Community Integrated Care, Osprey Housing, the individuals and their families, it was agreed to move to a progression focused model of supported living which offers greater choice, control, privacy and independence over how care and support needs are met.

The move to their new self-contained apartments in Fochabers and to a Supported Living model of care is a huge development, making the men tenants in their own homes for the first time. It marks the beginning of a very exciting future, with a greater sense of independence and choice, as well as a wealth of new life skills, including doing their own cooking, laundry and cleaning for the first time.

During Volunteer Week in June 2019, we formally recognised the invaluable contribution of our army of health and social care volunteers with a tea part in Elgin Town Hall.

Staff from the Community Development Team joined members of the Moray Be Active Life Long (BALL) Groups to travel to Edinburgh in October for the Health and Social Care Alliance Scotland where they were crowned Self-Management Project of the Year 2019.

**Key areas of focus during2019/20:**

- Implementation of Moray Partners in Care Strategic Plan and HSCM Transformation Plan (2019-2024).
- Continuation of Transforming Primary Care including the implementation of the General Medical Contract 2018 and Out of Hours care.
- Sustained focus on Health Improvement and active communities.
- Seeking to progress implementation of our Good Mental Health for All strategy.
- Continual development of housing based initiatives supporting people to live independently with a range of personal challenges or health and care needs.
- We continue to progress the Transformation Programme in Learning Disabilities Services through the application of the progression mode.
- Constant improvement in the proportion of care services graded ‘good’ or above

## Progress

Across the outcomes of well being there are areas of notable progress in the provisional figures for 2019/20:

- 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.

## Challenges

As partners in care, we face a range of challenges, which make the current model of service provision unsustainable. These include:

**Increasing demand** for health and care is growing at an unsustainable rate as people are living longer and with multiple chronic conditions and spending longer in poor health. This puts growing challenge on families communities, public, third sector and independent sector services.

**Growing pressure** on limited resources  the rise in demand puts pressure on our limited resources at a time of rising costs and restricted budgets. We struggle to recruit and retain staff in some sectors.

- Historically we predominantly find it difficult to recruit Social Care Assistants (Carers) in Speyside, Buckand Forres.

- We also find it difficult to recruit experienced Support Workers for Complex and Challenging care packages.

- We have experienced challenges in recruiting to the School Nursing Service, in particular Band School Nurse Posts.;contingency includes advertising and recruiting Band 5 school Nurse Posts.

- If we are in a position to recruit to the five posts this will be a positive for the School Nursing Service, but given that these will be trainees, their skillset and caseload will be limited, and that will not qualifty they until 2022 and that they will require significant supervision and support.

**Improving experiences and outcomes** people who use services, rightly, have increasing expectations of better experiences and outcomes from high quality services and more joined up ways of working, services and systems driven by continuous improvement.

HSCM are ambitious for transformational change to meet these challenges, bring about advances and drive towards achieving the Vision for Moray. We will do this with our workforce and the public to understand what is possible and develop new relationships that emphasis personal choice and responsibility.

In line with our Strategic Plan (Moray Partners in Care) we are committed to continuous review of services and ways of working with the aim being to be able to identify what is working well, and, how we can continue to make improvements. This will require thinking in a different way for the future.

## National Outcomes

The National Health and Well being 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 [page Numbers]

Health and Well being Outcomes

1. People are able to look after and improve their own health and well being 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 well being, 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

## National Indicators are identified for each of the National Outcomes

- Green performance is better than Scottish average,

- Amber performance is worse than Scottish average but within 5% tolerance,

- Red performance is worse that Scottish average by 5%. Arrows indicate the direction of the current trend.

# People are able to look after and improve their own health and well being and live in good health for longer

This national outcome is truly incorporated in our vision 'to enable the people of Moray to 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 well-being.

| No. | National Indicator | 2016/17 | 2017/18 | 2018/19 | Scotland 2019/20 | 2019/20 | RAG* |
|---|---|---|---|---|---|---|---|
| 1 | Percentage of adults able to look after their health very well or quite well | N/A | 93% | N/A | 93% | Not Yet Available | ● |
| 11 | Premature mortality rate (reported by calendar year) | (2016) 360 | (2017) 372 | (2018) 394 | (2018) 432 | Not Yet Available | ● |
| 12 | Emergency Admission Rate per 100,000 population for adults | 8,802 | 9,276 | 8,974 | 11,313 | 9,249 | ● |

## How did we do?

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 continued focus in 2019/20. 120 people were trained in use of Naloxone kits in 2019/18 and as at the end of September 2019 there were 109.

## What did we do?

The Scottish Services Directory (SSD) is all about connecting communities and sharing information.

NHS 24, Macmillan Cancer Support and the Health and Social Care Alliance Scotland have been working together to develop the new online SSD.

The SSD aims to improve individual and community health outcomes and will have an important role in supporting integrated and prevention-focused approaches to service planning and delivery.

The SSD brings together information about local health and well being services gathered from two sources:

- Community health and social care services, that are provided or commissioned by individual Health & Social Care Partnerships, NHS Boards or Local Authorities.

- Information about the wider range of community services and resources using the Local Information System for Scotland (ALISS), managed by the ALLIANCE, on behalf of the Scottish Government.

The community and Health and Social Care professionals have told us they would value a central information point they can turn to where they can find information about what's available and what activities they can join in.

www.nhsinform.scot/scotlands-service-directory

In collaboration with Moray existing databases including ALISS have been merged and embedded within the NHS inform SSD platform.

The SSD will support us to improve our health and well being, as information will be easy to find and access, supporting communities to self-care, self-manage, and make the most of what's available.

[Please include: NHS 24 Logo; the alliance logo and H & SC Moray logo]

SSD was launched in Scotland on March 19th 2020. Within Moray 243 health and well-being services are now listed; since the launch visits to the Moray page show an increase of 87.6%

Throughout 2019 the new merged health point service continues to maximise opportunities, increase reach and provide a flexible, holistic, person centred approach. In addition to the main health point situated within Dr Grays Hospital, the service has expanded to provide a locally based service embedded within GP practices across Moray and community settings.

The specialist health point team can offer bespoke 1:1 support, either face-to-face, telephone support and in some instances via email, – whichever suits the client's needs. Clients have been supported whilst working in the North Sea on trawler boats, oil platforms and long distance lorry drivers.

Impact of the merged services shows that the average smoking cessation 12 week quit rate for those accessing the specialist smoking cessation service is 30%; the overall quit rate for Moray is 22% (this includes quits recorded via the Pharmacy service); which is above the overall Grampian 12 week quit rates.

The new merged service provides access to;

- Practical ways to improve health and well being and health concerns
- Self care/self management, including promotion of National Campaigns
- Support groups and organisations; an example of which is the
- Power of Attorney information day, which generated a great response from the public.
- Long term conditions e.g. Diabetes & Asthma
- NHS services
- Free condoms

[power of attorney photo]

Health Point works within the community to continue to increase our visibility; delivering support and services within communities to all population groups across Moray including; schools, Men's Sheds, BALL groups, local workplaces as well as supporting strategic priorities such as locality planning and community learning and development.

Maximising on resources such as the Mobile Information Bus and in collaboration with partners from a range of local services; The Moray Council Income Maximisation Team, Penumbra Service, Rural Environmental Action Project (REAP) and Social Security Scotland delivered a 3 day health and well being event to a local workforce.

## Feedback includes:

Outreach delivery of our community service during 2019 has increased by 27% reaching local communities, GP practices and workplaces; with over 50% of those accessing the service being of working age and the older population.

## Case Study 1

John who has high blood pressure was referred to the health point outreach service, by his practice nurse, for support with smoking cessation. John had smoked for many years, but supported by his advisor disclosed he had a history of depression, loneliness and isolation. John was provided information on local groups/activities and, with support, joined a local Men's Shed. John continued to make good progress stopping smoking, which lowered his blood pressure. His mood also improved due to his increased connectivity within the community.

## Case Study 2

Marie is accessing the health point service for smoking cessation support. Having successfully stopped smoking Marie was concerned about her weight and wanted to increase her activity levels. Marie continued to receive motivational support from her advisor and information on the 'eat well guide', physical activity and weekly weight checks. Marie gradually started losing weight, which inspired and motivated a family member to access the health point service and together they attend, supporting and motivating each other.

## Moray Health Walks

To help support and encourage active lifestyles and promote the wide-ranging benefits of walking for mental and physical health, external funding supported the development of a Health Walk Co-ordinator Post in 2019. Over an 11-month timescale the following outcomes were achieved;

- 13 Moray wide health walks supported and actively promoted
- established five new health walks: three new buggy walks, a GP Practice walk, Cullen walk
- developed links with CLAN Cancer Elgin and supported them to set up their own Cancer friendly health walk
- approximately 100 new walkers attended health walks
- 31 Moray residents receiving Walk Leader training to either support existing or set up new health walks
- promotion of walking for health on social media pages and in local press
- walking for health talks delivered to Men's Shed and BALL groups

Further funding has been secured for 2020/21 from Paths for All to develop dementia friendly walking in Moray.

## Feedback includes:

*"I had lost some confidence and attending the Health Walk has been the best thing for me. Walking has really helped to alleviate the pain associated with my condition and I've also been inspired to walk more on my own. I now walk the Health Walk routes in between the Friday sessions because I know they are safe and local to me. It's also given me the motivation to try other things like joining the Ladies Fellowship in Lossiemouth."*

*– Jane, living with Osteoporosis*

*"Joining the walking group has brought me valuable friendship at a crucial time and made me motivated to get up and out once more."*

*– Margaret, coping with Bereavement*

## Moray Wellbeing Hub CIC activity in partnership with HSCM

In 2019-20 Moray Wellbeing Hub Community Interest Company (CIC), worked as a resource to support local services delivering health and social care and a key strategic partner in ensuring the voice of lived experience is at the heart of decision-making.

The organisation is a Moray based unique combination of 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.

Notably in 2019, building on a Moray ADP grant of £50k, they secured Moray LEADER match funding for their 'Wellbeing Connected Moray' project which scaled up many of their previous partnership activities. This £180k project completing in July 2020 has reached over 300 vulnerable and disadvantaged people in Moray with peer-led self-management courses, support for group start up and 1-2-1 support through Community Connectors.

Since C19 pandemic onset MWH has moved all its in-person activity to online and has been able to continue to provide a vital wellbeing support for those in need as well as become a driving force in the third sector around mental health collaboration by hosting the Making Recovery Real partnership in lieu of statutory partners redirected to other services.

Projects co-designed and delivered in partnership include:

www.discoverpathwaysmoray.org.uk

**Discover Pathways to Wellbeing in Moray:**

Since creation in 2018 of the first pathway tool, MWH has worked with partners including young people, to create a families, children and young people mental health version. Aiming to encourage a reflective conversation with self or supporters rather than replicate any signposting websites, there are a further two in development around Connecting Families and Harmful or Helpful Behaviors which should be launched summer 2020.

**'Wellness College' brand:**

Peer-led self-management courses continue with evidence-based tools such as 'Living Life to the Full' proving popular. In house created courses such as 'Being a good supporter', "Supporting your child with resilience and calm' and 'SIPP: Suicide intervention principles' founded on an NHS Angus tool, are delivered alongside courses such as Scottish Metal Health First Aid. In 2019 SMHFA was delivered to GMed team members and further mental health awareness sessions to ambulance crew members proved popular. This work was supported by See Me Scotland funds in challenging stigma within HSC settings.

**Training for Trainers:**

Peer2Peer, a course developed in part by the Scottish Recovery Network, continues to be core to MWH quality assurance for their peer-support delivery. They have delivered a further three 24h courses to ensure team members and partners have the knowledge and confidence to use lived experience in action.

**Social movement:**

With 270 Champions to date the social movement for change has grown by over a third in the last year with a large surge during C19 lockdown. This includes members under 16 with the youngest at 10 years old and a wide range of life challenges represented from neurodiversity to trauma, long-term condition management to carers, addiction to LGBTQI+. All members are now supported to interact online using Slack tool to encourage ideas and projects to form and with an expanded delivery team have increased mentoring opportunities to initiate action at a local level.

**Collective voice:**

Support from transformation funds through mental health services in Moray has enabled a stronger relationship between commissioned service Circles Advocacy and MWH Champions. Aiming to increase a collective voice to have input and work alongside partners, the work as seen promising strengthening of relationships around Ward 4 at Dr grays where skilled champions visited monthly to chat to patients and staff over a cake and cuppa. This has led to trialing some creative taster sessions with a view to encouraging connection to MWH wellness college courses on discharge and the community connector opportunity of 1-2-1 recovery support. Additionally, supported by small participatory budgeting funds, the young people Champion strand has been developed with a young Champion leading this work in the community and in-reach to Ward 4. This work has led to stronger links to development of the Moray Children Services plan and future strategic activity from this.

**Adding value to HSCM services and events:**

Supporting the delivery of events such as the NHS Grampian self-management conference in September 2019, Champions have shared appropriate testimony, used facilitation skills to support inclusion at events and brokered between other groups to increase a integrated approach.

**Moray IJB 3rd sector and lived-experience liaison:**

MWH has supported one of their Directors to take up this key role in supporting strategic planning in Moray. Working alongside a worker hosted from tsiMORAY this has proved to be a key conduit to supporting conversation for voting members decision making.

**Partnerships:**

Acting in a brokerage role to enable stronger links between HSCM and other groups and services, MWH has brought opportunities such as the 'For Enjoyment' creative brand to Moray. This successful approach to accessible creative sessions which started in Dumfries and Galloway is working in close partnership to deliver weekly accessible creative sessions for all ages in Moray.

## New Mental Health Recovery and Outreach Service

The new contract was launched with the adult mental health service as of the 1st of April 2019 integrating SAMH as third sector partners with the Secondary Care Integrated Mental Health Service. This service provides mental health care to people in their own homes, supporting and enabling them to manage their mental health and engage with resources in their local community. The service has 3 components:

- Recovery Service
- High Level Community Support
- Recovery Outreach Service

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

**Distress Brief Intervention**

Joint work with Penumbra continues to further roll out and embed the National Distress Brief Intervention (DBI) Programme.

This nationally award winning approach has provided access to mental health services and collaboration with other front line services – Primary Care, Scottish Ambulance and Police Scotland to people in Moray who are in acute mental health distress, including suicide intent and self harm. The service provides a rapid response to people in distress, and improves improved coordination across agencies and quicker access to support with an emphasis on more consistency in the compassion they receive

**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.

www.youtube.com/watch?v=pbk_6NIrBv4

Boogie in the Bar has been recognised nationally through the 'Age Scotland Patrick Brooks Award for the Best Partnership Work 2019'

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

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

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 and Making Every Opportunity Count (MEOC).

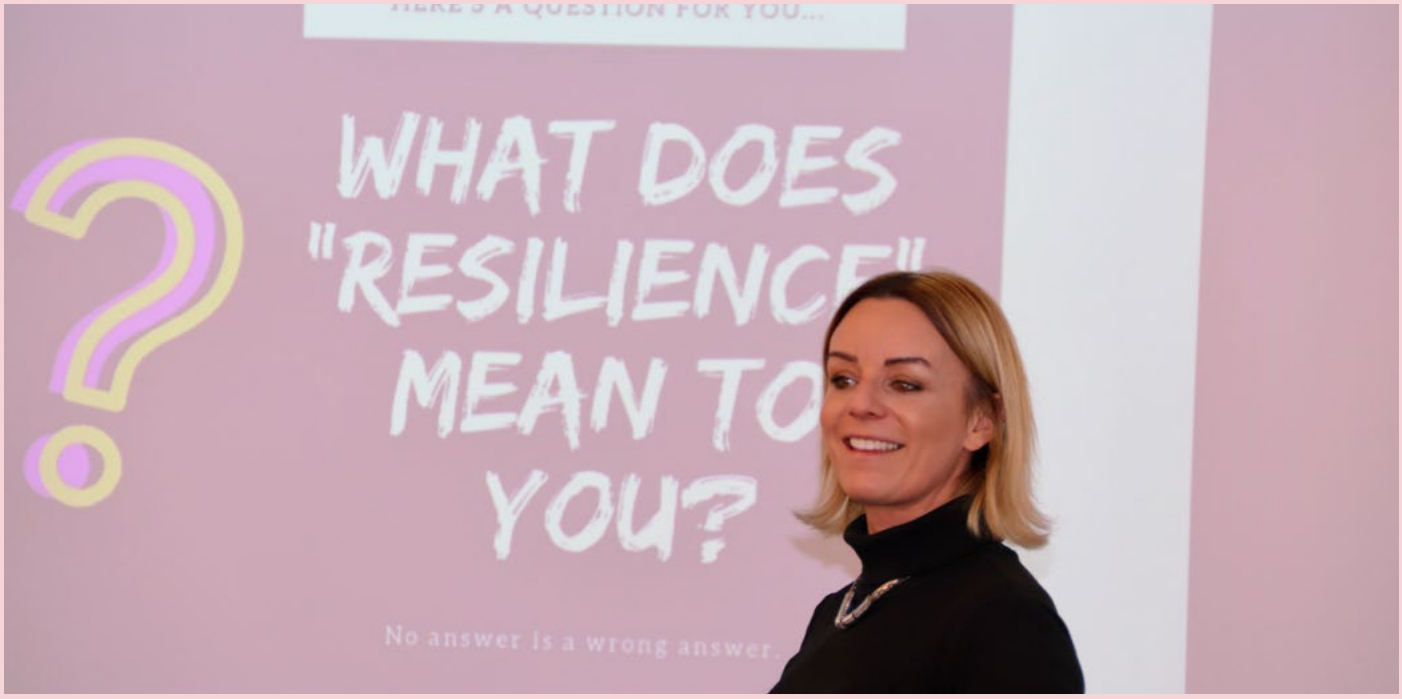
**Community Capacity Building**

The Community Wellbeing Development (CWDT) Team use the asset-based community development approach focusing on people as their biggest assets as community connectors.

Building community capacity through partnership working is a strength of the CWDT by influencing, enabling and training individuals and groups to develop their confidence, understanding and skills required to lead, develop and support the delivery of third sector Health and Social Care community groups across Moray. These include Be Active Life Long (BALL) groups, Men's' Sheds, University of Third Age, lunch groups and social groups.

| Year | No. Of Groups | No. Of people |
|---|---|---|
| 2015-16 | 41 | 820 |
| 2016-17 | 49 | 1160 |
| 2017-18 | 52 | 1230 |
| 2018-19 | 36 | 1178 |
| 2019-20 | 34 | 1203 |

Increase in membership in existing groups is growing, however most BALL groups are at capacity due to hall size restrictions.




**BALL Groups**

CWDT have developed a mechanism to support Community Capacity building for BALL members through offering learning sessions known as 'pow wow' workshops.

The aims of the Resilience workshop was to increase personal resilience as well as group resilience. With over 800 people accessing BALL groups weekly, capacity building can reach many members. This was achieved through working in partnership with Scottish Southern Electric Network (SSEN). SSEN offered learnings on the 'priority service' and also explained the need for personal resilience with reference to a Household Emergency Plan.

BALL group resilience was discussed through participation from all attendees sharing their views on how resilient they think their groups are. Learnings were shared with Duffus and Buckie BALL groups offering a new activity for others to use, along with practical examples lead by the CWDT. BALL representatives then relay the information to their BALL groups to share learnings and increase understanding.

Shona from SSEN was delighted with the response and feedback she got from the members:"One of our goals is to continually look at new ways to engage with our customers, and in particular those who could benefit from the free help that is on offer with our Priority Services Register.

*"we need to be resilient to bounce back quickly if we have a problem, now we know want we have to do in our groups and how to look after ourselves"*

*– Ball Group participant*

**Men Sheds**

Men's shed in Moray continues to grow.

Building stronger connections and being free to express ourselves are key ingredients for health and wellbeing. It's not just about men, the shed provides many avenues for connecting with the wide community (Cullen Men's Shed)

Moray have 6 sheds with more communities ready to embark on the development journey. Through parentship working Shed Members have received training in first aid, mental well-being, cooking, healthy eating and dementia training to mention but a few. Self care self-management is a focus of the sheds with support from the NHS public health team to share information and guidance.

Elgin Shed has secured a workshop premises, as well as Findochety securing their Scottish Charitable status. All Sheds have increased capacity to secure funding and regularly support community initiative within their community, building capacity within their locality. Keith Men's Shed support the annual flu clinic whilst Elgin Shedders are trained drivers to support the Mobile Information Bus belonging as voluntary driver for the NHS.

SELF MANAGEMENT AWARD 2019

Self Management Awards

Shortlisted Nominees

**Self Management Project of the Year: Be Active Life Long Groups (BALL) Moray**

At the Self Management Award ceremony hosted by Alex Neil MSP at the Scottish Parliament, Jeane Freeman MSP, Cabinet Secretary for Health and Sport, announce that the Moray BALL groups were winners of the Self Management Awards Project of the Year 2019.

BALL groups are recognised as innovated, cost effective and sustainable model to support people with long term conditions in communities, which can make a real difference in people lives.

BALL groups offer a mechanism for general healthy living as a key part of one's own Self Care Self Management programme whilst being based in their local community, led by local people.

Every BALL group is structured to provide physical activity as well as mental stimulation so can include anything from laughing yoga, Scottish dancing, or curling to quizzes, crafts, lectures or talks.

Annie Cole Chair of the BALL management Committee accepts the award and is a member of the Buckie BALL group.

**Social Return On Investment (SROI)**

Increasing Men's 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 outcome sofa 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**
**Sing – Exercise – Tea**

Gentle seated exercise with music for older people, Led by a trained facilitator from Dance North.

Meet people and share memories over a cuppa. Every one is welcome. Bring a friend or carer to join in!

*"This group is better than any medicine."*

*– SET group participant*

**B.A.L.L. (Be Active Life Long) Group**

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 number of participants in Moray continues to increase year on year with over 780 people attending BALL 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 groups participants and providers as well as showcasing Moray as a positive example of community Social Work.

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

*"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."*

*– BALL Group particpant*

# 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

**Strategic Housing Implementation Plan (SHIP)**

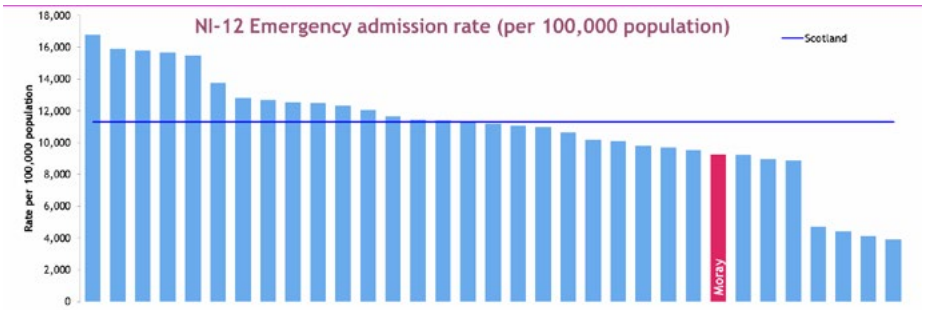
One of our strategic outcomes is 'Supporting people to live independently at home or in a homely setting for as long as possible will always be our default position.'

In the event of people finding themselves in hospital, our aim is to get them back home as soon as they 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.

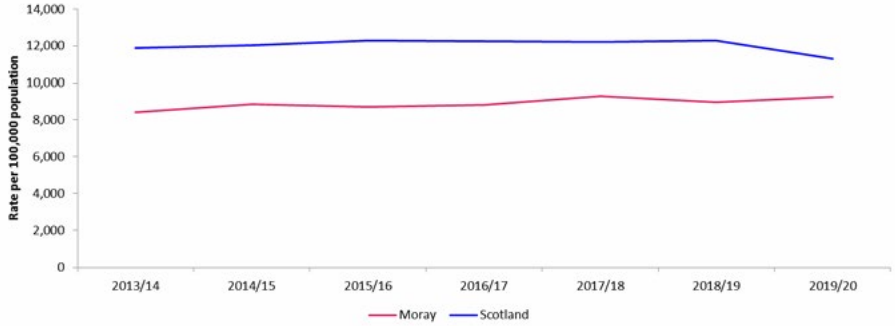
| No. | National Indicator | 2016/17 | 2017/18 | 2018/19 | Scotland 2019/20 | 2019/20 | RAG* |
|---|---|---|---|---|---|---|---|
| 2 | Percentage of adults supported at home who agreed that they are supported to live as independently as possible | 74% | N/A | 83% | (17/18) 81% | Not yet available | ● |
| 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% | (17/18) 76% | Not yet available | ● |
| 5 | Total % of adults receiving any care or support who rated it as excellent orgood | 79% | N/A | 80% | (17/18) 80% | Not yet available | ● |
| 12 | Emergency admission rate (per 100,000 population) | 8,802 | 9,276 | 8,974 | 11,313 | 9,249 | ● |
| 13 | Emergency Bed day rate (per 100,000 population) | 97,696 | 96,453 | 92,230 | 104,406 | 87,206 | ● |
| 14 | Readmission to hospital within 28 days (per 1,000 population) | 75 | 84 | 77 | 99 | 75 | ● |
| 15 | Proportion of last 6 months of life spent at home or in a community setting | 90% | 89% | 90% | 89% | 91% | ● |
| 19 | Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population) | 1,095 | 936 | 1,063 | 793 | 788 | ● |

## How did we do?

Survey results have shown that more people who are supported at home in Moray feel that they live as independently as possible (higher than the national average), but they would like more say in how that care is provided.

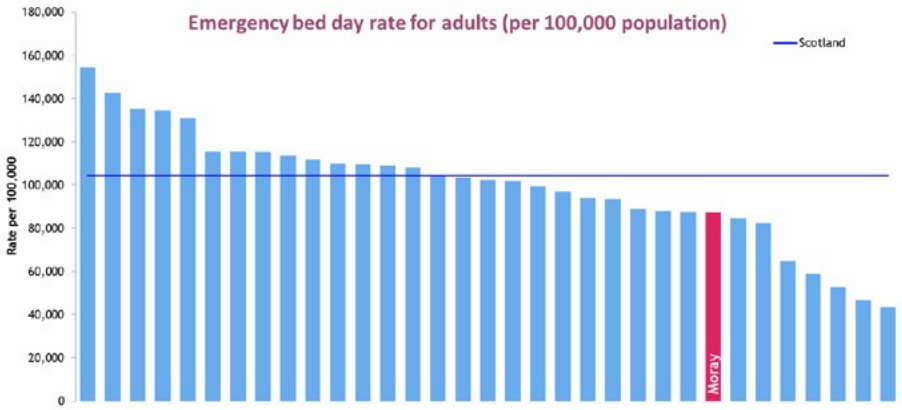


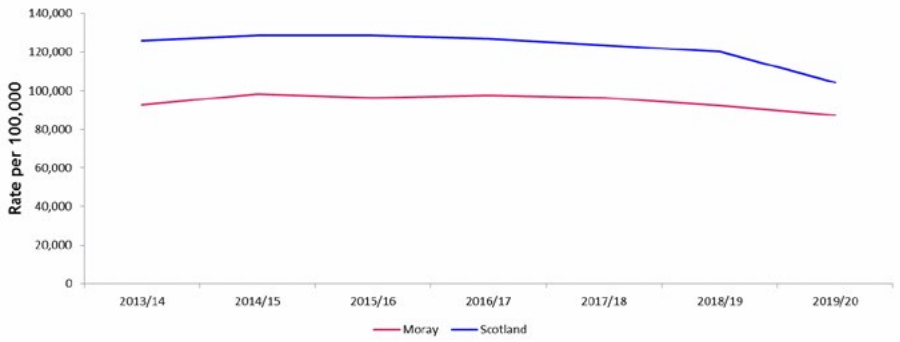

Whilst there was an increase in the provisional figures for2019/20, Moray remains well below the National average.




This is an area of work that is monitored closely by MorayIJB and HSCM as an indication of the progress I preventing unscheduled admissions to hospital.

In addition the length of time 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 2019/20 provisional figures indicate a continuing 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 | 2,211 | 2,294 | 2,412 | 2,360 |
| 2018-19 | 2,338 | 2,248 | 2,204 | 2,184 |
| 2019-20 | 2,375 | 2,293 | 2,430 | 2,151 |

## Delayed discharges

Prior to COVID-19 HSCM were already committed to reducing the time patients spent delayed in hospital who do not require to be in hospital whilst also increasing the acessibility of systems delivering safe, legal and person-centred discharge. There is unnecessary risk to health and wellbeing for people delayed when medically fit for discharge and also serious questions in regards people's liberty. Reducing delays also brings benefits such as; more efficient use of hospital and community-based resources; reducing costs and increasing service capacity.

- Following a whole system workshop held in July 2019 it was agreed a whole system approach is required. A prioritised action plan was taken forward from the outcomes of this session and ongoing actions included:

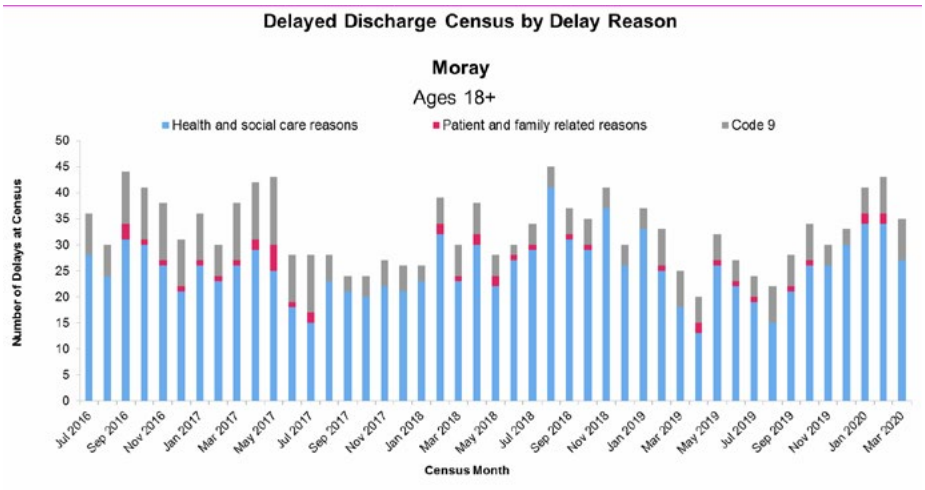
- Social Workers prioritising the assessment of those in hospital and extra resource directed to the Hospital Discharge Team. The Team Manager is also carrying out assessments.

- Care homes have been engaged in providing interim care. The Commissioning Team were in talks with providers as they were able to refuse to take on new residents even when they might have space.

- An alternative to keeping guardianships in hospital is to have an NHS contract with care homes. The commissioning process was being applied to investigate and source this extra resource.

- Extra focus was being put on ensuring that minor adaptations are carried out for those in hospital.

- Despite this, the numbers of delayed discharges has been increasing over the last 6 months with a reported peak of 43 being reached in February 2020. At the last available census date in March 2020 Moray had 35 delayed discharges where five of those were coded as Code-9 (Adults With Incapacity and Awaiting Specialist/Complex Care reasons).




## Caring delivered at home, or homely environment

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

Across Moray the HOMEFIRST approach is being put in place. The Aim of HOMEFIRST in Moray is to ensure that we focus on care being provided to the highest standard of quality and safety, whatever the setting. We aim to ensure that people return to home or community environment as soon as appropriate with minimum risk

Customer satisfaction surveys are issued to service users annually and any areas for improvement are identified and acted upon. Of the 497 questionnaires issued, 180 were received giving a response rate of3 6%.

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.

Feed back 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.

## Technology Enabled Care (TEC)

Progress continued on development of Attend Anywhere in General Practice continued in a small number of GP practices.

The wider NHS Grampian Scale Up programme for NHS Near Me (the umbrella service for all Attend Anywhere appointments) continued and included services in Moray.Medical Paediatrics and Diabetes Specialist Nurses were some of the early adopters in Dr Grays. The project team delivered drop-in awareness sessions at DGH in autumn 2019. As more Aberdeen based services adopted Near Me, patients in Moray were able to avoid travel to Aberdeen by opting to have their appointment by video.

At the start of March 2019, in response to the Covid-19 outbreak, and the resulting reduction in physical attendances at healthcare sites, rapid implementation was needed. All GP practices were supported both locally and by Healthcare Improvement Scotland to provide NHS Near Me appointments. There was additional focus on ensuring cancer care, mental health and maternity services continued remotely where appropriate but all acute and community services were supported with implementation by the NHSG project team on request. This work will continue at pace into the new financial year.

Near Me appointments delivered by Moray H&SCP services Apr 2019-Mar 2020 (excluding GP practices):

## Loxa Court

Commissioned by Health & Social Care Moray Loxa Court is a purpose built housing development providing housing with care facilities for those, including those with age impaired frailty. There are 30 properties in total for use; predominantly for those over 60; five of these are designed for wheelchair users, with another five for those with dementia.

Loxa Court was designed by Hanover House, in partnership with Health & Social Care Moray, to support older people.

Loxa Court build was finished in Autumn 2019 and the first tenancies commenced in November 2019.

Allied Health Care was awarded the contract to provide care and support and had no problem recruiting staff for Loxa Court

## Forres Locality Pathfinder Project

The purpose of the Forres Locality Pathfinder Projectis to reshape services within Forres locality to best meet the health & social care needs of the population..More recently, further scrutiny has been applied to determine whether the current model meets the needs of the identified population and whether it is having the necessary impact on sustainability of future services required to deliver high quality, person centred, effective care and demonstrating best value.

The Locality Manager will undertake a service review in partnership with key stakeholders. This review will outline a detailed plan for moving forward and will include capturing information from staff, patients and focus groups including staff from a range of services (locality partners, and secondary care/acute services)

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

We work in partnership with service users, carers, providers and a wide range of other Stakeholders to develop and improve the services we provide. We listen to the feedback from community engagement, surveys and planning groups when planning our services and the following table highlights what people think about our services.

| No. | National Indicator | 2016/17 | 2017/18 | 2018/19 | Scotland 2019/20 | 2019/20 | RAG* |
|---|---|---|---|---|---|---|---|
| 4 | Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated | N/A | 73% | N/A | (18/19) 74% | N/A | ● |
| 5 | Total % of adults receiving any care or support who rated it as excellent or good | N/A | 80% | N/A | (18/19) 80% | N/A | ● |
| 6 | Percentage of people with positive experience of accessing their GP practice | N/A | 80% | N/A | (18/19 )83% | N/A | ● |
| 15 | Proportion of last 6 months of life spent at home or in a community setting | 90% | 89% | 90% | 89% | 91% | ● |
| 17 | Proportion of care services graded 'good' or above in Care inspectorate inspections | 71% | 85% | 82% | 82% | 75% | ● |

## How did we do?

The latest GP survey results have been delayed due to the COVID-19 pandemic. These are to be released later in 2020 but to date no definite timeline has been communicated.

**Commissioning Services**

The Commissioning Team collates information from various areas and uses a range of 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 en

In Moray we now have 44 services registered with the Care Inspectorate on the commissioning database. Care Inspectorate score these servicesfrom1(lowest)to6(excellent).Comparisons with previous year's 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.

Overall 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

## Complaints & Compliments

| ID | Indicator Descriptor | Source | Q3 (Oct-Dec19) | Q4 (Jan-Apr) |
|---|---|---|---|---|
| L19A | Number of complaints received and % responded to within 20 working days – NHS | NHS | 36% (11) | 38% (21) |
| L19B | Number of complaints received and % responded to within 20 working days – Council | SW | 100% (3) | Not available at this time |

Adverse events and complaints reported on Datix continue to be monitored through the ClinicalRisk Management Group escalated and actioned appropriately.

On review of those taking longer than 20 days, delays could be attributed to the complexity of the complaint, requiring investigation and liaison with multi-disciplinary and multi-agency staff. In some instances the complaint had been allocated incorrectly, which added to a delay in responding. Complainants had been notified of the extended time required for the investigation.

A delay in sending final response letters was being experienced. This was escalated by the HSCM Clinical Governance Group, and a new way of working has been implemented which has resulted in a more efficient process allowing responses to be sent to complainants in a more timely manner. This will continue to be monitored to ensure efficacy .Adverse events and complaints reported on Datix continue to be monitored through the Clinical Risk Management Group escalated and actioned appropriately.

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

Evidence shows that by reducing social isolation and connecting people to their communities, there is a positive impact on mental well being and people's health overall. We are supporting those with long term conditions,by developing 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 | 2016/17 | 2017/18 | 2018/19 | Scotland 2019/20 | 2019/20 | RAG* |
|---|---|---|---|---|---|---|---|
| 6 | Percentage of people with positive experience of the care provided by their GP practice | N/A | 80% | N/A | (18/19) 83% | N/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 | N/A | 79% | N/A | 80% | N/A | |
| 12 | Emergency admission rate (per 100,000 population) | 8,775 | 9,269 | 8,974 | 11,313 | 9,249 | |
| 14 | Readmission to hospital within 28 days (per 1,000 population) | 74 | 84 | 77 | 99 | 75 | |
| 19 | Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population | 1,095 | 936 | 1,063 | 793 | 788 | |

## How did we do?

### Urgent and Unscheduled Care

These redesigned services will focus on urgent and unscheduled care, and the developing roles of clinical and non-clinical professions, working in practice, to support physical and mental health. We have practice based Advanced Nurse Practitioner's (ANP's) across the majority of GP practices and the scope of the urgent and unscheduled care plan would be to support the ANP's with the development of an Acute Response Team, which supports Home First and Community MDT.

This team could comprise of a range of clinical and non-clinical professionals including ANP's, OT and supporting staff that help with acute assessment and to keep people safely at home.

## What did we do?

**New GP Contract and the Primary Care Improvement Plan (PCIP)**

Implementation of the new GP contract is now at the half way point of the 3 year plan. Considerable progress has been made to establish the framework and governance requirements to deliver on the key objectives set out in the Health and Social Care Primary Care Improvement Plan (PCIP) allowing for flexibility whilst ensuring adherence to the core aims and principles of the new contract.

The Health and Social Care Moray PCIP described the high-level actions and initial proposals for service delivery models for each of the 6 priority areas agreed nationally.

**Vaccination Transformation Programme**

All pre-school immunisations including flu are now carried out by the Immunisation Team. Pharmacotherapy

All practices have input from a Pharmacotherapy Team and recruitment is ongoing to expand these teams.

**Community Treatment and Care Services**

Clinician Level Indicator Programme(CLiP): Facilitated workshops have taken place and a phased approach, to implementation is currently being rolled out across Moray, with recruitment underway for additional Band 3 Health Care Assistant (HCA) and Band 5 treatment room nurses to work as integral members of practice clinical teams, working with GPs and practice staff as part of a multi-disciplinary team

**Urgent and Unscheduled Care**

These redesigned services will focus on urgent and unscheduled care, and the developing roles of clinical and non-clinical professions, working in practice, to support physical and mental health. We have practice based Advanced Nurse Practitioner's (ANP's) across the majority of GP practices and the scope of the urgent and unscheduled care plan would be to support the ANP's with the development of an Acute Response Team, which supports Home First and Community MDT.

This team could comprise of a range of clinical and non-clinical professionals including ANP's, OT and supporting staff that help with acute assessment and to keep people safely at home.

**Additional Professional Roles**

Current evidence demonstrates that musculoskeletal (MSK) health issues are the most common cause of repeat GP appointments and account for 20-30% of demand in general practice. We have recruited First Contact Practitioners who provide input to all practices across Moray. The will develop and scale up to Moray wide of the overall MSK service to ensure fully streamlined pathways for patients with additional physiotherapist capacity per locality.

**National Mental Health Strategy**

Mental Health Development Workers recruited across Moray.

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, in place in 2 GP practices, to be rolled out across all GP practices in Moray.

Over the last year multi-disciplinary short-life working groups (SLWG) have been developed to lead on each priority area, linking with NHS Grampian and national groups. These SLWG's have collated information around existing workload, current skill mix, any skill gaps and potential models of delivery. This has produced options appraisal proposals on the future models of delivery.

Health & Social Care Moray Senior Management Team, comprising clinical, managerial, and professional leads, has provided governance and accountability with respect to decision-making and allocation of resource aligned to the PCIP. The HSC Moray has engaged with and updated the Integration Joint Board and GP Sub Committee as implementation has progressed.

The PCIP group has always and continues to have representation from GP Clinical Leads and GP Practice Managers. This working relationship is enhanced through a variety of methods including practice visits, update events and involvement in development workshops for key priority projects. Moray has GP Practice Manager Representatives on each PCIP work stream.

The Moray GP Cluster group continues to focus on Quality Improvement agenda and has strong links with Moray Alliance working towards a whole system approach. The PCIP group also contributes to Locality Planning Groups and to public engagement sessions to develop significant dialogue with all our stakeholders as we develop our plans and services.

Health & Social Care Moray has sought to maintain a whole system approach rather than the development of isolated services. This includes maintaining and further developing the well-established relationships and arrangements within our existing multiple disciplinary teams.

Our approach has sought to build on the many strengths within primary care in Health & Social Care Moray whilst being aware of potential risks, recognising the existing good outcomes for patients, and the need to ensure that outcomes must be maintained or improved through delivery of new services.

Moray's Primary Care sector has embraced new technological developments, including virtual consultation opportunities offered via NHS NearMe and Technology Enabled Care (TEC) e.g. remote blood pressure monitoring for patients.

**Transformational Change in Learning Disabilities Transformational**

The Moray Learning Disability Service continues to work through a series of five themes relating to the Transformation of Learning Disability, which was begun in 2017 based on identifying emerging best practice from England and Wales. Health & Social Care Moray realised that adopting new ways of working and delivering support in different ways could help people with a learning disability to achieve greater levels of independence. The five themes are based around the Progression Model, which is that with structured support over an extended period, people can increase their independence and decrease their reliance on support for health and social care services. This means that better outcomes for people with a learning disability can be achieved with less health & social care intervention.

- A higher quality of life occurs when services deliver better outcomes for people with a learning disability.
- Better outcomes result in an eventual reduced demand for services.
- Need is a driver of services, and therefore cost.
- By focusing on improved outcomes, and so reducing need, we have the opportunity to reduce the level of expenditure and develop a more sustainable financial model.

## Themes

**The Financial Impact**

The Learning Disability Transformation Project seeks to provide services in a way, which is more sustainable. People with a learning disability will always need a level of support and there will always be financial pressures on the system. Typically, people with aging parents who have been very well supported by their families in their family home will require significantly more support when they move into their own homes. Conversely, efficiencies can be achieved when people who have been placed out of area as children return to Moray as young adults to their own tenancies with support. The progression model acts over the medium to long term to ensure that the level of support is delivered in the most cost effective way. The other themes support us to deliver our service in the most sustainable way both in terms of our financial and staff resources.

**Implementing the Market Shaping Strategy**

In 2018, the Learning Disability Project Board approved a Market Shaping Strategy designed to provide an opportunity to have ongoing conversations with providers to ensure that the right type of accommodation and support is available to assist people at different stages of their personal development and their path to greater independence. This has resulted in important developments in housing noted below.

**The Learning Disability Housing Development Project**

One of the immediate outcomes of the Market Shaping Strategy conversations is The Learning Disability Housing Development Project. This is a 4 to 5 year project in collaboration with the Moray Council Housing Department. At time of writing there are thirteen houses under construction based on environmental needs assessments developed by the Learning Disability Team. A further thirty houses are under negotiation to be built over the next two years, including houses for those who present most as most challenging and those who are currently out of area with the highest financial impact to the Moray Health and Social Care Partnership.

**CareCubed Implementation**

CareCubed is an internet based software tool designed to ensure that the correct level of care is being commissioned to support each service user. It is also designed to support a move away from a block purchasing model andwill help to achieve the personal outcomes for service users. The output from the tool can be used in negotiations with provider agencies to ensure that the most sustainable level of care iscommissioned for each person.

A two year project plan has been established to test and then mainstream the use of this tool and the tool has proved its worth in designing care for the new builds noted above as well as in the recommissioning of existing services.

**Establishing a Learning Disability Forum**

Following the principles of co-production and of learning together, the Learning Disability Forum held an event in early March 2020, attended by over 40 family members of people with a learning disability. Four themes were discussed including; overnight Provision; Homes for the future; Responsive Support and the Future Model. The workshop suggested that whilst the use of technology would be appropriate for future accommodation, the change for those people who are currently in receipt of services would be too much of a challenge and would be problematic. The workshop attendees were in support of the development of future models of housing where technology would be incorporated as part of the build process and would be used from the beginning of a person's tenancy.

The Learning Disability Forum is a key means of engaging with people with a learning disability in Moray and further meetings are planned.

Learning Disability Services in Moray are on an exciting journey through the work done by the Transformation project. We want people in Moray who have a learning disability to be provided with the right level of support that helps them to be as independent as possible. To this end we are focusing on the outcomes that are important to people and their lives.

We have achieved some notable successes so far by helping several people move from residential care into their own homes where they are the tenant and where they can make real choices about how they live. We have supported our service providers to work in different and much more

flexible ways with people and we have noticed that the amount and level of challenging behaviour has reduced as people feel more independent and more in control of their lives.

The next phase of the project will focus on getting the care and support right for the many people who are waiting for the right type of accommodation. Our goal is to have houses and flats built to a high standard which are adaptable for people with different needs. The new housing will be combined with the right level of on-site care and support which is flexible and responsive and which makes full use of technology to support independence and to ensure that people are supported safely both day and night.

**Self-Directed Support**

The Self-Directed Support (SDS) legislation was enacted in April 2014, mid-way through the Scottish Government's 10 year national implementation plan for embedding the ethos of SDS. We are now working towards the 2019-2021 national strategy for Scotland, which sits alongside our local SDS implementation plan focusing on the recommendations from the previous SDS Thematic Review undertaken by the Care Inspectorate. Current developments have been focussing on the development of Option 2 of SDS to ensure that the choice, control and flexibility afforded with Option 1 of SDS was mirrored for those individuals who wanted their care and support to be arranged through Option 2.

Moray is working alongside Health and Social Care Alliance Scotland (the Alliance) on the My Support My Choice project, obtaining independent feedback from service users about their experience of SDS in Moray. The feedback was obtained by the Alliance in a variety of formats including paper questionnaires and face to face interviews. The outcomes are currently being evaluated by the Alliance and a report will be produced, which will be used to further develop the local SDS implementation plan The SDS team continues to provide dedicated 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 number of Direct Payment recipients has seen a gradual increase again this year, along with a steady increase in the number of unpaid carers who have been eligible for SDS to support them in their caring role.

To support the Personal Assistant(PA) workforce in Moray, the SDS team works in close partnership with PA Network Scotland, where quarterly meetings are held for Personal Assistants in Moray to attend. In addition to

this, the network hosts a closed private Facebook site for PA's to join and currently has 130 members, this is the second largest PA network page in Scotland, and is currently the most active.

We continue to work closely with Quarriers to implement the Carers Act, ensuring that the powers and duties in the Act are embedded in our daily practice, recognising the vital role of unpaid carers in Moray. This partnership is reflected in the significant increase in unpaid carers who are in receipt of SDS in their own right, ensuring that they feel support in their caring role. Further developments are underway in the form of an implementation plan to allow us to further embed the Act into our practice.

| Financial Year | Total Number of DP recipients Supported by SDS team |
|---|---|
| 2015/16 | 171 |
| 2016/17 | 199 |
| 2017/18 | 212 |
| 2018/2019 | 219 + 6 unpaid carers |
| 2019/2020 | 221 + 31 unpaid carers |

The Care Inspectorate published its findings in June from a 'Thematic review of self-directed support in Scotland' that included the release of the Moray local partnership report in which supported people were engaged.

The inspectors found the partnership had made significant progress implementing self-directed support and that this was making a difference to people's lives. Most supported people experienced choice and control in how they used personalised budgets and were achieving positive personal outcomes as a result.

For some people, relationships they had developed with their personal assistants had been transformative in delivering positive outcomes. The provision and impact of short-term focused interventions for supported people with moderate levels of need was particularly noteworthy. The self-directed support team was a valued and important source of support and advice for staff across the partnership. Members of the team were highly motivated and knowledgeable about self-directed support.

The partnership had worked hard to develop assessment and support plan templates that could effectively reflect self-directed support principles and practice. We saw good evidence of these working in practice, including a high proportion of good quality assessments and outcome focused support plans.

For the seven quality indicators assessed, the scrutiny body found Moray to be 'good' on six and 'adequate' on one.

# Moray Shared Lives

**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 Health Learning
- Disabilities & Social Isolation

The service provides:

- Day Support
- Respite & Short Breaks
- 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 both in the carer's own home and within the local community. A small respite service is offered to unpaid carers or family members for periods of 24hrs and developments continue to grow the Long Term Placement area of the service. Long Term Placements involve people living in the Shared Lives carer's home and being considered a family member.

Prior to the temporary suspension of the service due to the COVID 19 outbreak, 130 service users were supported in a Shared Lives setting each week and a waiting list was in place to track any outstanding referrals who are awaiting suitable placements. 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. Ongoing feedback from those who access the service and their families continue to support these findings.

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.

National 5 Outcome

# Health and social care services contribute to reducing health inequalities

Baby Steps, our award winning Health and Wellbeing programme for pregnant women with a BMI ≥ 30, is now in its third year, with 16 cycles of the 8 week midwife led programme being delivered in this third year. Baby Steps is a fun, free interactive programme that aims to support women to take small steps towards a healthier pregnancy, which includes gentle exercise and practical food skills.

Over a quarter of the women attending for a dating scan were eligible to attend the Baby Steps programme. 99.6%% of those who were eligible were invited to Baby Steps with 15.4% of them attending the programme.

Impact of the programme on the women's and their families' health and wellbeing is captured through the use of a Wellbeing Wheel, which the women complete on weeks 1, 4, 8 of the programme and in the postnatal period.

The data collated [Scottish health awards photo and caption] demonstrates an improvement in the knowledge and skills of those who attended:

- 85% of the women are more aware of how to reduce the risks associated with BMI ≥30
- 82% felt healthier and more active
- 75% were more aware of support available to them in the community
- 61% are more confident that they can take steps to improve their
- health and wellbeingand have a greater understanding of food labels
- Over half of the women attending felt more confident cooking from scratch
- Over a quarter of the women felt more supported by family and friends

The women attending Baby Steps are invited to meet postnatally when their babies are approximately 6 months old; the number of women returning to meet has increased by over 400% since the programme began in 2017. Evaluation shows the longer term impact of the programme and demonstrates sustained positive lifestyle changes made to their diet, activity levels and meal preparation during and after pregnancy. Women's knowledge and confidence scored more highly than before attending Baby steps and as well as the physical changes, the women have benefited both mentally and emotionally; remaining in contact with each other providing essential peer support.

Feedback includes: 'Baby Steps gave me the confidence to cook from scratch', 'I'm taking longer walks', 'I'm adding extra vegetables to meals', 'I'm now checking food labels'.

Data demonstrates that women are more aware of support within the local community and accessing services including; baby massage, BRAG (Breastfeeding, Reassurance, Awareness Group), Baby and Toddler groups, Step by Step and swimming.

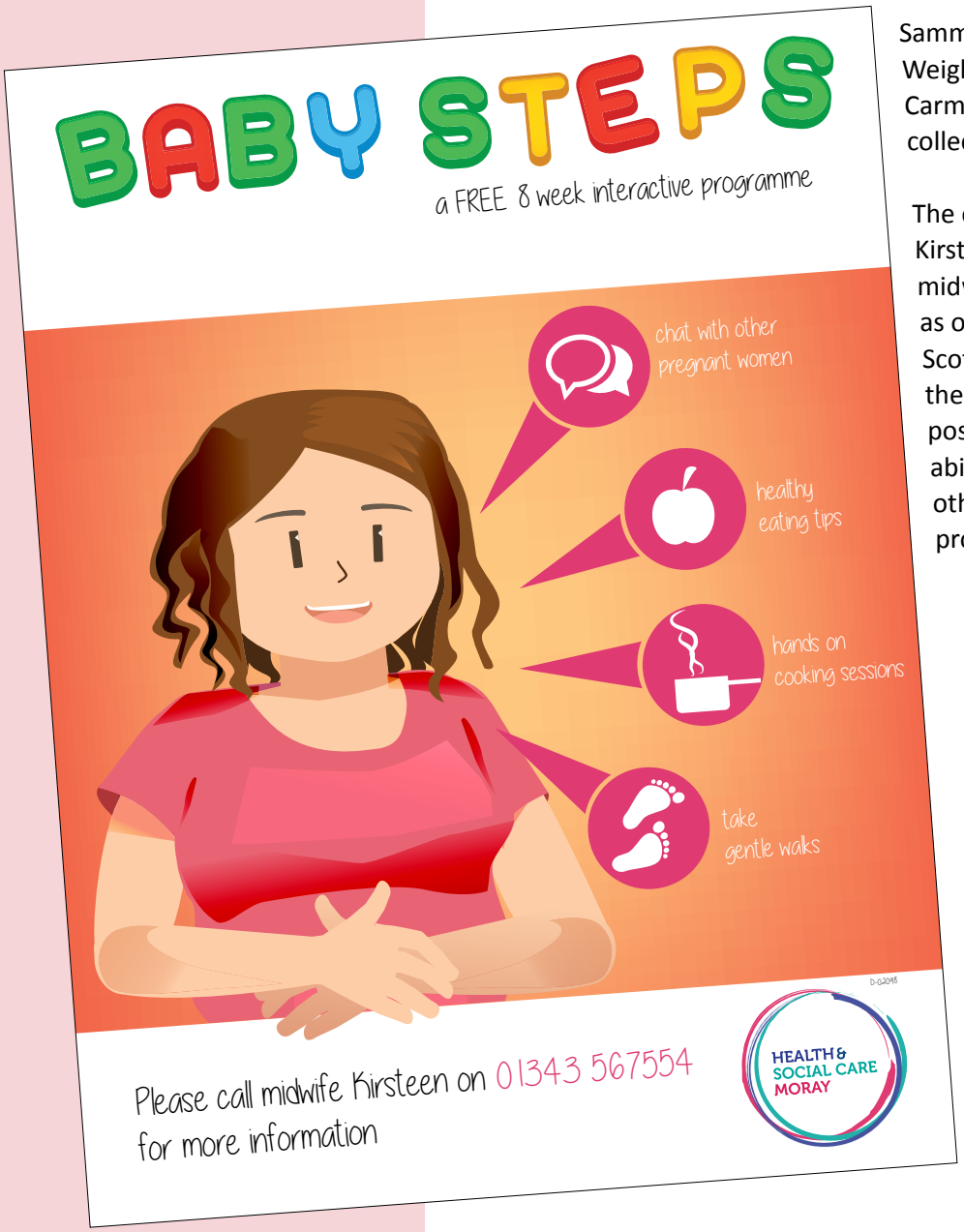
# BABY STEPS

**Baby Steps highlights include:**

National recognition: The Baby Steps team were invited to share their learning and lead a session at the Scottish Government's, Strategic Leads Improving Outcomes for Children and Young People Networking Event. Feedback from attendees was extremely positive.

Baby Steps received a site visit from Roseanne Macqueen (Policy Advisor, Services Reform Division, Scottish Government). The visit was to harness and identify ideas, concepts and innovative ways of working that could be considered for scale and spread across Scotland and inform 'Finding a way Forward'.

Baby Steps won the Inkwell Choice Award for community engagement and partnership working.




Sammy Morrison (Child Healthy Weight Coach) and Kirsteen Carmichael (Baby Steps Midwife) collecting the Inkwell Choice Award.

The commitment and dedication of Kirsteen Carmichael the Baby Steps midwife was recognised nationally as one of the three finalist in the Scottish Health Awards 2019 in the Midwife Category. Kirsteen's positivity, professionalism and ability to lead and motivate others has shone throughout the programme development.

## #YOUCHOOSE4 – BEHEALTHY:

**A Collaborative Approach to Participatory Budgeting**

Building on the success and impact of #YOUCHOOSE3 and the collaboration with tsi MORAY. This year #YOUCHOOSE4 aimed to address all six of Scotland's National Public Health Priorities which include; vibrant, healthy and safe places and communities.

#YOUCHOOSE4 exceeded expectations, with a record number of people taking part in deliberation and voting and over 50 projects across both themes; Be Healthy and Connecting Communities through CHIME. Be Healthy received over 30 applications (an increase of 30% from the previous year); 28 of those received award offers, others were considered within the other theme as they fitted criteria for both. This helped to maximise award offers

Be Healthy 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 has resulted in projects that are meaningful. Moreover these projects have been community led, promoting local connections, skills development and peer learning. Votes have increased year on year (on line and in person voting) from 695 in year 2 to 1136 this year.

This innovative approach was recognised nationally reaching the final 3 in the Scottish Health Awards 2019 in the Innovation category.

Projects and applicants this year include: Moray School gardens; growing, cooking skills in schools – Rural Environmental Action Project; Dads groups; including practical food skills; Digital Capacity Building – Elgin Street Pastors; No worries Moray; family based activities; Informing the community – Archiestown Community Council.

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

A key theme in the Moray Partners In Care Strategy 2019-2029 is the Home First approach with people being supported at home, or in a homely setting, as it is acknowledged it is better for people, particularly older people, to be cared for at home where possible. Health and Social Care Moray (HSCM) recognise the very significant role that unpaid carers have in achieving the aim of this theme.

As the proportion of older people increases across the region there will be a continuing need to support unpaid carers. Health and Social Care Moray together with our commissioned carer service, Quarriers, continue to work with unpaid carers to understand what they need to look after their own health and wellbeing, and help them achieve their identified outcomes.

The beginning of May saw Quarriers reach a 10 year milestone, supporting unpaid carers in Moray for a decade! “The last ten years have flown by with much success. A greater move towards care at home means the next are going to be very busy”.

## How did we do?

Locally in Moray, the percentage of carers who felt supported in their caring role in Moray in 2018/ 19 increased slightly on the previous year to 39.5% up from 39% in 2017/18. Figures for 2019/20 are not yet available. Local figures are slightly higher on national figures for Scotland, where in comparison, 36.6% of carers felt supported to continue in their caring role for the same period.

Local statistics from Quarriers carer service show a 12% decrease in the number of registered adult carers from 1526 last year. Of new referrals 113 were self-referrals and 114 were referred through health and social care.

| Headlines from Quarriers Carer Service | |
|---|---|
| Number of adults registered | 1342 |
| Number of young carers registered | 63 |
| Adults and young carers supported | 1136 |
| Number of new adult referrals | 240 |
| Number of new young carer referrals | 39 |
| Total amount of respite awards | £12,260 |
| Learning opportunity participants | 237 |
| Peer support sessions | 54 |
| Carer counselling hours | 256 |

Quarriers conduct an annual survey of adult carers; of the 55 respondents, 93% rated the overall service good/excellent, down slightly on last year's 94%. 95% rated the service good/excellent in relation to the Adult Carer Support Plan process. The advice and information service was rated good/excellent by 91%. Overwhelmingly, respondents stated that service responds quickly, communicates relevant information in the right way, and staff are helpful, knowledgeable, supportive, and respectful.

*"Quarriers provided the safety net when things were not so great. They helped me through some difficult periods"*

*Service User*

Throughout 2019/20 Quarriers have been supporting our unpaid carers in Moray through a variety of ways, including holding regular carer café's throughout Moray. For Carers Week in June, over 1,000 unpaid carers were invited to attend, with the event being used to facilitate a table top exercise to get the views of unpaid carers as to where they felt connected to their communities throughout Moray, and where they felt they needed to be better connected. The event also saw the launch of 'Through My Eyes', where carers of all ages throughout Moray were challenged to photograph what the lives of carers looked like. This challenge ended with Carers Rights Day in November with reflection, with the images being on display in various locations throughout Moray.
The reporting period also saw another successful Short Breaks programme, with a total of 50 breaks awarded. Following on from the short breaks:

- 84% of carers reported that they had improved health and wellbeing as a result of the break
- 72% of carers felt like they had more opportunities to enjoy life outside of caring
- 78% of carers reported that they were more likely to ask for help when they needed it

Development of our duties in line with the Carers Act is still ongoing, recognising the support carers need in their own right, ensuring all carers in Moray have access to an Adult Carers Support Plan, or a Young Carers Statement. There is a steady increase in the number of carers who have been eligible for Self-Directed Support in their own right, to support them to maintain their own health and wellbeing.

| No. | National Indicator | 2016/17 | 2017/18 | 2018/19 | Scotland 2017/18 | 2018/19 | RAG* |
|---|---|---|---|---|---|---|---|
| 8 | Percentage of carers who feel supported to continue in their caring role | N/A | 39% | N/A | (17/18) 37% | N/A | ● |
| 18 | Percentage ofadults with intensive care needs receiving care at home | 65% | 68% | N/A | 62% | Not yet available | ● |

**Volunteer Development**

The Scottish Government's vision for Scotland is one where everyone 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.

Volunteering has never been so integral to supporting people in our local communities as it is now. There have been many challenges to face but staying connected and finding different ways of working has been met with an acceptance and willingness to follow guidance necessary to keep everyone safe. We have been extremely fortunate that the 90 buddies have all remained on board and are phoning their clients every week, sometimes more than once a week and some are doing shopping. Most of our 50 alarm responders are still able to attend call outs and have PPE supplied. Our weekly Moray Callers service has been extended to include clients who do not yet have a buddy 25 clients are receiving this service.

We have been keeping in touch with all our volunteers on a regular basis checking on their well- being and hearing about all the activities and other volunteering some have been involved with e.g. making scrubs and masks, UBER volunteer with NHS, food deliveries through COVID 19 local groups, making meals to be delivered to local group for distribution. Many volunteers have taken up new or past hobbies and we have been sharing photos on our Hands Up to Volunteering facebook page. We have kept clients up to date re our service and passed on any concerns to Health and Social care staff and giving out details of local COVID groups so that no one goes without the help they need. The volunteers in Days Services and Projects have also been keeping themselves busy. Many volunteers have been keeping up to date with on line training through Learnpro council.

Celebrating Volunteers Week took place 1 -7 June 2020 and although we could not hold our planned celebration event our 170 volunteers have all received their certificates expressing our thanks and appreciation for the support and commitment they give to our service and the people of Moray.

We are currently developing our service plans for the transition stages of our services as restrictions start to lifted

# People using health and social care Services are safe from harm

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

| No. | National Indicator | 2016/17 | 2017/18 | 2018/19 | Scotland 2019/20 | 2019/20 | RAG* |
|---|---|---|---|---|---|---|---|
| 9 | Percentage of adults supported at home who agree they felt safe | N/A | 84% | N/A | 83% | N/A | ● |
| 11 | Premature mortality rate per 100,000 persons (people aged under 75) | (2017) 360 | (2018) 372 | Not yet available | (2018) 432 | | ● |
| 14 | Readmission to hospital within 28 days (per 1,000 population) | 74 | 84 | 77 | 99 | 75 | ● |
| 16 | Falls (rate per 1,000 population aged 65+) | 15.7 | 15.3 | 15.2 | 20.5 | 15.1 | ● |

## How did we do?

Moray has one of the lowest 28 day re-admission rates in Scotland and has consistently recorded lower than average Premature Mortality rates and Falls for those over 65 despite having an increasing elderly population.

Locally we monitor three measures around Emergency Admissions:

- EA-01: Rate of emergency occupied bed days for over 65s per 1000 population
- EA-02: Emergency Admissions rate per 1000 population for over 65s
- EA-03: Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population which are an indicator of how safe those in the community are and how secure they are in their community settings. In 2019/20 all of these measures had decreasing trends from previous years to a degree in which local targets have now been revised downwards to accommodate this good performance.

Further to this close monitoring of those who have had assessments carried out and who are awaiting care (Unmet Need) will be monitored more closely to ensure those with needs are kept safe.

## What did we do?

**Clinical Care & Governance Committee.**

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

The HSCM Clinical Governance Group and The Social Care Practice Governance Group have been convened to provide assurance through surveillance of the operational system, informing the C&CGC of any issues or are of concern. Risks, adverse events, complaints and compliments are reviewed at the weekly Clinical Risk Management Group to ensure risks are identified and appropriate processes are implemented accurately and consistently and opportunities for shared learning are identified. Significant reviews are undertaken for any Adverse Events and Duty of Candour incidents and published in a separate annual report.

hscmoray.co.uk/our-staff.html

**Adult support and protection**

Effective partnership and collaborative working is essential in protecting adults at risk of harm. Wpork in this area is overseen by the Moray Adult Protection Committee (MAPC). The MAPC is a multi-agency committee, chaired by an independent Convener. The agencies represented on the MAPC are; Moray Council (including the Lead Officer for Adult Support and Protection; the chief Social Work Officer and Elected Members/Councilors; Police Scotland, NHS Grampian, Scottish Ambulance Service; Scottish Fire and rescue Service; advocacy services and the HSCM.

The work of the MAPC is regularly reported to the Moray Chief Officers Group, which is chaired by the Chief Executive of Moray Council. Following a self-evaluation exercise, which was undertaken in April 2019, an Adult Support and Protection Improvement project has been underway in Moray with the aim of improving processes and service provision

**Occupational therapy**

Attached the latest version of the poster we were to be presenting at the Quality and Safety in Healthcare International Forum in Copenhagen at the end of April which was postponed

Early Occupational Therapy & Physiotherapy Intervention & The Lifecurve – The Maryhill Practice Frailty Pilot – see below for the Poster Abstract which was for the NHS Scotland event at the end of June in Glasgow which has been postponed.

**Descriptor**

Unscheduled Care has primarily focused on the Emergency Department (ED) 'front door' of hospitals and hospital interventions. There is growing evidence of the need to consider how early frailty intervention can impact upon the population who attend at the 'front door' and how their frailty journey is influenced.

The aim of this pilot was to provide early Occupational Therapy and Physiotherapy intervention focusing on function and wellbeing with patients identified as having frailty indicators to improve their personal outcomes.

**Methodology**

A GP Practice was identified as a pilot site.

A driver diagram was produced

Methodology included:

- Running an electronic Frailty index (eFi) report from Scottish Primary Care Information Resource (SPIRE)
- Reviewing records for 6 patients with moderate but increasing frailty and 16 records for patients escalating into severe frailty
- Choosing 5 patients from moderate but increasing frailty and 5 from escalating into severe frailty
- Joint Occupational Therapy and Physiotherapy assessment and focused treatment
- Implementing the Active and Independent Living Programme (AILP) LifecurveTM Survey at initial and final assessment
- Implementing the Canadian Occupational Performance Measure (COPM) as a person centred outcome at initial and final assessment
- A letter from the Maryhill Practice inviting patients to take part in the project
- A patient satisfaction questionnaire on completion

**Aims/Objectives**

To improve the personal outcomes for patients identified as having escalating frailty indicators within a GP practice in Moray through the provision of Occupational Therapy and Physiotherapy assessment and treatment.

To establish where these patients were on their LifecurveTM in order to measure the impact of this treatment.

**Results/Outcomes**

- 7 out of 8 patients completed the final assessment (one patient passed away)
- Patients showed improvement in 10 out of 14 activities identified by them in the LifecurveTM Survey
- Using COPM to score their perception of their performance in activities, 4 patients perceived they had improved and 3 perceived they had stayed the same

- Using COPM to score their perception of their satisfaction of their performance of activities, 6 patients perceived they had improved and one perceived they had stayed the same

- Early intervention in the upper half of the LifecurveTM assists patients to self-manage to improve their engagement in activities of daily living.

- Patients who are considered moderately or severely frail on eFi can be re-enabled through Occupational Therapy and Physiotherapy.

**The Innovation of a Moray Posture & Movement Multidisciplinary Clinic –** please see the poster abstract below which we submitted for the NHS Scotland event as above.

The Innovation of a Moray Posture & Movement Multidisciplinary Clinic

**Descriptor**

Patients with complex, long term neurological conditions previously required to travel to a specialist Posture and Movement Clinic in Aberdeen from Moray with a journey of up to 200 miles for some patients. This long journey results in fatigue and pain for patients and assessment is consequently more difficult. One patient reported deterioration in spasm and pain to the extent it took 3 days to recover from her clinic appointments.The journey is also a contributory factor for non attendance.

Our aim was to provide an accessable local clinic for Moray patients with a visiting specialist nurse practitioner and local multidisciplinary input to meet the complex requirements of these patients at a “one stop shop”. Whilst the primary aim was continued provision of the specialist assessment and treatments (i.e intrathecal baclofen, botulinum toxin, antispasmodic medications) to support posture and movement; the patient’s functional activities of daily living and any care or treatment issues are also to be addressed with input of a local occupational therapist and physiotherapist. These clinic appointments are conducted with a Making Every Opportunity Count and Healthworks approach.

**Methodology**

Monthly clinics were introduced in Dec 2018 at Dr Grays Hospital, Elgin with the visiting specialist nurse practitioner and a Moray occupational therapist and physiotherapist.

Patients were identified from the Aberdeen clinic and offered appointments at the Moray clinic as an alternative to travelling to Aberdeen.

No additional resource has been required however, therapists have been reallocated and the visiting specialist nurse practitioner commutes from Aberdeen to attend clinic.

**Aims/Objectives**

Our aim is to improve service access by providing locally delivered specialist care.

Additionally through a multidisciplinary approach, for patients to receive increased support to manage their long-term conditions with any issues immediately addressed through support to self-manage and referral to local services. This project supports Realistic Medicine where our patients are informed partners in choosing appropriate anticipatory care and treatment planning. It has potential to reduce inpatient requirements for these patients through anticipatory management in their own community.

**Results/Outcomes**

All patients attending the Elgin clinic are sent a postal feedback questionnaire to help determine impact of the new clinic. Feedback to date indicates that the local clinic has greatly enhanced their experience related to ease of access.

Additionally the multidisciplinary approach has resulted in a variety of interventions with 100% of patient feedback rating this as very useful.

# 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.

| ID. | Indicator Description | Source | Q4 (Jan-Mar19) | Q1 (Apr–Jun 19) | Q2 (Jul—Sep 19) | Q3 (Oct-Dec 19) | Q4 (Jan – Mar 19 | Target | RAG Status |
|---|---|---|---|---|---|---|---|---|---|
| L20 | NHS Sickness absence % hours lost | NHS | 3.8% | 3.9% | 3.8% | 4.7% | Not available | 4.0% | ● |
| L21 | Council sickness absence(% cal days lost) | SW | 7.4% | 7.7% | 8.8% | 8.0% | Not available | 4.0% | ● |

## How did we do?

HSCM are committed to building an effective and motivated workforce delivering a quality service and are aware that effective management of absence levels is a key element of this.

**NHS G Sickness Absence**

Across NHS Scotland there is a Local Delivery Plan (LDP) target for NHS Boards to achieve a sickness absence rate of 4% or less. Across the whole of 2018/19 Scotland had an average absence rate of 5.39%and has been increasing year on year since 2011/12

NHS Grampian recorded one of the lowest rates of 4.53% (Second Board only to Shetland) for the full year of 2018/19. The latest single month where data is available nationally and a comparison can bemade (March 2019), NHS Grampian had a rate of 4.4%, the lowest of the mainland boards

Other than an outlier month in Jan 18 sickness absence rates in Grampian have not increased and the seasonal peak in January 2019 was under 5%. The overall Grampian sickness absence rate has not exceeded 4.6% otherwise from April 2018 to December 2019.

Regular monitoring and reviewing sickness absence rates, staff turnover, levels of redeployment and the number of terminated contracts and ill-health referrals continue to be undertaken as part of the overarching NHS performance management programme and should continue to have a positive impact on this measure.

Whilst it is recognised that failing to meet the target consistently is a potential indication that absences are not being managed effectively, it is important to note the context of the Scotland and Grampian wide figures and trends when assessing overall performance. This serves to illustrate that the LDP target of 4% is achallenging one

**Moray Council Sickness Absence**

Staff sickness rates across comparator Partnership council services in Scotland in the health and social care sector appear to be high, initial investigations show rates between 5% and 7%. This indicates that HSCM Council employees are most likely above the average

The current sickness absence rate for Council contracted employees that fall under the HSCM umbrella is 8.01 and the trend over the last seven quarters is increasing.

These figures will continue to be monitored closely with the aim of reducing the rate over the coming year Absence indicator performance is discussed at System Leadership Group and managers are taking action within their own services to ensure that policies and processes are being followed effectively

## What did we do?

**Building Staff Capacity**

Throughout 2019 we have supported Community Planning Partners to build capacity through the provision of training that addresses key strategic objectives:

**Alcohol Brief Intervention (ABI):**

An alcohol brief intervention (ABI) is a short, evidence-based, structured conversation about alcohol consumption with a service user that seeks in a non-confrontational way, to motivate and support the individual to think about and/or plan a change in their drinking behaviour. National guidance from the Scottish Government (2018) seeks to embed ABI delivery into routine practice.

The Health improvement team deliver alcohol brief Intervention training to staff working within healthcare and wider community settings to promote changes in drinking behaviour and reduce alcohol related harm.

2019 has seen the number professionals trained in ABI increasing to 49 an increase of 45% in the last year. This year the majority of ABI training has been undertaken within healthcare settings,

Feedback from this year's training included 'very interesting', 'very helpful', 'interactive and informative'.

**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 have been embedded within Health&SocialCare as part of core business since 2017. The transformative 3-tiered approach is designed to support a shared way of preventative working.Through this simple flexible approach, practitioners can use the tools available; such as the DIY MOT self-check and sign-posting to services booklet which provide a structure for practitioners to offer support to 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 now offer the MeOC Managers Toolbox to show staff that their own health and wellbeing is equally as important.

TheMeOC Managers Toolbox is fully adaptable and provides managers/ organisations a mechanism to provide staff with support and to value them in the workplace and can be used as:

A person centred approach during 'return to work one to one interview'.

DIY self-checks issued to support colleagues identify any health and wellbeing concerns and where to access support.

The mangers toolkit is a new initiative implemented by 4 partner organisations (Public Dental Service, Community Justice Team, Community Learning Disability Team, Health Care Support Team)

Since embedding MeOC data demonstrates:

| | 2019-2020 | % increase |
|---|---|---|
| Number of recorded conversations | 1571 | 50% |
| Number of staff trained | 466 | 50% |
| Services embedding MeOC principles | 12 | 75% |
| Awareness sessions delivered | 62 | 50% |

**Healthy Working Lives**

Health and Social Care Moray continued to maintain the Gold Healthy Working Lives (HWL) award for the 9th consecutive year. Moray HSCMoray,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.

This year's Healthy Working Lives activities included the annual quiz, pedometer challenge, Christmas Safety campaigns, information events and training.

**Healthy Working Lives Moray: Clean Air Day**

Moray Health and Social Care Healthy Working Lives, Moray Council and Home Energy Scotland joined forces to promote Clean Air day 2019 at Dr Grays Hospital. The event showcased simple, but effective steps we can all take to reduce pollution and recognise the health benefits of smarter travel choices. Staff and visitors to Dr Gray's Hospital got the opportunity to find out more information, make Clean Air Day pledges and pick up some free resources. General Manager of the hospital, Alasdair Pattinson lent his support to the event and stressed the benefits that increased physical activity and active travel can have for staff and visitors to the hospital.

The Health Improvement team, Moray Council, Home Energy Scotland and Earthtime for all promoted Clean Air day 2019 on the High Street, Elgin. The event was a great opportunity to promote Clean Air Day messages and to try a variety of fun transport options. The Moray Council Sustainable Travel team brought an electric scooter, KMX bike, and elliptical bike among others. Home Energy Scotland brought along an electric bike and were on hand to provide information about ebike loans available through the organisation. Earthtime for All also showcased innovative ways to reduce and recycle everyday items and gave away plants to help keep the air that bit cleaner. Other Clean Air Day events took place in Speyside and in local schools.

The Clean Air Day promotional events represent a good example of partnership working to promote the holistic nature of health, travel and the wider environment

**Healthy Working Lives Moray: Scotland Cycling Friendly Employer Award**

Scotland Cycling Friendly Employer Award is a nationally recognised programme provides an award scheme and funding to help organisations make it easier for their staff to cycle. Cycling eases congestion, improves the local environment and enhances corporate social responsibility by reducing the carbon footprint, as well as supporting good physical and mental health for staff. Health and Social Care Moray is committed to increasing and supporting cycling provision across the organisation. Over the last 18 months, Health and Social Care Moray has worked to increase availability of pool ebike trials, pool bike and staff cycling proficiency training as well as looking at infrastructure on Moray Health and Social Care sites. There has also been promotion of community bike initiatives and competitions.

This year Dr Grays Hospital site was awarded a cycling friendly award, and the organisation hope to increase these awards to other sites in the coming year and beyond.

**Healthy Working Lives: Menopause**

Although it is rarely discussed at work, the menopause is a natural stage of life that high numbers of staff are either going through now or will experience in the future. For many women, menopause causes a great deal of stress, and being at work can make it worse. Through Healthy Working Lives, Health and Social Care Moray have promoted greater awareness of menopause, and tips for managing symptoms in the workplace. Information and support can be found through the NHS Grampian My Healthy Workplace website.

**iMatter**

iMatter is a continuous improvement tool created with NHS Scotland staff, managers and staff side representatives to understand the experience of NHS at work.

If experience of work can be understood at individual, team and organizational level then we can work towards improving our experiences and the experience of others at work.

At HSCM we are in the third year of using iMatter and we have seen some exiting new ways of working as a result

**Engaging with staff as partners in care**

The Care at Home Service 2019 staff survey shows some significant area of improvement compared to the 2017 results as well as areas where there is more work to do both by management and staff.

The survey – which gathered feedback from 86 staff members – highlighted that the twice-yearly supervision rate has risen from 76% to 91% and quality assurance visits have improved from 64% to 84%.

## Financial 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 at the start of the 2019/20 financial year was £129 million. In addition, the MIJB had a remaining reserve at the start of the year of £0.257m which is earmarked for the Primary Care Improvement Plan. This reserve is held in line with the Scottish Government Transformation Programme. Funding can be analysed as follows:

**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 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 2019a balanced revenue budget for the 2019/20 financial year was presented to the MIJB supported by a financial recovery plan to align service delivery with the approved level of funding. The progress against the recovery plan is reported at quarterly intervals throughout the year as part of the regular financial monitoring process.

After consideration of the application of slippage on Strategic Funds, the MIJB financial position resulted in an overspend of £2.073m 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 £1.306m NHS Grampian and £0.767m Moray Council. An expenditure summary is provided below:

| Service Area | 2017/18 Actual | 2018/19 Actual | 2019/20Budget | 2019/20Actual | Variance Fav/ (Adverse) |
|---|---|---|---|---|---|
| Community Hospitals | 5,475 | 5,383 | 5,092 | 5,466 | (374) |
| Community Nursing | 3,555 | 3,689 | 4,778 | 4,738 | 40 |
| Learning Disabilities | 6,025 | 6,749 | 7,062 | 7,481 | (419) |
| Mental Health | 7,447 | 7,720 | 8,372 | 8,568 | (196) |
| Addictions | 1,003 | 1,066 | 1,116 | 1,048 | 68 |
| Adult Protection & Health Improvement | 144 | 142 | 148 | 151 | (3) |
| Care Provided In-House | 13,427 | 14,427 | 15,959 | 15,514 | 445 |
| Older People's Services | 16,945 | 18,038 | 16,789 | 18,636 | (1,847) |
| Intermediate Care & Occupational Therapy | 1,508 | 2,197 | 1,555 | 1,736 | (181) |
| Externally Provided Care | 11,024 | 9,597 | 8,972 | 9,060 | (88) |
| Community Services | 7,143 | 7,110 | 7,860 | 7,712 | 148 |
| Administration and Management | 2,569 | 2,467 | 3,296 | 2,933 | 363 |
| Primary Care Prescribing | 17,844 | 17,354 | 16,905 | 17,573 | (668) |
| Primary Care Services | 15,085 | 15,498 | 16,757 | 16,555 | 202 |
| Hosted Services | 4,061 | 4,175 | 4,291 | 4,671 | (380) |
| Out of Area Placements | 658 | 650 | 669 | 807 | (138) |
| Improvement Grants | 787 | 795 | 925 | 933 | (8) |
| Total Core Services | 114,700 | 117,057 | 120,546 | 123,582 | (3,036) |
| Strategic Funds | 1,526 | 1,211 | 2,018 | 1,055 | 963 |
| Set Aside | 10,593 | 11,765 | 12,252 | 12,252 | 0 |
| Total Net Expenditure | 126,819 | 130,033 | 134,816 | 36,889 | (2,073) |

**Main Reasons for Variances Against Budget 2019/20**

Overall, the MIJB core services resulted in an overspend of £2.073m. Explanations of the major variances have been provided:

**Community Hospitals –** The Community Hospitals budget was overspent by £374k to the year-end. The main overspends relates to community hospitals in Buckie, Aberlour and Keith, offset by a small underspend in the Dufftown facility. Community hospitals generally continue to be challenged with staffing to the required level to run safely the bed complement. In Speyside, this includes the community hospitals in Dufftown and Aberlour where attempts to stabilise the trained staff complement have been a constant issue and the staff have been working across sites as a means of ensuring some resilience. Long term sickness has also been a factor. The increased use of bank staff weighs heavily on the overspend position. Work into the remodelling of Community Hospitals is underway.

**Learning Disabilities –** The Learning Disability (LD) service is overspent by £419k at the end of 2019/20. The overspendprimarily relates to day services and the purchase of care for people with complex needs, which includes young people transitioning from children's services.The increasing use of day service provision is to ensure that all service users with a level

of need have structured day time activity. The LD team are aware that without appropriate structure and routine, many of our service users will exhibit challenging behaviours which are costly to manage and are not desirable from the perspective of people's life experiences and human rights. Such behaviour has a big impact on carers, both family and the LD team experience indicates that the management of such behaviour is almost inevitably more expensive than a proactive approach.

The whole system transformational change programme in learning disabilities helps to ensure that every opportunity for progressing people's potential for independence is taken, and every support plan involves intense scrutiny which in turn ensures expenditure is appropriate to meeting individual outcomes.

**Care Services Provided In-House –** This budget was underspent by £445k at the end of the year. The most significant variance is due to the staffing element within Care at Home services for all client groups. Supported Living services which include Waulkmill and Woodview are also underspent significantly. The underspend is being reduced in part by overspends in Day Services for all client groups which is primarily due to client transport.

**Older People Services and Physical & Sensory Disability –** This budget is overspent by £1,847m at the end of the year.The year-end position includes an over spend for domiciliary care in the area teams, which includes the Hanover complexes for the new sheltered housing at Forres and Elgin. Income recovery also contributed to the significant overspend. There has been a reduction in spend in relation to permanent care which reflects the MIJB's aims to shift the balance of care and support people to remain in their homes for longer. The overspend is also representative of the true cost of care and the growth in demand.

**Primary Care Prescribing –** The primary care prescribing budget is reporting an over spend of £668k for the twelve months to March 2020. The budget to March includes an in-year uplift of £556k identified from within Moray IJB 19/20 funding resources and now allocated to prescribing. This seeks to address the recommendations made by the Grampian Medicines Management group to the MIJB based on rising costs and demand. This out turn includes a volume increase of 2.1% which reflects the national prescribing pattern after a period of two years where volume increase has been negligible. In addition, a further adjustment of 2.1% increase has been made to address the Impact of Covid-19 in March where volume increase in Month was estimated at 20%. Additional funding allocation was received from the Scottish Government to offset this impact in March although this is planned to be recovered in 20/21 as offsetting decrease in volume is anticipated. Other national factors include, variance in prices arising from shortage in supply and the timing and impact of generic medicines introduction following national negotiations also impact on the position. Locally, medicines management practices continue to be applied on an ongoing basis to mitigate the impact of external factors as far as possible and to improve efficiency of prescribing both from clinical and financial perspective.

**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.

For the 2020/21 financial year there will be an increased and continuous focus on financial recovery. The presentation of Covid-19 is already impacting on the recovery and transformation plan of the MIJB. It is therefore key to ensure consideration of opportunities at every juncture to ensure the MIJB can remain with the limits of the funding being made available through NHS Grampian and Moray Council.

**Financial Reporting on Localities**

The financial reporting for 2019/20 is not currently reported at locality level. This continues to be a work in progress and remains a priority for development.A recently implemented management structure has secured 4 Locality Managers who are all now in post and work is underway to align budget responsibility to locality areas.

## Localities and working with communities

**Engaging with locality partners in care**

In January, Health and Social Care Moray (HSCM) welcomed into post the four Locality Managers who will lead the development of locality planning, working in partnership with communities and local providers to ensure service development, continuous improvement and integration in all aspects of service delivery effectively meet local needs as set out in locality plans and improved outcomes.

**Forres and Lossiemouth Locality –** The journey of transforming health and social care services in the locality has been directed by the Forres Professional Group which has wide partner engagement including GPs, third sector, patient and staff. The Pathfinder Project is taking forward the development, implementation and review of initiatives including the Varis augmented care unit and Forres Neighbourhood Care Team.

In September the wealth of local support helping people draw on their own personal resources to keep well and live independently was celebrated at a community event in Forres Town Hall which also offered the opportunity to learn more about the pathfinder health and care interventions helping people at times of crisis.

**Keith and Speyside Locality –** The Keith & East Locality Project is planning for a purpose-built health 'village' in Keith that can offer patients, from the locality, access to a wide range of more joined-up community health and social care services brought together under one roof for the first time. A Project Board and Working Group have been set up to gather the information required for the Initial Agreement, which is the first stage of the Scottish Government's business case process towards getting the funding needed.

A broad range of stakeholders including GPs, patients, members of the community, the Third Sector and staff involved in health and care services are represented and are leading on the engagement needed to explore opportunities for improvement.

During the year patients, their families, unpaid carers and the wider community have been involved in meetings, surveys, focus groups and workshops to share their experiences, views and ideas, which will influence the direction of the project and evidence the case for change in the Initial Agreement document.

We hosted a Big Health and Care Conversation for Speyside in February to inform and engage the community in conversations around health and social care in the area. The evening event at Speyside High School provided an update on the temporary closure of Aberlour's Fleming Hospital to in-patients while a range of health and care services and initiatives were showcased.

It was preceded in December with a Know Who to Turn To awareness campaign to raise highlight the local services people can access when they are ill or injured to ensure they get help quickly.

**Elgin Locality –** Health & Social Care Moray (HSCM) established a tri-party project with Hanover Scotland and Allied Healthcare focused on the delivery of a new independent living scheme in the north west of Elgin.

Loxa Court, which opened in the autumn, is a purpose built housing development providing housing with care facilities for individuals and couples to maximise independent living. It also incorporates an unscheduled short stay assessment and intermediate care facility to meet the health and care needs of individuals from the community and prevent unnecessary acute hospital admission.

**Hosted Services**

Moray IJB host Grampian Medical Emergency Services (GMED) and Primary Care Contracts on behalf of the 3 IJBs in NHs Grampian.

**GMED**

The Service got through the Festive period 19 – 20 and delivered safe, sustainable, effective and person-centered patient care; without fail.

Between 23/12/19 and 06/01/20 we dealt with:

| | |
|---|---|
| Advice Calls | 843 |
| Advice calls to Minor Injury Units (MIU) | 3 |
| Centre Consults | 3421 |
| CPN | 52 |
| D Nurse/Marie Curie | 679 |
| Home Visit | 1119 |
| MIU | 330 |
| NHS24 Advice | 1590 |
| No Action | 746 |
| Total Contacts | 8783 |

- Twelve new vehicles were delivered in January and were brought into fleet operations..

- Chief Officers of the three IJBs approved the Framework Commissioning Brief which had been submitted to initiate a complete Service Review of Primary Care OOH Services. This was a major step forward in our journey as a Service. The anticipation was that this would be of huge benefit as a vehicle for change for our Service and that very exciting times lay ahead. Unfortunately at this point the Coronavirus Pandemic broke and developments planned were put on hold.

**Primary Care Contracts**

Primary Care Contracts develop and manage the shared administrative function for contractor services for NHS Grampian to support and enable the planning and delivery of integrated services within Health & Social Care Partnerships and governance processes, whilst adhering to legislation and national and local guidance.

PCCT provide the partnerships and, as appropriate, the Professional Leads with timely, accurate and relevant information on contract performance, to develop knowledge and expertise in all aspects of the legislative and regulatory framework that underpins the contractual process and to ensure the efficient operation of contract administration and governance processes including maintenance and distribution of all contract documentation.

There is a contractual relationship between each of the contractor groups (Dental, GMS, Optometry and Pharmacy) and NHS Grampian. There are a significant number of specific contracts for GMS which are detailed in that they specify volume, cost and quality. There are specifications for some of the locally delivered Pharmacy services, and as part of a NHS Scotland initiative, nationally agreed specifications have recently been finalised

for some pharmacy services. The relationship for Dental and Optometry services is one of a "licence to practice" with payment for 'items of service'.

To ensure financial governance NHS Grampian manages compliance with the requirements of CEL DL (2018) 19 through four separate groups established with a specific remit to implement and oversee the management arrangements covering pre and post verification of payments across all Independent Medical, Dental, Pharmaceutical and Ophthalmic primary care practitioners.

The groups are all chaired by the Service Manager, Primary Care Contracts and membership includes Health & Social Care Partnerships (HSCP) Primary Care Leads, Finance Manager, Clinical and Planning Leads for the specific primary care service, representatives from the Primary Care Contracts Team and National Services Scotland (NSS) Practitioners Services Department. Links are also maintained with NHS Counter Fraud Services and the Assistant Director of Finance, who is also NHS Grampian's Fraud Liaison Officer as appropriate. Formal PV Assurance Meetings are held quarterly by each of the groups to agree the programme of practice visits and to ensure appropriate management oversight of the process. PV issues are dealt with on an ongoing basis, as they arise during the course of the year, and are fed through a number of performance and management groups across all contractor areas and within local HSCP performance management structures as appropriate.

**Developing the new Strategic Plan: Moray Partners in Care 2019-2029**

With our Strategic Planning and Commissioning Group, we reviewed our first Strategic Plan 2015-18, considering the progress we had made towards the outcomes and strategic priorities we set for ourselves.

As with all health and social care systems Moray is facing increasing demand for services at the same time as resources – both funding and workforce availability – are under pressure. These challenges will intensify in the coming years as our population ages and more people with increasing complex needs require support to meet their health and care needs.

To meet the challenges identified in the Joint Strategic Needs Assessment, we set our sight on transforming the health and care system through the delivery of a new 10 year Strategic Plan to which all stakeholders contributed. This sets out the redefined vision of the IJB and the key priorities we will focus on in the short, medium and longer term to deliver integrated services which ensure people get the best possible experience and which enable them to achieve improve outcomes.

**The plan: Moray Partners in Care –** was launched following consultation on 19 December and emphasises the strength of integration. In addition to our two main partners - the Local Authority and NHS - the IJB recognises the importance of theThird Sector and Independent Care Sector in facilitating thesuccessful operation of the partnership of Health & Social Care Moray.

Engaging with staff as partners in care The Care at Home Service 2019 staff survey shows some significant area of improvement compared to the 2017 results as well as areas where there is more work to do both by management and staff.

**The survey –** which gathered feedback from 86 staff members – highlighted that the twice-yearly supervision rate has risen from 76% to 91% and quality assurance visits have improved from 64% to 84%.

**Engaging with sector partners in care**

tsiMORAY work with key partners to ensure the third sector is an equal partner in the delivery of integrated health and social care in Moray. It facilities a regular Health & Wellbeing Forum to provide a coordinated response to development in Moray.

We worked with tsiMORAY to offer small grant funding for communities through the fourth round of #YouChoose participatory budgeting programme. This year's themes were Be Healthy based around Scotland's public health priorities and connecting communities through CHIME (connectedness, hope and optimism, identify, meaning and empowerment).

Stakeholders involved in the commissioning and delivery of social care provision work closely together through contract monitoring processes to outline service development and improvements and to share good practice and innovations.

**Engaging with experts by experience partners in care**

Moray stakeholders were involved in the development in a series of pan-Grampian strategic frameworks for palliative care, care of the elderly and mental health and learning disability services over the summer.

The frameworks set out local and regional delivery requirements for integrated, future-proofed services to optimise outcomes and meet population needs.

**Mental health –** Aiming to reflect on the changes to mental health services and projects over the last couple of years driven forward by the strategy Good Mental Health for All in Moray, the Making Recovery Real celebration took place in May.

It brought together local practitioners, community groups and many who identified as community members with living experience of challenge and recovery in mental health to understand the journey we have been on. The event also engaged people in identifying gaps in service provision and support and opportunities to meet local needs in new and innovative ways.

**Mental health, drug and alcohol –** People who use services, deliver services and commission services took part in a self-evaluation workshop in June highlighting how people with co-existing issues can fall through the gaps if services are not joined up. The 'no wrong door' event considered opportunities to break down barriers and improve supports and services so that individuals can get the right help, at the right time and in the right place.

**Learning disability –** The Learning Disability Transformation Programme has continue to successful work with individuals, families and providers to rebalance the long-term and paid-for support that often follows people with learning disabilities which not only risks escalating expenditure but increasing social exclusion of those individuals.

The progression approach with its greater focus on longer term life planning has enabled people to become more independent and develop community relationships which mean that paid support can be reduced to a minimum, improving outcomes and the sustainability of the model.

A review was undertaken of residential overnight support to ensure the services the IJB plans continue to meet the needs of service users and are consistent with strategic principles. It was recognised that this review and subsequent test of change pilot proposal for an overnight responder service had not sufficiently engaged families.

All families of adults with a learning disability were invited All families of adults with a learning disability were invited to a Learning Disability Matters workshop in February to discuss the provision of current and future care and support.

**Self-directed Support –** The Care Inspectorate published its findings in June from a 'Thematic review of self-directed support in Scotland' that included the release of the Moray local partnership report in which supported people were engaged.

The inspectors found the partnership had made significant progress implementing self-directed support and that this was making a difference to people's lives. Most supported people experienced choice and control in how they used personalised budgets and were achieving positive personal outcomes as a result.

For some people, relationships they had developed with their personal assistants had been transformative in delivering positive outcomes. The provision and impact of short-term focused interventions for supported people with moderate levels of need was particularly noteworthy.The self-directed support team was a valued and important source of support and advice for staff across the partnership. Members of the team were highly motivated and knowledgeable about self-directed support.

The partnership had worked hard to develop assessment and support plan templates that could effectively reflect self-directed support principles and practice. We saw good evidence of these working in practice, including a high proportion of good quality assessments and outcome focused support plans.

For the seven quality indicators assessed, the scrutiny body found Moray to be 'good' on six and 'adequate' on one.

# Resources are used effectively and efficiently in the provision of health and social care

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.

It must be acknowledged the resource challenges we face in the availability of money and workforce.  There will as a result be some hard decisions to make as we move forward. As a Board, we understand that it is time to think differently and work and work with the diversity of views and experiences to understand the art of the possible whilst generating a system of health and care in Moray that is fit for the future and delivers clear priorities.

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