HEALTH & SOCIAL CARE MORAY

Annual Performance Report 2016-17

Contents

Welcome from Chair, Moray Integration Joint Board

I am delighted to share the publication of this, our first Annual Report setting out some of what we have achieved in our first full year. The report provides us with a chance to celebrate our strengths and achievements; and to consider the challenges ahead.

Delivering the best possible health and social service together is at the very core of our Integration Joint Board – we are person-centred and are determined to make sure people's voices are heard and their needs are met. Everyone using our services, their families and carers, all staff and stakeholders are working hard together to improve and shape the future of what Moray requires to improve the health and wellbeing of its local population.

After extensive consultation and working with partners across the integrated landscape, our strategic plan (2016-19) was endorsed by the Moray IJB 31st March 2016. Over the following pages, you will see some examples of specific pieces of work which ensure that our local communities have a voice in planning services that meet local needs. We will continue to strive to ensure we implement sustainable practices which demonstrate change at a local level and improve outcomes for the adult population.

We are proud of what we have achieved in our first 12 months. We have taken time to consider and understand how existing services are delivered. At the same time we have taken the opportunity to make decisions that we feel will impact positively on what health and social care in Moray will look like in the future.

Highlights included approval of construction of a £2.5 million housing development in Lhanbryde (Urquhart Place) which will support people to live as independently as they possible. Tenants and their families will know they can be safe while enjoying the privacy of living in their own home.

In an progressive partnership with Hanover Scotland and Moray Council, Varis Court in Forres is a purpose built development which provides tenanted flats and 'close to home nursing care' for older people including those with dementia. There will also be a small number of temporary extra care beds which can provide 24 hours nursing care in a homely setting.

Following the lead from partners The Moray Council we opened Jubilee Cottages in Elgin ; vacant houses transformed into halfway homes for people ready to leave hospital where they can work on regaining their independence in a homely setting.

Providing effective support for carers is central for those being cared for and our local communities. Providing the appropriate level of support is a key part of our locality planning. Moray was one of two successful bids to the Scottish Government to look at testing all of the SDS options with residential care. Health and Social Care Moray continue to lead the way in rolling out how SDS can best be used to deliver excellent Community Care.

During the last 2 years I have had the pleasure of meeting many of the staff who work tirelessly to make a difference to the people that they care for. They never fail to impress me and my fellow Board members with their enthusiasm and commitment. I would like to personally thank them for their contribution.

Moving forward and planning for change demands transparent decision making whilst maintaining highest standard of financial and operational management.

At times the integration landscape has proved challenging and it will continue to be so in the near future. We are certain we will face difficult situations and decisions to ensure that our resources are used effectively and efficiently. However the opportunity is great and we now have an excellent base on which to build a truly excellent community focused health and social care support system.

I would like to thank all my colleagues for their help and support over the past year. With strong leadership, community participation and the support of our Integration Joint Board, I am confident we will continue with the excellent work we have started this year.

Christine Lester
Chair, Moray Integration Joint Board

Chief Officer's Introduction

This has been a busy first year for Health and Social Care Moray under the direction of the Moray Integration Joint Board (MIJB). After extensive consultation and partnership working across the integrated landscape, our strategic plan (2016-19) was endorsed by the MIJB 31st March 2016, putting us in the position to 'go live' under the new arrangements seeking to modernise and integrated care delivery.

We have taken a cautious approach to our financial investment as we developed our change plans, ensuring our investments are prioritised in line with need. We have developed our overarching understanding of the current health and care system across Moray and therefore supporting good decision making about how it can develop going forward. Finances are tight and challenging and there is a need for us to ensure that we are working with people in our communities so that all parties have a chance to influence decisions and express opinion in the options open to us. We are likely to face difficult decisions as we try to make change happen and we have tried in the last year to open up the opportunity for all parties to have a voice. We recognise in this report that whilst we have made some headway in this we still have a long way to go and significant effort to make going forward if we are fully realise the potential here.

Building on learning from the earlier work in Moray we have applied a strategic logic model, Reshaping Care for all Adults in Moray. This model allows us to consider key health and care interventions across the spectrum alongside enablers such as developing the right workforce and use of technology to improve and modernise care provision. We have tried to consolidate all of the different strategies and develop a coherent way to plan and deliver care in and around the population needs as known across Moray. We are focussed on improving health and wellbeing as well as delivering high quality care for the people of Moray.

Also set out in the framework is Moray Partners in Care an way of working that is being adopted by integrated services to ensure that our approach to care supports an ethos that works alongside people in touch with services and their families and gives them the confidence to be decision makers in determining what happens; taking account of what matters to you as an individual when faced with health or care needs.

We have applied funding through the allocated change funds to specific areas for improvement and change and these initiatives have been instrumental in supporting the national health and wellbeing outcomes by which we are measured. For example:

- Enhanced Third Sector Interface (TSI) capacity through employing a flexible team to create community capacity and build community resilience.

- Enhanced management capacity in carers provider service to meet the current demand for carers assessment and drive forward funding applications and projects

- Development of carers strategy, consultation events, and respite for carers to attend

- Engagement of service users through a number of strategic workshops

A number of locality implementation groups have been established bringing together people from the local workforce who have traditionally not worked closely together and they have been challenged with looking at how they can develop and change together to meet the local community needs. So we are looking here at the team effect, and by team we mean the local workforce across health and social care alongside third and private sector. Crucial in this is the links with local communities, ensuring you have a voice around service redesign and are involved in planning solutions to meet local needs. As they develop and as we go through this year we are keen to strengthen this approach.

Successes

It is unlikely that the work over the past year has had a tangible effect on the overall health and care arrangements but rather set a good foundation from which we can improve. We recognise that for many folks little change will have been experienced and that for many people we have received evidence of positive experiences of integrated working already in existence. There are area where performance is particularly positive and we aim to maintain this and for those areas where there is work still to be done we are taking stock of our next steps, indeed in developing this report there is a chance to step back and consider our next step. Below are some of the areas that we feel have been particularly positive:

The engagement of all partners has been vital to the planning, developing and implementing of our change programme and like all good relationships we work hard to maintain a positive ethos and relationships. All partners have developed a shared understanding of the priorities for older people in Moray.

Much change activity in Moray has been around community based services to build community capacity and further develop an anticipatory and preventative approach to care. It is likely to be a number of years before we see the full impact of these change.

An increase in both the delivery and flexibility of respite provision based on local demand.

An increase in the number of people over 65 receiving 10+ hours of home care.

Engagement of the Housing Department has been very successful with plans for older peoples housing which meets their needs included in the draft local housing plan. Further plans are being developed around extra care sheltered housing and the recruitment of an officer to examine the process around adaptations. This has enhanced our relationship with housing and the work we are progressing regarding outreach housing support and the development work with sheltered housing.

Challenges/Opportunities

Moray is a small area and the sheer scale and pace of change, and how to make long term shifts towards prevention in the face of immediate and short term pressures from the rising demand and significantly reduced funding was a major challenge in our partnership. This however is balanced by our strength, being small and having good relationships can make us agile, so when change is required and we get people on board things can happen quickly and successfully, again throughout this report you will see evidence of this. The commitment of staff is unquestionable and the commitment of communities equally vibrant all of which had resulted in an ambitious first year going well, albeit huge areas of work to cover in the coming year.

I hope this report gives people a sense of the level of effort underway, the challenges before us but the huge opportunity to build resilience across Moray and ensure our services are robust going into the future.

Strategic Context

Health and Social Care Moray was formally established in April 2016 and brings together a wide range of health and social work services into a single operational system. The Moray Integration Joint Board (MIJB) is responsible for planning and overseeing the delivery of a full range of community health and social work/social care services and is also responsible for a number of Grampian health services relating to primary care.

Throughout the course of 2016/17, the MIJB has taken key decisions in relation to the establishment of the Partnership including the appointment of Officers, the delegation of functions and operating and governance arrangements.

"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."

It has also agreed the Strategic Plan 2016-19 and the establishment of a committee structure responsible for overseeing health and care governance, performance and audit, risk management, health and safety and other matters. Our vision was developed by listening to the views of people who use health and social care services, unpaid carers and those who deliver services in Moray and the wider community.

Reshaping Care for Older People: Programme and associated Change Fund enabled the partnership to accelerate local progress and to develop plans to drive sustainable improvements in the national outcomes that relate to the care of older people. It enabled us not only to shift the location of care (from institution to community) but also to transform the culture and philosophy of care from reactive services provided to people towards preventative, anticipatory and co-ordinated care and support at home delivered with people.

Housing as Partners: Housing has become a key partner in our joint commissioning process. The partnership acknowledges the vital contribution that housing can make to improving health and wellbeing outcomes.

Community Care Redesign: Programme aims to meet future demand. A single point of access to community care is established. The access service provides an early intervention and preventative approach to care with greater choice and control over the support people need.

Moray Partners in Care: Community care has developed a new model of care and support in the community which promotes independence and supports greater choice and control and improved outcomes. It is based on three offers – Help to help yourself, help when you need it and ongoing support for those that need it.

Improvement Programmes currently underway in Moray include:

- Modernisation of Primary Care
- Focus on Dementia
- Self-Directed Support
- Unscheduled Care
- Older People in Acute Care
- Patient Safety Programme
- Long Term Conditions Action Plans

All of these components co-exist and as we move forward we will seek to continue to build on this good work, evolving through the identification of local needs with the aim of building community resilience in Moray.

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

- above average educational attainment, employment, income
- below average crime, homelessness, alcohol-related mortality and hospital admissions
- average smoking rates
- health condition prevalence rates that are similar to, and often lower than, the national average; some emergency hospital admission rates that are higher than elsewhere in Grampian, lower multiple admission rates nationally
- above average fuel poverty, traffic accident casualties, and potential geographical challenges to equal access to services

National Outcomes

The 9 National Outcomes which guide the activity of Health and Social Care Moray are:

Health and Wellbeing Outcomes

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

National Health and Wellbeing Outcomes

The National Health and Wellbeing Outcomes are the Scottish Government's high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care. These outcomes provide a strategic framework for the planning and delivery of health and social care services. They focus on the experiences and quality of services for people using these services, carers and their families.

The following pages provide an assessment of our performance against these outcomes; and against agreed core national integration indicators linked to these outcomes. The core integration indicators provide an indication of progress towards the outcomes that can be compared across Partnerships and described at a national level over the longer term.

Performance against the National Health and Wellbeing Outcomes

Performance against each of the National Health and Wellbeing Outcomes and associated National Performance Indicators is detailed in the following pages. Where relevant, performance against associated Local Performance Indicators is also provided. The extent to which implementation of the Strategic Plan 2016-19 is contributing towards meeting the National Health and Wellbeing Outcomes is noted below with each associated action cross referenced within the footnotes.

National Health and Wellbeing Indicators

An associated core suite of 23 National Performance Indicators has been developed, drawing together measures that were felt to evidence the nine National Health and Wellbeing Outcomes. Of the 23 indicators, 14 evidence the operational performance of Health and Social Care Moray - with the data provided by the NHS Information Services Division (ISD). The data for the remaining 9 indicators is taken from responses from the Scottish Government's biennial Scottish Health and Care Experience Survey.

Outcome 1

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

To support our strategic outcome 'more people will live well in their communities', we are committed to growing community capacity that focuses on early intervention and a preventative approach. Our approach is to provide care, based on co-production principles, developing new community driven models of care, and to help people maintain their independence wherever possible.

Our relationship with the Third Sector will support us to continue the development of a Moray based third sector network focused on health and wellbeing in our communities.

We have commissioned 6 Mental Health GP Link Workers across Moray to signpost to a range of alternative community and non-medical resources, services and opportunities that can contribute to people's health and wellbeing. These include arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help. People can also get support with issues relating to employment, benefits, housing, debt, advocacy support, legal advice or parenting.

The referral rate has been high so far with some link workers already having caseloads of 40+. The nature of the contact is that subsequent to a holistic assessment the link worker remains in touch with a person for 'up to 12 months' depending on the circumstance and only as appropriate. The individual works on tasks/goals that they have defined and touches base with the link worker to review their progress on them. It has been found that some people have needed a bit more practical support in the initial stages.

It is important to people with addictions that they are seen as early as possible and a national target has been set – 90% of people referred for drug and alcohol support must be seen within three weeks. We have performed above this national target, and well above the Scottish average.

Performance has improved throughout 2016 with the Moray team successfully seeing 100% of service users within 3 weeks.

To further develop our locally provided community based services, mental health charity Penumbra was commissioned to provide a new mental health and wellness centre in Elgin. The service acts as a 7-day per week, single access point for a range of adult services designed to promote positive mental health and support people to recover from mental ill health, concentrating on prevention, early intervention and education whilst also supporting people to access a range of advice and information in other areas, such as finances, benefits, housing, healthcare, and employment and educational services. Health and Social Care Moray will provide the charity with funding totalling nearly £1.2 million over the next three years to provide the service. The Centre is part of Moray's new Mental Health and Wellbeing Strategy, Good Mental Health for All in Moray. The Centre opened in March 2017, initially to provide a service for Elgin residents before service provision is expanded to include all of Moray in April 2018.

We are continuing to promote community wellbeing by working with our partners to deliver a range of groups and events across our localities. Vintage Tea Parties are being held with the aim of developing resilient communities promoting a culture of choice, independence, positive health and wellbeing for older people.

Vintage teas have been delivered in Keith, Elgin, Forres, Fochabers, Buckie and Lossiemouth to date.

Over 600 older people have engaged and participated in the events.

Priorities are identified in each locality which support self care/ self management and people living independently at home for as long as possible.

Impact reports with recommendations are presented to each locality lead officer and support the Older People's day service review.

Outcomes to date have included Men's Shed development, peer befriending (increased volunteering opportunities both formal and informal) and increased access and awareness of community and public transport services.

A key asset in working in and with communities is the Outreach Mobile Information Bus. Working in collaboration with communities and Community Planning partners, the OMIB Service enables us to address health inequalities and promote social inclusion, by taking a more integrated and focused approach to supporting vulnerable and often more isolated communities; strengthened community partnerships will improve health and wellbeing outcomes.

Our partnership approach; delivered through the OMIB Service helps us:

- Build relationships, trust and capacity within communities, maximising opportunities for health gain.
- Increase community engagement and involvement by providing another mechanism for two-way communication with communities, not only giving but gathering information related to unmet health and social needs in the local areas.
- Increase access to approved information, advice and support to enhance community resilience.
- Support specific/targeted interventions through planned programmes as well as providing a rapid response service.

Vintage Tea Parties have been held across Moray

Outcome 2

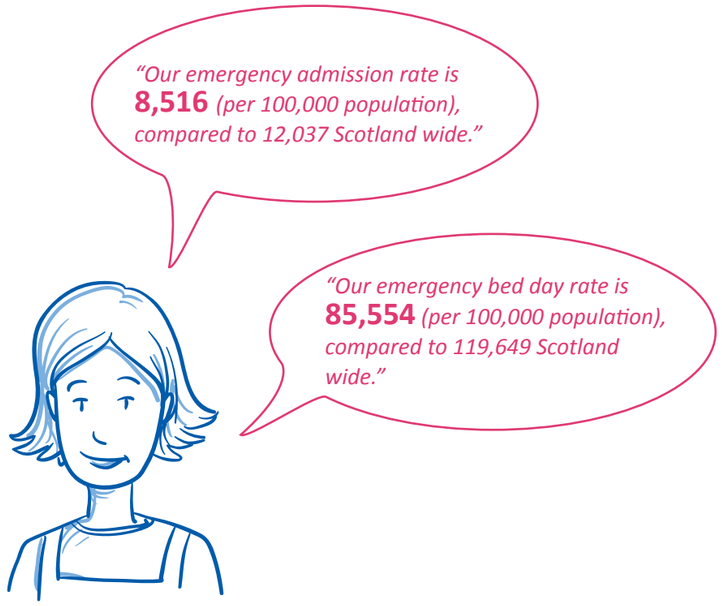
People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Addressing the issue of unscheduled care was a key driver of the Integrated Care Fund programme for 2016/17. Moray is currently below the national average for both emergency admissions and bed day rates.

A lower percentage of adults with intensive needs receive personal care at home, 38% in Moray compared to 62% nationally. The rise in this figure is expected due to the focus in relation to supporting more people with complex needs within the community.

The proportion of people who spend the last 6 months of life at home or in a community setting (90%) has remained level over the past year and remains close to the national average of 86%.

The Urquhart Place project underlines our commitment to support people to life as independently as they can. Construction of a £2.5 million housing development in Lhanbryde is nearing completion and preparations are underway to welcome the first four tenants. All are adults with severe learning disabilities who need support to carry out daily living tasks, look after their general health and wellbeing and take part in social activities. The bungalows at Urquhart Place will be fitted with technology such as door and bed sensors and an alarm call system. This will reduce the need for the tenants to have staff with them around the clock so they can stay safe while enjoying the privacy of living in their own home.



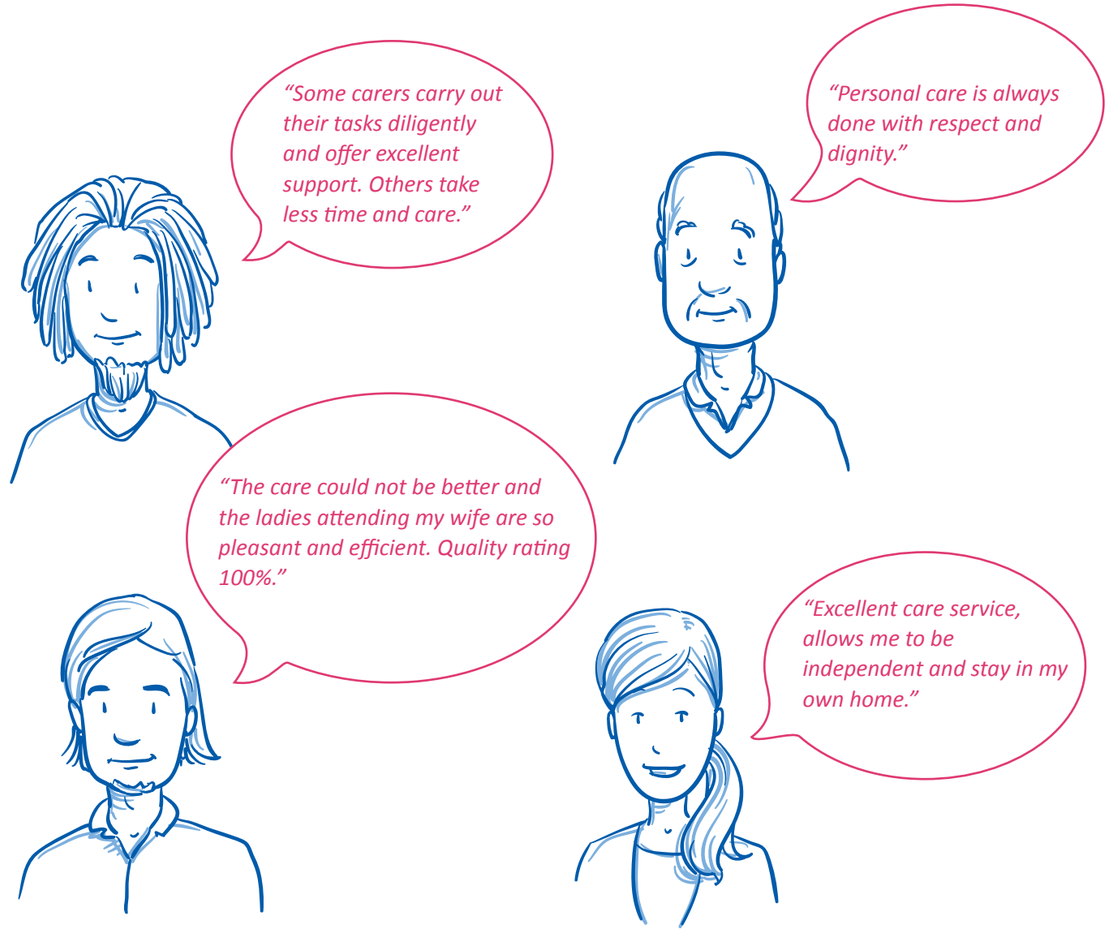
In partnership with Hanover Scotland and Moray Council, Varis Court is a purpose built development to provide 'close to home nursing care' for older people including dementia and extra care facilities. The development provides 33 individual flats with additional communal facilities including 2 courtyards. Staff onsite will support people to manage their tenancy, provide meals and extra care depending on the tenancy. The dementia friendly properties include bespoke communal facilities including dining area and access to prepared meals, activity and relaxation areas along with staff facilities. Tenants of the extra care flats will have access to care and support provided by onsite staff.

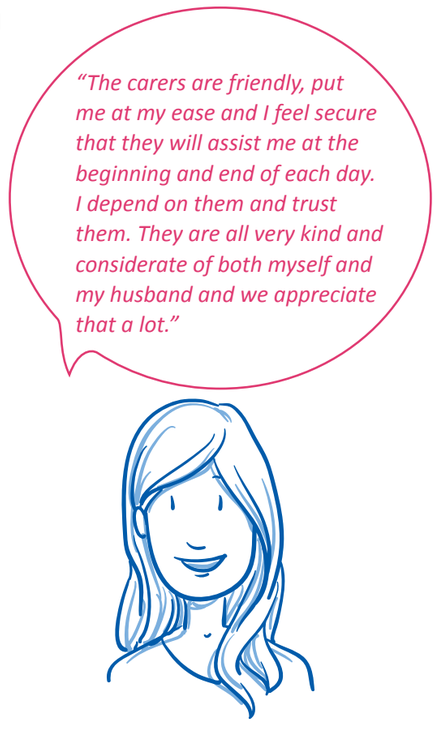
In February 2017, 6 vacant houses were transformed into halfway homes for people ready to leave hospital. The £120,000 project provides a homely environment where people can work on regaining their independence. During their short stay in the cottages, they are supported by a team of staff to manage everyday living tasks such as getting in and out of bed and preparing meals. The specific rehabilitation aimed at the Jubilee Cottages differs from standard rehabilitation in the way that the service is provided in a low risk, controlled home environment through high intensity and collaborative rehabilitation to foster an encouraged independence to return home in a maximum of 6 weeks. The rehabilitation service is provided free of charge by the Community Care Department and cottages are equipped with a telecare service to provide a 24-hour on call response. The project opened in February 2017 and currently has 3 residents.


Jubilee Cottages, Elgin

During the final quarter of 2016/17, we worked to deliver the aims and aspirations in the Scottish Government's 6 Essential Actions to Improving Unscheduled Care Programme (Winter Plan). This plan set out the need for Health and Social Care Moray to provide safe and effective care, ensuring flow through additional surge capacity and ensuring continuity of social care access for people.

Our staff demonstrated the highest levels of commitment and endeavour in supporting people to remain at home.





Outcome 3

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

The Self Directed Support (SDS) Residential Care Project focuses primarily on older people and people with learning disabilities. Its aim is to explore the potential benefits Self Directed Support (SDS) can offer people living in residential care or residential accommodation and its impact on people, providers and processes. The Moray project is one of two test pilots in Scotland and will be used to inform both local and national learning.

To further support our commitment to shifting the balance of care, in early 2016, we established a Dementia Action Group for people with dementia who wanted to become involved in training or service development, utilising their personal experience of dementia.

*"**78%** of adults receiving care or support rated it as good or excellent. That's an increase of 3% since 2013-14. The national average is 81%, and at our presnet rate of improvement we should attain that during 2017-18."*

*"**87%** reported positive experiences of care within their GP practices, an increase of 2% since 2013-14, putting Moray above the national average!"*

*"**72%** of adults are supported at home agreed that they had a say in their help, care or support. The national average is 79%"*

Outcome 4

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

In early 2016, we extended the team at Ardach GP practice with an Integrated Care Fund (ICF) funded project designed to assess, provide and co-ordinate person centred care in the frail, complex patient with multi-morbidity. A Frail Elderly Nurse Co-ordinator was appointed to identify frail older people with complex multi morbidity, with or without co-existing dementia and coordinate access to assessment services and re-enablement with the aim of reducing hospital admissions, out of hours contacts and A&E attendances. The project effectively promoted frail elderly to remain safely in their own homes utilising prevention and early intervention tools.

The majority of co-morbidity of physical and mental illness in acute hospitals affecting older people is due to three disorders: dementia, depression and delirium. These conditions are a predictor of increased length of stay. We tested out an older adult liaison service with staff based in the Acute hospital to increase the detection, recognition and early treatment of older adults inpatients with co-morbidity, physical and mental illness.

The report 'Pulling Together – transforming urgent care for the people of Scotland' was led by Professor Sir Lewis Ritchie OBE and recommended developing a set of national standards for urgent out of hours care and the development of an implementation plan to support these recommendations. During 2016, we established a Transforming Urgent Care Group across Grampian to ensure our services are fit for purpose in providing services underpinning the 28 recommendations within the report. Our services will be shaped to ensure we:

- Deliver high quality, safe and clinically sustainable services
- Increase the use of alternative service
- Focus on prevention & self care
- Ensure patient's receive the right advice, care at the right time and place
- Connect urgent care services together more efficiently
- Design a better service to include the right skill mix of professional support for people during the out-of-hours period
- Reduce attendance in Emergency Department and Out of Hours

Good Mental Health for All: we set out a shared vision of change developed by people with live experience of mental health, their family members and people involved in health and social care working together. The strategy was launched in 2016, written for everyone of all ages to provide opportunities for better promotion, prevention and early intervention in mental health while creating more responsive and effective recovery focused services for people with mental health problems. The strategy has

Case study
Frail elderly co-ordinator

Mrs and Mrs C are both in their eighties.

Mrs C has a number of long-standing health issues including breathlessness and dizziness and is unable to walk for any distance. Her husband is concerned about going out and leaving her on her own.

The couple felt medical professionals never got to the bottom of her condition despite a number of hospital admissions.

They struggled with their home not being suitable for Mrs C's needs. Mr C has made changes to their sleeping and living arrangements to try to ease his wife's condition and has been supported by their family.

The frail elderly co-ordinator visited the couple at home. She carried out a blood pressure check and was concerned over Mrs C's variable heartbeat. She arranged an ECG at Ardach and Mrs C was admitted to ARI to be fitted with a pacemaker.

The co-ordinator arranged for handrails to be fitted on the stairs which enables Mrs C to continue sleeping in the bedroom.

Mr C said: *"The co-ordinator was very helpful and sympathetic. It was reassuring to know she could come here and visit us at the house. Someone like her should be visiting all older people."*

been informed by what people have said is important to them, an analysis of available evidence about mental health needs and issues, best practice and national evidence of what works in addressing mental health and wellbeing. The strategy sets out priorities for what a new mental health strategy should aim to achieve over the next decade and where mental health issues need to be considered in a range of other policy areas.

The Making Recovery Real in Moray programme via the Moray Recovery Partnership consisting of the Scottish Recovery Network, local partners and those with lived experience of mental health problems will be a key driver in the delivery of the strategies recovery focused priorities and objectives. This will ensure that recovery focused principles and values, and the experience of those with mental health problems are at the centre of delivering upon our shared vision for good mental health for all in Moray.

The Learning Disability Transformation Project is a 15 month initiative that takes a whole systems approach to improving the way that the Integrated Learning Disability Team supports the delivery of better outcomes for people who access learning disability services in Moray. The overarching aim is to help adults with learning disabilities achieve their aspirations for independence.

The project will focus on 3 key work streams; professional practice development (CLDT), commissioning support and in-house support. At the end of the initiative, the project will have supported the Moray learning disability team to support the delivery of better personal outcomes for people in a more financially sustainable way.

Outcome 5

Health and social care services contribute to reducing health inequalities.

Quarriers Arrows Service was commissioned to provide drug and alcohol support for anyone worried about drug and alcohol use, whether their own or their loved one's. The service was established in August 2015. Arrows supports anyone with any concerns about drinking, drugs or legal highs. It also supports friends and family to understand and discuss problematic substance use with their loved ones. One-to-one peer group support helps to build motivation, set goals and manage addictions/dependency using Cognitive Behavioural Therapy approaches and Motivational Interviewing.

In the planning and development of the pop up cafes, Arrows has developed links with community assets and groups, receiving positive and encouraging feedback in terms of inclusion and recovery support. This has encouraged both staff and service users and is a successful first step in establishing a recovery friendly community. Our cafes were successful in engaging a different user group in the consultation process and we now have a more solid foundation of broader feedback and evidence from which our year 2 development plan will be built.

Making every Opportunity Count (MeOC) is an ambitious, integrative and transformative 3-tiered approach for cultural shift with everyone, every system and service doing a little to enable service users, and providers, to keep well. MeOC is designed to support a common way of preventive working suitable for all public and third sector services by providing a simple approach to the 'how'; the principles and practice are embedded within Health and Social Care services as part of core business. This approach is endorsed by Health and Social Care Moray.

MeOC supersedes and builds on the principles of Keep Well health inequalities sensitive programme; supporting the transition from a funded, target driven programme to a set of clearly identified, sustainable processes and flexible tools to address health inequalities.

Health & Social Care Moray Keep Well Performance: 2016-17						
	Wellbeing Checks			Wellbeing Brief Interventions		
	Annual Target	Achieved	Achieved as % of target	Annual Target	Achieved	Achieved as % of target
Moray performance against its share of the NHS Grampian annual targets	170	301	177%	58	150	259%

The target has been achieved and exceeded; through Primary Care and links with a range of Community Planning Partners, such as Quarriers (carers), Department of Work and Pensions, and Health and Social Care workforce.

Outcome 6

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

In line with the Carers Act 2016, we undertook extensive consultation with unpaid carers and professionals to develop our new Carer's Strategy. **Carry on Caring 2016 – 2019** was launched in 2016. We undertook extensive consultation ensuring ownership of the strategy for carers. The strategy has built on all the work that has been achieved by previous strategies as well as supporting the development of current services and information for carers.

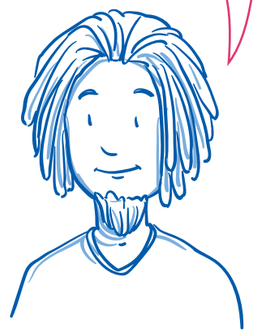
Carers in Moray state that they want to be able to continue in their caring role. The Social Care (Self Directed Support) (Scotland) Act 2013 introduced the principles of Self Directed Support into mainstream delivery of community care. Through the implementation of SDS, we have been able to devise new paperwork to assist with assessment and support planning enabling us to promote choice, control and flexibility, the ethos of SDS. Moray was one of two successful bids to the Scottish Government to look at testing all of the SDS options with residential care. A project team has been recruited for this test project and work is underway in relation to this. There will be liaison with Scottish Government, East Renfrewshire (other successful local authority) to look at SDS and residential care over the next two years. We will be working alongside providers of residential care in Moray to develop the process to test out the viability of allowing all four of the SDS options to be chosen when accessing residential care, in particular that of Direct Payments (Option 1 of SDS).

*"**217** people have completed a carer's assessment in Moray."*

*"**7,809** people in Moray provide unpaid care, thats about 8% of the population."*

*"**43%** said they felt supported to continue in their caring role, +2% over the national average."*

"Employers should interview and employ people with disabilities. It is all very well to have reasonable adjustments once you have the job. It is all those people with hidden disabilities that fall between a physical and a mental impairment who are excluded from work and benefits. Not only do carers lose money as they often work part time, they are caring for someone with no prospect of employment which can result in mental health problems including low self-esteem for both the carer and the cared for."



"As someone caring indirectly for elderly parents in failing health and a disabled child and having to work full time, knowing that when I contact the council someone will ring me back would be good. Having rung social work more than once regarding my parents and never getting a response was really frustrating."

"I think that it is important that people be assisted to think about the future when they care for someone eg. if the cared for person's care needs increase; if the wellbeing of the carer decreases; and such practical issues as Power of Attorney, encouraging people to express their wishes for their future."

"Ensure that all carers are identified and that they are fully aware of the support, help and guidance that is available to them, and what benefits they may be entitled to as unpaid carers. Ensure that all the services and officials that they come into contact with are understanding and sympathetic to their needs."

'Since I began receiving support through the Quarriers Carers Support Service (Moray) I have felt less alone as a carer and feel significantly more confident in my caring role. Also the knowledge that there is support there (should I use it or not) helps me get through the tougher times."

Case Study
Self Directed Support

Paul and Barbra Zealand use Self Directed Support to employ a team of five part-time personal assistants to enable their two sons to live life to the full.

That means Alex (21) is able to run his own business mowing lawns and cleaning windows, while Callum (18) works and trains at a social enterprise project near Banff, as well as working alongside his big brother.

Mrs Zealand said: *"There is no need for people with disabilities to sit on the side lines and watch life go by. Having a job and the self-worth that brings and being able to be part of the community – we always said we didn't see why people with disabilities shouldn't have that."*

With employment prospects limited for Alex, the family – who live near Buckie – used his SDS Direct Payment to make the change he wanted in his daily life.

"We started off employing two care workers three years ago. It was nerve-wracking as we didn't know how things were going to work out. What would we do if someone called in sick or they just didn't work out for instance?" Mrs Zealand explained.

"We have just learned so much as we've gone on and found that things have fallen into place. As long as you are open and honest and care for your care workers, they will do the same for you."

The team of care workers grew to five once Callum left school and they now work with both boys.

"They are employed to enable the boys to live their lives - lives which mean going to work, going swimming and going to see a film. Alex and Callum need their care workers alongside them to enable them to have that," Mrs Zealand added.

Alex was attending a local day service but wanted to work and he started off by cutting grass two days a week for elderly residents who would struggle to carry out the task themselves.

Demand for his hard work and enthusiasm grew, so much so that Alex now works four to five days a week, carrying out a range of tasks which have expanded to include power washing patios, repairing garden furniture and making wooden planters. He now has his own workshop.

Mr Zealand said: *"Six months on he started walking tall and looking you straight in the eye. He is very proud of the work he does."*

Callum and his parents decided that Boynie offered a great opportunity to work, be with other people and learn new skills. He attends two days a week with one of his care workers, travelling by bus each day, and works with Alex for two days.

Mr and Mrs Zealand believe that when people are asked by their social worker what they want for themselves or their family member, they often don't know because they don't know what is out there. They would urge others to think about using a Direct Payment to employ their own staff and enable them to go for their goals.

"We have to be imaginative in Moray and SDS is the way to do that," said Mrs Zealand. *"Don't worry that everything is set in concrete from the start, you can change things as you go along. That's the beauty of SDS – you can tweak it and make it work your way."*

The family do their own accounts as they like to have a real-time overview of how things are adding up. It's important, they stress, that you realise it's not your money to go and spend; it's public money so you have to be able to account for it.

Mr Zealand added: *"People do worry about getting it wrong and so do nothing and that's the worst thing."*

Outcome 7

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

We resurrected our Falls Steering Group in order to provide governance and guidance around the uninjured falls pathway and the falls response team pilot. The group is currently looking at the pathway for follow up care post hospital discharge and osteoporosis patients who are frequent fallers.

Another development over the year was our pilot of a Falls Response Team. The Falls Officer interfaces with Out of Hours Social Work, Independent Living Service, Marie Curie (Out of Hours) carers, Community Alarm, volunteer responders, GMED, Fire, Police, Ambulance and 999 call handlers. An attendance and lift, if faller uninjured the pathway leads to a level 1 screening tool being filled out and forwarding on to the relevant District Nurses for onward care. More engagement is needed with the out of hours pathway to ensure reliability and it is anticipated interface with the Out of Hours Social Work pilot project will accomplish this.

With support from the clinical lead GP on the Integration Joint Board, a joint letter has been circulated to all GPs in Moray to open the door for engagement around falls. It is anticipated that this will allow data sharing in identifying our population most at risk of falls and work towards a preventative pathway.

People supported at home reporting feeling safe stood at 81% which was an increase of 5% from 2015/16. However, this remains lower than the national average of 85% and we continue to address this.

The aim of the Scottish Patient Safety Programme is to reduce the number of events which could cause avoidable harm from care delivered in any setting. Work has been undertaken in the following areas in primary care: safety culture, high risk medicines and safer medicines, pressure area care, safety at the interface including results handling.

In Mental Health, monitoring the use of non-pharmacological interventions are being used before issue of as required medicines, implemented a communication tool in order that both medical and nursing staff receive the right level of information to determine whether they agree to an admission/transfer of a patient from the acute sector of the hospital. This will be tested and changed where indicated. Nursing and medical staff are determining whether changes are required to nursing/medical documentation in order to monitor whether patients have had the offer of relevant health checks where their stay in hospital has missed this opportunity eg. mammogram, dentist, smear test, 50 year old bowel cancer check.

Within our out-of-hours primary care (GMED) service, in order to ensure practitioners were delivering safe and effective care for patients, an 'Audit of GMED Practitioner's Consultations' was carried out. The sample included salaried GPs, nurses and paramedics. The aim was to examine the documentation, consultation and diagnostic skill and treatment plans. In total 463 consultations were reviewed. Overall there has been little change in the results from the first audit carried out in 2011 to this audit in 2016, although a significant improvement in the quality of record keeping from 2011 to 2016 has been made.

For the majority of patients seen by both GPs and nurse practitioners, the assessment, diagnosis and treatment plans were satisfactory. It is reassuring for patients, staff and management that in the majority of cases clinicians are providing safe and effective care to patients out-of-hours.

Feedback on the audit results was provided to all practitioners as this is an important method of facilitating learning. A GP will also provide teaching sessions to the advanced nurse practitioners on their case results. We will re-audit again later in 2017.

Outcome 8

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

Workforce development and planning is being taken forward on a number of levels and this is being translated into an Integrated Workforce Plan and an agreed Organisational Development Plan underpinned by current activities. A Workforce Forum has been established to support employee relations and is focused on encouraging a healthy organisational culture. We are measuring our success by the implementation of the iMATTER programme rolled out across all our teams in November 2016. The iMATTER programme seeks to empower staff in fulfilling their potential as teams. Our 2016 results were as follows:

iMatter Questions	Staff Experience Employee Engagement Components	Average Response Percentage
I am clear about my duties and responsibilities	Role Clarity	86%
My direct line manager is sufficiently approachable	Visible and Consistent Leadership	85%
I would recommend my team as a good one to be a part of	Additional question	83%
I feel my direct line manager cares about my health and well-being	Assessing Risk and Monitoring Work Stress and Workload	83%
My work gives me a sense of achievement	Job Satisfaction	82%
I am treated with dignity and respect as an individual	Valued as an Individual	82%
My team works well together	Effective Team Work	81%
I have confidence and trust in my direct line manager	Confidence and Trust in my management	81%
I am treated fairly and consistently	Consistent Application of Employment Policies and Procedures	80%
I understand how my role contributes to the goals of my organisation	Sense of Vision, Purpose and Values	79%
I get the information I need to do my job well	Clear, Appropriate and Timeously Communication	78%
I would be happy for a friend or relative to access services within my organisation	Additional question	78%
I have sufficient support to do my job well	Access to Time and Resources	77%
I am confident performance is managed well within my team	Performance Management	76%
I am confident my ideas and suggestions are listened to	Listened to and Acted Upon	74%
I feel involved in decisions relating to my team	Empowered to influence	74%
I would recommend my organisation as a good place to work	Additional question	73%
I get enough helpful feedback on how well I do my work	Performance Development and Review	72%
I feel appreciated for the work I do	Recognition and Reward	72%
I am given the time and resources to support my learning growth	Learning and Growth	71%
I am confident my ideas and suggestion are acted upon	Listened to and Acted Upon	69%
I feel involved in decisions relating to my job	Empowered to influence	69%
I feel my organisation cares about my health and wellbeing	Health and Wellbeing Support	69%
I get the help and support I need from other teams and services within the organisation to do my job	Appropriate Behaviours and Supportive	
Relationships	69%	
I am confident performance is managed well within my organisation	Performance Management	62%
I have confidence and trust in senior managers responsible for the wider organisation	Confidence and Trust in my management	62%
I feel senior managers responsible for the wider organisation are sufficiently visible	Visible and Consistent Leadership	60%
I feel involved in decisions relating to my organisation	Partnership Working	56%

Gold for Moray

We celebrated maintaining the Gold Healthy Working Lives (HWL) award. The accolade from Health Scotland recognises the organisation as an employer who strives to create a safer, healthier and more motivated workforce and helps improve the health, safety and wellbeing of everyone.

Moray was the first sector within NHS Grampian to achieve Gold status in 2010 and is seen as an exemplar HWL client. The award has been achieved by offering a wide range of activities, opportunities and information to staff to help address their needs. Staff engagement really is at the heart of business. One of the most successful initiatives has seen the innovative staff Weight Management Programme which has seen sustained weight loss for the vast majority of those attending a variety of sessions bringing together exercise, cookery and psychological support.

"Our greatest achievement is that Healthy Working Lives is now seen as part of core business rather than simply an award"

HWL working group member

During August and September 2016, we delivered 4 single days of development for Home Care workers. 420 care workers were invited to attend the conferences and 314 people attended. Home Care staff were asked during the evaluation how they felt at present, with where they are now in Care at Home. Of those that took part in the evaluation, some 224 people, 81.7% noted a positive attitude and recognised the benefits of behaviour change in regards to the subjects covered.

Furthermore staff spoke of how they felt appreciated and valued. It gave them according to a number of respondents, an increased sense of self-worth. Just 27 people, 12% felt that the day had no effect on them in either positive or negative ways. The feedback wall gave us a host of information and overall the comment that care workers made was, that they need to feel communicated with. Many of the comments noted that it recent months there had been huge strides made in this area in positive ways. Safe administration of medication was clearly a concern for many and the exercises and workshop completed on the day were very popular with 79.4 % of attendees commenting positively on the section. Clearly this is an area that needs improvement.

Our staff embraced the move from one of our key sites at Spynie Hospital to a new purpose-built accommodation. The Spynie site had a significant backlog maintenance cost, with the buildings deteriorating over the years. Some 130 staff moved to new accommodation in February 2017, with the majority moving to Southfields in Glassgreen, Elgin. The move gives us the opportunity to maximise capacity across our other sites and crucially has provided staff with an open plan arrangement the benefit of enhanced flow of information and team work.

Outcome 9

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

The number of people waiting to be discharged from hospital when they are ready (**Delayed Discharges**) peaked within 2016/17. This is due to recording timeframes of 72 hours being implemented, and as a result the incidents appear to increase.

Homecare has been reported as well coordinated and delivered within Moray, scoring 77% over the national average of 75% within Scotland. There has been a major shift within the delivery of home care, staff are now working with increased flexibility and availability rather than working fixed packages and with the successful launch of Varis Court supporting the reablement and recovery of people who have recently been discharged from hospital.

Through our delayed discharge funding, we operated a 7 day service which has ensured patients were assessed within 24 hours of referral by physiotherapy and occupational therapy at Dr Grays Hospital.

Healthpoints and heathline offer free and confidential health advice from trained staff on a wide range of topics:

- Practical ways to improve your health
- Your health concerns
- Support groups and organisations
- How to access NHS services
- Long term conditions e.g. Diabetes, Asthma
- Access to free condoms
- Access to smoking cessation services

The number of enquires in 2016/17 = **11,112**

The top 3 enquiries for NHS Grampian were focused on: Nutrition/weight management, physical activity.

There were 36 requests for Carers information.

There were 41 requests in relation to social welfare

Case study
Health Point

Kevin, a diabetic in his fifties, recently lost both big toes through complications associated with diabetes.

During his weekly visits to podiatry, he visited healthpoint for advice on how to make changes to improve his health and wellbeing. Since his ‘drop-in’ visit in January 2017, Kevin has been supported to lose just over 5 stone (15% of his body weight); he is absolutely delighted and feels great.

Kevin used to take a taxi for his return journey to his podiatry appointment at DGH, but now he walks and uses the ‘taxi’ money to pay for two sessions at a local gym.

Reporting on Localities

The delivery of health, social and community care is changing. From April 2016 the Integration of health and social care brings services together in a way that will deliver coordinated care that is easy to access and is focused on the best outcome for the individual person.

In practice this will mean NHS and Council staff and those from the third and independent sectors working with service users, carers and community-based groups to plan and deliver care and support that is designed for the individual.

This is known as ‘locality planning’ and it is a key part of health and social care integration. It is also a legal requirement under the Public Bodies (Joint Working) (Scotland) Act, 2014.

Significant progress has been made in 2016/17 on the development and approval of a locality planning framework for Moray which will be at the centre of efforts towards changes in the balance of care by growing capacity in local communities, developing local assets, and through locality planning groups providing local forums where local people and professionals from across the sectors can meet to discuss local needs and priorities and seek to have these inform and be reflected in the Partnership’s Strategic Plan.

Lead Partnership Responsibilities

The MIJB is the lead for the following services on behalf of the three North East IJBs for Primary Care out-of-hours Services (GMED) and Primary Care Contracts.

This means that the MIJB is responsible for the strategic planning and operational budget of these services.

Inspection of Services

Internal

Internal care services, such as Home Care, Day Care and Respite are regulated and inspected by the Care Inspectorate.

One of the Scottish Governments suite of national indicators is the proportion of care services evaluated as 'good' (4) or above by the Care Inspectorate. 75% of inspected services were graded 'good' (4) or above. The trend shows a 33% increase in grading across all services.

The foundations have been established for the MIJB to respond positively to the recommendations arising from inspection reports where these provide opportunities to strengthen governance arrangements.

External

Commissioning Officers are responsible for managing the relationship between external providers and our service users.

Any concerns raised about the quality of care provided by an external provider are recorded and considered against other known information about the provider, such as previous concerns raised; and reports produced by the Care Inspectorate.

Where a concern has been raised, providers are responsible for developing and delivering an action plan identifying planned improvement activity which satisfies the MIJB (and Care Inspectorate if they are involved). This action plan will be monitored by Commissioning Officers to ensure it is being progressed and that improvements are being delivered within agreed timescales. This level of contract monitoring activity will continue until such times until the MIJB is satisfied that the provider has made the necessary improvements to ensure the care, safety and wellbeing of residents.

Where no improvement is evidenced, the Senior Management Team will take decisions in relation to any further action required to address on-going concerns, such as reductions in rates paid, increased monitoring activity such as on-site visits, and imposing conditions on the service until issues are resolved or contracts are terminated. Any action taken to address concerns raised about provider's service provision will attempt to do so in ways that put the best outcomes for service users first and which promote safety and wellbeing.

There were no external inspections during 2016/17.

Financial Performance and Best Value

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

Revenue Summary 2016/17

The financial performance for the MIJB in 2016/17 was:

Service Area	Budget £'000	Actual £'000	Variance Fav / (Adverse) £'000
Community Hospitals	5,301	5,520	(219)
Community Health	3,638	3,653	(15)
Learning Disabilities	5,325	5,288	37
Mental Health	7,218	7,405	(187)
Addiction	825	823	2
Adult Protection & Health Improvement	174	165	9
Care Services Provided In-House	13,074	13,047	27
Older People & Physical and Sensory Disability	16,032	16,267	(235)
Intermediate Care & Occupational Therapy	1,468	1,629	(161)
Care Services Provided by External Contractors	10.137	9,945	192
Other Community Services	7,121	7,169	(48)
Administration & Management	2,821	2,703	118
Primary Care Prescribing	16,888	17,304	(416)
Primary Care Services	14,878	14,890	(12)
Hosted Services	3,623	3,681	(58)
Out of Area Placements	669	525	144
Improvement Grants	969	930	39
Strategic Funds	**4,364**	**877**	**3,487**
Total Net Expenditure	**114,525**	**111,821**	**2,704**

Main Reasons for Variances Against Budget

Overall, the MIJB core services resulted in an overspend of £0.8m. This position has been improved considerably when the slippage on strategic funds are taken into consideration resulting in an overall underspend of £2.704m.

Community Hospitals: Overspends have occurred within community hospitals in each of the four Elgin, Buckie, Forres, Keith/Speyside totalling £0.219m to the year-end. These are historical overspends arising from maintaining staff cover alongside cumulative efficiency targets. At the same time, non-financial objectives, including meeting waiting times, patient safety and delayed discharge targets still require to be maintained. A review is ongoing and will be addressed service re-design in support of the Moray population.

Mental Health: Mental Health services were overspent by £0.187m at the year end. This includes senior medical locum staff costs, nursing and other staff I addition to an efficiency target still to be met. Services have continued to be delivered where funding has been reduced or withdrawn.

Older People and Physical and Sensory Disability Services: This budget has overspent by £0.235m at the end of the year. The end of year position includes an over spend for domiciliary care in the area teams of £0.298m and bad debts were higher than anticipated by £0.047m. The overspend is reduced in part by and underspend in permanent care of £0.085m and an over achievement of income within this area of £0.024m. The variances within this overall budget reflect the shift in the balance of care to enabling people to remain in their homes for longer.

Intermediate Care and Occupational Therapy: This budget has overspent by £0.161m at the end of the year. Primarily this relates to overspends on Aids & Adaptations of £0.096m, a year-end stock adjustment of £0.030m and a community alarm and telecare equipment overspend of £0.020m. In addition there were minor variances of £0.015m all of which can be attributed to the facilitation of helping people remain in their own homes.

Primary Care Prescribing: The primary care prescribing budget is reporting an over spend of £0.416m for the twelve months to March 2017. The average unit cost per item prescribed varies throughout the year and can vastly affect the pressure on the budget.

Integrated Care Fund

The additional funding received from the Scottish Government for the Integrated Care Fund (ICF) for 2016/17 was £1.59m and is included as part of the Strategic Funds in the table above. The ICF is used to deliver change in the way services are delivered with the overall aim of shifting the balance of care from a hospital based setting to the community.

Financial Outlook

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 Scottish Government.

The Scottish Government 2017/18 funding settlements, for both health boards and local authorities, announced in December 2016 were significantly more challenging than was anticipated and so had an adverse impact on the onward negotiation of funding to the MIJB. Whilst the strategic outcomes and intent remain unchanged, the challenge is to ensure that the economic impacts of decisions taken are highlighted as there is likely to be insufficient funding to maintain current levels of service in future years.

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 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.

Best Value

NHS Grampian and Moray Council have delegated functions and associated budgets of these functions to the MIJB. It is the responsibility of the MIJB to decide how to use these resources to achieve the objectives of the Strategic Plan.

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

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

Financial Reporting on Localities

The financial reporting for 2016/17 has not been presented at locality level. This has been highlighted as a priority in development terms for 2017/18.

Reporting on the Integrated Care Fund

MIJB received a total of £1.59m from the Scottish Government's Integrated Care Fund (ICF) in 2015/16 to support delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and early intervention and further strengthen our approach to tackling inequalities. A further allocation of £1.59m was also received in 2016/17 to assist the continuation of programme delivery and in line with the overarching strategic policy drivers outlined in the Strategic Plan. Over the financial years 2015/16 and 2016/17 has focussed on delivering the following key themes:

Allocation to date of the ICF resources can be summarised as follows:

Theme	2015/16 Allocation £ 000	2016/17 Allocation £000	Total Spend to Date £000	Overall Underspend to Date £000
Promoting Community Wellbeing	128	97	115	110
Staying Independent, Self-Management of Long Term Conditions	348	213	290	271
Recovery, Rehabilitation & Enablement	235	163	250	148
Intensive Support	137	0	117	20
Related Enablers	267	560	482	345
Unallocated Balance	111	557	0	668
Total ICF spend – 2016/17	**1,226**	**1,590**	**1,254**	**1,562**

The Year Ahead

Annual Review of the Partnership's Strategic Plan

Review of Strategic Plan: this new plan seeks to build on the learning gained during the first year of operation and includes initial locality planning priorities; updated performance indicators; an updated Strategic Risk Register and an updated Implementation Plan. In 2018, following the initial 3 year period covered by the original document, the Plan will be completely re-written and a new Strategic Plan produced.

It has been a progressive and encouraging first year for the Moray Integration Joint Board and the foundations have been set to take forward our priorities at an accelerating pace of change. We are committed in our approach to ensure next year is even better.

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