HEALTH & SOCIAL CARE MORAY

Moray Partners in Care

The Strategic Plan for Health and Care in Moray over the next 10 years

2019

What you will find in this document

For more information on the Moray Integration Joint Board and Health & Social Care Moray, or to request this document in large print, other formats and languages, please contact the Public Involvement Officer by emailing involvement@moray.gov.uk or calling 01343 567187.

The Health and Social Care Strategy at a glance

Moray Partners in Care

Our vision:

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

Our values:

- Dignity and respect
- Person centred
- Care and compassion
- Safe, effective and responsive

Outcomes:

- Lives are healthier
- People live more independently
- Experiences 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

Theme 1:

Building Resilience

Taking greater responsibility for our health and wellbeing.

Theme 2:

Home First

Being supported at home or in a homely setting as far as possible.

Theme 3:

Partners in Care

Making choices and taking control over decisions affecting our care and support.

Transformation (Delivery) Plan supported by enablers:

- Medium Term Financial Plan
- Performance Framework
- Locality Plans
- Existing Strategies
- Infrastructure Planning
- Housing Contribution
- Organisational Development and Workforce Plan
- Communication and Engagement Framework

Welcome

Welcome to the Moray Integration Joint Board's 2nd Strategic Plan – Moray Partners in Care 2019-2029. The Board has now been in place for 3 years and has demonstrated many achievements throughout this time; our annual performance reports published each year showcasing many examples of success as well as the challenges ahead. This new plan builds on those strong foundations.

The plan has 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 their independence and a very clear intention to work to a Homefirst model of care, described in this plan.

We have to acknowledge from the outset the resource challenge we face in the availability of both money and workforce. It would be wrong to pretend that there are not some hard decisions to be made as we move forward. As a Board we understand that this is a time to think differently 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 to clear priorities.

It is incontrovertible that the Health and Social Care Partnership cannot deliver our ambitions on its own. The plan relies on everyone getting involved and working together to generate different solutions from a much broader perspective. Since the inception of the Board we have worked hard to build up relationships with the people of Moray and key partners delivering care from all sectors with the aim of improving and changing. Accordingly, this plan has been developed through close cooperation with our partners in the Local Authority, NHS Grampian, the third and independent sectors and, most importantly, our staff. It is not just 'our plan'; it is everyone's plan and binds the partnership in its widest sense to work toward this shared vision and guide us all through the decisions that are required to deliver on that vision.

We look forward to progressing these ambitions and the associated transformation programme that will underpin success, through strong partnership, evidencing change through robust measures that consider people experiences, and learning from this to ensure improvement and change activities thrive.

We will not be doing this in isolation, working within the context of the Community Planning Partners, responding to the National Performance Framework, then locally to the Local Outcomes Improvement Plan, taking cognisance of the NHS Grampian Clinical Strategy and the Moray Council Corporate Plan, seeking collaborative effort and synergy to ensure we make the most of what we have to improve health and wellbeing outcomes for the people of Moray.

Jonathan Passmore
Chair, Moray
Integration Joint Board

Pam Dudek
Chief Officer, Health
& Social Care Moray

Introduction

“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.”

Health, wellbeing and independent living are important to us all, which is why everyone has a stake in the success of this Strategic Plan.

The Moray Integration Joint Board brings together partners with a shared goal of everyone in Moray being able to live longer, healthier lives as independently as they can at home or in a homely setting.

We have a strong record of accomplishment in joint working to improve outcomes for our citizens. As with all health and social care systems, however, 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 grows older and the numbers of residents living with multiple and complex health and care needs rise.

To meet these challenges we have set our sights on transforming the health and care system through the delivery of this Strategic Plan.

We want to see a transformed, sustainable health and care system that manages demand for services in order to safeguard the continued delivery of high-quality care, support and treatment services for those in most need and to get the best value from our limited resources.

Key to this is the strengthening of our partnerships. By working more closely together we can make the most of the assets and talents of the people, communities and organisations in Moray. We will encourage one another to consider what we can do for ourselves, what we will need support to achieve and the areas of health and wellbeing for which we will depend on services.

Success will see everyone in Moray building resilience individually and collectively to prevent poor outcomes, enable independence and for positive live experiences to prevail.

Who we are

The Moray Integration Joint Board has responsibility for a range of services in the community and the resources needed to deliver them. These services include:

- Social care services;
- Primary care services including GPs and community nursing
- Allied health professionals such as occupational therapists, psychologists and physiotherapists
- Community hospitals
- Public health
- Community dental, ophthalmic and pharmaceutical services
- Unscheduled care services;
- Support for unpaid carers.

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

The board also has delegated responsibility for the strategic planning of unscheduled care that is delivered in emergency situations such as A&E, acute medicine and geriatric medicine at Dr Gray's Hospital and Aberdeen Royal Infirmary (ARI). The unscheduled care responsibilities seek to further enhance what can be delivered locally in communities, reducing the demand on acute hospitals where this is preventable.

The full list of delegated functions can be viewed at the link:
www.moray.gov.uk/downloads/file102766.pdf

The Board directs Moray Council and NHS Grampian to deliver on this plan through the staff they employ and associated resources, seeking them to work together as the Health & Social Care Moray partnership to directly provide or commission services.

Where we are

A Joint Strategic Needs Assessment was carried out in 2018. This looked at the current and future health and care needs of our local populations. A number of areas were highlighted from the wealth of intelligence compiled.

- There are continuing inequalities in health status across Moray, with an evident association between level of neighbourhood affluence and morbidity and mortality.
- The population is ageing, with a growing proportion represented by adults over the age of 65, and growing numbers of adults aged over 80, with implications for increasing morbidity.
- Significant demand for health and social care services arise from chronic disease and a growing proportion of the population is experiencing more than one condition ("multi-morbidity").
- There is significant morbidity and mortality due to mental health problems.
- There is significant morbidity and mortality due to lifestyle exposures such as smoking, alcohol and drug misuse.
- Moray is characterised as remote and rural, and there are significant access challenges for some in the population to access health services.
- Care activity is highly demanding of informal carers, and there is evidence of distress in the informal carer population.
- Moray's military and veteran population constitute a significant group, requiring both general health services and specific services.

The full assessment can be viewed at:
www.hscmoray.co.uk/partners-in-care-2019-2029.html

The challenges we face

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

Increasing demand – demand for health and care is growing at an unsustainable rate as people are living longer and with multiple chronic conditions. While people are living longer, they are spending longer in poor health. This puts a 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 sufficient staff in some sectors.

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 system driven by continuous improvement.

We are ambitious for transformational change to meet these challenges, bring about advances and drive us towards achieving our vision for Moray.

This requires us to work with the public and our workforce to understand what is possible and to develop new relationships that absolutely emphasis personal choice and responsibility, seeking to protect the finite resources we have to ensure that when they are needed they are available and give best value.

This does require thinking in a different way about our future, identifying what is working well and how we can continue to make improvement as well as making difficult decisions. We recognised the challenge of this.

Developing our Strategic Plan

Many partners in care worked to develop this Strategic Plan. They shared their experiences of the 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 the 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

The landscape in which we operate

In developing the Strategic Plan we needed to review and consider the wider landscape in which we operate and which is critical to our success.

The staff working in the partnership of Health & Social Care Moray remain employed by the local authority and NHS. The infrastructure support to operate the integrated arrangements of Health and Social Care Moray is provided by these bodies. Our Strategic Plan must therefore take account of the Moray Council Corporate Plan and the NHS Grampian Clinical Strategy.

Delegated responsibility for the strategic planning of unscheduled care allows us to plan alternative community options for care. Where admissions to hospital are preventable as a result of these developing community models of care, we will be able to maintain people at home in their communities, ensuring better outcomes in the longer term.

We reviewed our performance in delivering our first strategic plan launched in 2016; financial, service and workforce pressures; national legislation and policy; and direction from the Moray Community Planning Partnership as set out in the Local Outcomes Improvement Plan (LOIP) www.yourmoray.org.uk/downloads/file118306.pdf

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 a significant impact on outcomes for people, families and communities.

The Moray Alcohol and Drug Partnership (MADP), which has responsibility for the delivery of priority 4, reports to the CPP and its funding flows through the MIJB. Leadership and responsibility sits with the Chief Officer who is the current Chair of the MADP.

The Children and Young People (Scotland) Act 2014 places a requirement upon the local authority and relevant health board to produce a Children`s Services Plan (CSP) www.moray.gov.uk/downloads/file112627.pdf

The priorities identified for the CSP in Moray are:

- Ambitious and confident children
- Healthier children
- Safer children.

MIJB are partners in the development of the Moray Children's Services Plan and the governance arrangements that oversee the running of Integrated Children's Services.

MIJB also as a statutory body has responsibilities with regards to corporate parenting and again as a Community Planning Partner takes these responsibilities seriously. These duties require us to do our very best for Moray's children so that they may achieve their full potential with our support. The Moray Strategy for Corporate Parenting sets out commitments to those children and young people who are care experienced, ensuring best opportunity for them to reach their true potential.

It is really important that the outcomes for children are maximised as this determines adulthood. Children and families approaches cannot be seen in isolation. They need to be dominant in our planning of services if we are to achieve our ultimate goal of positive wellbeing, health and independence.

We recognise that Moray Integration Joint Board has a duty to contribute to reducing health inequalities (Outcome 5). Health inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups. They are a key challenge and have a significant demand on health and social care services.

We will take every opportunity throughout the continuous cycle of planning, implementing and reviewing services and processes required to deliver this Strategic Plan, to take forward actions to address inequalities.

Where we want to be

Our vision - Where we are aiming to be

“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.”

Our mission - What we are striving for

We work to deliver the triple aim of the national Health and Social Care Delivery Plan in that we seek to:

- Improve the health and wellbeing of the population (**better health**)
- Improve the quality of care people receive (**better care**)
- Improve the efficiency of health and social care services to ensure we spend public money on services that get good outcomes for people (**better value**)

Our values - What guides our behaviour

We will demonstrate our values and principles in the way we engage with people and how we behave.

- Dignity and respect
- Care and compassion
- Person-led
- Safe, effective and responsive

Our standards

We work to meet the National Health and Social Care Standards that are:

- People experience high quality care and support that is right for them
- People are fully involved in all decisions about their care and support
- People have confidence in the people who support and care for them
- People have confidence in the organisation providing their care and support
- People experience a high quality environment (if the organisation provides the premises).

Our strategic themes

Building on what we know, we have identified three strategic themes where we will direct effort.

Simply put, we wish to major on health and wellbeing.

For individuals experiencing challenges with their health and wellbeing, we start first with understanding how we can support them to take care of their own health and wellbeing.

We will seek to understand how we can intervene helpfully to ensure independence is retained, enabling people to be in charge of their own future where they make choices around what is important for them and the ways in which this can happen.

As these themes are closely linked, improvements in one area will influence positively on the others.

Areas for activity are highlighted in general ambitions under each theme. Greater detail on the actions to be undertaken, timescales and performance measures will be set out in the Transformation Plan for the delivery of this strategy.

Theme 1: Building Resilience

Taking greater responsibility for our health and wellbeing

We are committed to working with all our partners in care across Moray to support people to live healthier lives for longer.

We will encourage people to take charge of their own health and wellbeing and that of their families and communities. We want people to be able to draw on their own personal resources and those of their community - not only when they experience health and care challenges but to prevent problems happening.

We want it to be easy for people to be active, to make positive choice and be connected within their communities. All of these are good indicators of positive health and wellbeing. The public health priorities set out nationally for Scotland echo the need to work together to shift our focus towards preventing ill health, reducing inequalities and working more effectively in partnership to success.
www.gov.scot/publications/scotlands-public-health-priorities/

Personal responsibility - We will support people, including members of the workforce, to take their physical and mental health seriously throughout their lives.

Self-management - We will support people to build their skills and confidence to manage their own long-term health conditions and build resilience, helping them develop stronger, more resilient, supportive, influential and inclusive communities to improve life chances.

Information - We will help people to access information to improve their knowledge and signpost them to sources of advice and help to maintain their independence. Staff will make every opportunity count by promoting positive health messages during all interactions.

Early intervention and prevention - We will promote prevention, early intervention and harm reduction programmes, including around mental health and loneliness.

Changing our relationship with alcohol - Through our commitment to the delivery of this objective as set out in the Moray Local Outcome Improvement Plan (LOIP) we will take a whole population approach to prevention and reducing related harms.

Building a better future for our children and young people in Moray - Through the Children's Service Plan and Corporate Parenting, we will take forward our responsibilities in delivering effective interventions within the integrated arena of children's services to ensure children get the healthiest start in life.

Theme 2: Home First

Being supported at home or in a homely setting as far as possible

Good health and wellbeing begins at home and in communities. This is where most people would choose to remain with the right support.

Our **home first** approach is not aimed at keeping people at home who need to be in hospital but acknowledging that today it is widely accepted through research that it is better for people, particularly older people, to be cared for at home where possible.

We know that older people very quickly lose their independence through loss of confidence and often reduced mobility when admitted to hospital. This is why there is such an emphasis on preventing admissions and people not being delayed in hospital. The longer an older person spends in hospital the more difficult it will be to get them home and functioning as they have prior to admission.

We aim to start with examining the possibility of **home first** and in doing so optimising outcomes for people. We will aim to deliver care as local as possible and as specialist as necessary, depending on need and available resource.

We will develop services in partnership with providers of health and care services and support - including the Third Sector and Independent Care Sector - to deliver better and more joined-up care.

Locality management - We will put in place lead managers with responsibility for getting to know their location, the people and resources within it, working hand in glove with communities to shape services by interacting better with what communities themselves have to offer. They will ensure coherent co-ordination of the teams locally and support the workforce in their daily endeavours.

Multi-Disciplinary Teams - We will enhance locality-based care delivered by health and social care professionals from different disciplines working together as multi-disciplinary teams (MDT) to provide more co-ordinated care locally. These MDTs will expand to include Third Sector partners. They will implement models to identify people at risk of losing their independence, for example those with frailty, and work with them to develop their anticipatory care plans. This will allow people to think ahead to what their wishes are in the event of becoming ill, ensuring those choices are followed consistently by teams.

Discharge to assess - We seek to move away from hospital-based assessments that can often cloud the true potential of individuals given the artificial environment created. Discharging people where appropriate to their home environment to assess their needs allows people to demonstrate how they function in their own homes.

Crisis support - We will continue to develop rapid responses for people at home who have an urgent care and support need. This will include access to equipment and care at home to prevent avoidable hospital admission where possible and to help people return home from hospital quickly.

Rehabilitation, reablement and recovery - We will continue to work with people to provide them with the services and support they need, in the most appropriate setting and by the most appropriately skilled staff group, to regain and maintain their health, wellbeing and independent living skills. We will always try to explore your own personal resources and the resources around you that can contribute to your wellbeing or recovery.

Housing, adaptations and technology - We will continue to work with housing providers to support people in homes which best meet their care and support needs, such as dementia friendly housing. They will be able to access technology to support independent living.

Theme 3: Partners in Care

Making choices and taking control over decisions affecting our care and support

We are committed to working with people not as passive recipients but as partners in their own care, support and treatment.

We will continue to change our relationship with people who use services, their families and carers so that they are in charge of making informed choices and decisions on what their care and support looks like and how it is delivered within resources so they can live their life and achieve the outcomes that matter to them.

Personalised care and support planning - We will involve people and their families in all processes from assessing their own health and wellbeing needs through to the planning and commissioning of the support to meet their needs. We will build on the implementation of self-directed support (SDS) to support people to identify and achieve their personal outcomes. We will uphold the rights of carers to be involved in the care and support planning of the person they care for or intend to care for.

Realistic Medicine - We will continue to encourage health and care workers to find out what matters to the person so that the care of their condition fits their needs and situation. Through shared decision-making individuals and their families will feel empowered to discuss and understand possible treatment available and the benefits and risks of these, including the option of doing nothing and what effects this could have.

Long-term conditions - We will explore the opportunities presented by the House of Care programme to help people with long term conditions be more involved in their care and self-management.

Palliative and end of life care - We will support people to exercise their preference in relation to palliative and end of life care in the setting of their choice, creating meaningful advanced care plans.

Engagement in services - We will engage with people so they have more say in decisions about local services and more involvement in designing and delivering them.

Market shaping strategies - We will work with current and potential providers to develop a diverse and thriving market place of opportunities and services from which people can choose to access their care and support.

Our enabling plans

The Strategic Plan for 2019-2029 is the overarching plan under which many existing programmes of work, client group strategies and delivery plans sit.

These include strategies to improve services and responses for unpaid carers; older people; physical and sensory disabilities; mental health; learning disability; the Moray Alcohol and Drug Partnership Delivery Plan; and the Primary Care Improvement Plan aligned to the new General Practice Contract for Scotland.

These can be seen on the Health & Social Care Moray website:
www.hscmoray.co.uk/our-strategies-and-plans.html

Delivery of the Strategic Plan will be through the Transformation Plan, supported by a number of enabling plans. These include:

- **The Medium Term Financial Plan -** achieving financial sustainability
- **The Organisational Development and Workforce Plan -** developing a positive organisational culture among the workforce, assessing and considering new roles.
- **Locality Plans -** communities working together to identify local needs and local solutions.
- **Housing Contribution -** agreeing the key areas of focus to meet current and future needs.
- **Communication and Engagement Framework -** guiding how we share information, listen to and learn from each other to support partnership working.
- **Infrastructure Framework -** looking at our physical estate with partners to maximise the use of what we have and to plan together for the future.
- **Digital Matters -** ensuring we maximise the use of technology to enhance self-management alongside health and care options.

The difference we want to make

All our plans must deliver on the nine National Health and Wellbeing Outcomes. These are used by the Scottish Government to measure the success of integration by boards across Scotland.

The outcomes we want to achieve	
1	People are able to look after and improve their own health and wellbeing and live in good health 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 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.

Measuring success

Maintaining consistently high standards through a period of transformation is a challenge, but to the people who rely on health and social care services it is vitally important we achieve this.

We will continue to ask people about their experiences of services, listen to what they say and act on it. This will help us learn if outcomes are being met and where improvement should be made.

Performance management arrangements are in place to monitor and scrutinise our effectiveness in delivering the vision and priorities of the Board, and our progress in meeting the national outcomes. Areas for improvement are also highlighted.

Performance information is gathered at service level. Governance and operational performance reports are scrutinised by the Moray IJB that publishes an Annual Performance Report to reflect on activity during each financial year.

Staying Involved

The Moray Integration Joint Board and Health & Social Care Moray are committed to meaningful and sustained engagement with all stakeholders.

If you would like to be added to our Partners in Care involvement database please contact us and we will send you an application form. We will keep you up to date with opportunities to work with us and use your knowledge, skills and lived experience to help achieve positive change.

Health and Social Care Moray
9C Southfield Drive
Elgin
IV30 6GR

www.hscmoray.co.uk

01343 567187

involvement@moray.gov.uk

Glossary of terms

Acute hospital	Acute hospitals provide specific care whether planned (surgical) or unplanned (emergency) for disease or illness that progress quickly, feature serious symptoms and have a brief duration.
Allied Health Professionals	Clinicians working in a variety of settings, such as hospital, health centre and people's own homes as part of community teams, whose professions include physiotherapy, occupational therapy, speech and language, podiatry and dietetics.
Anticipatory care plan	A plan to help reduce avoidable and unscheduled acute admissions for people with pre-existing conditions. The purpose of anticipatory care planning is to support the individual to have greater choice and control of care preferences.
Carer (informal and unpaid)	The Carer (Scotland) Act 2016 defines a carer as "an individual who provides or intends to provide care for another individual (the cared-for person)".
Community Planning	A process by which public agencies work in partnership with communities, the Independent and Third Sectors to plan and deliver better services.
Corporate Parenting	The formal and local partnerships between all services responsible for working together to meet the needs of care experienced children, young people and care leavers.
Early intervention and prevention	Giving support, care and/or treatment as early as possible to prevent the development of future problems and promote the necessary conditions to improve health and wellbeing.
Health inequalities	When health and access to groups and services that would benefit a person's health are poorer because of income, gender, race, sexual orientation, disability, age or any other factor out with the person's control.
House of Care	A way of providing co-ordinated services that aims to deliver proactive, holistic and person-centred care for people with long-term conditions.
Independent Sector	Traditionally referred to as the 'private' sector, organisations from single to national providers involved in delivering social care services including care homes, care at home, housing support and day care.
Intermediate care services	Services supporting people to improve their independence through enabling, rehabilitative and treatment approaches in community and residential settings to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living.
Integration Joint Board	The public body that is responsible for planning joined up/integrated care. It will decide which integrated services will be provided, how they will be funded and what they should look like. They will direct the NHS Board and Local Authority to deliver those services.
Joint Strategic Needs Assessment	Assessment of the current and future health and care needs of populations to inform and guide commissioning of services within the area.
Local Outcomes Improvement Plan (LOIP)	Community Planning Partnerships are responsible for producing the plan that describes their local priorities and planned improvements.
Moray Council Corporate Plan	The local authority's primary statement of what it aims to achieve and the resources required to do this.
Multi-disciplinary team (MDT)	A team made up of professionals across health, social care and third sector who work together to address the holistic needs of their patient or service user in order to improve delivery of care and reduce fragmentation.
National Performance Framework	The framework provides a clear vision for Scotland with broad measures of national wellbeing, covering a range of indicators and targets.
NHS Grampian Clinical Strategy	A high-level plan focusing on activities that relate to clinical practice, supporting staff in the planning and delivery of safe, high quality, person-centred and sustainable clinical services.
Primary care	Health services provided in the community by family doctors, community nurses and allied health professionals such as pharmacists, optometrists and physiotherapists.
Realistic Medicine	Puts the person receiving health and social care at the centre of decisions by finding out what matters most to them so they can be supported to maintain health and to prevent and treat illness.
Scheme of Integration	Prepared by the Health Board and Local Authority and approved by the Scottish Government, the document sets out key agreements to support integrated arrangements.
Self-directed Support	The support individuals have after making an informed choice on how their individual budget is used to meet the outcomes they have agreed.
Strategic Plan	The plan that describes what the partnership aims to do and the local and national outcomes we will use to measure how we are doing.
Third sector	The range of organisations that are neither public sector nor independent (private) sector. It includes voluntary and community organisations, social enterprises, mutuals and co-operatives. It also includes Third Sector interfaces (tsiMORAY).
Transformational change	An opportunity to drive change and reshape the way in which services are delivered in order to respond to challenges.
Unscheduled care	Unscheduled care (USC) is sometimes referred to as unplanned, urgent or emergency care. As this can happen at any time, services must be available and ready to respond 24 hours a day, seven days a week.
Whole systems approach	Identifying the various components of a system and understanding how they could work better together to achieve a positive impact.

This publication is also available in other formats and languages on request. Please call Equality and Diversity on 01224 551116 or 01224 552245 or email grampian@nhs.net

Ask for publication CGD 190580

the moray Council

NHS Grampian