
HEALTH &
SOCIAL CARE
MORAY
Strategic Delivery Plan
2025-2028
Partners in Care
The Strategic Plan for Health & Social Care
in Moray over the next 10 years
2022-2032
Ladder Hills
Hill of
Three Stones

Contents

Foreword

As Chair of the Moray Integration Joint Board, I am pleased to present our Strategic Delivery Plan for 2025–2028. This plan represents our shared commitment to transforming health and social care services in Moray ensuring they are sustainable, person-centred, and responsive to the needs of our communities.

The plan sets out how Health & Social Care Moray will deliver on the ambitions of our Strategic Plan, Partners in Care, over the next three years. It connects strategic objectives with the activity we need to deliver and provides a framework for how we make the best use of our integrated resources.

It outlines the key areas of work that will help us improve health and wellbeing outcomes for the people of Moray through our focus on preventing ill-health, reducing health inequalities, promoting independence, and supporting resilient communities.

This is not a static document. It will be reviewed regularly through our Strategic Planning and Commissioning Group to ensure that actions are progressing, priorities remain relevant, and improvements are made where needed. It will also serve as a key tool in monitoring how well our Strategic Plan is working in practice.

We are under no illusion about the real and growing pressures on the health and care system. An ageing population, increasing levels of poor health, workforce challenges, and financial constraints, all mean we must think differently, work differently, and continue to build on the strength of our partnerships.

I would like to thank everyone who has contributed to shaping this plan. It is only through collective effort across our communities, our workforce, and our partners that we will succeed. I am confident that, together, we can deliver meaningful, lasting improvements for the people of Moray.

Councillor Elaine Kirby

Chair, Moray Integration Joint Board

1 Introduction

This Strategic Delivery Plan should be read alongside the Moray Health and Social Care Partnership (HSCM) Strategic Plan which was agreed by the Moray Integration Board (MIJB) in November 2022. This delivery plan sets out the programme of transformational

and improvement work underway to enable the HSCM to meet its strategic priorities. The Strategic Plan itself is also supported by the HSCM's Workforce Plan, Medium Term Financial Strategy and Commissioning and Procurement Plan. The work of the HSCM also supports, in part, the delivery of Moray Council's Plan and NHS Grampian's Plan for the Future.

Our key focus continues to be progressing the integration agenda by increasing access to community-based health and social care services, shifting the balance of care from hospital to more homely settings, and supporting our most vulnerable citizens. Whilst setting out our vision, which remains **"We come together as equal & valued partners in care to achieve the best health & wellbeing possible for everyone in Moray throughout their lives".** We continue to deliver on our three strategic themes by setting clear strategic objectives which can lead us to improving outcomes over the next ten years.

BUILDING RESILIENCE

HOME FIRST

PARTNERS IN CARE

2 Moray Health & Social Care Partnership

Many of the pressures and challenges being faced within Moray are reflected across Scotland. The joint strategic needs assessment was updated as part of refreshing and continuingly informing the development of the delivery plan. There is a changing dynamic over the last 20 years where the population is becoming healthier and living longer but we appreciate that an increasing number of people experience the burden of long-term medical conditions. Moray is a large rural area where the average life expectancy is above the Scottish average. However, due to socio-economic factors and population spread, there are different rates of life expectancy and healthy life expectancy across Moray.

2.1 Joint Strategic Needs Assessment

The revised Joint Strategic Needs Assessment was approved by MIJB on 26 September 2024. The key aspects identified in the assessment for Health and Social Care Needs in Moray identify the specific challenges and pressures on the health and care system within Moray, and are set out below:-

Ageing Population

Moray is projected to have an increasingly ageing population structure. Between 2023 and 2038 it is projected that the number of 5-17 year-olds in Moray will decline by 19% (-11% for Scotland). Conversely, those aged 85 and over will increase by 63% in Moray and 47% in Scotland.

Above average limiting long term illnesses

Approximately 40% of Moray residents live with limiting long term illnesses, above the Scottish average of 36%. Moray has a higher prevalence for all diseases when compared to Scotland as a whole, the only exception being COPD.

The prevalence of Dementia

Within the Moray population has increased from 4.9 per 1,000 population in 2017/18 to 5.6 in 2022/23.

The prevalence of Depression

In both Moray and Scotland has risen between 2017/18 and 2022/23.

Above average smokers

In the 2018-2022 aggregate time period, 18% of Moray adults aged 16 years and over were smokers, above the Scottish average of 13%.

A&E attendances at Dr Gray's Hospital

There were 28,402 attendances in 2022/23, an 11.2% increase on the previous financial year and reaching a value above pre-pandemic levels (in contrast to Aberdeen Royal Infirmary). High intensity use is greatest in areas of deprivation, and across all age groups it is associated with issues such as homelessness, being out of work, mental health conditions, drug and alcohol problems, criminality, and loneliness and social isolation.

Care Homes

Moray has higher rates of 65-84 year olds than Scotland

Care at Home

A decrease in the number of people supported with care at home provided/funded by Moray Health and Social Care Partnership for the fourth consecutive year. Moray's Care at Home Service recipients have high levels of A&E attendances as a rate per 1,000 at 189.6 (Jan-Mar 2023) compared to 155.6 for Scotland.

Access to GPs

52% report they cannot get a GP appointment within 3 days.

Cancer Screening

GPs in Moray report that they are seeing and referring more people with cancer symptoms, but less cancer is being diagnosed and it is being diagnosed later. This is a concern as there will be increasing 'unfound' cancers, and later diagnosis means less will be treatable.

Inequalities

Clear inequalities are present: females in the most deprived areas of Moray have a 3% lower life expectancy than Moray as a whole; males in the most deprived areas have a 5% lower life expectancy than Moray as a whole.

Fuel Poverty

32% of Moray residents faced fuel poverty, far higher than the overall Scottish figure of 24% over the same period. Extreme fuel poverty in Moray (2017-2019) was estimated to be 19%, higher than Scotland's 12% over the same period. Cost of Living - almost 40% of Moray households (39%) describe themselves as experiencing problems with meeting housing payments, which ranges from 42% in Buckie to 33% in Speyside. 15% of Moray households describe themselves as having financial difficulties now, in comparison to 4% pre COVID. One in five households in Keith were currently experiencing financial difficulties (20%).

Increasing child poverty

24.1% children (4,228 individuals) were in poverty in 2021/22 in Moray, a rise in percentage from 20.8% in 2014/15 (3896 individuals).

Food insecurity has increased in Moray: in the 2018-2022 period 8% of residents were worried that they would run out of food, up from 7% in 2017-2021, and 6% in 2016-2019

Veterans - There are two large military bases in Moray: RAF Lossiemouth and Kinloss Barracks, which employ around 4000 people at present. We also need to consider the health needs of veterans of the armed forces; where the population often differs in structure to the non-veteran population; usually older and more males than females.

Unsuitable housing

The Moray HDNA 2022 estimated 2,160 households across Moray (which equates to 5% of the total households in Moray of 43,995) require to move to alternative housing to address housing unsuitability.

Delayed Discharges

On average, 39 beds were occupied by delayed discharges each day in Moray in the 2022/23 financial year. This is a 34.5% increase on the 2021/22 value of 29 beds.

2.2 Establishing Sustainable Models of Care

As a partnership, we are cognisant of the financial constraints we, and our partners, are working within. The existing available budget does not meet the demand for services being delivered at the current rate, and in order to be sustainable we will have to make difficult choices and continue with designing services through transformational change where the person receiving the

service remains at the heart of the conversation. The future of Health and Social Care delivery very much depends on the decisions that will require to be made, as the option to remain as we are is not viable.

Therefore, there is a strengthened focus on prevention and early intervention to promote good, positive physical and mental health and wellbeing for all people across all ages and client groups. We know 70 to 80% of people with long term health conditions could manage their conditions themselves with support from informal health systems, and a number of identified projects will seek to explore the options to maximise every opportunity for informal supports.

We must continue to work with our communities as we move forward, placing communities at the heart of public health can reduce health inequalities, engage those most at risk of poor health, empower individual and communities, and build resilience. That also involves supporting people to enable them to be responsible for their own health, and to work with health and care professionals to manage existing conditions.

HSCM is responsible for almost 1,795 staff members employed by NHS Grampian or Moray Council. Not only do we recognise the tremendous amount of effort and work undertaken each day in Moray to support people in our communities, but we also recognise the role of 'communities' themselves, in supporting the most vulnerable and providing resilience.

We have to change, we have to deliver differently, we have to focus on what we can support, what we ask people to do and how we ask communities support us.

2.3 Relationships and Collaboration

Our partner organisations, Moray Council and NHS Grampian are facing similar financial challenges along with our neighbouring Health and Social Care partnerships in Aberdeen City and Aberdeenshire. There is agreement that we need to work together to ensure we maximise every opportunity whilst minimising any negative impact of change across our whole health and social care systems. We are committed to sharing best practice and learning from each other and a Grampian Health and Care Strategic Change Board was established in November 2024. As the Board develops it will be responsible for developing and implementing the **NHS Grampian's Route Map for Strategic Change** in collaboration with Integration Joint Boards (IJB), which will be a key

document outlining our shared strategic priorities for the future of health and care across the North East, coupled with the practical steps required to create a sustainable health and care system.

3 Key Enablers

The delivery of the strategic plan is underpinned by key workstreams shown under the theme of **Strategic Leadership, Planning and Performance.** This workstream encompasses the development and implementation of strategies that will set the culture and standards for HSCM in relation to Finance, Communications, Workforce, Performance and Quality Assurance, Commissioning, Infrastructure, Digital Health Care and Governance. These elements combined will form the basis and structure for the delivery of the specific priorities outlined under the Strategic Objectives and our strategic themes of Building Resilience, Home First and Partners in Care.

4 Performance and Governance

The Strategic Planning and Commissioning Group (SCPG) has responsibility for oversight of the development work streams arising from the HSCM's Strategic Delivery Plan and will consider options appraisals and key project documentation as progress is made. HSCM Senior Management Team will lead the implementation of the delivery plan and the definition of SMART objectives, against which progress will be measured.

Progress of the actions within this delivery plan will be overseen and scrutinised by the Senior Management team and Strategic Planning and Commissioning group and will be reported to the MIJB on a six monthly basis. An annual review process will provide the opportunity for the MIJB to review both the progress of the projects during the previous year as well as the focus for the forthcoming year. In developing this approach, we aim to remain cognisant of prioritising areas of change and transformation that will enable the delivery of our strategic priorities in an environment which very much requires a flexible approach

The performance reporting framework is being revised and will be implemented for reporting in 2025. To provide assurance and oversight a high-level summary of performance against the outcomes of the Strategic Delivery Plan will be reported to the Audit, Performance and Risk (APR) Committee on a quarterly basis.

Outcomes to be achieved will be set against each project, along with key milestones for delivery, and the performance indicators that will provide assurance that the required changes and improvements are taking place.

The Strategic Delivery Plan will be closely aligned with the HSCM Medium Term Finance Strategy (MTFS) and Workforce Plan, as the three main levers through which we will deliver the HSCM Strategic Plan.

5 Strategic Delivery Plan

As previously described, this Strategic Delivery Plan sits within a wide and complex planning and policy environment where the HSCM plays a critical role in working collaboratively with partners to deliver on whole system priorities and work streams, including supporting delivery of the NHS Grampian Plan for the Future and Moray Council Plan. It is therefore not exhaustive of all areas of HSCM activity where we are a key partner, for example: in delivery of the Moray Children's Services Plan to improve the wellbeing of children and young people in line with the GIRFEC (Getting It Right For Every Child) philosophy; in the initiative Discharge Without Delays, to develop improve the integrated model across the whole-system for frail older people accessing hospitals; and in developments around population health initiatives to support prevention and early intervention for all.

The plan below reflects the key actions being driven by HSCM over the next three years. The Strategic Delivery Plan will remain a live document to ensure we can be agile and responsive to new or emerging priorities whilst ensuring a focus on delivery of the HSCM's own strategic priorities.

This Strategic Delivery plan provides high level information about each action, links to strategic objective and strategic themes including a key summary and the priority tasks that will be undertaken. Some of the projects identified will go beyond the duration of this Strategic Delivery Plan due to their nature and complexity.

5.1 STRATEGIC THEME - BUILDING RESILIENCE

Objective 1: We focus on prevention and tackling inequality

				Years				
	Key Heading	**Description**	**Lead**	**1**	**2**	**3**	**Timescale**	**Outcomes**
1	**Early Intervention and Prevention**	We aim to provide support to the citizens aimed at improving outcomes and preventing escalating need or risk						
1.1	LD Health Checks	Annual Health Checks for People 16+ with Learning Disabilities	LD Service Manager	X	X		Apr-26	Evaluation completed and learning shared
1.2	Social Prescribing	To scale up the current test of change and deliver a social prescribing model across all Moray localities	Health Improvement Team Leader	X	X		Apr-26	To improve health and well-being by connecting individuals to community resources and activities that address their social, emotional and practical needs. To reduce unnecessary pressure on clinical healthcare services
2	**Poverty Strategy**	To work with partners to raise awareness and to work to reduce the impact of poverty on people's health and wellbeing in Moray						

2.1	Contribute to development of Moray wide poverty Strategy and Action Plan	Contribute to Fairer Moray Forum in order to develop Moray-wide poverty strategy and action plan.	Localities Manager (West)	X			Sep-25	Moray-wide strategy and action plan in place to tackle poverty, and in progress by March 2025
2.2	Raising awareness of the Impact of Poverty on health	Develop and deliver training to front line staff and decision makers in order to raise awareness & understanding of impact of poverty on health and ability to access health services/comply with treatment	HI Team Leader	X	X		Sep-26	Increased number of frontline staff trained & confident in speaking about poverty/referring on for appropriate support

Objective 2: We nurture and are part of communities that care for each other

	Key Heading	**Description**	**Lead**	**1**	**2**	**3**	**Timescale**	**Outcomes**
3	**Supporting Unpaid Carers**	Continue to work collaboratively with partners to achieve a support network and deliver high level services to ensure unpaid carers are supported to meet their own individual needs and the needs of the person they care for						
3.1	Unpaid Carers delivery plan	Implement the actions outlined in the Unpaid Carers delivery plan	Unpaid Carers Strategy Group		X		Mar-26	Increased awareness of unpaid carers with professionals across health and social care and within the community.

3.2	Produce & plan implementation of the Unpaid Carers Strategy for 2027-2030	**Unpaid Carers Strategy for 2027-2030** Review and update Unpaid Carers Strategy, to determine the effectiveness of a new strategy to determine if an extension and review of the current strategy is more beneficial. Develop implementation plan	Unpaid Carers Strategy Group			X	Mar-27	Published strategy implementation plan actioned
4	**Primary Care Sustainability**	Aiming for sustainable General Practices across Grampian that enables people to stay well in their communities through the prevention and treatment of ill health through the VISION aims and objectives (Hosted Services).						
4.1	Support the delivery of GP VISION aims and objectives for GPs and Primary Care improvement Plan (PCIP) across Moray	The VISION is supported by 10 Key themes, with the agreed initial focus on 5 areas:- Data; Digital; Multi-Disciplinary Team; Models of Contracts; Premises To provide support and guidance to PCIP works-streams and GP practices through transformation and delivery of	Primary Care Development Manager GP Clinical Lead	X			Jul-25 Sept-25	Ensure delivery Moray PCIP within budget through implementation of a Financial plan Workstream service plans for Moray PCIP reviewed and

		the key theme changes To provide support and guidance to GP practice to safeguard sustainability To support the delivery of the 2018 GMS contract and Memorandum of Understanding (MOU) for PCIP To develop and support opportunities for flexibility in the contract					Ongoing Mar-26 Ongoing	updated by Sept 2025 Vision programme progressing towards aims and objectives of 2018 contract and MoU and implementation of the improvement plan
5	**Mental Health Services**	Intact the Moray Good Mental Health for All Strategy (2016-2026) and the underpinning Mental Health Delivery Plan						
5.1	Mental Health - Early intervention, prevention and self-management	Move towards a preventative, population health model which promotes and sustains good mental health and wellbeing.	Mental Health Services Manager / Health Improvement Team Leaders / Mental Health Strategic Lead	X	X		Mar-26	- developed social connections, tackled isolation, - increased individuals resilience, - strengthened use of community assets.
5.2	To deliver services in line with the Mental	A focus on **Mental Health Standard 1: Access**	Mental Health Services Manager /Child	X	X		Oct-26	- improved responses to people in distress - creation of a shared

	health Quality Standards; 1: Access 2: Assessment 3: Transitions 4: Workforce 5: Governance & Accountability	Develop mechanisms so People in Moray have equitable and non-discriminatory access to effective and relevant support for their mental health, within appropriate timescales.	Health Commissioner / Mental Health Strategic Lead					understanding of mental health pathways in Moray - increased staff recruitment and retention
6	**Collaboration & Partnership Working** to enable people to manage their own physical, social and mental well-being	Our communities and third sector partners provide a vital and valuable contribution to the levels of prevention, support and resilience that can be provided in and across Moray. This is an area we need to grow, encourage and nurture in order to meet increasing demand for low level needs appropriately.						increase number of people being supported by third sector and community partners
6.1	Build the infrastructure and capacity in the community to support people to self-manage	Invite third sectors representation in design of services and contracts, where there is an opportunity for working differently.	All Service managers / Commissioning	X			Mar-26	Third Sector representation in all appropriate service redesign or contract reviews

6.2	Increase resilience, sustainability and growth of our own groups and third and community led groups across Moray	Work alongside our own groups, and other community and third sector groups as capacity allows, to provide support and equip them with the tools to enable independence and sustainability of groups. Continue to grow and strengthen collaborative and partnership working opportunities.	Community Wellbeing Development Team	X	X		Jun-26	Increased number of resilient community led groups and partnerships supporting mental and physical wellbeing, prevention and enablement in Moray
7	**Children Service plan 2023-2026**	Plan aims to embed Corporate Parenting and implement the foundations of The Promise for Children, Young People and families of Moray)						
7.1	Delivery of the 6 improvement priorities	- Improving Outcomes for looked after and care experienced young people - Tackling child poverty - Supporting children and families who experience challenges due to disability/neurodiversity - Keeping children safe - Improving emotional and mental wellbeing - Strengthening family support	Head of Service / CSWO	X	X			delivery of the actions improvements in Key performance measures identified

8	**Provision of a Sustainable Locality Model**	Rooted in the principles of proximity, accessibility, and community engagement, the locality model seeks to enhance the responsiveness, effectiveness, and relevance. of health and social care provision by decentralising services and fostering strong partnerships at the neighbourhood level.	Locality Managers				Sept-25 Sept-26 Jun-26	Locality Plan in place Multi-Disciplinary Teams embedded in all localities Communities involved in monitoring effectiveness of local service delivery

5.2 STRATEGIC THEME - HOME FIRST

Objective 3: We work together to give you the right care in the right place at the right time

	Key Heading	Description	Lead	1	2	3	Timescale	Outcomes
9	**Discharge Without Delay (DWD)**	Discharge without Delay (DWD) is a whole-system programme for frail older people currently accessing Scottish hospitals, pulling best practice, individual services and pathways into an integrated model that strives to deliver Comprehensive Geriatric Assessment (CGA) in the timeliest manner, while ensuring no negative impact from hospital induced harm or dependency to the person.						1. Reduce acute geriatric length of stay (LOS) by >20% by December 2026 2. Reduce community hospital/ step-down LOS to 20% by December 2026 3. Reduce total respective HSCP delayed discharges by >20% by December 2026 4. Less 25% of delayed discharges are in acute hospitals by December 2025 5. Aim acute hospital geriatric service and community hospital occupancy to 90% by December 2026
9.1	Discharge to Assess (D2A) & Home First	To discharge people home in a timely manner to minimise hospital induced dependency. With services providing a responsive community home care support to enable discharge without delay.	Head of Service	X			Dec-25	Reduction in delayed discharges
9.2	Community	Facilities should be staffed and	Professional lead	X	X		Dec-26	"To be" status designed and

	Hospital and Step Down Rehabilitation Units	empowered to take frail people required rehabilitation and more prolonged periods of assessment, ideally from frailty units and discharge back to communities via agreed PDD process, both without delay.	OT / Team Manager (Independent Living)					action plan developed and approved Changes identified in plan are implemented Reduction in length of stay Avoidance of unnecessary admissions :- Reduction in unnecessary admissions from Emergency Department, AMAU and CDU Number (& %) of people re-abled through the D2A/START process within 12 week target
9.3	Frailty at Front Door	Acute hospitals should deliver early comprehensive geriatric assessment (CGA) in specialist acute frailty units from point of acute admission.	Head of Service	X			Mar-26	Pathways completed and communicated increase assessments for support (inc care) undertaken in the home
9.4	Planned Date of Discharge (PDD) process and Integrated Discharge Teams	Acute hospitals should aspire to single point of referral for complex discharges with the process of discharge planning via MDT proactive advanced discharge date setting.	Lead Nurse	X	X		Dec-26	Increase in % (and number) of compliant PDD

10	**Promotion of Self Directed Support (SDS) Options**	Increase the promotion and use of SDS Options (from baseline) to meet individual needs. Increasing choice and control of individual needs and how their support and care needs are delivered.						Quarterly Audits of use of SDS options (establish baseline)
10.1	Develop SDS Framework for options 1, 2 & 3 providers	Develop SDS framework for option 1, 2 & 3 providers. Collaborate with In-Control Scotland and CCPS to ensure the model is sustainable and has longevity taking into consideration national developments	SDS Officer / Procurement Officer MC, Provider Services Manager	X			Dec-25	Framework for providers established for SDS options to promote choice and control driven by individual preference opposed to market availability. Social work processes and assessment align with the principles of SDS
10.2	Self-evaluation against national SDS framework of standards to inform future requirements to improve performance and delivery	Benchmark local practise against the national SDS Framework of Standards (rev. May 2024) through self-evaluation against the core components and practice statements.	SDS Steering Group	X			Aug-25	Utilising the self-evaluation, identified areas of improvement are identified and a robust implementation can be developed to improve practise and peoples lived experience of accessing SDS. Internal process will align with the national vision for SDS. Social work process and assessment and Commissioning activity aligns with the principles of SDS.

10.3	Continue promotion of independent support and advise for SDS options	Continue to promote the use of Moray's Support in the Right Direction (SiRD) funded projects to promote independent support and advice relating to the options of SDS (Cornerstone) and independent SDS Advocacy (Circles)	SDS Steering Group	X	X	X	Mar-28	Individuals have access to independent support and advice enabling them to make informed decisions around the four options of SDS. Individuals have access to independent SDS Advocacy to support with accessing SDS.

OBJECTIVE 4: We help build communities where people are safe

	Key Heading	**Description**	**Lead**	**1**	**2**	**3**	**Timescale**	**Outcomes**
11	**Managing frailty in the community**	To create the conditions for a whole system frailty pathway within Moray encompassing community approaches to promoting aging well, and early identification.						Reduction in presentation / readmission rate of frail patients
11.1	Identification and assessment of frailty within primary care over 65s	The early identification and assessment of frailty in primary care, to support proactive case management in order to prevent deterioration and hospital attendance	GP Strategic Lead / Moray Frailty Lead	X	X	X	Jun-27	- Active engagement with the public, health and social care staff and third sector / community groups to promote healthy ageing - a proactive integrated planning and management approach in place to ensure best outcomes for the Individual

								- maximise the potential for digital innovation; from a prevention and early intervention approach, through to condition monitoring and self-management
12	**Protecting People in Moray**	In the community, we are committed to keeping people safe, through our Public Protection agenda, the services supported by the Alcohol and Drug Partnership (ADP), our Justice Services and contributing to the community safety agenda, including the Violence Against Women Partnership. We will take a trauma-informed approach across these services.						
12.1	**Preventing Suicide and Self Harm** Deliver the Moray Suicide Prevention Action Plan 2025-28 (in draft pending approval)	Working in partnership so that People: •in distress experience timely, compassionate and trauma informed responses. •who have self-harmed receive effective treatment and aftercare •are prevented from future suicide attempts and/or self-harm.	HSCM Mental Health Strategic Group Moray Suicide Prevention Group	X	X	X	2028	(SP1) More people in our communities have a clear understanding of suicide, risk factors and its prevention (SP2) People experiencing suicidal crisis are kept safe and their situations do not further escalate (SP3) More people are supported through Distress Brief Interventions

12.2	**Reducing drug and alcohol related harm** Deliver the Moray Alcohol & Drug Partnership Strategic Delivery Plan 2025-28 (in draft pending approval)	Working in partnership so that People: • who take harmful drugs are offered evidence-based harm reduction and advice • can access the services they need to support their recovery. remain in treatment for as long as they need to.	Moray Integrated Drug and Alcohol Service (MIDAS) Moray Alcohol & Drug Partnership	X	X	X	2028	(ADP1) More people receive overdose awareness advice and provision of take-home naloxone (ADP2) People wait no more than three weeks for specialist drug and alcohol treatment (ADP3) More people have access to Residential Rehabilitation placements (ADP4) Fewer people disengage from specialist drug and alcohol treatment
12.3	**Protecting Children and Young People** Deliver the Moray Children's Services Plan 2023-26 (Priority -Keeping Children & Young People Safe)	Working in partnership so that children and young people: •are safer because risks have been identified early and responded to effectively. •lives improve with high quality planning and support experience sustained loving and nurturing relationships to keep them safe from further harm.	Moray Children & Families Social Work and Community Child Health Services Moray Child Protection Committee	X	X	X	2026	(CPC1) More children and young people are supported to develop healthy relationships with peers, online and in the community (CPC2) More children and young people are protected from harm because of improved home circumstances (CPC3) Children who have experienced or witnessed abuse are supported through recovery and do not experience further trauma.
12.4	**Protecting**	Working in partnership so that	Moray Adult	X	X	X	2026	(ASP1) More Adults are

	Adults at risk of harm Deliver the Moray Adult Support and Protection Self Evaluation Improvement Action Plan 2024-2026	Adults at risk of harm: •are safer because risks have been identified early and responded to effectively. •lives improve with high quality planning and support	Social Care Services Moray Adult Protection Committee					protected from harm due to a reduction of risk (ASP2) Adults at risk of harm report feeling safer because of their adult support and protection plan (ASP3) Adults at risk of harm experience improvement to their health, wellbeing and overall quality of life
12.5	**Reduce reoffending** Deliver the Moray Community Justice Outcome Improvement Plan 2024-27	Working in partnership so that: • People can access the services they need to support desistance • People have access to suitable accommodation following release from a prison sentence People in police custody receive support to address their needs	Moray Justice Social Work Service Moray Community Justice Partnership	X	X	X	2027	(CJP1) More people successfully complete their community payback or drug testing and treatment orders (CJP2) Less homelessness applications are made by people released from prison (CJP3) More people are referred onto support services by custody centres
12.6	**Eradicating Violence against Women & Girls** Deliver the Moray Violence against Women and Girls Partnership	Working in partnership so that: • People in Moray are equally safe and respected • Survivors of VAWG have access to trauma-informed recovery, support and justice. • Children affected by domestic abuse are supported to stay	Moray Children & Families and Justice Social Work Community Child Health Services	X	X	X	2028	(VAWG 1) More people in our communities understand the causes and consequences of VAWG (VAWG 2) Women and children report feeling safer as a result of the specialist support they have received.

	Delivery Plan 2025-28 (In draft/pending approval)	safe and remain in the care of their non-offending parent Perpetrators are held to account and supported to change their behaviour	Moray Violence against Women & Girls Partnership					(VAWG 3) Fewer children and young people are placed in care due to domestic abuse (VAWG 4) More people successfully complete specialist perpetrator interventions

5.3 STRATEGIC THEME - PARTNERS IN CARE

Objective 5: We are an ambitious and effective partnership

Objective 6: We are transparent and listen to you

Ref	Key Heading	Description	Lead	1	2	3	Timescale	Outcomes
13	**Redesigning Models of Care**							
13.1	Community Hospital Redesign	Review and redesign model for community hospitals using research undertaken in Moray and learning from other areas. Engaging with stakeholders to consider options and ultimately establish the model for Moray	Head of Service	X	X	X	Dec-27	Model for community hospitals in Moray agreed
13.2	GMED - redesign	Through the redesign, the service will find the balance between financial pressure, clinical governance and patient safety, staff governance with a focus on prevention	Service Manager - GMED	X			Dec-26	Model of service delivery agreed and implemented
13.3	Care at Home - Strategic Review and redesign of care at home	Strategic review and redesign of the care at home service to create options and capacity within a sustainable model	Service Manager - Provider Services	X			Nov-25	Increased capacity for provision of care at home at a financially sustainable cost.

	service	that will meet future needs						
13.4	Review and Redesign of Adults Day Care services	A full redesign and modernisation of Adult day services where individuals are able to access sustainable day support, which is person centred and meets their agreed outcomes and aspiration. Where appropriate day service will be provided within their own local communities, and where this is not possible the review of the transportation policy will provide clarity of what support will be available.	Service Manager - Provider Services	X			Mar-26	Redesign model agreed and implemented Transportation policy revised and adopted
14	**Suitable Housing - Strategic oversight of accommodation requirements**	In collaboration with partners in developing the Local Housing Strategy (SHIP), work with people and their families in establishing tenancies in appropriate accommodation to prevent inappropriate long-term placement and breakdown of care.						
14.1	Learning Disability long term sustainable accommodation	In collaboration with partners supporting people with learning disabilities and their families in establishing tenancies in new supported accommodation.	Service Manager Learning Disabilities / Localities Manager Elgin	X	X	X	ongoing	Reduction in the out of area placements and associated costs Increase in the number of people with learning disabilities establishing

		Continuation of LD Housing Projects in collaboration with partners to develop sustainable accommodation provision within Moray						tenancies
14.2	Older People - provision of sustainable supported accommodation	Local Housing Strategy Priority 3 Partnership working maximises housing role in improving health and wellbeing Define model for mixed groups for extra care	Local Housing Strategy Steering Group	X			Aug-25	Requirement defined for incorporating into the Local Housing Strategy
14.3	Mental health - provision of sustainable, appropriate supported accommodation	Assessment of need within Moray and development of plan to address need	Local Housing Strategy Steering Group	X	X		Sep-26	Plan for provision of supported accommodation
15	**GIRFE**	Getting it Right For Everyone (GIRFE) will take a multi-agency approach to health and social care support and services from young adulthood to end of life.						

15.1	To embed the GIRFE toolkit and principles into the planning and delivery of services.	The promotion of GIRFE to key Moray stakeholder groups	GIRFE lead officer	X	X		Mar-26	GIRFE principles embedded in service delivery
16	**Support for long term conditions**	Support people with long term conditions to stay well and independent for as long as possible through a variety of tools and models.						
16.1	Heart of Moray - Making it easier to improve our health and wellbeing. - Diabetes	Using research from DHI and working with partners to develop new range of services to help people improve their diet and lifestyle. Initial focus to work with people aged 40 and under who have type 2 diabetes - **Moray Heart,** with future focus around Respiratory and Heart Failure services	Lead Dietician	X	X		Sep-26	Improvement in health of participants in the programme Increased number of participants accessing the services
16.2	Initial review of palliative models of care for cancer services in line with the National Palliative Care Framework	**Cancer Journey-** Initial review of palliative cancer services in Moray, including engagement with stakeholders, to develop a model for Moray	Chief Nurse	X			Dec-25	Sustainable model of care in place Support available to those who need it

16.3	Establishment of a Moray Dementia Strategy & Moray Dementia Pathway in line with Grampian and National dementia delivery plans.	**Dementia-** Establishment of a Moray Dementia Strategy and Moray Dementia Pathway in line with Grampian and National dementia delivery plans.	Mental Health Services Manager	X			Sep-25	Moray Dementia pathway in place
16.4	Embed promotion of technology enabled care (TEC) options within assessment process to increase use and impact of TEC, supporting self-management (i.e. to support management of longer-term conditions)	**Technology Enabled Care** Embed promotion of technology enabled care (TEC) options within assessment process to increase use and impact of TEC, supporting self-management (i.e. to support management of longer-term conditions)	Digital Lead	X	X	X	Mar-28	Increase in use of TEC to support people to live independently
17	**Moray Growth Deal - Researching sustainable services**	Working with DHI as part of the Moray Growth Deal to design the sustainable services for the future that enable people to live as independently as possible for as long as possible. (including Community Connections, Personal Data Store, Smart Housing)						Increase ratio of those supported to live at home, independently, with technology enabled care rather than in person care Manage the impact of demographic growth on care

								at home provision via hybrid approaches to care, such as social prescribing, as opposed to in person care
17.1	Partnership working to support the research and development initiatives led by DHI	To support the research and development of the 5 Living Lab research and design projects:- 1. LL1 Supported Self Management 2. LL2 Long Term Condition Management 3. LL3 Care in Place 4. LL4 Smart Housing / Smart Communities 5. LL5 Mental Wellbeing	DHI / Digital Health Lead	X			Mar-26	Reduced dependency on HSCM Services through: - Increased access to community spaces. - Development of a community occupational health pathway - Development of a Personal Data Store and the Community Connections Moray digital platform - Increased access to SMART housing and remote monitoring within the community

5.4 STRATEGIC LEADERSHIP, PLANNING AND PERFORMANCE

ENABLERS	E1	Digital Health and Care	To improve the care and wellbeing of people in Moray by making best use of digital technologies in the design and delivery of services Ensuring we utilise modern technologies, systems and tools that assist and empower our workforce to deliver high quality services	Digital Health Project Board	X	X	X		Localisation of the National Digital Health and Care Strategy 2021.
	E1.1	Develop Strategy for Technology Enabled Care (TEC)	Implementation of the Analogue to Digital plan for community alarms Developing and implementing a strategic approach and framework for TEC support, based on evidence, to provide sustainable options through collaboration with DHI	Project Board A2D / DHI / Team manager (OT)	X	X		Dec-25 Mar-26	First phase of transfer completed by December 2025 Model of support is in place and shared widely

E1.2	New Social Work and Social Care Information Management System (SWIMS)	Procure and Implement a new Information Management system for Social Work and Social Care with the scope to develop and integrated information management system across wider services providing support to individuals and families	Head of Service /CSWO	X	X		Mar-27	Procurement completed and tender awarded. System implemented services migrated and operational
E1.3	Incorporating new technologies	Work in collaboration with partners to explore the opportunities of Artificial intelligence for performance of routine tasks to achieve efficiencies	Digital lead	X	X	X	Ongoing	Implementation of use of artificial intelligence in various functions to release capacity for other tasks.
E2	**Strategic Commissioning**	In collaboration with stakeholders, develop a Strategic Commissioning Strategy and Market position statement that underpins the MIJB Strategic Plan	SMT / Strategic Planning and Commissioning Group	X	X	X	Mar-27	Strategic Framework and governance approved and implemented
E3	**Communications**	Develop and embed a strategy to inform and engage with all stakeholders and to include management of expectations	Corporate Manager / SMT	X			Sep-25	Communications Strategy approved

E4	**Workforce**	Ensuring we have a Workforce that is agile and motivated to meet the challenges presented and that is sustainable and safe with a focus on staff wellbeing. Our volunteers provide a vital and valuable contribution to the levels of support that can be provided to our communities. This is an area we need to grow in order to meet needs appropriately.	SMT	X	X	X	Dec-25 Apr-26 Apr-27 Apr-28 Apr-28	Annual Report (via NHSG) Workforce plan implemented Increase in Volunteer numbers and roles Improved retention rates Succession Planning embedded
E5	**Infrastructure**	Working with partners, review of occupancy and use of premises to seek opportunities for rationalisation or collaboration with partners, to secure sustainable and efficient use of buildings and premises and establish the Infrastructure plan for HSCM Moray		X	X	X	Apr-27 Dec-27	Accommodation assessed as suitable for service delivery Infrastructure plan developed and adopted
E6	**Performance and Quality Assurance & Improvement Frameworks**	Develop framework to further support informed decision making	Deputy Head of Service / Corporate Programme manager	X	X		Dec-26	Performance framework updated and implemented Quality Assurance Framework embedded

E7	**Embed Robust Governance systems**	With partners develop good governance protocols based on up to date policies that support delivery of efficient, effective and quality services. Streamlining the decision making structure to enable the organisation to be agile in responding to emerging pressures, whilst also ensuring learning from Audits and inspections are actioned and embedded Implementation of learning from audits and inspections	SMT	X X	X	X	Ongoing Dec-25 Ongoing	Policy and protocol are updated and implemented Review to streamline meeting structures and confirm appropriate delegation completed and implemented. Positive inspection and audit reports received
E8	**Finance**	Develop and monitor the Financial Recovery Plan that will enable the delivery of the Strategic Plan objectives whilst maintaining Financial Sustainability.	Chief Finance Officer	X	X	X	ongoing	Budget savings plan approved and delivered Medium term financial plan approved by MIJB