Annual Performance Report 2024/25

Moray Integration Joint Board

Contents

1. Foreword

On behalf of the Moray Integration Joint Board, we are pleased to present our Annual Performance Report for the financial year 2024/25.

This year has been one of continued determination, transformation, and collaboration. As we navigated the complexities of a changing financial landscape and increasing demand for services, our commitment to delivering person-centred, high-quality care has remained steadfast.

Throughout 2024/25, we have taken significant steps toward long-term sustainability by developing and beginning to implement our financial savings plan. These efforts have required careful prioritisation and a willingness to make difficult decisions, always guided by the principle of protecting and supporting the most vulnerable members of our communities.

The report that follows offers an honest and comprehensive reflection of our performance against key national indicators, alongside real-world examples that highlight how we are adapting our services to meet the evolving needs of the people of Moray.

Our focus has remained on improving outcomes, promoting independence, and ensuring that people can access the right support at the right time.

None of this would be possible without the dedication of our health and social care workforce. Their professionalism, compassion, and adaptability have once again proven to be the foundation of our progress. We are equally grateful to our partners across the third and independent sectors, whose collaborative spirit and innovative approaches continue to strengthen our shared response to complex challenges.

We extend our heartfelt thanks to our unpaid carers and volunteers. Their vital contributions underpin the resilience of our communities, and we recognise the invaluable role they play in supporting health and wellbeing across Moray.

As ever, we remain mindful that there is more work to do. The coming year will bring further change and challenge, and we must continue to improve where we fall short, listen to and learn from feedback, and work closely with individuals, families, communities, and partners to co-design better, more sustainable services.

This report reflects not just the achievements of the past year, but also the values that guide us — integrity, collaboration, and a deep sense of responsibility to the people we serve.

We invite you to read this report and learn more about our journey. Together, we will continue to strive toward our vision of a Moray where everyone can start well, live well, and age well.

Councillor Elaine Kirby
Chair
Moray Integration Joint Board

Dennis Robertson
Vice Chair
Moray Integration Joint Board

2. Introduction

All Integration Joint Boards (IJBs) in Scotland are required to publish annual performance reports to inform the public of progress in delivering their strategic intent and against the National Outcome Indicators.

This is the ninth annual report of the Moray Integration Joint Board (MIJB) which is a Statutory Public Body under the Public Bodies (Joint Working)(Scotland) Act 2014.

The MIJB has a broad range of health and social care services delegated to it by NHS Grampian and Moray Council and has responsibility to undertake the strategic planning and commissioning of those services for the benefit of the population of Moray. Operationally, these services are then delivered by Health and Social Care Moray (HSCM) which is the partnership entity which brings together and delivers care across the region.

This report is the MIJB's assessment of performance in carrying out its delegated functions. This has been scrutinised against national performance (Appendix B) and Ministerial Strategic Group indicators identified by the Scottish Government to measure progress in delivering the National Health and Wellbeing Outcomes (Appendix G) and local key performance indicators (Appendix C).

It also describes the progress of services managed and delivered by Health & Social Care Moray in delivering on the vision and commitments set out in the MIJB's Strategic Plan, **Partners in Care 2022-32**, which was approved in November 2022 and the delivery plan which was approved in October 2023.

Also included in this report is an assessment of the board's financial performance.

3. Board and Partnership overview

Our board

The Public Bodies (Joint Working) (Scotland) Act 2014 established a legal framework for the integration of health and social care services in Scotland.

The purpose of integrating health and social care is to improve the experience of people who use these services, and to make it easier for them to get the care and support they need. This should be at the right time and in the right setting at any point in their care journey, with a focus on community-based and preventative care.

Since it was established in April 2016, the Moray Integration Joint Board (MIJB) has been responsible for a range of functions delegated to it by Moray Council and NHS Grampian. These are set out in the **Scheme of Integration**.

There are eight voting members on the MIJB – four appointed by Moray Council and four appointed by NHS Grampian. They are supported by non-voting members made up of leading officers from the council and NHS, and representatives of the third sector, people who receive services and unpaid carers.

The MIJB's role is to set the strategic direction for community health and social care services and to deliver the priorities set out in its Strategic Plan through the local partnership of Health & Social Care Moray (HSCM).

The board receives payments from Moray Council and NHS Grampian to enable delivery of local priorities for health and social care. It gives directions to the local authority and health board as to how they must carry out their business to secure delivery of the strategic plan.

Our partnership

Services are commissioned and delivered through the partnership of HSCM which brings together staff employed by the local authority and by the NHS.

The partnership is led by the Chief Officer supported by a Senior Management Team and Operational Management Team. The Chief Officer reports to the Chief Officers of Moray Council and NHS Grampian.

In addition to directly providing services, the partnership also contracts for health and social care services from a range of partner organisations in the Third and Independent sectors.

Within primary care services, a range of independent contractors including GPs, dentists, optometrists, and pharmacists, are also contracted by the Health Board under national frameworks.

Services delegated to the MIJB and which are managed on its behalf by HSCM include:

- Social work and social care (older people's services, mental health services, learning disability services, physical and sensory disability services)
- Primary care services including GPs and community nursing
- Allied health professions including occupational therapy and physiotherapy
- Community hospitals
- Health improvement
- Community dental, ophthalmic and pharmaceutical services
- Aspects of acute services (hospitals) relating to unscheduled care
- Support for unpaid carers.

Children and families health services hosted within the MIJB's Scheme of Integration include:

- Health visiting
- School nursing
- Allied health professions.

Grampian-wide services hosted by Moray on behalf of all three health and social care partnerships are:

- Primary care contractors
- The GMED out of hours primary care service.

In 2022, Moray Council, NHS Grampian Board and the MIJB agreed to progress with delegation of Children & Families and Justice Services to the MIJB. The Moray Integration Scheme was revised to reflect these changes and was approved by Scottish Ministers on 16 March 2023.

4. Our Strategic Plan – Vision and Priorities

A key statutory duty of the Moray Integration Joint Board (MIJB) is to develop a Strategic Plan which must be reviewed every three years. A refreshed strategic plan was approved by the Board in November 2022.

The integration of Children & Families and Justice Services into Health & Social Care Moray under the direction of the MIJB is not yet reflected in the board's Strategic Plan. Work is ongoing to ensure appropriate governance and integration of performance reporting across all services in future MIJB Annual Performance Reports.

The Strategic Plan sets the vision and local priorities that will help improve the health and wellbeing of the people of Moray. It outlines how services will be delivered to meet the National Outcomes for Health and Wellbeing, and achieve the core aims of integration.

Our Moray vision

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

The plan has three strategic priorities to be delivered on.

Building Resilience

Supporting people to take greater responsibility for their health and wellbeing by:

- focusing on prevention and tacking inequality;
- nurturing and being an integral part of communities that care for each other.

Home First

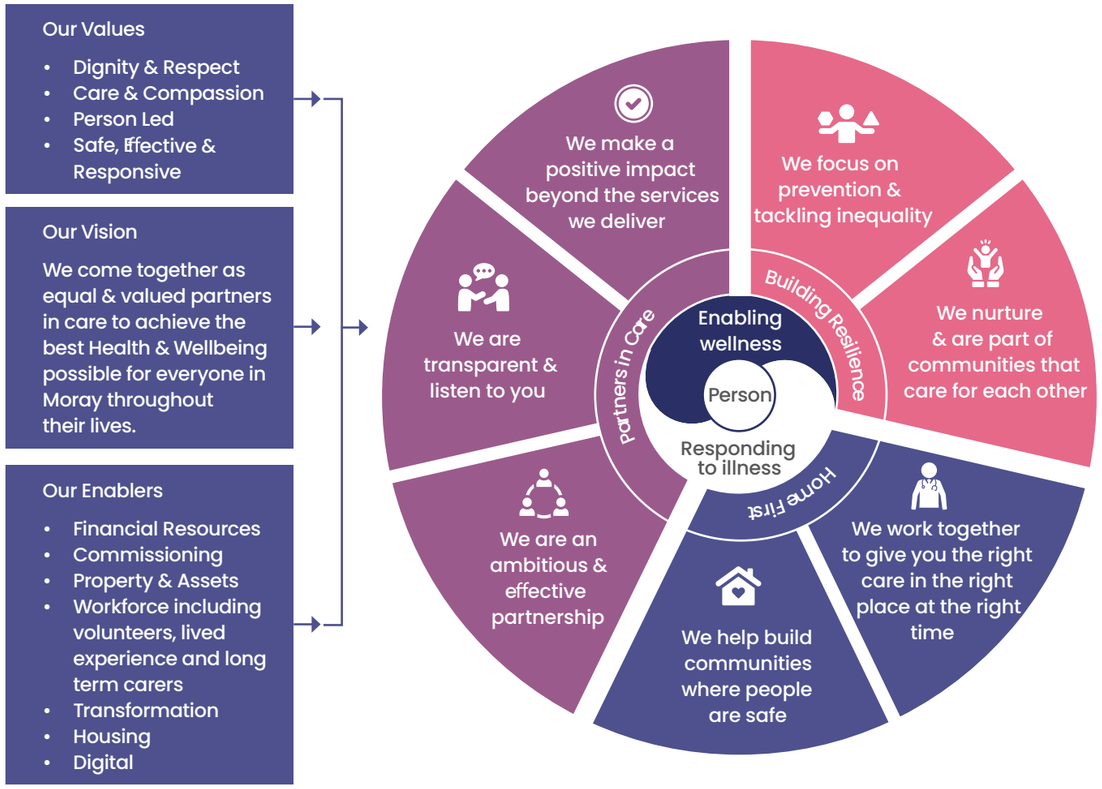
Supporting people at home or in a homely setting as far as possible by:

- working to give citizens of Moray the right care in the right place at the right time;
- building communities where people are safe.

Partners in Care

Supporting people to make choices and take control of their care and support by:

- working in partnership with all;
- listening to what citizens are telling us and being transparent in our decision making and communications;
- ensuring we make a positive impact beyond the services being delivered.



The strategic intentions continue to focus on the triple aim of the national Health and Social Care Delivery Plan which is summarised as:

- **Better Care:** improving the quality of care by targeting investment at improvement and delivering the best, most effective support.

- **Better Health:** improving health and wellbeing through support for healthier lives through early years, reducing health inequalities and focusing on prevention and self-management.

- **Better Value:** increasing value and sustainability of care by making best use of available resources, ensuring efficient and consistent delivery, investing in effectiveness, and focusing on prevention and early intervention.

The Strategic Delivery Plan was updated in May 2025 and sets out the actions that will be taken forward to deliver on the strategic priorities.

Transformation and improvement priorities

A revised Strategic Delivery Plan for 2025 to 2028 was approved by MIJB in May 2025. This plan incorporates the developments required to enhance our ability to meet predicted future demands for services, whilst undertaking reviews of existing models of care to ensure that the services provided are sustainable and fit for purpose. There are also projects to implement more efficient ways of working, to aid in meeting the financial challenge that is impacting on all public sector organisations. A robust governance framework will be essential to ensure that projects can be delivered within available resources and have a clear focus on outcomes.

The work being progressed through the Rural Centre of Excellence led by the Digital Health Institute (DHI) on research and development projects, and local delivery of national programmes such as the Primary Care Improvement Plan (PCIP) and Discharge without Delay (DwD) are key focuses and are incorporated into the delivery plan. DwD will encompass workstreams relating to frailty, delayed discharges, and Getting it Right for Everyone (GIRFE) that are already underway.

Rural Centre of Excellence

Moray is leading the way in the development and testing of digital solutions that could transform how health and social care services are delivered and received nationally and globally.

The Rural Centre of Excellence (RCE) is a £5 million UK Government project, based in Moray and led by the Digital Health & Care Innovation Centre as part of the Moray Growth Deal.

It brings together partners including Health and Social Care Moray and local citizens to find better ways to support people's health, wellbeing and independence —especially in a rural setting like Moray — by creating digital tools and services that are easy to use and accessible to everyone, regardless of income, location or digital skills.

The RCE is focused on solutions to everyday challenges identified by health and social care staff, people who receive services and families. Early developments include:

- **Community Connections Moray:** an easy to use online service directory to help people find local support and information.
- **Personal Data Store (PDS):** a secure way for people to store and share their health story with services, if they choose, so they only need to tell it once.

In 2024/25, five **'Living Lab'** projects have progressed. These are practical, real-world trials where local people, staff, digital specialists and researchers work together to design and test new ideas that improve care and free up resources.

- **Supported Self-Management & Long-Term Conditions Management:** Focused on healthy weight and diabetes, these projects have come together to create the 'Heart of Moray' wellness community—a new approach to healthy living supported by digital tools.
- **Community Occupational Therapy Lab:** Developing online tools to help people find the right equipment and support more quickly, including a self-assessment tool, and options for more efficient digital referrals and assessments.
- **Care in Place:** Testing how the Community Connections and personal data store tools can make life easier for unpaid carers, starting in Forres and Lossiemouth.
- **Smart Housing, Smart Communities Lab:** Exploring how home sensors and digital tech can help people stay safe and well at home, and alert carers or services early if something seems wrong. Testing starts in Buckie in summer 2025.
- **Mental Wellbeing:** Now underway, this project focused on making it easier to find mental health and wellbeing information and support through Community Connections.

Primary Care Improvement Plan

Implementation of the Moray Primary Care Improvement Plan, in response to the 2018 General Practitioner (GP) Contract and accompanying Memorandum of Understanding (MOU), is continuing. A key aspect of the Plan is to provide support to GPs by expanding the Multi-Disciplinary Team.

Key areas of progress through 2024/25 were:

- **Pharmacotherapy – established;** every Moray GP Practice has some access to all 3 levels; Level 1 (core), Level 2 (additional advanced) and Level 3 (additional specialist).
- **Vaccination transformation programme – established;** all eligible vaccinations have moved from GP practices to HSCM. GP practices continue to assess patients' eligibility for certain vaccinations. Travel vaccinations and all travel health advise has now transferred to HSCM.
- **Community Treatment and Care, Primary Care Occupational Therapy (Urgent Care and intervention for prevention), Mental Health & Wellbeing Practitioners and First Contact Physiotherapy Services are all available at each Moray GP practice.** In addition to the Moray Primary Care Improvement Plan, the Grampian GP Strategic Vision programme 2024-2030 brings together the three HSC partnerships and NHS Grampian to address challenges around transforming general practice into the sustainable service, which enables people in their communities to stay well through the prevention and treatment of ill health.

The Vision programme focuses on a 10-point plan including a focus on modern premises, integrated IT systems, data driven decisions and a robust education and workforce development plan. A progress review recently undertaken shows that the 5 prioritised objectives are progressing well (Data; Digital; Multi-Disciplinary Team; Models of contract; Premises). Consideration is now being given to the remaining objectives. An action plan outlining changes to the delivery of the objectives, the steps and resources needed to move forward is being progressed

Discharge Without Delay (DWD)

NHS Grampian and the three Health and Social Care Partnerships (Aberdeen City, Aberdeenshire and Moray) are participating in the Scottish Government programme that aims to reduce hospital length of stay and improve the overall patient journey by facilitating timely and efficient discharge from hospital, through early and effective planning for discharge and promotion of a "Home First" ethos.

The 4 workstreams of this national programme are:

- **Planned date of discharge/integrated discharge hub** – from point of admission to hospital a realistic date and plan for discharge should be set by the multi-disciplinary team to provide a focus
- **Frailty at the front door** – involves early comprehensive geriatric assessment for identified frail older people as early as possible to ensure informed discharge planning.
- **Discharge to assess (D2A)/Homefirst** – provision of responsive community-based home care support that enables patients to return home without unnecessary delays.
- **Community hospital/step down rehabilitation units** – to care for frail individuals who require rehabilitation and extended assessments as part of their discharge process, ensuring no delays.

The benefits will be reduced length of stay in hospital, improved patient experience, improved hospital capacity and provision of appropriate care in a person's preferred setting.

The national DwD programme has completed phase one, which included the completion

of a national self-assessment tool, the creation of actions and the identification of leads to represent Moray locally, regionally and nationally. The Moray leads are now attending local, national and regional meetings and will develop action plans for planned work which will be fed back to all groups.

This is a collaborative approach in Moray and local leads for each of the workstreams will work together with teams from Dr Gray's Hospital and HSCM to achieve the goals set and it will build on the work already undertaken for the Frailty Pathway.

Moray's DWD self-assessment has been submitted and has been added into a single submission to Scottish Government from NHS Grampian and will inform next steps.

Frailty Pathway

The **'Focus on Frailty'** collaborative, facilitated by Health Improvement Scotland took place between May 2023 and Nov 2024. Moray was one of six Health and Social Care Partnerships who participated within the national collaborative.

A combination of national events and webinars took place which led to Moray designing a local frailty plan covering community and primary care through to acute services. A Moray Frailty Strategic Group was put in place to oversee the delivery, monitoring and evaluation of the local plan. The Moray group worked closely with Grampian colleagues and developed a Grampian Frailty Board to align planning across the three health and social care partnerships.

Much of the national collaborative work has now been subsumed into the national Discharge Without Delay work. The Moray and Grampian Frailty groups continue to meet periodically to develop on the good work that took place during the national collaborative.

Areas of progress during 2024/25 include:

- **Making Every Opportunity Count (MEOC) and Rockwood combined document** used in a variety of community settings such as vaccination clinics, health centres and community hubs. Several other teams have now implemented this across Scotland. Promoting a positive approach to aging well.
- **Identification of severe frail patients** in two primary care settings; Culbin Medical Practice and Maryhill Medical Practice.
- **Primary Care Occupational Therapy** – EQ5D & Falls/Frailty programme 69% improvement. Integration of Tai Chi into treatment programmes for patients who are starting to become frail.
- **Polypharmacy reviews** by clinical pharmacist led to reduction in prescribed medications, resulting in reduced risks of falls,
- **A dedicated frailty ward** is now in place at Dr Gray's Hospital; Ward 7.
- **Education and awareness sessions** in Dr Gray's Hospital ward areas and Emergency Department led by front line staff.
- **Physiotherapist now full time permanent** in the Emergency Department – increased assessment of frailty, turn around and admission avoidance.
- **Increased use of data** from Health Intelligence to display at department level.
- **Application of Super 6** to these patients.
- **Document created and shared with the public regarding services available to them in Moray** – very well received and positive feedback gained. This is now also available in the Emergency Department and shared with patients identified as frail regardless of where they sit on the frailty scale.
- The licensing of **an NHS Grampian version of the 'The Broons' frailty comic strip** first developed by NHS Highland.
- The **introduction of a Frailty Icon** has progressed but has not been completed as yet.
- **Bench marking of the Frailty Standard** which were published in November 2024

A quality improvement approach has been taken to this work, with successful tests of change then being scaled up. Early evidence indicates a reduction in people being admitted to hospital, a reduction in the length of time people are in hospital and a reduction in readmissions.

Getting It Right for Everyone (GIRFE)

Health & Social Care Moray became a partner within the national Getting it Right for Everyone (GIRFE) programme in October 2023. GIRFE is a multi-agency approach for health and social care services from young adulthood to end of life care. It builds on the previous Scottish Government policy Getting it Right for Every Child (GIRFEC). 10 partnerships were involved in work to co-design and test the principles which will support the national approach to GIRFE and the development of a toolkit to support staff to roll out and embed the approach. This work concluded in early 2025 and has been recently published.

A Moray GIRFE Strategic Group has been formed and will continue to oversee the embedding of GIRFE within Moray.

Key achievements in 2024/25 include:

- Agreement that all newly commissioned services will require to demonstrate how they will adhere to the GIRFE principles
- Ensuring GIRFE principles are embed in all new and updated polices and strategic plans
- Promotion of GIRFE to health and social care practitioners and members of the public
- Benchmarking of locality practice and performance against the GIRFE principles
- Alignment of GIRFE plans across Grampian

5. Our continuing challenges

Like all our community planning partners, we are ambitious for Moray. Already a great place to live, work, grow and enjoy life in wonderful surroundings, we recognise the importance of continued collaborative working with public sector bodies, third and independent sector organisations, other key groups and agencies, to tackle inequalities across Moray and improve the lives of residents and the services they receive.

Our progress in improving health and wellbeing outcomes continues to be challenged in many areas. Year on year, we have reported on the same issues of an ageing population, inequalities in health, workforce shortages, growing pressures on primary care and acute hospitals, and increasing reliance on unpaid carers.

The cost of living crisis continues to impact on the health and wellbeing of children, families and more vulnerable people.

We are challenged to balance providing statutory services to meet people's assessed needs, offer choice and control in how their support needs are met and to keep them safe in times of crisis, with also supporting them to manage their own health and wellbeing and increase their independence to reduce their reliance on formal support services.

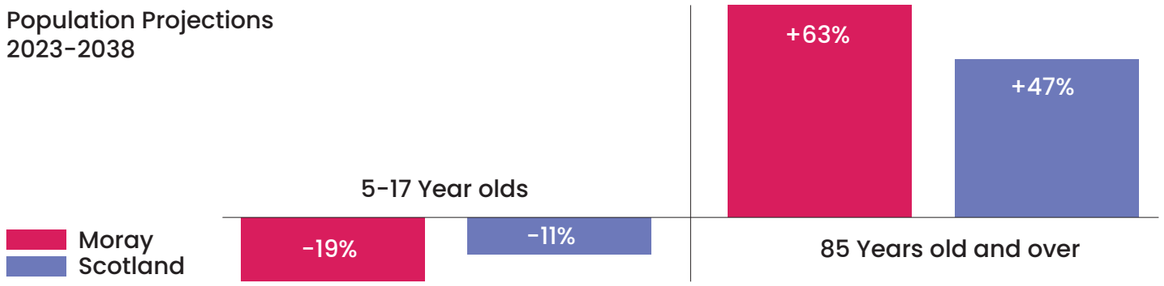
One of our greatest challenges remains our funding position. The MIJB is delegated funding by both NHS Grampian and Moray Council to deliver the services for which it has responsibility. There are increasing pressures on the budgets of both partners, with NHS Grampian under increased level of financial scrutiny. The increasing costs of delivery of health and care (e.g. wage growth, national increases, costs of medicines etc) mean that budgets continue to be under significant pressure. The Financial Delivery Plan was implemented in 2024/25 where actions to achieve savings and reductions in overspends were identified to ensure that the Board can operate within its financial resources. Added to this, we continue to see growing demand for services as the population grows and as more people live with and experience ill health, frailty or other health and social care needs.

The 2024/25 Annual Accounts, subject to audit, show an overspend on the provision of services of £4.26m for the year ending 31 March 2025. Our financial performance is detailed in section 10 of this report.

It is recognised by the MIJB that there will be difficult decisions on how to allocate resources to meet the need to streamline pathways or transform the way supports and services are provided to make them sustainable and fit to meet future challenges.

Our key challenges identified in our Joint Strategic Needs Assessment include:

Population projections.



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.

Across all the over 65 age groups, the percentage growth in both males and females is expected to be higher in Moray than Scotland. There is the potential for increased demand for health and social care services with a limited workforce.

Inequalities

Although life expectancy is comparatively higher than the Scottish average, 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.

Demand

Some services have struggled to manage increase in demand due to a multitude of factors such as the impact of the pandemic on health and wellbeing, staff fatigue, and workforce challenges.

Workforce

We have an aging workforce with a sizable proportion of staff potentially nearing retirement as well as ongoing issues around recruitment and retention.

Mental health

Data from General Practices in Moray shows depression is the second most prevalent long-term condition recorded (4,005 patients) after hypertension. The prevalence of depression risen between 2017/18 and 2022/23. The rate per 1,000 population in Moray has increased from 42.5 to 53.7.

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.

Behavioural risk factors

The three leading groups of causes of ill-health and early death in Moray are cancers, cardiovascular diseases and neurological disorders. These groups of causes account for 50% of the total burden of health loss. The largest differences in burden - compared to Scotland - occur due to substance use disorders, digestive diseases and cancers. A large proportion of cancer and cardiovascular disease is preventable.

Overweight, obesity and poor diet impact on health and wellbeing in a major way, affecting 67% of people in Scotland. Obesity is now the leading cause of death in Scotland and is linked to 23% of all deaths.

Smoking is the single biggest avoidable risk factor for cancer and remains a leading cause of preventable disease and premature death. Alcohol is also recognised as a contributory factor in many other diseases including cancer, stroke and heart disease.

Armed Forces veterans

Veterans and service personnel have higher rates of certain health conditions, giving rise to greater need for services than in the general population. These conditions include mental health problems (e.g. PTSD, suicide, substance misuse); severe and enduring physical health conditions (e.g. multiple, complex injuries; ongoing support through the national trauma network); impaired mobility and musculoskeletal disorders; chronic pain.

The Moray area profile is included at Appendix A.

6. Measuring our performance

Performance management arrangements established within the partnership facilitate overview and scrutiny of performance in relation to delivery of our Strategic Plan and against a range of local and national key performance indicators.

Quarterly performance reports are produced for HSCM management to review performance and to determine actions required to address areas for concern or to highlight areas showing improvement. This information is further scrutinised by the Senior Management Team and then reported to the MIJB's Audit, Performance and Risk Committee on a quarterly basis.

National context

The Scottish Government measures the performance of all health and social care partnerships against a set of high-level statements of what we should be aiming to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.

The National Health and Wellbeing Outcomes provide a strategic framework for the planning and delivery of health and social care services and they focus on the experiences and quality of services for people receiving these services, carers and their families. We have used this framework as the basis for our performance report.

National Indicators

The Core National Indicators (Appendix B) have been developed from national data sources to enable comparisons between Integration Authority areas and with Scotland. Each indicator acts as a measure of progress against at least one outcome.

There are 23 indicators in total with four (10, 21,22 and 23) still to be defined. Indicators 1-9 are taken from the Health and Care Experience (HACE) Survey which is carried out nationally every two years. They were provided in 2023/24 therefore they are not due to be updated until 2025/26, so will remain the same as reported last year.

The National Health and Wellbeing Outcomes

1		**Health & wellbeing** People are able to look after and improve their own health and wellbeing and live in good health for longer.
2		**Living in the community** 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		**Positive experiences** People who use health and social care services have positive experiences of those services, and have their dignity respected.
4		**Quality of life** 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 inequalities** Health and social care services contribute to reducing health inequalities.
6		**Support for carers** 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		**Safe from harm** People using health and social care services are safe from harm.
8		**Workforce** 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		**Use of resources** Resources are used effectively and efficiently in the provision of health and social care.

Our 2024/25 performance report looks at each of the Health & Wellbeing Outcomes alongside National Indicators.

7. Our performance in 2024/25

Moray Core Suite of National Integration Indicators Headline Performance

The National Integration Indicators included in this report are provided in accordance with the instructions from Public Health Scotland (PHS).
"PHS recommend that APRs should report data for indicators 12, 13, 14, 15 and 16 for the calendar year 2024 as a proxy for 2024/25, as data for the full financial year is incomplete and, in some cases may be misleading. However, for earlier years, financial years should be used for reporting as normal." Further information on data completeness can be found at **Public Health Scotland** (https://publichealthscotland.scot/services/data-management/data-management-in-secondary-care-hospital-activity/scottish-morbidity-records-smr/completeness/)

Health & Social Care Moray was in the top 50% for nine of the 19 reported indicators for this reporting period. This was a increase from the previous reporting period where 8 were in the top 50%.

Areas of strength were in relation to lower premature mortality rate, emergency admissions, emergency bed days, readmissions within 28 days and falls. There have been notable improvements in emergency admission rate (NI-12) (per 100,000 population), emergency bed rate (per 100,000 population) (NI-13) and falls rate (NI-16) in comparison to the Scottish rate.

Overall, we performed the same or better than Scotland for 15 of the 19 national indicators, with four performing worse than Scotland. This is an improvement on the previous reporting period however the figures reported for 2024 are calendar year not financial year.

In the 2023/24 report we highlighted areas where there were reductions in performance such as the percentage of adults supported at home who agree that they are supported to live as independently as possible (NI-2) reduced by 7% and the percentage of adults supported at home who agree they had a say in how their help, care or support was provided (NI-3) which reduced by 10%. Although the difference between years cannot be directly compared due to the changes in wording of the survey, and we were in line with Scotland, it was concerning that these indicators seemed to have declined. In addition, the fact that unpaid carers did not feel adequately supported is very concerning.

These indicators are only collated every two years so there is no update this year, however there is a focussed effort to improve choice and control for people in how their support is provided through increasing knowledge of and use of conversations based on the principles of self-direct support (SDS), increasing knowledge of and access to opportunities in the communities and through progression of the plan for development of supports for the unpaid carers, described in the following pages.

The detail of each of the indicators is included in Appendix B.

National Indicators

	Our performance has improved compared to last year.
	Our performance is similar to last year.
	Our performance has got worse compared to last year.

Please note that National Indicators 1-9 are based on the HACE survey which is undertaken every two years. 2024/25 figures remain the same as reported in 2023/24 Annual Performance Report.

Results for 2, 3, 4, 5, 7 and 9 are not comparable to previous years due to changes in survey wording.

		National Indicator	Scotland	Our result	
Outcome indicators	1	Percentage of adults able to look after their health very well or quite well	91%	92%	
	2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	72%	72%	
	3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.	60%	59%	
	4	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	61%	66%	
	5	Percentage of adults receiving any care or support who rate it as excellent or good	70%	69%	
	6	Percentage of people with positive experience of the care provided by their GP practice	68%	69%	
	7	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	70%	69%	
	8	Percentage of carers who feel supported to continue in their caring role	31%	28%	
	9	Percentage of adults supported at home who agree they felt safe	73%	70%	

	Our performance has improved compared to last year.
	Our performance is similar to last year.
	Our performance has got worse compared to last year.

		National Indicator	Scotland	Our result	
Data indicators	11	Premature mortality rate (rate for 2024 not yet available)	442 (for 2023)	384 (for 2023)	
	12	Emergency admission rate	11559	6096	
	13	Emergency bed day rate	113627	63060	
	14	Readmission to hospital within 28 days	103	61	
	15	Proportion of last 6 months of life spent at home or in a community setting	89.2%	93.3%	
	16	Falls rate	22.5	12.2	
	17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	81.9%	73.8%	
	18	Percentage of adults with intensive care needs receiving care at home	64.7%	60.4%	
	19	Number of days people spend in hospital when they are ready to be discharged	952	865	
	20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	Not yet available	Not yet available	

Moray Local Indicators

Performance in on target or within agreed tolerance in five of the 11 indicators. The following is an assessment of performance in the areas not meeting target.

The rate for attendance at the Emergency Department (ED) (Accident and Emergency) is only slightly over target in March 2025.

The number of people waiting to be discharged from hospital at census date (DD-01) fluctuated through the year but ended with a high figure of 40. The number of bed days occupied (DD-02) fluctuated through the year but was 1149 at Quarter 4 which was a reduction in comparison to the same period in the previous year. The contracted partner struggled throughout this year to accept new people for care packages, but through working collaboratively with partner changes to funding arrangements have been implemented recently resulting in recruitment of more staff leading to an increase in hours available for new people requiring care, which will contribute to reducing delays in discharges.

Readmissions to hospital at 7 days of discharge has fluctuated through the year and is just over target. It is anticipated that the continuation of the focussed work around frailty at both the national and Moray levels will provide a reduction in presentation to Hospital, within the frailty age groups.

The percentage of patients starting psychological therapy within 18 weeks is not achieving target. Some people remain in treatment for extended periods due to the complexity of their illness and there are increased people requiring mental health support that means that demand continues to outstrip resource with ongoing uncertainty in relation to primary care funding for psychological therapies delivery. Group sessions are held, where appropriate, and further development should ensure a greater throughput of people and ongoing job planning with professional leads ensures that capacity is maximised across services.

Moray is continuing to progress well with the implementation of the Medication Assisted Treatment Standards (MATS) and early feedback indicates Moray continues to meet the benchmarks set.

NHS employed staff sickness absences have reduced significantly to 4.9%, the lowest figure since April 2023. Council employed staff sickness has increased to 8.2%. The NHS figures is getting closer to the target of 4% but Council figures remain well above target. Common causes of absence remain mental health and musculoskeletal issues, with seasonal spikes in respiratory and gastrointestinal illnesses during winter months.

The detail of each of the Local Indicators is included in Appendix C.

Summary of our performance at a glance – Local Indicators

	Moray is performing better than target.
	Moray is performing worse than target but within agreed tolerance.
	Moray is performing worse than target by more than agreed tolerance.

	National Indicator	2024/25 (Q4)	Target	
Local Indicators	A&E attendance rate per 1000 population all ages	22.0	21.9	
	Number of Delayed Discharges (inc code 9) at census point	40	26	
	Number of bed days occupied by delayed discharges (incl. code 9) at census point	1149	850	
	Rate of emergency occupied bed days for over 65s per 1000 population	2412	2681	
	Emergency admission rate per 1000 population for over 65's	177.8	187	
	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	125.7	131	
	% Emergency readmissions to hospital within 7 days of discharge	3.9%	3.7%	
	% Emergency readmissions to hospital within 28 days of discharge	7.4%	7.9%	
	% of patients commencing Psychological Therapy Treatment within 18 weeks of referral	65%	90%	
	NHS Sickness Absence (%of hours lost)	4.9%	4%	
	Council Sickness Absence (% of calendar days lost)	8.2%	4%	

8. Our progress & achievements in 2024/25

Outcome 1 : Health & wellbeing

Outcome 2 : Living in the community

Outcome 3 : Positive experiences

Outcome 4 : Quality of life

Outcome 5 : Health inequalities

Outcome 6 : Support for carers

Outcome 7 : Safe from harm

Outcome 8 : Workforce

Outcome 9 : Use of resources

Outcome 1 : Health & Wellbeing

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

Indicator	Title	2023	2023/24	2024
NI - 1	Percentage of adults able to look after their health very well or quite well		92.2%	
NI - 11	Premature mortality rate per 100,000 persons	384		
NI - 12	Emergency admission rate (per 100,000 population)		8,338	6096

(Due to the caveats on completeness of national indicator 12, 13, 14, 15 and 16 it is not possible to draw conclusions over trends at this stage. 2023 is the latest available information for NI-11)

Community Appointment Day

The aim of a Community Appointment Day (CAD) is to create the right environment to enable clinicians to support people with their condition on the day and beyond, learn about available local community services, embed personalised care and focus on prevention. With the intention of addressing increasing waiting lists by trialling a new model of care, NHS Grampian delivered their first CAD in Moray for MSK Physiotherapy and Podiatry patients. This was a new way of working, moving away from treatment led health and delivering services differently by strengthening local partnerships, particularly with communities, to enhance both patient and practitioner experience. There were 210 patients on the waiting list who were all invited, 162 opted to attend and 120 actually attended on the day. Patients were linked their own online Personal Health Passport, which they completed as they moved around the zones. Patients received a one-to-one consultation with the appropriate clinician and were encouraged to have meaningful conversations about what matters most to them.

The CAD followed Realistic medicine principles, focusing on personalised and values-based care. The voice of lived experience was heard throughout the planning process by involving the local Versus Arthritis Chronic Pain Group who offered valuable feedback and guidance.

19 community groups and partner services were in attendance to provide information about the support available within the local community. Bringing health and community organisations together under one roof, allowed people's health and wellbeing to be viewed in full totality

Preliminary Feedback was largely positive, indicating that patients felt the day had been 'enlightening', benefited greatly from having services available in one place and found out about what is available in communities.

High level analysis showed that patients particularly valued the focused time given to them, being listened to what matters to them, having access to a one-stop-shop, patient centred care and feeling informed. Included in the patient evaluation was the Collaborate tool; 78% reported that every effort was made to help them understand their health issue, 74% reported that every effort was made to include what mattered to them in choosing what they do next, 79% reported that every effort was made to listen to things that mattered to them most about their health issues. Overall, patients rated the experience 4.5 out of 5.

60% of patients were either recommended a Patient Initiated Reviews within 6 months or fully discharged from the service. Additionally, waiting lists dropped by 124 over a four-month period following CAD implementation, indicating a tangible impact on service demand.

Follow up interviews are ongoing in partnership with Health Intelligence colleagues, and a final evaluation report is expected June 25.

The MSK CAD recently featured as a good practice example in the Scottish Government's **Realistic Medicine Casebook.**

Heart of Moray

The majority of people in Moray are living with excess weight and a problem of this scale needs a whole system approach which focuses on:

- Children, to give them the best start in life - they eat well and have a healthy weight
- The food environment so it supports healthier choices
- Ensure people have access to effective weight management services that meets their needs
- Leaders across all sectors promote healthy weight and diet
- Diet-related health inequalities are reduced

During 2024/25 the Dietetic team worked collaboratively with NHS Grampian, Moray Leisure Centre and the Rural Centre of Excellence/ Digital Health and Care Innovation Centre (DHI) to develop a whole system approach to addressing obesity. HSCM received some Scottish Government funding to enable better detection, early intervention and management of overweight and obesity.

The Heart of Moray launched in February 2025 and will build on pan Grampian weight management work which has significantly increased weight management provision in Moray through a range a interventions which span from Community Connections/Heart of Moray (Heart of Moray – Improving health and wellbeing together), Counterweight Core and exercise at Moray Leisure Centre, digital weight management services with Second Nature and a new NHS Grampian Specialist Weight Management Service. Public health teams will also be involved to deliver the whole systems approach to obesity across all localities in Moray.

Heart of Moray – Improving health and wellbeing together
The Heart of Moray makes it easier to improve our health and wellbeing. It's now at Moray Leisure Centre, a community place with friendly staff, social spaces and ways to be more active, learn about food and lifestyle and be supported for healthy weight management.
heartof.co.uk

Making Every Opportunity Count (MeOC)

Using the making every opportunity count (MeOC) approach to have light touch early intervention and prevention conversations with people on lifestyle and life circumstances is a key focus to help people manage their own health and wellbeing.

This year saw the launch of updated booklet and accompanying digital resource (webpage) for contact information for a variety of support services. Over 185 people have been trained and 812 conversations were recorded during 2024/25, with people accessing the supports they identified that met their needs.

Ageing Well - Supporting older people to maintain their independence

The Realistic Medicine Wellbeing Coordinators adapted existing resources to create a tool with a focus on older people's health concerns. It support individuals to check in on their health and be more aware of available support services.

The MeOC self-check tool links with the Realistic Medicine approach, which supports people using healthcare services to feel empowered to discuss their treatment, test or procedure fully with healthcare professionals. The aim of this discussion is to ensure people are aware that suggested treatment might come with side effects – or even negative outcomes - and also to reduce harm, waste and unwarranted variation.

Community Justice Groups

The Community justice social work team support the Ladies' group RISE (Recovery Inclusion Support & Energy) and the Men's group: SWITCH (Skills Wellbeing Inclusion Thrive Connection Hope) to meet weekly to progress a health & wellbeing programme that compliments the ongoing support provided by the social work team. The programme offers a holistic approach to health and wellbeing, introducing new experiences and instilling confidence, motivation and encouraging access to services. Those who attend these groups are currently under a supervision order and attendance at the groups is voluntary and participation is growing with a steady attendance throughout the year for RISE (with 36-40 attendees), and SWITCH has seen an increase from 15 to 41 attendees. Overall, 18 health and wellbeing sessions have been facilitated through a collaboration of participants, social work team and public health co-ordinator with a range of local third sector partners to help build the programme.

Feedback from participants has been very positive and a particular highlight was a fencing session.

"we all had lots of fun fencing today and making music and photography a great variety where everyone was able to get involved, total escapism". This session was very much enjoyed by all, the coach leading was enthusiastic and motivated all participants to give this a try and others who were unable to physically take part were encouraged to be part of this.

Other general feedback:

"good guys, very engaging, easy to talk to"
"Really useful session, friendly trainer and a relaxed atmosphere let people feel ok to give it a go"
"Very interesting & helpful. Enjoyed it though it felt a bit scary to start with"

Leading healthy, active lives

The Community Wellbeing and Development Team exists to prevent, reduce, and significantly delay the need for long-term and residential care by enabling people to maintain their independence and lead healthy, active lives.

The team supports a range of community health and wellbeing groups across Moray:

- **18 x B.A.L.L. Groups (Be Active Life Long Learning):** These active ageing groups are designed for older people and aim to support mobility, reduce the risk of falls, and combat isolation and loneliness through regular physical activity and social engagement.
- **4 x S.E.T. Groups (Seated Exercise and Tea:** A natural progression for some B.A.L.L. participants, S.E.T. groups offer adapted seated exercises in a welcoming setting, encouraging continued movement and community integration.
- **Health and Wellbeing Groups:** Specialist groups that support and improve physical, emotional, and mental wellbeing. Delivered in partnership with health professionals, these groups offer a follow-on option after rehabilitation sessions, helping individuals build confidence, self-manage their health, and form new community connections.

The team currently supports over 1,300 older people each week through these activities, enabling them to stay active and connected in their communities.

Throughout the year, the team also works with external partners such as Wild Things Environmental Education in Action to deliver inclusive "green space" activities that promote mental health and wellbeing in nature.

In 2024, a key focus was engaging with the wider community to identify local service gaps. One such gap was found in Portknockie, where—after multiple engagement events—a new community-led social group, "Knockin-on Abit," was established. Run by the community, for the community, the group is helping reduce isolation and bring people together in a rural location.

Through the team's Information and Activities Booklet, people are supported to access relevant local resources that promote wellbeing and independence. Over the past year, the Community Wellbeing and Development Team supported more than 2,500 older people to stay connected and active in their communities.

Social prescribing

Whilst social prescribing continues to be delivered in Forres and Lossiemouth locality the good progress in 2023/24 was impacted in 2024/25 by the Community Connector services experiencing reducing staffing capacity which impacted the number of referrals accepted and the data returned. The Listening Service also ceased in April 2024 but restarted in Forres in March 2025.

The impact of the staff reduction meant that there was a decrease of referrals of 210 (73% from previous year) from Forres and a decrease of 334 (57%) from Moray Coast. The majority of referrals were for smoking and weigh management, followed by benefits advice, carer's information, physical activity, mental health, Clan and local support services.

The aim is to scale up and implement social prescribing across other GP practices in Moray and to explore digital possibilities to facilitate earlier intervention and prevention, whilst acknowledging limited resources.

Outcome 2 : Living in the community

People, including those with disabilities, 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.

Indicator	Title	2023/24	2024
NI - 2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	71.9%	
NI - 3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	59.5%	
NI - 5	Percentage of adults receiving any care or support who rate it as excellent or good	68.7%	
NI - 12	Emergency admission rate (per 100,000 population)	8,338	6,096
NI - 15	Proportion of last 6 months of life spent at home or in a community setting	91.1%	93.3%

(Due to the caveats on completeness of national indicator 12, 13, 14, 15 and 16 it is not possible to draw conclusions over trends at this stage. 2023 is the latest available information for NI-11)

Care at Home Service

Care at Home is one of the key services which enables people to live independently in their own home for longer.

As at March 2025, the planned weekly hours of care being delivered by the internal Moray Council service and Care Quality Service, our external partner, were 4,672.

	Number of planned weekly hours (March 2024)	Number of planned weekly hours (March 2025)	Change in hours	%
Internal Care at Home	3,692	4008	+316	+8.56%
Partner provider	660	664	+4	+0.61%
TOTAL	4,352	4,672	+244	+7.35%

A weekly care at home hub meeting is in place to manage performance and ongoing challenges faced for each locality, to keep track of care provision. Understanding risks faced by those using services and providers assists with development of strategies for improvement across the service. Performance information from these meetings is submitted weekly to the Collaborative Care Home Support Team Meeting which oversees provision of care at home and care homes by internal and external services.

A Strategic review of the approach for Care at Home service was undertaken and the MIJB decided in March 2025 to develop a flexible framework approach intended to grow availability of care provision.

Self-Directed Support

The Self-Directed Support (SDS) team within HSCM continue to demonstrate a strong and continued commitment to the principles of Self-Directed Support, ensuring that people in Moray are empowered to live the lives they choose through collaboration, innovation, and person-centred approaches.

A key milestone has been the establishment of the SDS Standards Steering Group, created to support the consistent embedding of the National SDS Framework of Standards across local practice relating to children and young people, adults and unpaid carers. This group brings together key stakeholders to ensure that the principles of SDS are reflected in every aspect of support planning and delivery as we progress.

There has been a notable increase in the uptake of SDS Option 1 (Direct Payments) enabling families to have more flexibility in managing their own support. This has been achieved through effective recruitment of Personal Assistants (PAs) supported by the SDS team, expanding the local workforce and providing individuals with greater flexibility and control when choosing who supports them for personal care, social support and support for unpaid carers to get a break from their caring role. Currently there are approximately 450 PAs in Moray (increased from 415 last year), supporting 284 people (compared to 301 individuals last year). There was a vacancy for a Social Worker for Unpaid Carers for most of the year which had an impact on the number of people that could be supported to receive SDS as a Carer.

The SDS Enablers ensure the SDS approaches are being used to support individuals in achieving their personal outcomes through low-cost or no-cost interventions wherever possible. This

strength and asset, community based, resource-conscious approach has helped individuals access support that is both meaningful and sustainable.

Ongoing efforts to develop a local framework of supports are progressing well. This framework aims to ensure that everyone eligible for SDS has access to a wide range of flexible, locally available options, strengthening true choice and control in line with SDS legislation. The Framework of Support will give transparency relating to cost and service availability across Moray for those individuals who require support funded through the four options of SDS.

Communities and volunteer teams

In 2024/25, 107 Health and Social Care Moray volunteers, coordinated by the Communities and Volunteering Team, gave over 9,000 hours of their time to support people across Moray. The service is open to adults aged 18 and over, with the majority of referrals relating to older people at risk of isolation and loneliness, delayed discharge, or loss of independence.

As demand continues to exceed capacity, the team has been reshaping volunteer roles to deliver more responsive, place-based support that promotes **early intervention, prevention, and self-management**. This includes two key pilot projects: the Welcome Home Service, offering short-term support following hospital discharge, and Community Responder Teams, who provide practical help for people with no local support. These responders play a key role in supporting the Home First approach—helping to prevent unnecessary hospital admissions and enabling faster, safer discharges. To better manage referrals and increase reach, the team is developing localised cohorts of Volunteer Responders, moving away from one-to-one matching. This shift enables faster, more responsive and flexible support where it's needed most.

To help manage waiting times for the befriending service, the **Moray Caller Volunteer Service** was expanded to offer regular phone contact for individuals awaiting a befriender, where appropriate. This interim support ensures that those referred continue to receive meaningful connection while awaiting face-to-face visits. Meanwhile, Befriending Volunteers continue to provide in-person visits, with a strengthened focus on helping individuals move from crisis to confidence, reconnect socially, and participate more fully in their communities.

"Moving with Dignity" – Proportionate Care

Using a person-centred approach, respecting an individual's abilities and preferences, whilst minimising the need for multiple people to be involved in moving and lifting is being adopted across services in HSCM. Currently there are a number of people with mobility issues, who currently require support from two people to safely move them, and discharges from hospital can be delayed whilst awaiting availability of carers to support them at home.

A first cohort of staff have been trained in using specialist equipment, aids and techniques and meet regularly to practice their skills and problem solve for individual circumstances. There is a plan to cascade training out to the wider assessment teams and community hospitals in early 2025/26.

Whilst a handful of cases are underway at present it is anticipated that adoption of these principles will assist with discharges from hospital, as part of the discharge process an assessment will be undertaken and individuals will have access to hoists and other necessary equipment, which will also reduce the requirement for two carers, releasing capacity for others.

The Project team are focussing on rolling out training to local care teams to meet the need of specific clients and more broadly across all care teams including other partner care agencies.

Outcome 3 : Positive experiences

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

Indicator	Title	2023/24	2024/25
NI - 4	Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated	65.7%	
NI - 5	Percentage of adults receiving any care or support who rate it as excellent or good	68.7%	
NI - 6	Percentage of people with positive experience of care at their GP practice	68.6%	
NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	81.1%	73.8%

Inspections

Many of our services are assessed by the Care Inspectorate to ensure that services provided meet the required standards and peoples' outcomes are being met. Where gradings are below 4 action is taken to implement the Care Inspectorate requirements and recommendations, and this would be reflected in improved grading after follow up inspections. Appendix F provides details of all the inspections during 2024/25.

Learning from complaints and feedback

We place huge importance on using the comments and feedback we receive to continuously improve the quality and safety of services. As well as the feedback received directly by services and gathered via surveys conducted as part of monitoring the quality of services and service redesign, another source of information and learning is obtained from complaints received.

A total of 138 complaints were received by Health and Social Care Moray in 2024/25.
We record all complaints received onto either the DATIX system for health related services or LAGAN for social work and social care related services.

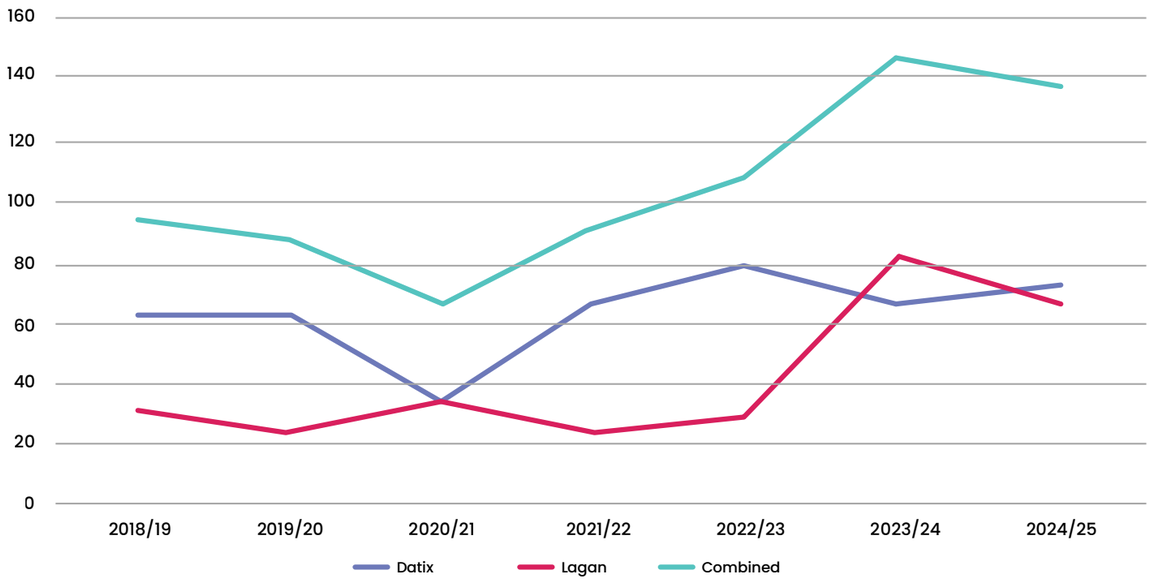
It should be noted the figures reported for 2023/24 onwards include Children & Families and Justice Social Work Services, as these services were delegated to the Moray Integration Joint Board on 16 March 2023. This accounts for the increase in complaints recorded on Lagan from 2023/24 onwards.

The number of complaints recorded in DATIX include the Out of Hours Primary Care Service (known as GMED) for the whole of Grampian, not just Moray. This is because the Moray Integration Joint Board host this service for the whole Grampian.

The GMED service cares for patients who have urgent care needs and cannot wait until their GP Practice is open. GMED operates 18:00 until 08:00 each weekday, all weekends and each public holiday including the festive period. The services has on average 90,000 contacts annually (1/6 of the Grampian population).

Complaints Received by Year

Year	Total (recorded in DATIX)	Total (recorded in LAGAN)	Total complaints
2018/19	62	31	93
2019/20	62	25	87
2020/21	33	32	65
2021/22	68	24	92
2022/23	78	30	108
2023/24	67	80	147
2024/25	71	67	138



In 2024/25, 23% (27) complaints were upheld fully, with the remainder being partially or not upheld.

Aspects of services leading to complaints were around processes not being clear or not being followed appropriately by staff, communication issues relating to messages or guidance not being sufficiently clear for people and the right people not having been informed at the right time.

HSCM governance structures allow ongoing review of complaints and incidents to identify areas for improvement and learning opportunities, to drive positive change.

It is positive to note that complaints regarding provision of care are small in number and that very positive feedback is regularly received from people receiving support from services

When a complaint is straightforward and does not require investigation, we aim to respond within 5 working days (often called frontline or early resolution complaints) but when an investigation is required, we aim to respond to complaints within the target of 20 working days. Performance during 2024/25 did not always achieve these targets. An average of 25 working days for frontline complaints and 51 working days for investigative complaints for social work and social care services were recorded. For health related services there was an average of 3 working days for early resolution complaints and 45 working days for investigative complaints. This is an area for improvement and processes internally have been reviewed to ensure they are as streamlined as possible.

Outcome 4 : Quality of life

Health and social care services are centred on helping to maintain or improve the quality of life of service users.

Indicator	Title	2023/24	
NI - 6	Percentage of people with positive experience of care at their GP practice	68.6%	
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	69.3%	
NI - 12	Emergency admission rate (per 100,000 population)	8,338	6,096

(Due to the caveats on completeness of national indicator 12, 13, 14, 15 and 16 it is not possible to draw conclusions over trends at this stage)

Day opportunities

The Day Opportunities Team continues to play a vital role in enhancing quality of life for individuals and their carers. By facilitating access to social activities and meaningful engagement, the team has supported both individuals and unpaid carers in achieving greater wellbeing. These opportunities have also provided much-needed respite for carers, contributing to their ongoing sustainability and resilience.

The work of the Day Opportunities SDS Enablers has received regular and positive feedback from families and individuals who have benefited from their support. This feedback reflects a high level of satisfaction and underlines the impact of enabling roles in promoting choice, independence, and tailored outcomes. Such feedback includes ***"so happy with the supports put in place, feel like my wishes were listened to"*** highlighting the value individuals place on being fully engaged in the creation of their support. Further feedback includes:

"in the short time I have known you I can't believe how much you have done for us which has really benefitted my mental health and wellbeing. B loves the Bosie, the choir and hopefully she will get to the darts club and craft group shortly. All supported by you"
and
"I'd be lost without the support, it's fine to get out of these 4 walls. It's nice to get a chance to go to places in Elgin, as I don't have a chance otherwise".

Housing developments

Our strategic vision for Learning Disability (LD) housing in Moray is clearly articulated in the strategic plan. We are committed to sustainable accommodation through continued collaboration with partners to develop long-term supported housing for individuals with learning disabilities. Additionally, we aim to provide tenancy support to help individuals and families establish and maintain tenancies in appropriate settings, thereby reducing the risk of inappropriate placements or care breakdowns. We are also working to integrate LD housing needs into the broader housing policy, specifically the Local Startegic Housing Investment Plan (SHIP).

Over the previous year, the Partnership, led by the LD service, has been collaborating with Moray Council Housing Dept, Grampian Housing Association, and Springfield. Together, we have been planning and building flats and bungalows specifically for people with Learning Disabilities. Excitingly, the bungalows are due for occupation in August 2025.

Outcome 5 : Health inequalities

Health and social care services contribute to reducing health inequalities.

Indicator	Title	2022	2023	2023/24	2024
NI - 11	Premature mortality rate per 100,000 persons	330	384		
NI - 12	Emergency admission rate (per 100,000 population)			8338	6,096

(Due to the caveats on completeness of national indicator 12, 13, 14, 15 and 16 it is not possible to draw conclusions over trends at this stage.)

The Joint Strategic Needs Assessment, which helps us understand the current and future health and wellbeing needs of the local population and identify future priorities, was completed and approved in September 2024.

Throughout 2024/25, HSCM continued to prioritise actions to address health inequalities and improve equity of access to care for all population groups, in alignment with the Public Sector Equality Duty and our Strategic Plan.

Our **Healthpoint service** expanded its outreach activity, delivering 2,363 individual contacts across Moray through community-based campaigns and pop-up events. Key campaigns included Nutrition and Hydration Week, which engaged older adults in supported housing and care settings, and Ageing Well presentations delivered to 10 community groups with 237 attendees. These initiatives not only promoted physical wellbeing but also tackled social isolation which is a key determinant of poor health.

Smoking cessation services reached increasing numbers of individuals.

- 104 smoking quit attempts were recorded in 2024/25, with 24 successful 12-week quits.

The Walk Moray programme continued to improve physical activity and reduce isolation. In 2024/25, 19 health walks, including evening and dementia-friendly walks, attracted 122 new walkers and maintained an average of 100 participants per week thanks to the support of 101 volunteer walk leaders. Feedback highlighted improvements in confidence, mobility, and social connectedness.

A multiagency assessment tool that identifies neglect and promotes early intervention to improve outcomes for families has been implemented. **The Health Visiting and Family Nurse Partnership (FNP)** teams are referring families to the council's income maximisation team to ensure they are accessing the financial support they are entitled to.

Through current Scottish Government funding, a local plan is in place to increase the qualified school nursing staffing establishment. The school nursing role focuses on prevention, early intervention, and support for the most vulnerable children over five years old.

T**he School Nurse Pathway in Moray** includes specific measures to identify and support young carers. Nurses respond to referrals, contribute to the child's chronology, and carry out wellbeing assessments using the GIRFEC National Practice Model. They coordinate health-related aspects of the child's plan, alert relevant professionals, and link families to appropriate children's and adult services.

Making Every Opportunity Count (MeOC) is a health promotion approach that encourages colleagues to leverage everyday interactions to support individuals in making positive changes to their physical and mental health. In 2024/25, 185 new starts with the Care at Home Service received MeOC training as part of their induction.

We extended our support to unpaid carers through development of **Adult Carer Support Plans** and embedded young carers into the **School Nurse Pathway.**

Funding mechanisms such as the **Health Improvement Fund** and **Third Sector Winter Support Fund** provided nearly £25,000 in 2024/25 to community-led projects focused on healthy eating, financial inclusion, and local wellbeing initiatives.

Service users with lived experience played a central role in shaping mental health service improvement. **The Making Recovery Real partnership** and collaboration with **Moray Wellbeing Hub** led to peer integration in mental health wards and influenced contract awards.

Through participation in the **National Frailty Collaborative**, HSCM co-developed a **Frailty Action Plan** to promote early identification and prevention, and support people to age well in their communities.

Over the past year, we have made significant strides in the delivery and development of the **Learning Disability Annual Health Checks programme** across Moray. Following the resounding success of an initial small-scale trial in Aberlour, of one nurse a day a week over six weeks, a proposal was taken forward to fund a community-based model by recruiting a nurse within the Learning Disability Team. This nurse is now rolling out the Health Check to everyone with a diagnosed Learning Disability, ensuring that all are offered a check.

Looking forward

The 2025-2029 Equality Outcomes have now been set by the Board.

1. Provide accessible services that support people to remain safe in their own homes through person-centred care and digital transformation.

2. Unpaid carers will be given choice, opportunities, and support to care for their loved ones, ensuring their well-being enabling them to balance their caring responsibilities with their personal lives.

3. Support people with learning disabilities and their families in maintaining their health and wellbeing and establishing tenancies in new supported accommodation.

4. Continue to embed LD Annual Health Checks with a focus on early detection of health issues, improved health outcomes, enhanced access to healthcare, personalised health action plans, and reducing health inequalities for individuals aged 16+ with learning disabilities.

5. Support children and young people affected by their own or someone else's drug or alcohol

use. Ensure they can easily access support from their school and other services, and that families are supported to find their own recovery.

6. Support hub and outreach efforts in disadvantaged communities through tackling poverty, income levels, poor housing, and disadvantage to help individuals avoid substance use. Expand efforts to other areas, including school talks, online conversation café, education and drug awareness, and naloxone training.

7. A full redesign of adult day services will enable individuals to access day support that is person-centred and meets their agreed outcomes and aspirations. Where appropriate, day services will be provided within people's own communities.

8. Prioritise the health and well-being of all staff by providing opportunities for personal well-being, development, and learning in a supportive and inclusive work environment.

Outcome 6 : Carers are supported

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

Indicator	Title	2023/24	2023	2024
NI - 8	Percentage of carers who feel supported to continue in their caring role	28.2%		
NI - 18	Percentage of adults with intensive care needs receiving care at home		60.6%	60.4%

Ensuring appropriate support is available for unpaid carers is essential to help meet the increasing demands for care of our aging population. Work described below is underway to support carers directly, and in addition there is a focus to increase availability of providers of care within Moray that is being taken forward through our commissioning approach (see page 53)

Unpaid carers

Unpaid carers can be any age, from young people to older people, with Carers UK predicting 3 in 5 of us will be a carer at some point in our lives. There are an estimated 16,200 unpaid carers in Moray. Not all unpaid carers in Moray require formal support from statutory services to assist them to meet the demand of the role, or to receive formal support for the person they care for, however, carers legislative rights are enshrined by the Carers (Scotland) Act 2016.

During the 2024/2025 period, there has been steady, positive progress in the development and implementation of **Moray's Unpaid Carers Strategy.** The focus has remained on enhancing awareness and recognition of unpaid carers across Moray.

A key initiative is the ongoing promotion of the Moray Carer Aware campaign. This campaign aims to improve the identification and recognition of unpaid carers and includes the development of a proposed badge and ID card. Public engagement is planned to gather feedback and ensure the initiative aligns with carers' needs and preferences.

A pilot project with Elgin Health Centre has introduced a carer awareness training programme. This bespoke training was aimed at increasing staff knowledge and ability to identify unpaid carers and has led to a rise in the number of carers recorded in the GP system. This programme is part of a broader unpaid carer pathway designed to enhance identification, recording, and referrals to appropriate support services.

As of March 2025, there were:

- 1188 adult carers registered with the service, of which there were 58 new adult carers referred to the service between Jan -March 25. 19 carers are receiving intensive support during this period.
- 198 young carers registered with the service, of which there were 45 new young carers referred to the service between Jan-March 25. 1 young carer is receiving intensive support during this period.

The Unpaid Carers Team also participated in the most recent Moray Integrated Joint Board (MIJB) development session. In collaboration with Quarriers, the commissioned carer support service, and with contributions from two young carers and an adult carer, the session provided valuable insights from lived experience and further supported awareness raising efforts.

Access to day opportunities for cared-for individuals continues to be a vital form of support for unpaid carers, offering them essential breaks from their caring role. These opportunities help unpaid carers manage their mental health by giving them time to focus on their own well-being, reducing feelings of stress and isolation. **The Day Opportunities team** supports both the unpaid carer and the cared-for person in engaging with the community and creating space for meaningful breaks. This dual approach positively impacts the mental health and well-being of both parties.

A testimonial from an unpaid carer supported by the **Day Opportunities SDS Enablers** in January 2025 stated: ***"Everything's fine since Day ops got involved. I can go to Elgin or Tesco. I can get a haircut without worrying. The care side of support is good, but when the social side of it started, I felt a bit free. I know my wife is safe when I am not here."***

The Day Opportunities team continues to offer weekly support through a person-centred, strengths-based approach aimed at delivering positive outcomes.

Quarriers, as the commissioned carer support provider, plays a central role in promoting the mental health and well-being of unpaid carers through a wide range of tailored support services. These include:

- Free professional counselling services to help unpaid carers manage stress, anxiety, and emotional strain related to their caring roles.
- Sound therapy and art therapy sessions, which offer creative and holistic approaches to relaxation and mental health support.
- Time to Live Short Break Awards, which allow unpaid carers to take restorative breaks tailored to their personal needs.
- Respite break options, such as vouchers for activities like afternoon tea or play sessions, offering informal and enjoyable respite.
- Hand massage workshops, which teach practical relaxation techniques to help carers manage day-to-day stress.
- Monthly carer drop-in sessions, which provide a welcoming space for carers to connect, share experiences, and receive advice and support.

Together, these services and initiatives represent positive steps toward improving the recognition, support, and well-being of unpaid carers across Moray.

Outcome 7 : People are safe

People who use health and social care services are safe from harm.

Indicator	Title	2022	2023	2023/24	2024
NI - 9	Percentage of adults supported at home who agree they felt safe			70%	
NI - 11	Premature mortality rate per 100,000 persons	330	330		
NI - 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)			77%	61%
NI - 16	Falls rate per 1,000 population aged 65+			17.7	12.2

(Due to the caveats on completeness of national indicator 12, 13, 14, 15 and 16 it is not possible to draw conclusions over trends at this stage)

Falls Pathway

To continue the focus and significance of addressing falls risks, a review of falls pathway was undertaken in collaboration with Scottish Ambulance Service. A test of change is planned to ensure multifactorial falls screening takes place at the earliest opportunity. Falls awareness and prevention groups have been held and run by the Primary Care Occupational Therapy service in sheltered housing and at The Oaks.

Adult Support and Protection

In 2024 a progress review by the Adult Support and Protection Joint Inspection Team was undertaken in Moray. The progress review was a follow up from our 2022 Joint Inspection where a number of improvement areas were highlighted as part of the report.

Moray made significant progress in all the identified areas for improvement within the progress review. Inspectors also told us that in some areas of work, for example in the use of chronologies, we had made some of the best progress that they had seen across the country.

The significant level of improvements made are testament to the hard work, dedication and expertise of frontline staff, managers and leaders across Moray Council, Police Scotland, NHS Grampian and our Voluntary Sector Partners who make up the Adult Protection Partnership in

Moray and who form the governing body of Moray's Adult Protection Committee (APC).

The Review found that Moray had made significant progress in all seven areas recommended in the 2022 joint inspection. The full report from the Care Inspectorate was published in October 2024 and can be found **here.**

Key findings included:

- Consistent application and delivery of key processes. Practitioners were noted to be confident and highly professional and followed the multi-agency adult support and protection procedures meticulously
- Investigations were carried out for all adults at risk who required them. Almost all Investigations were rated good or better (85%).
- Adults at risk of harm had in place a Chronology. 80% of Chronologies were rated good or better, which is a significant improvement from 39% in 2022.
- The Quality of Risk Assessments and Protection Plans had improvement significantly
- Case Conferences were found to be carried out effectively. The right people from partner agencies prioritised attendance. Almost all Case Conferences were rated good or better for quality.
- Initial Referral Discussions (IRDs) were found to be of an **exemplar** for the sector
- The Adult Protection Committee (APC) and Chief Officers Group (COG) exercised sound and effective multi-agency governance over the delivery of improvements to adult support and protection
- The partnership had a cohesive programme of multi-agency audits and quality assurance activities. These included involvement from front line practitioners.

The below table evidences the significant progress Moray has made in relation to key processes comparing the findings of the 2022 Joint Inspection to the Progress Review 2024.

Process	2022 Inspection	2024 Progress Review
Chronology presence	27%	100%
Chronology quality – good or better	39%	80%
Risk Assessment presence	56%	68%
Risk assessment quality – good or better	75%	100%
Protection plan presence	68%	90%
Protection plan quality – good or better	64%	80%
Investigation presence	48%	100%
Investigation quality – good or better	52%	85%
Case Conference quality – good or better	83%	91%

The direction of the APC over the next two years will be based on the below main areas for development alongside activities within our Multi-Agency Improvement Plan.
As a partnership, we recognise that we still have a distance to travel. However, we are proud of the journey thus far and the progress made over the last two years and know that adults at risk of harm are safer as a result of the work we undertake.
The table below highlights areas of work we will focus on in the coming two years.

Area for Development	Where We Want To Be	How Will We Get There?
Involving the Adult in a Trauma Informed Way	**Have in place a trauma informed workforce for ASP in Moray**	**Grampian wide programme of work for Trauma Informed ASP activity currently in progress.**
Chronologies	**All practitioners carry out good quality chronologies and discuss information within meetings alongside the Adult**	**Suite of multi-agency training and guidance devised and carried out.**
Strategic Resourcing	**ASP in Moray to be fully resourced**	**On going discussion at COG and APC to highlight risk.**
Quality Assurance Activity	**Have in place a clear suite of multi-agency and single agency audit activities that support in monitoring evaluating and improving ASP in Moray**	**Audit and Quality Assurance yearly timetable devised and followed – with full participation of all partners**

Monitoring of commissioned services

A particular strength of the Adult Social Care Commissioning team continues to be the proactive and reactive monitoring of contracts. The team have developed the monitoring process in the last financial year by including a second formal contract meeting for each provider as well as a monthly informal meetings. This ensures that relationships with providers remain strong, and they are well supported. The commissioning team also lead a Learning Disability Provider Forum that meets 4 times a year with specific themes and guest speakers. In 2024/25 the themes were recruitment, care inspections, advocacy and staffing structures, including the Support Worker role.

In 2024/25, the Commissioning Team were required to respond effectively to undertake enhanced monitoring for 5 external services and one internal service. These were required as a result of concerns raised by social work teams, from an annual site visit or a poor Inspection from the Care Inspectorate. Each of these enhanced monitoring programmes ensured a return to the required standards and resulted in delivery of services to meet outcomes for people, improved Care inspections or improved processes for the provider.

Urgent health care out of hours

GMED is the Grampian-wide out of hours primary care service that cares for patients who have urgent but non-life threatening health needs that cannot wait until their GP practice is open. GMED is not an emergency service, a minor injury service or a walk-in service. To access urgent

care services, patients need to call 111 (NHS 24) who will triage the patient and refer to the most appropriate service, including GMED. Community pharmacies, Scottish Ambulance Service (SAS), community nursing, social work and some other services can refer patients directly to the dispatch hub via the professional-to-professional telephone line.

In 2024, GMED dealt with 107,608 cases which was a 4% decrease in demand compared to the previous year (112,148). There were:

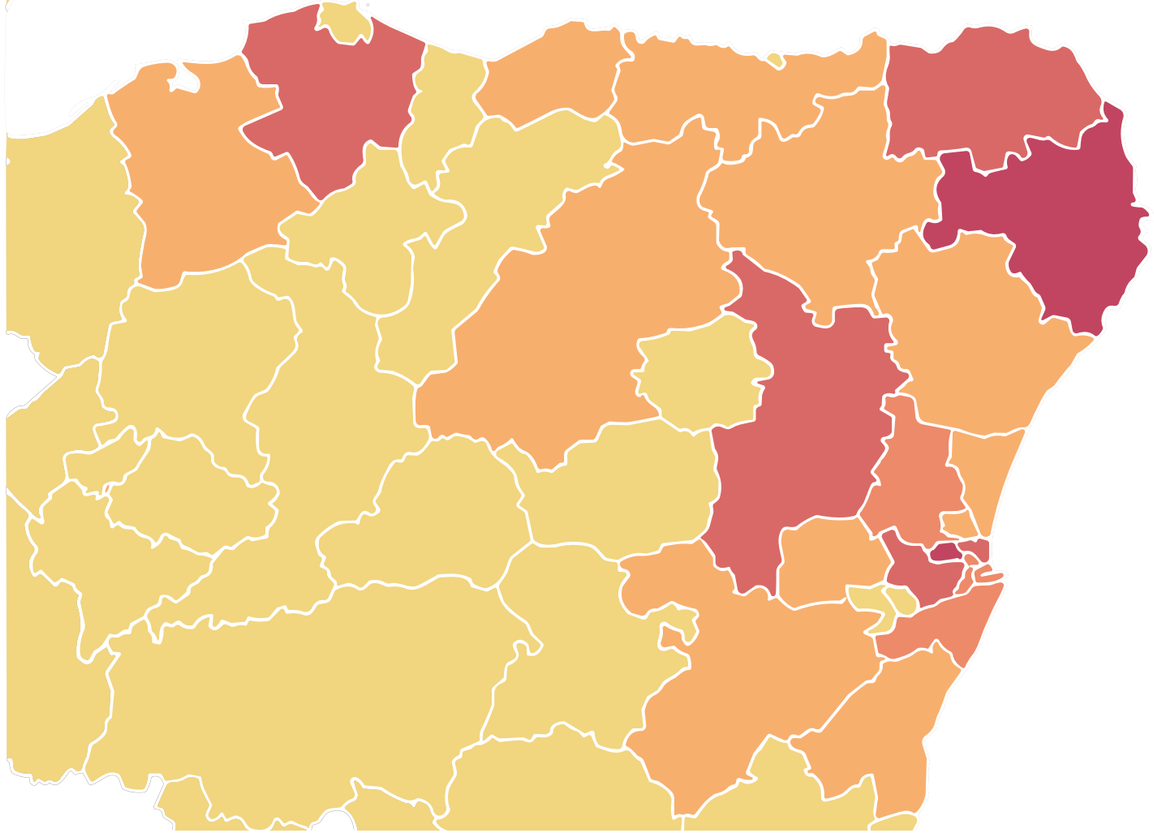
- 58,634 advice calls,
- 34,656 centre consultations,
- 11,128 home visits and
- 3,190 mental health advice calls

However, if we compare the activity levels from 2020 (pre-Covid) there has been in increase in activity of 35.6% or 79,358 cases which is significant.

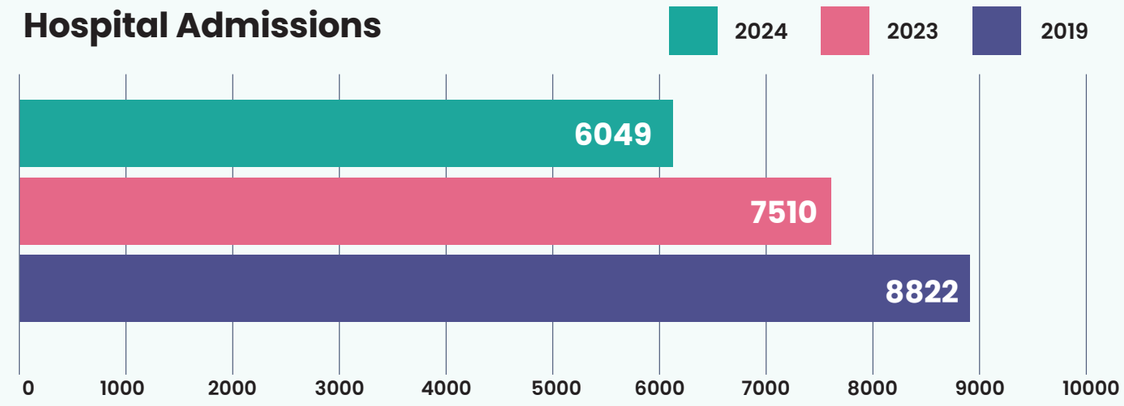
GMED Activity Heat Map

The heat map shows the demand in all locations across NHS Grampian in 2024. Elgin, Forres and Buckie are the busiest locations in Moray.

In 2024 the service had 24,329 contacts in Moray which represents 22.6% of all GMED activity, compared to 2020 (pre-COVID), when there were 19,488 contacts (24.6%) of all GMED activity. This demonstrates that even though the number of overall contacts has increased in Moray, as a percentage of GMED activity it has slightly reduced.



GMED is a successful gatekeeper for secondary care services. In 2024, we have admitted 6049 patients to the hospital, this shows a decrease of 19.5% compared to the previous year (7510) and by 31.4% pre-Covid (8822).



Outcome 8 : Workforce

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

Indicator	Title	2023/24
N/A	There are no National Indicators to measure our progress towards this outcome. Our performance is in part measured using staff surveys.	

Feedback from Inspections

The feedback from Care Inspectorate highlights how engaged staff are in the support and care they provide, as evidenced in section 8 of this report, examples:

ASP inspection: "Robust measures were in place to identify concerns early and promptly implement remedial action. Operational managers worked diligently and effectively to bring about necessary improvements to adult support and protection".

START: "People enjoyed support which was dignified and respectful. Staff felt supported by their supervisors and colleagues".

Moray Supported Lodgings project: "Young people benefit from leading and directing their own support within a multi-agency approach to care planning"

Community Support Services: "People were supported by staff who were kind and caring"

Staff survey

The iMatter is an annual staff survey sent to all employees across health and social care in Grampian. During 2024/25 there was 56% response rate showing an employee engagement index of 77, and overall score of 7.1 which were similar to the previous year.

Responses with the lowest scores were: "I feel the board members who are responsibility for my organisation are sufficiently visible", "I have confidence and trust in Board members who are responsible for my organisation", "I have sufficient support to do my job well" and "I am confident performance is managed well within my organisation". There has been more information shared via newsletters and briefings during 2024/25 so it is hoped that this will have an impact on future scores.

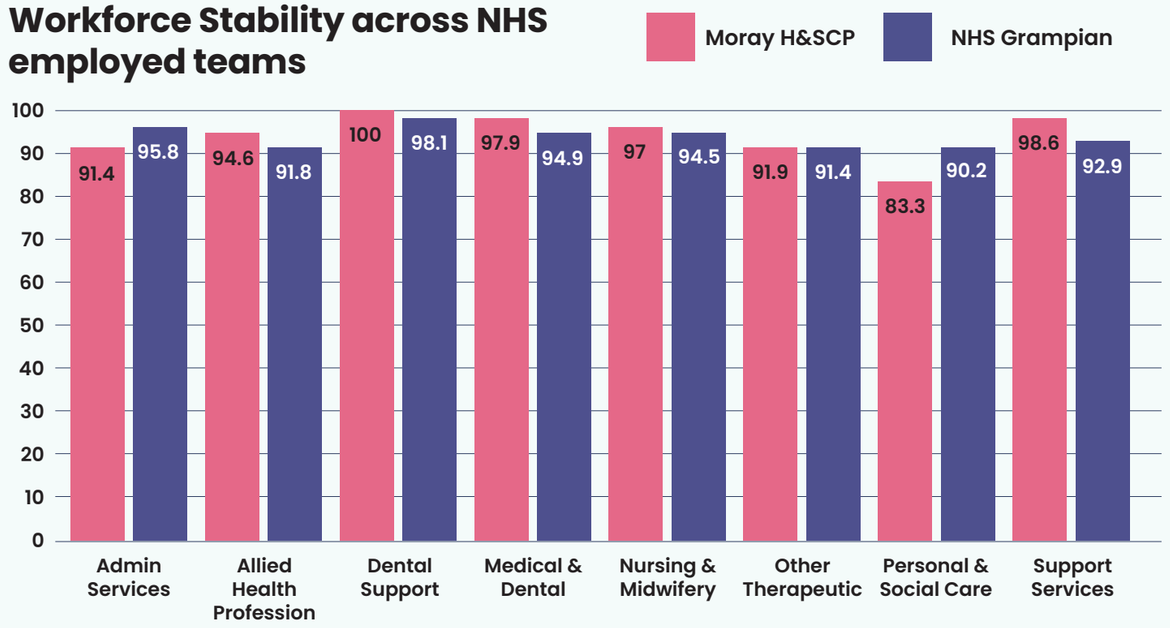
Feedback for the current year survey is expected in June 2025 which will inform priorities for our Workforce Plan.

Workforce Forum

The Workforce Forum provides an opportunity for open dialogue between workforce, partnership and health and safety representatives, and enables colleagues to discuss and raise issues and best practice. Attendance at these meetings has increased significantly which is positive as more teams are now represented and engaged. During 2024/25 several discussions have been around difficult to fill vacancies and how these are managed.

Personal & Social Care was the only job family to fall below the 90% stability target, with a stability rate of 83.3%. Alongside Admin services this is an area where we would anticipate there to be greater turnover as people develop experience and skills and then seek higher grade jobs. More stringent vacancy controls have been implemented across NHS Grampian and this has led to fewer new starts during January 2024 to January 2025 which therefore increases figures of stability as there are less workforce with less than one year service.

Workforce Stability across NHS employed teams



Between February 2024 and January 2025, Moray HSCM experienced a turnover rate of 9.18%, higher than the NHS Grampian turnover rate of 7.46% for the same period. A turnover rate of around 10% is typically expected, suggesting that lower figures indicate a stable workforce.

Absence actions and Wellbeing Initiatives

Absence is monitored by all teams across the partnership and is governed by the application of the attendance policies of NHS Grampian and Moray Council.

Across Health and Social Care Moray, sickness absence occurs across all staff groups, however

there are elevated rates in nursing and social work, and provider services in particular. This is in part due to workload, exposure to infection and travel impact on an ageing work population. The most common long term sickness are related to Mental Health or Muscular-skeletal injuries and we have a number of wellbeing initiatives to help combat and recognise stress and general physical wellbeing.

- Wellbeing features as a regular standing item at our Workforce and Health and Safety groups where two way flow of information is encouraged with peer to peer support and appropriate escalation where necessary. Moray Council has mental health first aiders which have proved a very useful resource.

- Peer to peer support has been established and some teams have a wellbeing weekly get-together, known as 'Wellbeing Friday'. Other teams such as our AHP services operate a 30 minute 'wellbeing window' weekly where they will actively take a break and do something physical such as walking or stretching or yoga.

- Collaboration with Moray Council and NESTRAN Health & Transport Action Plan for Grampian in promoting 'active travel' campaigns.

- Promotion of the 'At your best with Rest' campaign to encourage staff to take their allocated breaks to increase efficiency and reduce fatigue and burn out. Some services have dedicated break areas and set times which allow the whole team to take a break together. Other teams have established a virtual tea break which has been very successful. We are very well supported by our Wellbeing colleagues in Grampian and the 'We Care' resources.

- Promotion of flexible and hybrid working where appropriate.

- Through 'We Care' we have a Covid Reflection listening service available as well as Recovery in Mental Health, Relaxation workshops and stress awareness training available to all.

- We have an active Menopausal awareness programme, which offers training and tea and talk sessions.

Outcome 9 : Use of resources

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

Indicator	Title	2023/24	2024	2024/25
NI - 4	Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated	65.7%		
NI - 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	77	61	
NI - 15	Proportion of last 6 months of life spent at home or in a community setting	91.1%	93.3%	
NI - 16	Falls rate per 1,000 population aged 65+	17.7	12.2	
NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	980		865

(Due to the caveats on completeness of national indicator 12, 13, 14, 15 and 16 it is not possible to draw conclusions over trends at this stage)

There is a focussed effort across many services to reduce the number of days people spend in hospital and prevention of delays for discharge.

Vaccination uptake

The World Health Organisation (WHO) describes vaccines as one of the two public health interventions that have the greatest impact on the world's health, the other being clean water. It is also considered as one of the most impactful and cost-effective public health interventions available to communities and populations across the world.

Vaccination can prevent or reduce the severity of disease, minimise disability and save lives, often in many of the most disadvantaged people in society. It offers excellent value for money by reducing current and future public expenditure on health and social care provision.

Uptake of seasonal flu and covid-19 vaccinations in Winter 2024/25 was similar in Grampian to elsewhere in Scotland and highest in the oldest age groups, and the Spring 2025 programme continues to perform well. Uptake shows a socioeconomic gradient with highest uptake amongst least deprived.

COVID 19 Vaccination Uptake

COVID 19	Uptake	
Cohort	**2023**	**2024**
Age 65 to 74	77.0%	65%
Aged 75+	83.9%	75%
All social care workers	14.5%	6%
At risk age 5 to 11	7.3%	7%
At risk age 6 months to 4 years	13.6%	13%
At risk age 12 to 64	35.8%	25.2%
Frontline health care workers	30.2%	19%
Older people care home residents	89.9%	83%
Weakened immune system	59.3%	38%
TOTAL	60%	50%

Influenza Vaccination Uptake

Influenza	Uptake	
Cohort	**2023**	**2024**
Age 50 to 64	43.1%	Not offered
Age 65 to 74	77.1%	70%
Aged 75+	84%	80%
All health care workers	24.7%	25%
All social care workers	13.1%	8%
At risk age 18 to 64	44.2%	34%
Older people care home residents	91%	85%
Weakened immune system	63.9%	46%
TOTAL	58.3%	55.6%

The uptake of vaccinations amongst frontline health and social care staff continues to be lower than the partnership would like it to be, despite significant work by the Moray Immunisation Team to increase uptake. Several extra clinic dates were put on to increase numbers, with very little interest. There has been a marked decrease among most of the other cohorts too. It has been found that the lower uptake rates this year, compared to previous years, seem to be due to vaccine fatigue within the population.

Improved access to medications for patients

Moray Pharmacotherapy team undertook a cost efficiency project during 2024/25 that achieved £660k savings through working collaboratively with GP practices. A Specialist Pharmacy Technician (SPT) was appointed 'Savings Champions' in each practice cluster to motivate and guide and met with all GP practices teams/prescribers/clinicians to discuss project and effective methods re cost efficiency.

A variety of methods were implemented including use of system tools to ensure most efficient prescribing, generic medications prescribed rather than branded, ensuring regular medication reviews of repeat prescriptions to ensure still relevant and regular care home polypharmacy reviews to look at stock levels held in care homes.

Significant savings occurred in relation to inhaler switches, skin dermatology prescribing reviews, Diabetes blood monitoring testing aspects, dosage forms and changes in pack size and dosage reviews. Many of the changes benefited individuals through a reduction in the amount of prescriptions or the frequency of dose.

Due to the success of the project a further project is being taken forward in 2025 with GP practices but another project is underway with local Care Homes and it is anticipated savings will be in the region of £269k.

Commissioning of services

In the last year the commissioning team have been focusing on various workstreams that are linked with exploring and widening the provider market in Moray. Care at Home are progressing well with a test of change to give advance payment that provides greater stability for the provider enabling recruitment to meet their commitments. The result is a strengthening of the relationship and increased confidence and assurance that the hours can be provided, by staff working to the required standards. Quality of service provision has increased, with the most recent Care Inspectorate inspection reporting good and very good grades across all areas. This approach will be further progressed in 2025/2026.

In June 2024, the Learning Disability Service secured 13 flats and 4 bungalows in partnership with Springfield and Grampian Housing Association. The service provider was procured through a competitive tendering process with family members scoring the presentation element. This is the first time that family members have had autonomy like this in a tendering process and the feedback from them and from the presenting providers was that it was an experience that was valuable. The families also influenced the appointment of the successful provider, Community Integrated Care and this has ensured that all parties have a good understanding of expectations. The Service is due to open in August 2025.

The Commissioning Team worked closely with external providers to progress the Financial Delivery Plan project and efficiencies within contracts. This was undertaken by a joint review of service provision, management structures and capacity. By working in partnership with each provider and alongside Social Work colleagues, the saving achieved through contracts was £184,269 for 2024/25. This will continue throughout 2025/26 where significant savings are predicted to be realised.

The Commissioning Team have awarded 21 contracts and undertaken nine letters of extension. The team are currently working on 19 contracts which are at various stages of the commissioning cycle. Within this, the voice of the citizens of Moray and learning from the Western Village tender will be embedded into practice so that the Health and Social Care Moray Adult Commissioning Team continue to promote and guide colleagues through Ethical Commissioning practices.

Localities, finance & priorities for 2024/25

9. Working with communities across our localities

For service planning and delivery purposes, the four localities in Moray are: Forres and Lossiemouth; Elgin; Buckie, Cullen and Fochabers; Keith and Speyside

Locality managers are leading on the development and delivery of locality plans to respond to local needs and reflect the priorities of communities. First drafts were published in 2022 and updated plans for 2023-2026 were approved by the MIJB in March 2023.

Elgin Locality

Multidisciplinary Team developments

This is a continuing piece of developmental work for the Elgin locality. Following feedback form "How Good is our MDT" survey there is further work to ensure all professionals are represented at local MDT's. Recently the Local Authority Occupational Therapy service has been attending the MDT's with an understanding of how they can best support the MDT's moving forward.

Social Prescribing

The Elgin locality is starting to focus on social prescribing and working firstly with the Maryhill Practice to trial this. It will then be extended to Linkwood practice once we have a model and services that suit the Elgin population to support social prescribing. The aim of the model is to support health and social care professionals to connect individuals to non-clinical support and community activities. The aim to support their health and wellbeing. The Health Improvement Team are supporting the development of this alongside the Locality manager. The next phase of the development will be to meet with the Practice and ascertain which are the top key areas of focus for the practice population that would benefit for the social prescribing model.

Community Appointment Day (CAD)- Chronic Obstructive Pulmonary Disease (COPD) 16th April 2025

Preparations were carried out for this event following on the success of the CAD held for MSK in September 2024 with the purpose of inviting people with COPD registered with the Maryhill and Linkwood GP practices.

Keith and Speyside Locality

The Fleming Health Hub now has over 30 services that are able to provide appointments, classes and drop ins and that can be used by anyone across Moray who finds it easier and closer to home to access. In the Keith and Speyside Locality we have been forging working

relations with other HSCM teams operating in and around the Locality and with third sector and local groups to look at what we can do in collaboration to support the health and wellbeing needs of our communities.

This has included intergenerational work where services on offer ranging from birth through to our older population . We have been around our secondary schools hosting 'Lets talk Health, Wellbeing and your Community' events and have had various educational events for staff and drop ins for the local population including Realistic Medicine and MEOC training and Dental Care guidance and demonstrations.

We have a room specifically set up at the Fleming Health Hub for Moving With Dignity (proportionate care) training for our own staff and where appropriate other organisations and Care Homes, which will reduce the number of care staff required for visits to certain people. We are now also able to host annual health checks for people with Learning Difficulties and our OT teams have been able to introduce several new sessions around falls prevention.

We have also been utilising space at our hospital sites in Dufftown and Keith to introduce specialist third sector services as appropriate, to encourage and make easier, access to these services.

We are also in discussions with our GP Practices and other professionals around what services they would like to see introduced to meet local identified need and we will be taking this forward in the coming year.

Our online Professionals directory continues to support MDT working across the Locality and we are utilising this to share updates and information across our teams. This does not replace the many other MDT meetings that take place regularly across our GP practices and Community Hospitals but does support staff in ensuring the right people are involved and around any specific discussions at the right time and as required in support of a person, which should be at the heart of all MDT working.

With Keith and Speyside being in places very rural, we have been working hard to ensure that we can raise awareness of services and support available that people can access in support of their own and their families health and wellbeing. Information areas in GP practices have been updated, HSCM teams have access to an online Health and Wellbeing directory and some teams have identified a Wellbeing Champion who is now taking the lead on ensuring their teams are able to look after their own wellbeing, this is supported by our Locality Health Improvement Coordinator. Poverty and the rising cost of living is something that impact us all and to support this we have also ensured that all GP practices are able to order and hand out free period products and condoms to patients and staff and that this is promoted.

All of the above will support us encouraging and equipping people to start taking responsibility for their health and wellbeing and awareness of alternatives to medication where appropriate or in addition to medication as part of a more holistic approach. This aligns with Social Prescribing and something we will be championing more in the coming years.

Forres and Lossiemouth Locality

The Forres and Lossiemouth Locality Steering Group continued to meet on a bi-monthly basis during 2024/25 to review performance data and progress in relation to their Locality Action Plan. The group continues to have public, health and social care and third sector representation. The group also has active involvement from Children Service Locality Planning and the Moray Council Community Support Team to avoid duplication and ensure alignment of various plans.

Of particular note over the past year was the ongoing engagement activity that took place; this included pop up engagement clinics in health and care centres, engagement activity in local schools, and events in community settings. Events were facilitated by Health and Social Care, Children's Services, Moray Council Community Support Unit and GP staff.

Work has continued to take place to strengthen MDT working and development of virtual wards to ensure the most vulnerable receive support when and where they require.

Forres and Lossiemouth have supported the work of the Digital Health Design and Innovation Centre (DHI) and in particular the development of Living Lab 3 - the Personal Data Store and Community Connections Moray platform.

In terms of overarching performance against the 17 indicators within the Moray Locality Dashboard, Forres and Lossiemouth Locality have performed better than the Moray average in all but one of the indicators, and better than the National Average in all but two. Of particular note is the low rates of delayed discharges, low rates of emergency hospital admissions, and low rates of mental health unscheduled bed days.

10. Financial performance and best value

Financial review and performance

Financial performance forms part of the regular reporting cycle to the MIJB. Throughout the year the Board, through the reports it receives, is asked to consider the financial position at a given point and any management action deemed as necessary to ensure delivery of services within the designated financial framework.

From the first quarter in the financial year, the Board was presented with financial information that included a forecast position to the end of the year. In November 2024 the Board received a financial report which forecast an expected overspend to the end of the financial year of £5.58m. This forecast remained consistent throughout the remainder of the year and in January 2025, MIJB were forecasting an overspend to the end of the year of £5.51m, the MIJB actually out turned at £4.26m overspent. Both partners in line with the Integration Scheme, put in additional funding to cover this overspend, so with the use of ear marked reserves totalling £0.536m, this leaves a balance of £1.45m in ear marked reserves to be carried forward into 2025/26.

In May 2024, the MIJB agreed a savings plan of £8.297m, with a mixture of recurring savings and recurring reductions in spend. At the end of the financial year, this had been achieved in part, with recurring savings of £2.302m and £2.331m reduction in overspend.

Given the uncertainties associated with funding and the emerging overspend position at the early stage of the financial year, it was necessary to update the Board regularly on the emerging financial position. This was done formally through MIJB meetings and informally through development sessions.

The table below summarises the financial performance of the MIJB by comparing budget against actual performance for the year.

Service Area	Budget £000's	Actual £000's	Variance (Over)/ under spend £000's	Note
Community Hospitals & Services	7,700	8,328	(628)	
Community Nursing	5,979	6,166	(187)	
Learning Disabilities	17,702	19,975	(2,273)	1
Mental Health	12,140	12,055	85	
Addictions	1,907	1,763	144	
Adult Protection & Health Improvement	249	273	(24)	
Care Services Provided In-House	24,743	22,754	1,989	2
Older People Services & Physical & Sensory Disability	24,775	27,034	(2,259)	3
Intermediate Care & OT	1,771	1,972	(201)	
Care Services Provided by External Contractors	1,835	1,816	19	
Other Community Services	10,383	10,280	103	
Administration & Management	3,333	3,152	181	
Other Operational Services	1,377	1,535	(158)	
Primary Care Prescribing	18,748	21,937	(3,189)	4
Primary Care Services	21,427	21,331	96	
Hosted Services	5,713	5,665	48	
Out of Area Placements	720	1,971	(1,251)	5
Improvement Grants	1,207	1,021	186	
Children's & Justice Services	19,523	19,625	(102)	
Total Core Services	**181,235**	**188,656**	**(7,421)**	
Strategic Funds & Other Resources	14,891	6,020	8,871	
TOTALS (before set aside)	**196,126**	**194,676**	**1,450**	
Set Aside	15,639	15,639	-	
TOTAL	**211,765**	**210,315**	**1,450**	

Significant variances against the budget were notably:

Note 1
Learning Disabilities
The LD service is overspent by £2,272,694 at the year-end. The overspend is essentially due to the purchase of care for people with complex needs which resulted in an overspend of £2,806,801 and client transport of £13,781. This is offset by more income received than expected of £524,800 (income due from another authority and Change Fund funds from NHS) and other small underspends of £18,619 which primarily relate to property costs. There was a minor underspend of £4,469 in other Learning Disabilities clinical services. This budget has been under pressure for a number of years due to demographic pressures, transitions from Children's services and people living longer and getting frailer whilst staying at home. The biggest overspends was for services provided to individuals in their own homes to support their daily living needs which enables people to stay living at home or in a homely setting for as long as possible and day care which provides activities during the day in the community.

Note 2
Care Services Provided In-House
This budget is underspent by £1,988,757 at the end of the year. This relates to underspend in staffing across all the services in this budget totalling £2,291,755 and other minor underspends of £8,275 which is being reduced by overspends relating to transport costs £97,970; insurance costs £29,047, utility costs £62,430 and less income than expected £121,826. Unfilled vacancies have been the main reason for the underspend throughout the year, and the issue of recruitment has been an ongoing problem.

Note 3
Older People Services and Physical & Sensory Disability
This budget is overspent by £2,259,056 at the end of the year. This primarily relates to overspends for home care in the area teams £539,818, permanent care £1,766,157 due to the increase in the number of clients receiving nursing care rather than residential care and respite care £105,776 this is being reduced by an underspend for day care £152,695. The variances within this overall budget heading reflect the shift in the balance of care to enable people to remain in their homes for longer. The ageing population requiring more complex care and local demographics also contributes to this overspend as well as the correlation between the recruitment and retention of the internal home care service provision.

Note 4
Primary Care Prescribing
The primary care prescribing budget is reporting an over spend of £3,189,386 for the twelve months to 31 March 2025. The overall average price has remained relatively consistent and includes cost reduction savings identified by Pharmacy implemented countered by the impact of short supply causing an increase in costs. This is spread across a range of products and is ongoing. This overall volume increase at 3.5% is less than previously anticipated.

Note 5
Out of Area Placements
This budget is overspent by £1,250,899 at the year end. This is due to the continuing number of high cost individual specialised NHS placements.

Earmarked Reserves

MIJB's financial performance is presented in the comprehensive income and expenditure statement (CIES). At 31 March 2025 there were ear marked reserves of £1.45m available to the MIJB, compared to £1.986m at 31 March 2024. These remaining reserves of £1.45m are for various purposes as described below:

Earmarked Reserves	Amount £000's
GP Premises	39
National Drugs MAT	250
OOH Winter Pressure funding	172
Moray Cervical screening	35
Moray hospital at home	5
Moray Psychological	315
MHO Funding	138
Adult protection funding for CA	18
Adult Disability payment	45
National Trauma Training services	62
Moray School Nurse	32
Moray Winter Fund HCSW & MDT	182
LD Annual Health Checks	69
Community Planning partnership	2
Moray District Nurses	56
OOH Dev Fellowship scheme	30
Total Earmarked	1,450
General Reserves	0
TOTAL Earmarked & General	1,450

GP Premises: balance of funding for improvement grants including the making of premises improvement grants to GP contractors. The continued digitalisation of paper GP records. Modifications for the purposes of improving ventilation and increase to the space available in NHS owned or leased premises for primary care multi-disciplinary teams.

National Drugs Medication Assisted Treatment (MAT) for embedding and implementation of the standards will he be overseen by the MAT implementation support team (MIST).

National Drugs Mission Moray: balance of funding for range of activities including: drug deaths, taskforce funding, priorities of national mission, residential rehabilitation, whole family approach, outreach, bear fatal overdose pathways and lived and living experience.

Out of Hours Winter Pressure funding: balance of funding to sustain GO out of hours and to support resilience to explore operational solutions.

Moray Cervical Screening: balance of funding for smear test catch up campaign.

Moray Hospital at home: development of Hospital at Home provides Acute hospital level care delivered by healthcare professionals, in a home context for a condition that would otherwise require acute hospital inpatient care.

Moray Psychological: funding streams for mental health, psychological wellbeing, facilities, post diagnostic support and psychological therapies.

Mental Health Officer (MHO) funding: funding to support additional mental health officer capacity.

Adult protection funding for care at home: balance of funding to build capacity in care at home community based services.

Adult Disability payment: funding to assist with the implementation of the adult disability payments.

National Trauma Training services: training for dealing with people affected by trauma and adversity.

Moray School nurse: funding to support NHS Grampian to retain school nurse posts.

Moray Winter Fund Health Care Social Workers (HCSW): additional funding for further HCSW in both the IJB and Emergency department.

Moray Winter fund Multi Disciplinary Team: additional funding for service pressures includes Discharge to Assess, Home First Frailty team and volunteer development.

Learning Disability Annual Health Checks: to implement the annual health checks.

Community Planning Partnership: funding towards community planning partnership.

Moray District Nurses: allocation to support recruitment and training of District Nurses.

Out of Hours (OOH) Development Fellowship Scheme: scheme to keep GP's within clinical practice, increase GP's confidence and competence in OOHs work

All reserves are expected to be utilised for their intended purpose during 2025/26

Set Aside

Excluded from the financial performance table but included within the Comprehensive Income & Expenditure Account is £15.639m for Set Aside services. Set Aside is an amount representing resource consumption for large hospital services that are managed on a day to day basis by the NHS Grampian. MIJB has a responsibility for the strategic planning of these services in partnership with the Acute Sector.

Set Aside services include:

- Accident and emergency services at Aberdeen Royal Infirmary and Dr Gray's inpatient and outpatient departments;
- Inpatient hospital services relating to general medicine, geriatric medicine, rehabilitation medicine, respiratory medicine, learning disabilities, old age psychiatry and general psychiatry; and
- Palliative care services provided at Roxburgh House Aberdeen and The Oaks Elgin.

The budget allocated to Moray is designed to represent the consumption of these services by the Moray population.

The figures for 2024/25 have been derived by uplifting 2019/20 figures by baseline funding uplift in 2020/21 (3.00%), 2021/22 (3.36%) ,2022/23 (6.70%), and 2023/24 (5.35%) and 2024/25 (6.64%):

	2024/25	2023/24	2022/23	2021/22	2020/21
Budget	**15.639m**	**14.665m**	**13.92m**	**13.04m**	**12.62m**

11. Looking forward – priorities for 2025/26

Health and Social Care Moray is in a period of change. With the appointment of Judith Proctor as Chief Officer the senior management team have led a review of the Strategic Delivery plan and set clear objectives with a focus on delivering improvements to services for people, whilst ensuring efficient and effective use of resources, ever mindful of the severe financial constraints that are affecting all Health and Social Care Partnerships, Local Authorities and NHS services.

Key priorities will be:

Realignment of Organisational Structures
A review of the HSCM organisational structure will take place to ensure that the right resources are in place and the governance structure to support implementation of plans is clear to ensure we drive progress to achieve our priorities. This will also include strengthening the integration and oversight of Children, Families and Justice services within our system to ensure that all partners fulfil their statutory obligations, whilst a review of current reporting arrangements will reduce any duplication in reporting whilst strengthening oversight of performance and delivery.

Strengthening Performance Oversight
With the approval of the revised Strategic Delivery Plan in May 2025 work is underway to review the performance framework and improve line of sight from the plan through to programmes and services who will deliver it so that we can clearly evidence the intended and actual impacts on outcomes for people.

Discharge without Delay (DWD)
There have been clear objectives set out at a National level for this programme of work and resources have been allocated to take this forward for Moray in collaboration with NHS Grampian and Scottish Government.

Digital solutions
Evaluation and implementation of digital tools, new systems and solutions will help in the provision of efficient and effective services. Research being led by DHI and the living labs will inform options for expanding the use of **Technology enabled care** information and tools available for people to be able to live at home and feel safe and supported and the Smart Housing that will help people to live independently whilst ensuring they are save. The developments of the **Community Connections** tool, and the **Personal Data Store** will be integrated into business as usual pathways so people have ownership of their information but can share it with those directly involved in their support to prevent having to repeat it.

Implementation of a new Social Work and Social Care Information Management system will enable services to utilise a modern system that is fit for the future and which will be able to link to other emerging technologies, ensuring we can provide responsive and well co-ordinated supports to people.

Expanding the principles of **Self-Directed Support** into all aspects of service provision and development of flexible frameworks to provide people with more choice and control over who provides support for them is underway.

The redesign of the **Care at Home** service will be implemented in the coming year with the aim of expanding capacity to meet the growing need, whilst continuing to further develop pathways to increase provision of care at home.

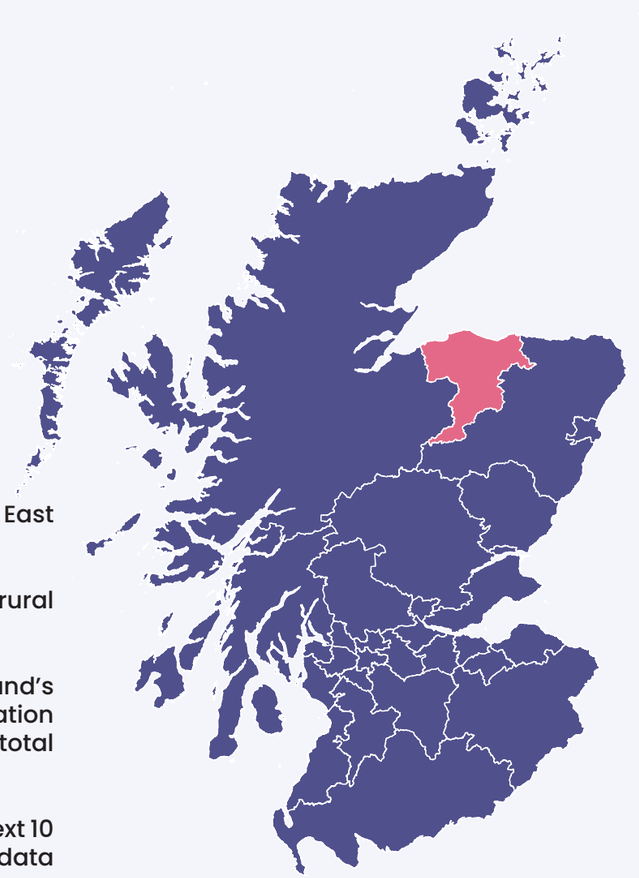
The Grampian wide pathway redesign of **Mental Health Services** is in progress and HSCM will be heavily involved to establish a sustainable service for Moray that ensures access to services needed.

A new website is under construction that is aimed to aid **Communication and Engagement** to provide more information about services and how to access them and a new system will be implemented that will facilitate engagement and two way communication with various groups. Through the implementation of a communication strategy, we will provide regular updates for staff on the financial delivery plan and strategic delivery plan progress, and key aspects of the organisation. We aim to deliver more direct, honest and open messaging with people to manage expectations and to ask for help and support from individuals and communities on identifying ways we can support them better.

Appendices

Appendix A

Moray Area Profile



- Moray spans 864 square miles in North East Scotland
- Comprising mainly coastal and rural communities
- Rounded Population 93,400 (Scotland's Census 2022 – Rounded population estimates, 2023), 1.72% of Scotland's total population.
- Population predicted to fall by 2.6% in next 10 years according to publicly available data last updated in 2022

Moray Age Profile		
(Data from Census 2022 (published 14/09/2023))		
		
0-14 year olds	15-64 year olds	People aged 65+
14,600	**58,200**	**21,500**
15.6% of population	62.3% of population	23.1% of population
(Scotland 15%)	(Scotland 65%)	(Scotland 20%)

Community

- In 2023 it was estimated that there were 43,891 households in Moray.
- 62.2% of adults living in Moray rate their neighbourhood as a good place to live (Scotland 59.1%)
- The crime rate in Moray is 41 per 1,000 population (Scotland 55)
- The rate of non-accidental fires in Moray is 13 per 10,000 population (Scotland 28)
- In Moray, 45 drug crimes are recorded per 10,000 population (Scotland 97)

Economic Status

- 12.5% of Moray households are estimated to be workless (Scotland 17.8%)
- 20.1% of children aged under 16 within Moray are living with low income families (UK 20.1%)
- In May 2023, 11.6% of all Moray households were on Universal Credit - 5,103 households (Scotland 18.7%)
- 63.6% of homes were in Council Tax Bands A-C, 7.34% were in Council Tax Bands F-H, compared to 60.0% and 14.2% respectively in Scotland.

Deprivation

- Moray is the second least deprived mainland local authority in Scotland (SIMD 20)
- 2.7% of Moray population live within the highest of the Scottish Index of Multiple Deprivation (SIMD) quintiles (most deprived)
- 13.3% live in the least deprived quintile.

Appendix B

Core suite of National Indicators

Source information from **Public Health Scotland**

Survey fieldwork was carried out between October and December in the financial year presented and respondents were asked about their experiences over the previous 12 months.

Please note results for indicators 2, 3, 4, 5, 7 and 9 for 2023/24 are not comparable to previous years due to changes in survey wording. Also results for 2019/20 and 2021/22 for indicators 2, 3, 4, 5, 7 and 9 are comparable to each other, but not directly comparable to figures in previous years due to changes in survey wording and methodology.

Calendar year 2024 is used here as a proxy for 2024/25 due to the national data for 2024/25 being incomplete. We have done this following guidance issued by Public Health Scotland which was communicated to all Health and Social Care Partnerships. Using the more complete calendar year data for 2024 should improve the consistency of reporting between Health and Social Care Partnerships.

National Indicator 1 (NI-1)

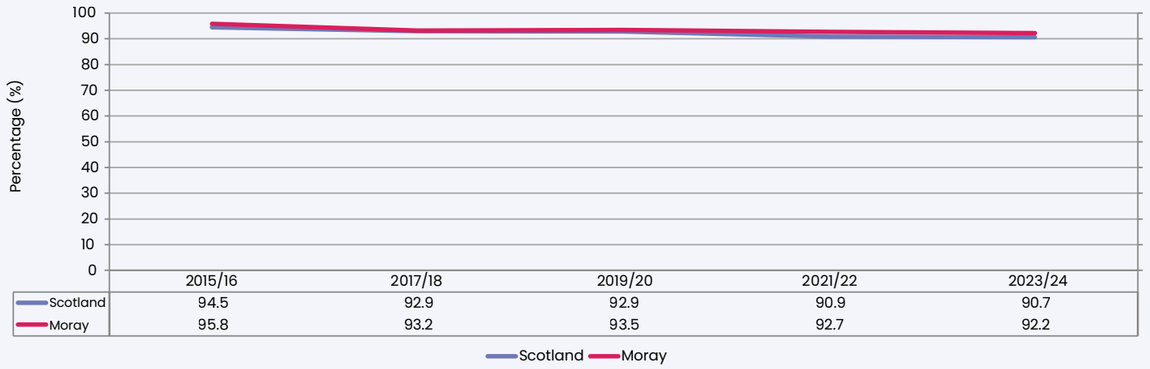
Percentage of adults able to look after their health very well or quite well

2023/24

92.2%

Moray's results for 2023/24, whilst very slightly reduced from the previous year, remain above the Scottish rate.

Note: Health and Care Experience Survey is a sample survey of people aged 17 and over registered with a GP practice in Scotland. A change in survey wording between 2019/20 to 2023/24 has resulted in a small sampling error so care needs to be taken when comparing results.



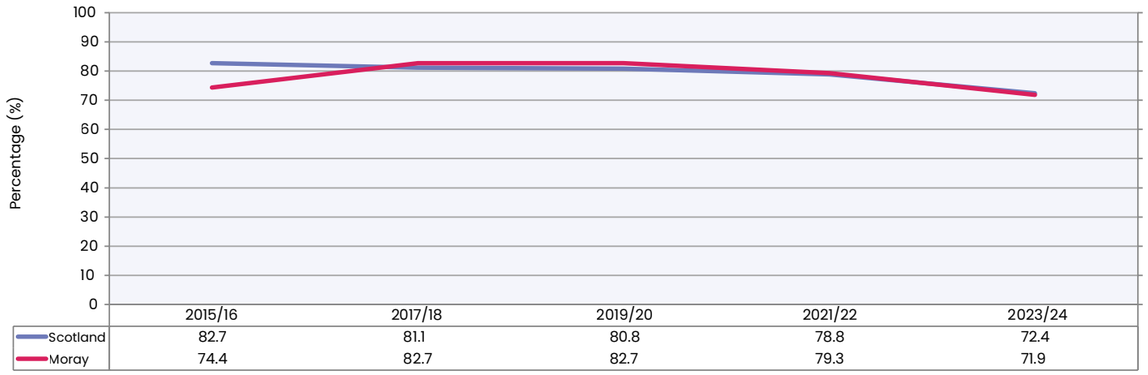
National Indicator 2 (NI-2)

2023/24

71.9%

Percentage of adults supported at home who agree that they are supported to live as independently as possible

Whilst there has been a reduction in this indicator over the period, the change in wording of the survey means we cannot compare previous years. It is however in line with the Scottish rate. This may reflect how people in the community feel, where there are continued levels of unmet need, following assessment. This remains a key focus to address and it is hoped that the work being undertaken in areas such as social prescribing, community health and wellbeing teams support and investigations into utilising developing digital technology to support people in their own homes may help release some capacity so that available care can be directed to those who these other solutions will not be suitable for.



	2015/16	2017/18	2019/20	2021/22	2023/24
Scotland	82.7	81.1	80.8	78.8	72.4
Moray	74.4	82.7	82.7	79.3	71.9

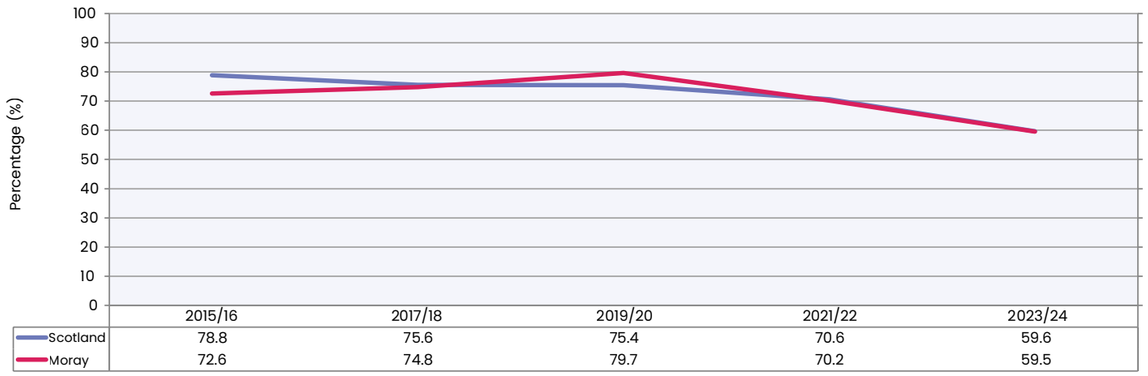
National Indicator 3 (NI-3)

2023/24

59.5%

Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.

This is another indicator in which HSCM are in line with national trends. It is disappointing that despite efforts to ensure that people are involved in how their support is provided, that people do not feel that they are. In relation to the care provided at home by our internal service the results from the recent care inspectorate report were excellent and the feedback from other inspections would indicate that the majority of people in receipt of services are happy and feel supported.



	2015/16	2017/18	2019/20	2021/22	2023/24
Scotland	78.8	75.6	75.4	70.6	59.6
Moray	72.6	74.8	79.7	70.2	59.5

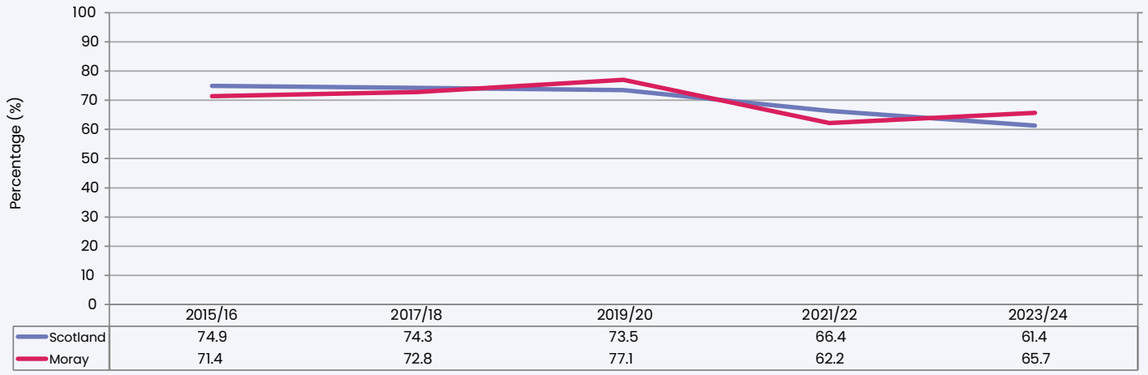
National Indicator 4 (NI-4)

2023/24

65.7%

Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated

Progress in this indicator is above the national rate. A direct comparison is not possible with previous years due to the change in wording of the survey.



	2015/16	2017/18	2019/20	2021/22	2023/24
Scotland	74.9	74.3	73.5	66.4	61.4
Moray	71.4	72.8	77.1	62.2	65.7

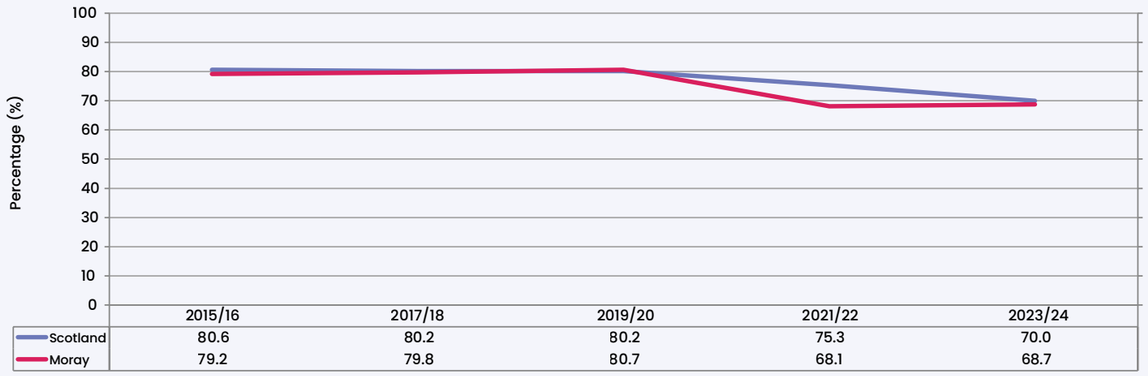
National Indicator 5 (NI-5)

2023/24

68.7%

Percentage of adults receiving any care or support who rate it as excellent or good

This indicator is now nearer the Scottish rate than it was previously. With the positive feedback from survey's undertaken locally for various inspections it was anticipated that there would be an improvement in this indicator. It may be that the positive results will be shown in next year, but in any case, feedback is actively sought and acted on to enable improvements to be made.



	2015/16	2017/18	2019/20	2021/22	2023/24
Scotland	80.6	80.2	80.2	75.3	70.0
Moray	79.2	79.8	80.7	68.1	68.7

National Indicator 6 (NI-6)

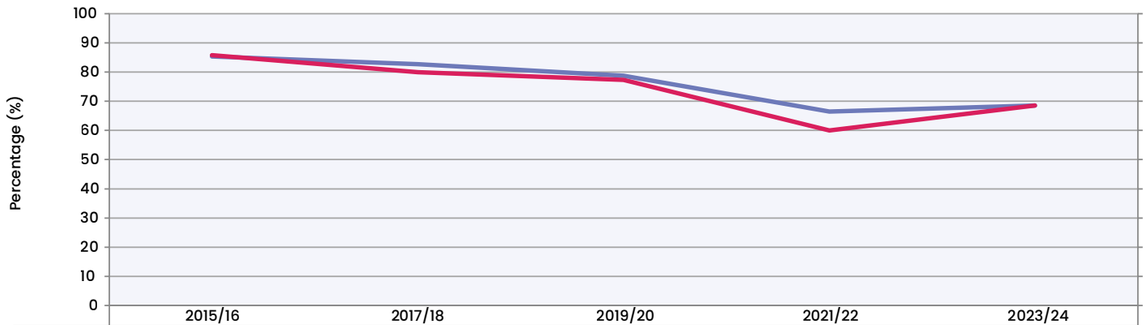
Percentage of people with positive experience of care at their GP practice

2023/24

68.6%

There has been a significant increase in the percentage of people with a positive experience of care at their GP practice and Moray is now in line with the Scottish rate.

Whilst the figures are below where we would want to be it reflects the ongoing challenges of providing care and support in the community, for an increasingly older population who have more complex health issues.



	2015/16	2017/18	2019/20	2021/22	2023/24
Scotland	85.3	82.7	78.7	66.5	68.5
Moray	85.8	80.0	77.3	60.0	68.6

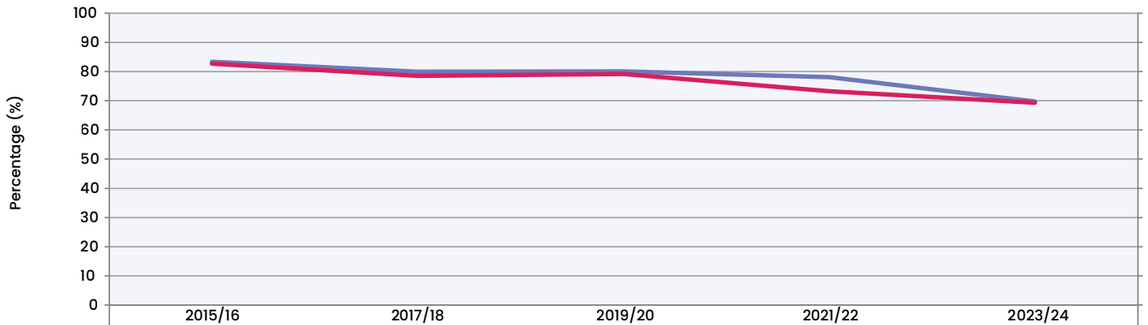
National Indicator 7 (NI-7)

Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life

2023/24

69.3%

Due to the change in wording of the survey we cannot draw a direct comparison to previous years, however it is encouraging that we are in line with the Scottish rate and whilst the percentage has dropped, it was not as big a drop as the Scottish rate.
Given the impact of the financial constraints on all health and care services, NHS and Local Authorities budgets it is likely that this indicator will not improve in the short term, and may in fact decrease, because the equivalent services and support are not available to the same amount of people as before. Efforts are being directed to encourage early intervention and prevention to assist people to take more ownership of their health and wellbeing.



	2015/16	2017/18	2019/20	2021/22	2023/24
Scotland	83.4	80.0	80.0	78.1	69.8
Moray	82.7	78.5	79.2	73.3	69.3

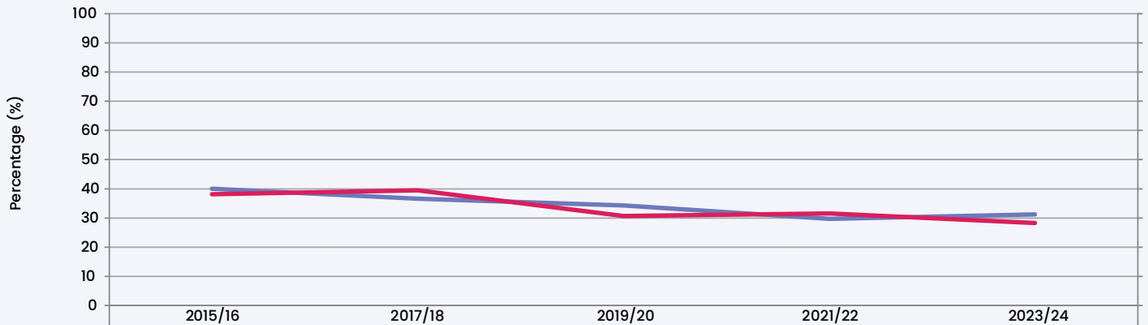
National Indicator 8 (NI-8)

Percentage of carers who feel supported to continue in their caring role

2023/24

28.2%

This result is below where HSCM would want it to be. Unpaid carers are an essential element of the provision of support and care in the community and it is a strategic priority for HSCM to support them. A new carers strategy was implemented during 2023/24 and work will continue to address the areas identified to try to have a positive impact on how carers feel.



	2015/16	2017/18	2019/20	2021/22	2023/24
Scotland	40.0	36.6	34.3	29.7	31.2
Moray	38.1	39.5	30.7	31.6	28.2

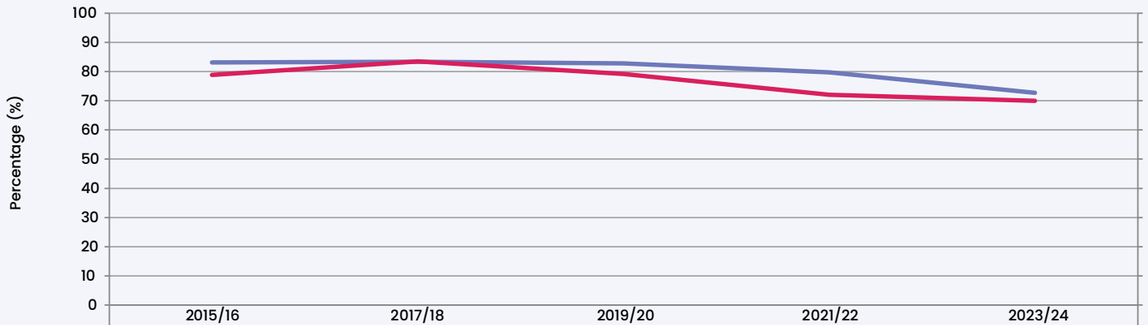
National Indicator 9 (NI-9)

Percentage of adults supported at home who agree they felt safe

2023/24

70.0%

Again, this is an indicator that we can't compare with previous years however there is less of a gap between the Scottish rate and Moray's position, which is positive. There is some way to go to get to the pre-Covid position but it is hoped that there will be a positive impact of the work that is being undertaken to conduct reviews to ensure people receive the support they need whilst drawing on the connections and relationships that people already have in their communities which is hoped will assist in establishing an increase in their feeling of safety.



	2015/16	2017/18	2019/20	2021/22	2023/24
Scotland	83.2	83.3	82.8	79.7	72.7
Moray	78.8	83.5	79.2	72.1	70.0

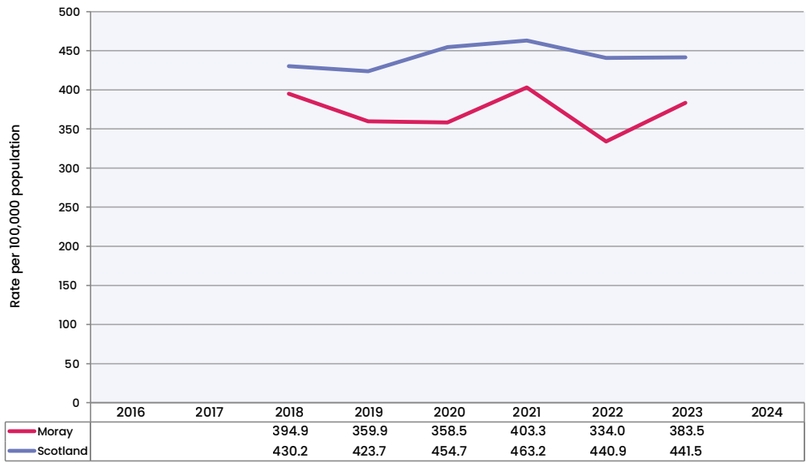
National Indicator 11 (NI-11)

Premature mortality rate per 100,000 persons

2023

384

Moray's premature mortaility rate remains lower than the rate for Scotland although the rate has increased since 2022. Figures for 2024 are not yet available.



	2016	2017	2018	2019	2020	2021	2022	2023	2024
Moray			394.9	359.9	358.5	403.3	334.0	383.5	
Scotland			430.2	423.7	454.7	463.2	440.9	441.5	

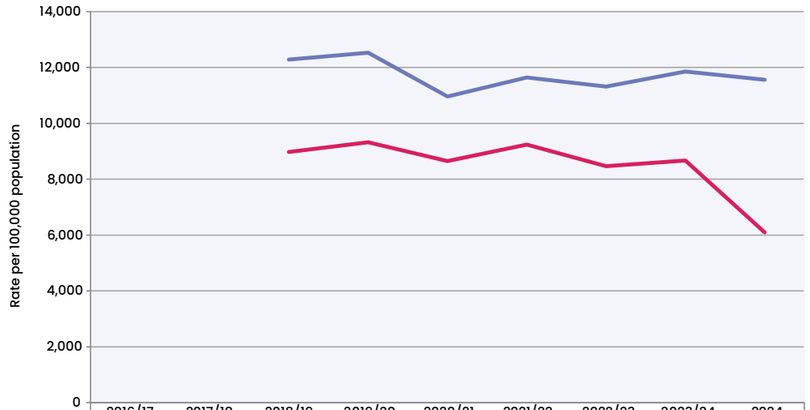
National Indicator 12 (NI-12)

Emergency admission rate (per 100,000 population)

2024

6096

The emergency admission rate for 2024 remains much lower than the emergency admission rate for Scotland.



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024
Moray			8973.2	9319.3	8645.8	9240.7	8468.9	8668.9	6095.5
Scotland			12284.7	12532.2	10964.8	11645.3	11318.5	11859.1	11559.0

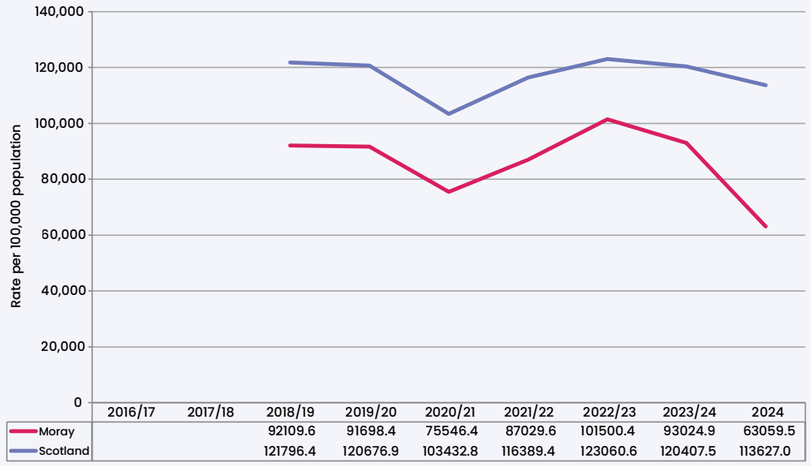
National Indicator 13 (NI-13)

Emergency bed day rate (per 100,000 population)

2024/25

63,060

Moray continues to be below the Scottish rate in relation to the emergency bed day rate.



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024
Moray			92109.6	91698.4	75546.4	87029.6	101500.4	93024.9	63059.5
Scotland			121796.4	120676.9	103432.8	116389.4	123060.6	120407.5	113627.0

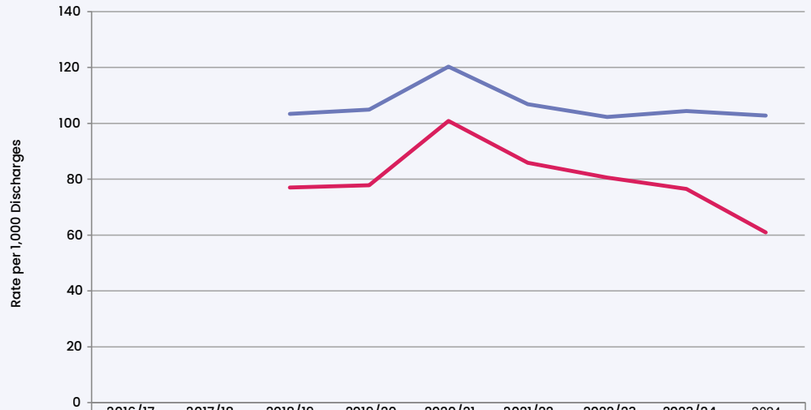
National Indicator 14 (NI-14)

Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)

2024

61

Emergency readmissions within 28 days has continued on the decreasing trend and is at the lowest figure since 2020/21.



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024
Moray			77.1	77.8	100.9	85.9	80.6	76.5	61.0
Scotland			103.4	104.9	120.3	106.8	102.3	104.4	102.8

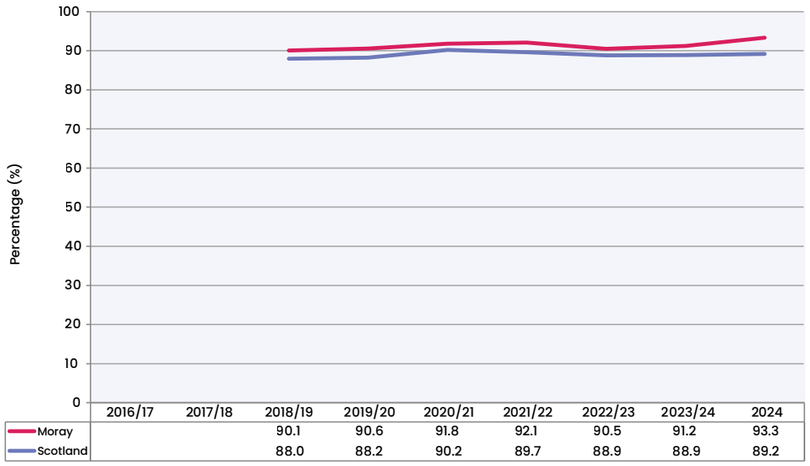
National Indicator 15 (NI-15)

Proportion of last 6 months of life spent at home or in a community setting

2024

93.3%

With a further increase on 2023/24, Moray continues to be above the Scottish rate for the last 6 months of life being spent at home or in a community setting.



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024
Moray			90.1	90.6	91.8	92.1	90.5	91.2	93.3
Scotland			88.0	88.2	90.2	89.7	88.9	88.9	89.2

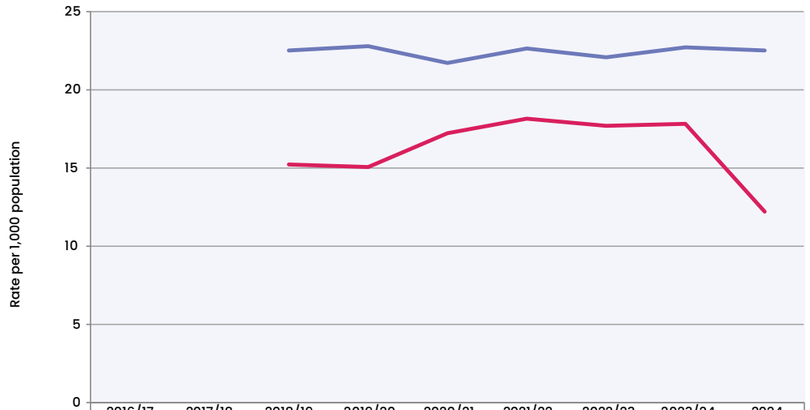
National Indicator 16 (NI-16)

Falls rate per 1,000 population aged 65+

2024

12.2

The rate of falls per 1,000 population aged 65+ is lower than in previous years, despite little change in the Scottish rate, and Moray remains below the Scottish rate. Our rate is now back to pre-Covid levels and remains a focus area for the partnership, due to its impact on people's health and wellbeing.



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024
Moray			15.2	15.1	17.2	18.2	17.7	17.8	12.2
Scotland			22.5	22.8	21.7	22.6	22.1	22.7	22.5

National Indicator 17 (NI-17)

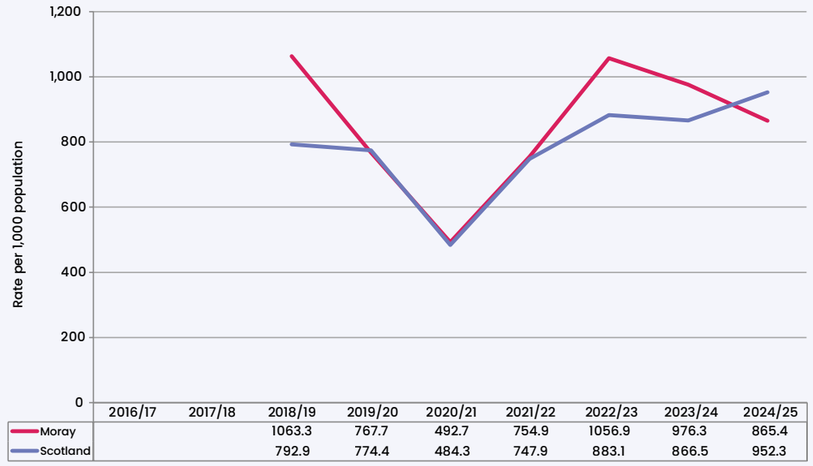
Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

2024/25

73.8%

The rate of falls per 1,000 population aged 65+ is lower than in previous years, despite little change in the Scottish rate, and Moray remains below the Scottish rate. Our rate is now back to pre-Covid levels and remains a focus area for the partnership, due to its impact on people's health and wellbeing.

We continue to support internal and external partners to improve services across all the communities in Moray.



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Moray			1063.3	767.7	492.7	754.9	1056.9	976.3	865.4
Scotland			792.9	774.4	484.3	747.9	883.1	866.5	952.3

National Indicator 18 (NI-18)

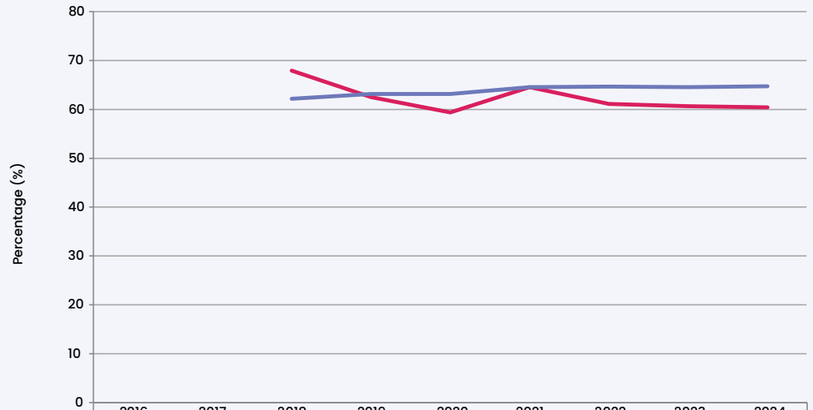
Percentage of adults with intensive care needs receiving care at home

2024

60.4%

This indicator has had a small decrease which indicates less of our adults with intensive care needs are receiving care at home and may be in a long term care setting. It remains below the Scottish rate of 64.7%.

It is anticipated that the level of need will increase with the aging population trend in Moray. Early intervention and Prevention is one of the key heading in Morays Strategic plan focussing on preventing escalating need or risk.



	2016	2017	2018	2019	2020	2021	2022	2023	2024
Moray			67.9	62.5	59.4	64.5	61.1	60.6	60.4
Scotland			62.2	63.1	63.1	64.5	64.7	64.5	64.7

National Indicator 19 (NI-19)

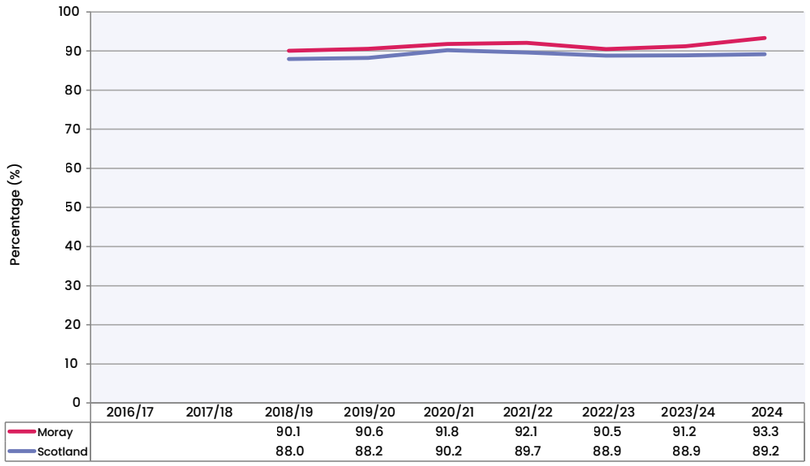
Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)

2024/25

865

There has been another reduction in number of days people spend in hospital (per 1,000 population) since 2022/23, with Moray now lower than the Scottish rate for the first time since 2019/20.

Efforts continue to be made to reduce delays to discharge so that people do not become dependent on support from remaining in hospital too long and so they can return home as soon as it is safe for them to do so.



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024
Moray			90.1	90.6	91.8	92.1	90.5	91.2	93.3
Scotland			88.0	88.2	90.2	89.7	88.9	88.9	89.2

Appendix C

Local indicators

Indicator	2020/21 (Q4)	2021/22 (Q4)	2022/23 (Q4)	2023/24 (Q4)	2024/25 (Q4)	Target
A&E Attendance rate per 1000 population (all ages)	17.8	20.2	22.6	22.6	**22**	21.9
Throughout 2024/25 the figure has hovered around the target of 21.9 and whilst there was a slight increase in numbers presenting the last two quarters of the year it was still below the high in March 2024. Emergency Departments are under considerable pressure and whilst considerable efforts have been made to inform people about alternative sources of emergency care such as pharmacies, dentists, opticians and NHS24 further detailed work will be undertaken to try to understanding why and how people access emergency care, to help us develop intelligence about avoidable attendances, and how we can intercept them through alternative early prevention and intervention work.						
Number of delayed discharges (Inc. code 9) at census point	17	46	26	43	**40**	26
Delayed discharges continue to fluctuate despite significant efforts from across many teams and services to reduce the delays and the potential negative impacts for people. There has been sustained focus of daily multi-disciplinary meetings with colleagues in Dr Grays and ARI to support collaborative decision making and improve system flow. All delayed discharges over 90 days are subject to enhanced scrutiny and actions to facilitate discharge prioritised. Challenges with provision of care at home in rural locations and increased complexity of needs of frail, elderly patients requiring discharges whilst maintaining choice and control for individuals need to be addressed. It is hoped that initiatives such as "Moving with Dignity"(proportionate care) will help discharges through the use of equipment and tools to assist those with mobility issues and reduce the need for double up care (two carers). The nationally led programme Discharge Without Delay is being taken forward across Grampian in collaboration with NSH Grampian and Health Intelligence Scotland to progress system wide actions to reduce delays and the clear performance targets identified will provide oversight of the progress being made over the next year.						
Number of bed days occupied by delayed discharges (incl. code 9) at census point	496	1294	751	1501	**1149**	850
The number of bed days has decreased from the high in March 2024 but is still sitting well above target and showing an increasing trend. The initiatives and focus on delayed discharges should reduce this number over the next year.						
Rate of emergency occupied bed days for over 65s per 1000 population	1773	2140	2749	2509	**2412**	2681
The figures are showing a reducing trend and have been below target throughout the year.						
Emergency admission rate per 1000 population for over 65's	174.8	183	185.8	179.7	**177.8**	187
This year the rates have been significantly lower than the previous year, with the exception of the period October to December, where there was peak in previous year's which indicates it may be a seasonal variation.						

Indicator	2020/21 (Q4)	2022/23 (Q4)	2023/24 (Q4)	2023/24 (Q4)	2024/25 (Q4)	Target
Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	119.3	125.2	129.2	125.8	**125.7**	131
This rate is well below the target albeit there is slight increasing trend.						
% Emergency readmissions to hospital within 7 days of discharge	5%	3.4%	3.6%	4.4%	**3.9%**	3.7%
This indicator has fluctuated during the year with a high in September, and although it has just gone over target it is below the March 2023/24 figure and overall is stable						
% Emergency readmissions to hospital within 28 days of discharge	9.8%	8.0%	7.5%	8.3%	**7.4%**	7.9%
This rate has been showing a slight decreasing trend and with the exception of a high in September 2024 has been below target. The increase in September figures has been reflected over several years so may be a seasonal variation.						
% of patients commencing Psychological Therapy Treatment within 18 weeks of referral	100%	33%	73%	57%	**65%**	90%
This indicator has reflected the challenge the service is experiencing with significantly increased demand and despite initiatives to undertake group work (where appropriate) to increase throughput and maximise capacity it has not been possible to generate the capacity required to meet the standard and achieve the target.						
NHS Sickness Absence (%of hours lost)	3.1%	4.7%	5.9%	5.7%	**4.9%**	4%
Council Sickness Absence (% of calendar days lost)	-	8.9%	9.7%	9.7%	**8.2%**	4%
Application of the appropriate absence monitoring procedures are monitored closely and support provided to individuals as required to ensure that absences are minimised. There are various wellbeing initiatives and supports available to staff and managers, such as vaccination campaigns for flu and Covid-19 to reduce severity and duration of illness, workstation assessments where ergonomic equipment is needed and access to Occupational Health Service to provide support for both physical and mental health issues.						

Appendix D

Moray Integration Joint Board decisions and directions

Agendas and reports for all MIJB meetings during 2024/5 are set out in the papers which are published on the Moray Council website.

Board meetings are open to the public and webcast, meaning they can be watched remotely as they happen or the recording viewed at a later time.

2024

May 2024	• Agreed to note the expected financial position at the end of the current financial year and the implications for 2024/25 and noted the recovery action plan and the intent to progress the savings highlighted. • Agreed to note the updated Financial Strategic Risk Register which provides an overview of the strategic financial risks, along with a summary of actions which are in place to mitigate those risks. • Formally approved the revenue budget for 2024/25, following consideration of the risks highlighted in the report.
June 2024	• Approved the unaudited Annual Accounts to be submitted to the external auditor, noting all figures remain subject to audit. Noted the Annual Governance Statement and accounting policies applied in the production of the unaudited Annual Accounts. • Approved the updated Local Code of Corporate Governance which supports the Annual Governance Statement. • Approved the MIJB Directions Policy.
September 2024	• Approved the Audited Annual Accounts for the financial year 2023/24 • Approved the Moray Mental Health and Wellbeing Delivery Plan 2024-2026 and approved the proposed governance structure in Moray. • Approved the Adult Joint Strategic Needs Assessment 2024 for Moray. • Approved the publication of the Health and Social Care Moray Annual Performance Report 2023/24. • Approved the publication of the Health and Social Care Moray Annual Complaints report 2023/24.
November 2024	• Approved the draft Public Sector Climate Change submission to Sustainable Scotland Network for the reporting year 2023/24.

2025

January 2025	• Endorsed the establishment of the Grampian Strategic Change Board. • Endorsed the collaborative approach proposed to develop a Route Map for Strategic Change. • Agreed that the IJB Chief Officers should actively participate in the development and implementation of the Route Map for Strategic Change and work collaborative with other partners to ensure the success of this crucial transformation program. • Approved the charges for services for the 2025/26 financial year for recommendation to Moray Council for approval and inclusion into their budget setting processes. • Approved the Children's Services Plan 2023/24 annual report. • Approved the outline business case for the replacement of the Social Work and Social Care case management system. • Endorsed the collaborative whole system approach being taken in Moray and by partners across Grampian with regards to the Getting in Right for Everyone (GIRFE) programme. • Agreed to adopt the Standards Commission's Model Code of Conduct for Members of Devolved Bodies as the Code of Conduct for the Moray IJB.
March 2025	• Approved the 2025/26 proposed savings plan. • Formally approved the Revenue Budget for 2025/26. • Approved the updated Medium Term Financial Framework. • Approved the draft Moray IJB Equality Mainstreaming Progress Report 2021-2024 for publication by April 2025. • Approved the strategic objectives of the Strategic Care at Home Group.

Appendix E

Changes to Membership of Moray Integration Joint Board during 2024/25

- **Councillor Tracy Colyer** became MIJB Chair on 1 April 2024. She resigned from the Board in September 2024. **Denis Robertson**, Vice-chair, took over the role of Chair until the end of 2024/25.
- **Councillor Elaine Kirby** takes on the role of Chair of the Board from 1 April 2025 until 30 September 2025, following which the role of Chair will revert back to a Health Board Member in line with the Integration Scheme.
- Following an open recruitment process, **Sheila Brumby** was appointed as Service User Stakeholder and Janette Topp as Third Sector Stakeholder in May 2024. Ms Topp resigned from the Board on 11 February 2025.
- NHS Grampian nominated **Alex Stephen**, Director of Finance, to MIJB, as of 1 July 2024. **June Brown,** Executive Nurse Director, is Mr Stephen's nominated substitute.
- **Dr Malcolm Simmons**, GP Lead, stood down from the Board on 31 March 2025. This vacancy will not be recruited to. **Dr Robert Lockhart**, GP Lead, will continue as member of the MIJB and Clinical and Care Governance Committee.
- **Judith Proctor** was appointed Chief Officer of the MIJB and HSCM in November 2024, having served as Interim Chief Officer for the previous five months. She succeeded **Simon Bokor-Ingram** who stepped down from the position at the end of May 2024 due to health reasons.
- **Jim Lyon** was appointed Interim Chief Social Work Officer and Head of Service in June 2024. He succeeded **Tracey Stephen** who stepped down from the MIJB on her relocation to take up a role with a local authority in England.

Agendas and reports for all MIJB meetings during 2024/25 are set out in the document packs which are published on the Moray Council website.

Hybrid board meetings combine in-person attendance with remote participation, via video conferencing. They are open to the public to attend and are also webcast, meaning they can be watched remotely as they happen or the recording viewed at a later time.

Appendix F

Inspections of services

The annual performance report requires the MIJB to report on inspections by external bodies.

Joint Inspection

Adult Support and Protection

Moray's multi-agency Public Protection Partnership has evidenced substantial improvement in supporting and protecting adults at risk of harm.

The positive impact achieved by local authority, health and police colleagues in their work to keep people safe, has been acknowledged with publication in October 2024 of the Joint Inspection of Adult Support and Protection in Moray.

The progress review by the Care Inspectorate and its scrutiny partners was a follow-up to a joint inspection carried out in 2022. On their return in August, inspectors found significant progress had been achieved across all seven priority areas identified for improvement.

Key accomplishments identified in the progress report include:

- Consistent application and delivery of key processes: Frontline staff were confident and highly professional. The partnership overall followed its comprehensive multi-agency adult support and protection procedures rigorously.
- Improved investigations: Full adult support and protection investigations were now carried out for all adults at risk of harm who required them. The quality of these investigations had significantly improved, with almost all rated as good or better. This was described by inspectors as "another impressive improvement."
- Enhanced management of risk: The quality of chronologies (recording the order of events), risk assessments, and protection plans had greatly improved. Presence of risk assessments required further improvement, so that all adults at risk of harm had one.
- Effective case conferences: Case conferences were now clearly defined and held for all adults at risk of harm who required them. There were competent and well-executed, with almost all rated good or better for quality. The partnership was actively working to support people to participate in their own case conferences.
- Strategic leadership: The partnership had rigorously implemented its improvement plan following the 2022 inspection and taken forward a range of notable improvement focused activities.
- Strengthen governance: Robust measures were in place to identify concerns early and promptly implement remedial action. Operational managers worked diligently and effectively to bring about necessary improvements to adult support and protection.
- Multi-agency self-evaluation: The partnership had achieved significant progress and its cohesive programme of multi-agency audits and quality assurance activities was successful. Frontline staff were involved in informing the improvement work.

Care Inspectorate

The following services managed by the HSCM were inspected in 2024/25.

Short Term Assessment and Reablement Team (START) - Support Service

Key messages:

- People enjoyed support which was dignified and respectful.
- Staff felt supported by their supervisors and colleagues.
- Staff recruitment was managed well by the service.
- People's reablement benefitted from good links between the service and other health and social care colleagues.
- Improvements were required to ensure people benefitted from safe medication procedures.
- Care plans required more detail and more regular review.

Evaluation of service

How well do we support people's wellbeing?	4 - Good
How good is our leadership?	4 - Good
How good is our staff team?	5 – Very good
How well is our care and support planned?	3 - Adequate

Moray Supported Lodgings Project – Adult Placement Services

Key messages:

- The management team evidenced insight to service gaps and provided a service improvement plan, which is in the early stages of implementation.
- The impact of a six-month vacancy of the only supervising social worker post has had a negative impacted on predictable support for caregivers and taking forward service improvement plans.
- Supported lodging caregivers provide young people with a safe and stable home base.
- Young people are supported to reconnect with family and establish a positive network of support that aligns with their ethnicity, culture, traditions, and beliefs.
- Educational attainment is a high priority with young people, who are enrolled in 'English as an additional language lessons, and secondary and further education provisions.
- Young people benefit from leading and directing their own support within a multi-agency approach to care planning.

Evaluation of service

How well do we support people's wellbeing?	3 - Adequate
How good is our leadership?	3 - Adequate
How good is our staff team?	2 - Weak
How well is our care and support planned?	4 - Good

Community Support Service - Housing Support Service

Key messages:

- People were supported by staff who were kind and caring.
- People were supported to access health care, meaning their care and support benefitted their health.
- Improvements were required to ensure people benefitted from safe medication procedures.
- Quality assurance checks and audits, that should improve people's care, required further development.
- People did not know who was supporting them and were not confident that they received the correct amount of support.
- People's care, and care plans, had not been reviewed regularly.

Evaluation of service

How well do we support people's wellbeing?	**3 - Adequate**
How good is our leadership?	**3 - Adequate**
How good is our staff team?	**3 - Adequate**
How well is our care and support planned?	**3 - Adequate**

Mental Welfare Commission for Scotland

Muirton Ward, Seafield Hospital, Buckie

An announced visits was carried out on 11 July 2024 to Muirton Ward at Seafield Hospital, Buckie, which is an older adult assessment unit for people with dementia.

Key positive findings:

- **Compassionate Care:** Individuals and most relatives described staff as caring, approachable, and experienced. The ward atmosphere was calm and settled.
- **Environment:** The ward offered spacious and dementia-friendly areas, with good use of garden and communal spaces. Privacy was respected, and signage aided navigation.
- **Care records:** Files were well organised, and care plans addressed both physical and mental health needs. Covert medication and legal documents were appropriately documented.
- **Physical health monitoring:** There was consistent attention to physical health alongside mental health needs.
- **Rights awareness:** Advocacy services were engaged, and information on rights was visible and included in carers' information packs.

The Commission made five recommendations:

- Ensure a formal process is in place to regularly review risk assessments and risk management plans.
- Provide dedicated psychology support to inform care and assist with recovery, particularly in managing complex or distressed behaviours.
- Review and improve the system for obtaining updates from community services (e.g. social work) to support timely discharge planning.
- Ensure all psychotropic medications are legally authorised and that a regular audit process is implemented to maintain compliance.
- Appoint a dedicated activity therapist to support a structured and meaningful activity programme tailored to individual and group needs.

Ward 4, Dr Gray's Hospital, Elgin

An announced visit was carried out on 16 October 2024 to Ward 4, Dr Gray's Hospital, Elgin, which is an18-bedded adult acute psychiatric admission ward for adults.

Key positive findings:

- **Staff dedication:** Most individuals spoke positively about the caring and helpful nature of staff.
- **Patient involvement:** People felt involved in decisions about their treatment and had regular access to their consultant psychiatrist.
- **Improved discharges:** There has been some progress in discharging long-stay patients, although challenges remain due to delays in arranging community support.
- **Electronic records:** The introduction of the TRAKCare healthcare information system has improved record-keeping, with more consistent and detailed updates.
- **Multidisciplinary team (MDT) records:** MDT meeting documentation has significantly improved, providing clear, detailed summaries of care and treatment decisions.

The Commission made 10 recommendations, including:

- Better risk assessment and care planning.
- Improving the quality of care plans
- Ensuring access to psychology and pharmacy support.
- Developing a seven-day activity programme.
- Addressing outstanding environmental safety issues.
- Improving legal compliance and promoting patient rights.

HSCM submitted improvement action plans to address the recommendations from both visits.

Inspections of externally commissioned services

Care and support is commissioned from independent and third sector providers and these services are subject to contract monitoring by the Commissioning service to ensure that services are safe, effective and that they meet people's needs.

Performance is monitored through formal contract meetings, review of compliments, complaints and feedback from staff, carers and people who use services. Visits to providers involve observing care and support and looking at records and documents. The team also work closely with the Care Inspectorate.

The following services commissioned by the partnership were inspected by the Care Inspectorate in 2024/25.

The six-point scale

6	Excellent	Outstanding or sector leading
5	Very good	Major strengths
4	Good	Important strengths, with some areas for improvement
3	Adequate	Strengths just outweigh weaknesses
2	Weak	Important weaknesses - priority action required
1	Unsatisfactory	Major weaknesses - urgent remedial action required

NA = Not Assessed or Not Applicable

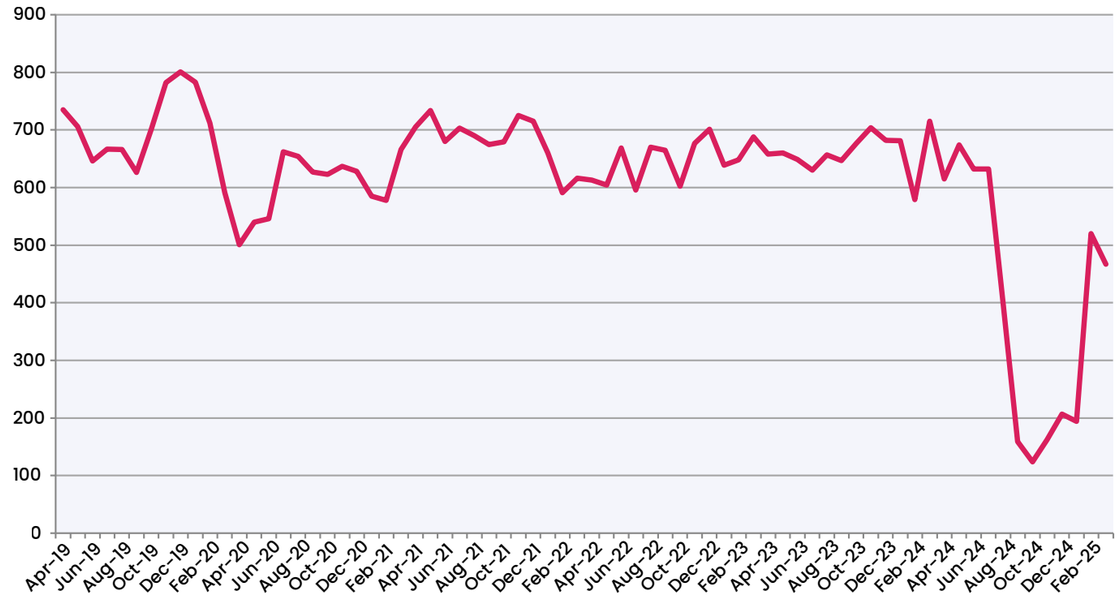
Name of service	Service Provider	How well do we support people's wellbeing?	How good is our leadership?	How good is our staff team?	How good is our setting?	How well is our care and support planned?
Wakefield Nursing Home, Cullen	Parklands Group	4	4	4	4	4
Abbeyside Care Home, Elgin	Abbeyside Care Group	4	NA	4	NA	NA
Spynie Care Home, Elgin	Intobeige	3	4	3	4	4
Moray Services (Housing Support)	Cornerstone	4	3	3	NA	3
The Grove Care Home, Elgin	Abbeyside Care Group	4	5	5	NA	NA

Name of service	Service Provider	How well do we support people's wellbeing?	How good is our leadership?	How good is our staff team?	How good is our setting?	How well is our care and support planned?
Meadowlark Care Home, Forres	Renaissance Care	4	5	5	4	5
Ark Moray support service, Forres	Ark Housing Association	3	4	3	NA	NA
Care at Home	Care Quality Services Limited - Moray	3	3	3	NA	NA
Cathay Nursing Home, Forres	Wallace Management Services Limited	4	4	4	4	4
Wakefield House Care Home	Parklands Group	4	4	4	4	4
Greyfriars Close, Elgin	Turning Point Scotland	4	4	4	NA	4
Moray Services	Cornerstone	4	3	3	NA	3
SAMH Housing support service	SAMH	5	6	NA	5	5
Parkholme, Lossiemouth	Cornerstone	3	3	3	3	3
RLO, Elgin	Real Life Options	5	5	NA	5	5
Chandlers Rise, Elgin	Hanover Housing Support Service - Care (North)	4	4	NA	4	4
Cornerstone Buckie	Cornerstone	5	5	NA	5	5

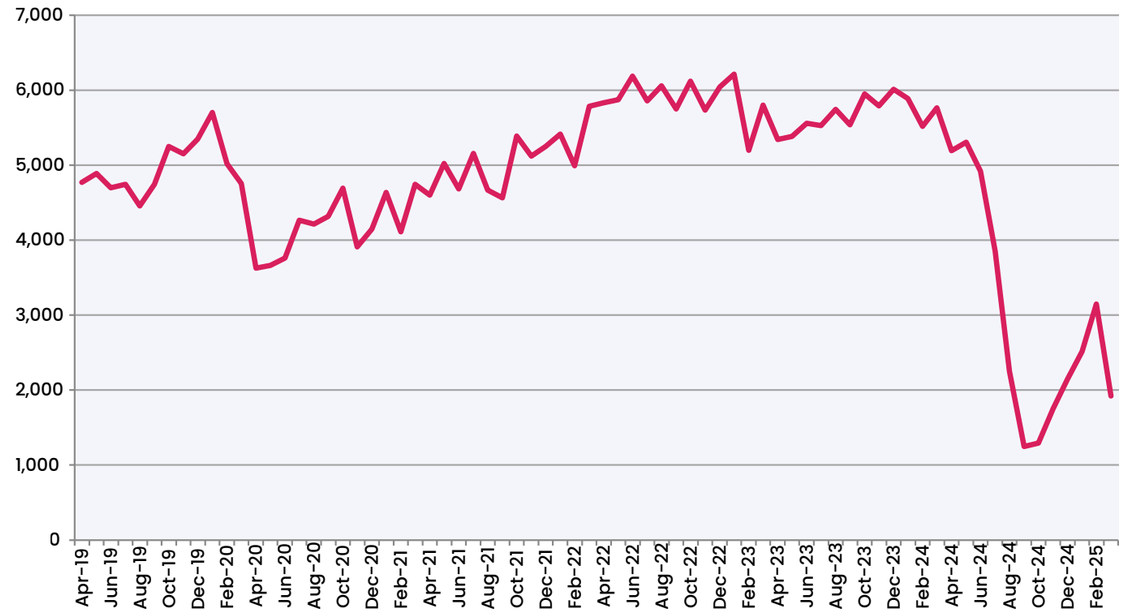
Appendix G

Ministerial Strategic Group Indicators

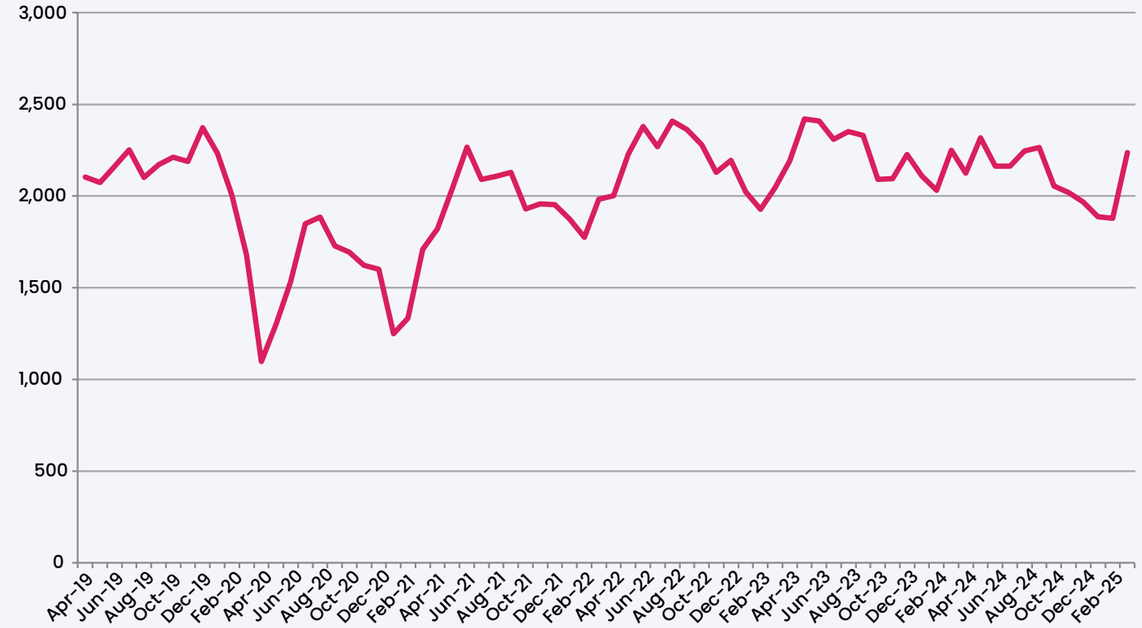
1 - Number of emergency admissions



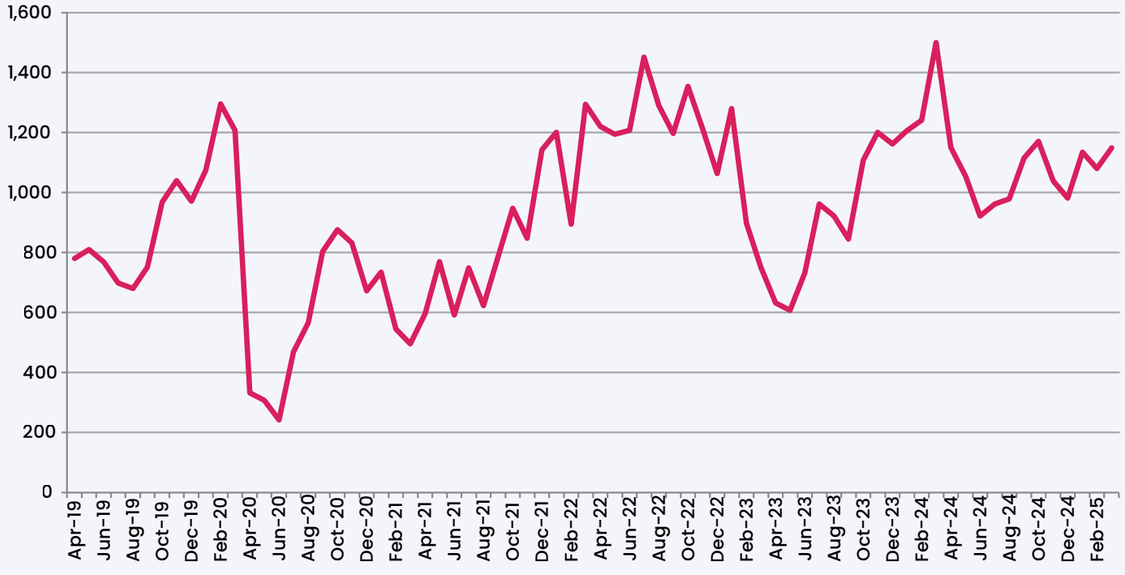
2 - Number of unscheduled hospital bed days (Acute/Geriatric Long Stay/Mental Health)



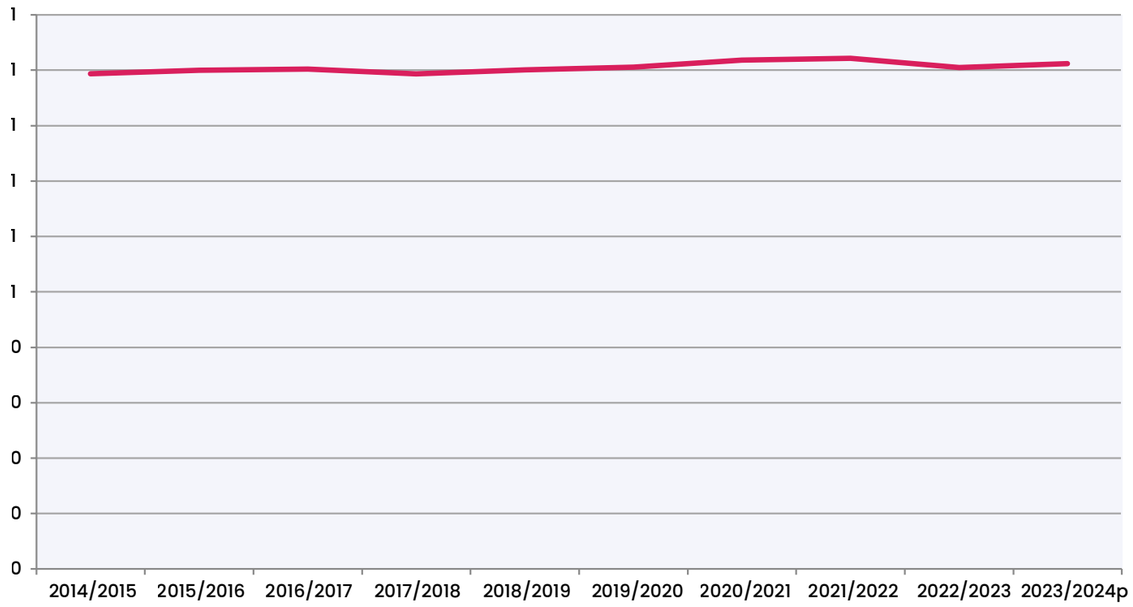
3 - Number of A&E attendances



4 - Number of Delayed Discharge bed days

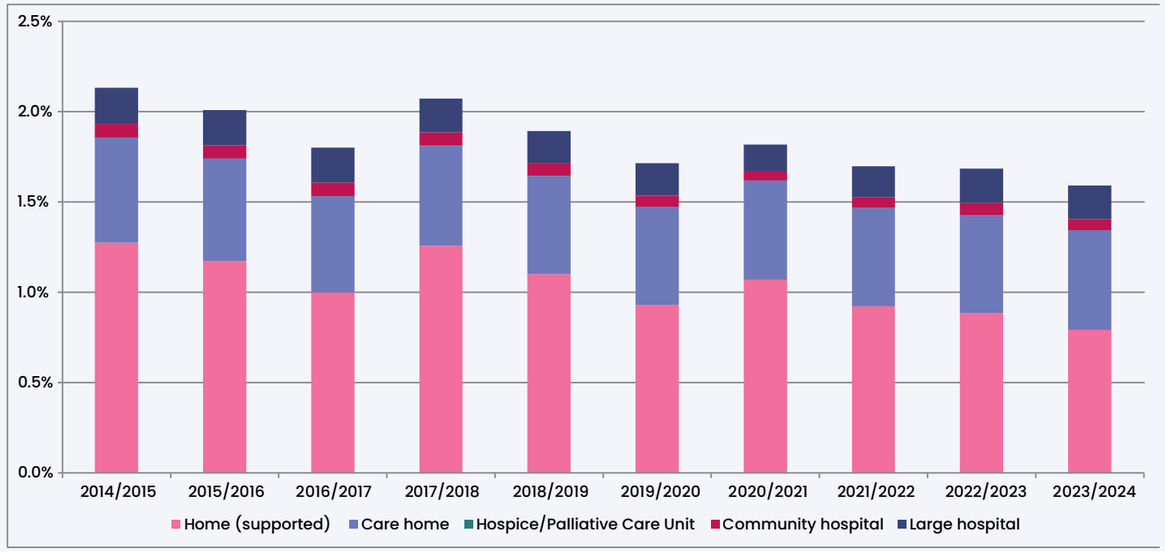


5 - Percentage of last 6 months of life



Setting	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Community	90.2%	89.4%	90.1%	90.5%	91.8%	92.1%	90.5%	91.2%
Community Hospital	4.2%	4.6%	4.4%	3.6%	3.2%	2.5%	2.8%	2.6%
Large Hospital	5.6%	6.0%	5.5%	5.7%	5.0%	5.2%	6.5%	6.1%
Palliative	0.1%	0.0%	0.0%	0.1%	0.0%	0.1%	0.2%	0.1%

6 - Balance of care: Percentage of population in a community or institutional settings



Age Group	Setting	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
All	Acute	0.2%	0.2%	0.1%	0.2%	0.2%	0.2%
All	Care Home	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
All	Community Hospital	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%
All	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
All	Home (supported)	1.1%	1.1%	1.1%	0.9%	0.9%	0.9%
All	Home (unsupported)	98.1%	98.1%	98.3%	98.3%	98.3%	98.4%
65+	Acute	0.5%	0.5%	0.4%	0.4%	0.5%	0.5%
65+	Care Home	2.5%	2.4%	2.4%	2.3%	2.5%	2.6%
65+	Community Hospital	0.1%	0.2%	0.2%	0.2%	0.2%	0.3%
65+	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
65+	Home (supported)	4.2%	4.0%	3.6%	2.7%	2.7%	2.7%
65+	Home (unsupported)	92.6%	93.5%	93.4%	94.1%	94.2%	94.8%
75+	Acute	0.7%	0.7%	0.5%	0.6%	0.6%	0.6%
75+	Care Home	4.9%	4.8%	4.8%	4.6%	4.5%	4.7%
75+	Community Hospital	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
75+	Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
75+	Home (supported)	6.1%	6.1%	6.0%	4.6%	4.6%	4.1%
75+	Home (unsupported)	86.1%	88.0%	87.8%	89.3%	89.6%	90.0%

HEALTH & SOCIAL CARE MORAY

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