APPENDIX 2: WORKING TOGETHER

Working Together

Stakeholder engagement is a process that goes well beyond the traditional ways of involving service users, carers, local people, organisations and health professionals. Engagement means giving the people of Moray the power in determining and designing services and in selecting providers. This document summarises our shared approach to strategic commissioning and how we worked as partners to develop the Moray Strategic Plan.

1.0 Strategic Planning Steering Group

A Strategic Planning Steering Group was established across health and social care, the group had the role of leading and driving the development of the strategic plan through a wider stakeholder group - Strategic Planning Group.

1.1 Strategic Planning Group

A Strategic Planning Group was established for the purpose of developing, finalising and reviewing the strategic commissioning plan. It's remit was to provide the necessary guidance, support and direction so the strategic plan is in line with the vision articulated within the Moray Integration Scheme and with the national Health and Wellbeing outcomes.

The group had representation from all sectors and includes people who use health and social care services and their carers. It includes key stakeholders across the local authority, NHS, Third and Independent Care sectors.

The Group was chaired by The Chief Officer of the Health & Social Care Partnership and the group reports to the Moray Community Health and Social Care Partnership Integrated Joint Board.

Table 1 details the membership as at April 2015:

Strategic Planning Group Membership:	
Aileen Marshall, OPRG rep/Area Forum rep	Pam Gowans, Chief Officer MHSCP
Aimee Borzoni, Carers Strategy Officer	Patricia Robertson, OPRG rep
Alasdair Walker, Clinical Lead/Service Manager Mental Health	Paul Johnson, Service Manager Drug & Alcohol
Lesley Attridge, Service Manager	Pauline Maloy, Health Intelligence
Alison Sands, Consultant Geriatrician	Robin Paterson, Project Officer
Alison Smart, Service Manager	Roddy Huggan, Commissioning Manager
Alistair Kennedy, Chair Joint Community Councils	Sandra Anderson, Manager the Oaks
Angus Henderson, Dental Manager	Sarah Geoghegan, Alzheimer Scotland
Anita Milne, Third Sector	Susan Leonard, Quarriers
Ann Hodges, Consultant Psychiatrist	Sandy Thomson, Lead Pharmacist
Ann Maxwell, Carer rep (autism)	Sean Coady, Operational Lead
Anne Earle, PPF rep	Steven Lindsay, Staff Side rep
Anne McKenzie, Service Manager	Steve McCluskey, Strategic Programme Manager
Alexander Dustan, Dr Gray's Manager	Irena Paterson, OPRG rep/PPF
Bob Sivewright, Finance Officer NHS	Ivan Augustus, Carer rep
Brian Yeats, Independent sector	Jamie Hogg, GP Lead
Catriona Campbell, Research & Info. Officer	James Baird, Service Provider LD
Chris Littlejohn, Consultant Public Health	Jane Mackie, Joint Operational Manager
Christina Cameron, Modernisation Unit	Jean Pryde, Service Provider
Claire Power, Practice/Service Manager Dental	Jennifer Wishart, Scottish Care
David Meldrum, Fire Scotland rep	Jill Fletcher, Scottish Abulance
Deborah O'Shea, Principal Accountant	Jim Anderson, Housing Independent Sector
David Williams, Lead Consultant (Medical)	John Campbell, Service Manager
Tim Shallcross, Consultant Geriatrician/Medicine	John Donaghey, May Bank rep
Elidh Brown, TSI Moray	Joyce Lorimer, Service Manager
Karen Thomson, Unit Operational Manager (Medicine & Unplanned Care)	Julie Mackay, Clinical Nurse Manager Mental Health
Euan Christie, Team Manager	Karen Birse, Scottish Ambulance
Fabio Villani, Chief Officer TSI Moray	Elsie Watson, PPF
Fiona Geddes, Housing Strategy Officer	Les Petrie, Staff Workforce rep
Fiona McPherson, Public Involvement Officer	Linda Oldroyd, Divisional Lead Nurse
Gail Robertson, Housing Independent Sector	Lorna Bernard, Telehealthcare Strategy Manager
George McLean, Business Manager	Nicola Scott, Modernisation Unit

Gillian Murphy, Service provider	Tracey Gervaise, Health & Wellbeing Lead
Graham Findlay, North East Sensory Service	Tracie Wills, Sen Commissioning Officer
Graham Taylor, GP Clinical Lead	Sylvia Stobbart, Service User rep
Heidi Tweedie, Service User Mental health	

(OPRG – Older Peoples Reference Group. PPF- Public Partnership Forum)

1.2 Our commissioning Framework

The strategy has been developed by a wide range of stakeholders from across all sectors (including public), who worked through the four stages of the commissioning cycle.

The Social Work Inspection Agency (SWIA) in its guide to strategic commissioning, states: "**Strategic Commissioning is the term used for all activities involved in assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Strategic Commissioning should provide a clear rationale for the development of services and procurement activity."**

There are a number of benefits in jointly commissioning services:

- Agencies share common customers – people do not live their lives within the organisational boundaries we create.
- Services should be organised around the service user.
- Services are usually inter-dependent – decisions taken by one agency will often have a significant impact on its partner.
- Quality and cost effectiveness of services can be significantly improved when organisations work well together.
- Better outcomes can be achieved for service users.

1.3 Commissioning Cycle

The commissioning cycle developed by the Institute of Public Care has been adopted as a model for Moray (Figure 1). The key principles of the agreed model are that:

- All four elements (analyse, plan, do and review) are sequential and of equal importance.
- Commissioning for all client areas should be developed which focus on the needs of the clients across different agencies.

- The outer circle of the model, the commissioning cycle, should drive the inner circle, purchasing and contracting activities. However, the contracting experience must inform the on-going development of commissioning.
- The commissioning process should be equitable and transparent, and open to influence from all stakeholders via on-going dialogue with service users, carers and providers.

Figure 1: Institute of Public Care commissioning cycle model

1.4 Agreed Commissioning Principles

The partnership agreed the following principles to guide those working to commission adult services. These principles are important and we expect those working on the commissioning of services for adults, their carers and families to use them as a basis of their work.

1. Commissioning activities and decisions will be based on a clear rationale for improving outcomes for adults, their carers and their families.

2. Commissioning is based on robust evidence of current and future needs of the adult population, their carers and their families, and about the quality and cost effectiveness of services.

3. We promote equality of opportunity by commissioning, specifying and securing services appropriate to the needs of adults and their carers and families.

4. We prioritise investment in preventative services, asking people for their solutions, and strengthening their support to meet their needs.

5. We engage meaningfully with adults, their carers and families as equal partners in all of our joint commissioning activities.

6. We build and maintain good long-term relationships with service providers, investing in a culture of trust and mutual respect.

7. Our process of developing and implementing the joint commissioning strategy are as open and transparent as possible.

8. We ensure that there is an appropriate level of skills, expertise and capacity available to develop and implement our joint commissioning strategy.

9. We ensure our procurement and contracting arrangements are compatible with EU and UK law, regulations and guidance.

10. Our purchasing and contracting arrangements are proportionate to the scale and complexity of the service we are buying. And we do not discriminate against organisations from different sectors of the market.

11. We encourage the development of a diverse local market so that there are a range of flexible, personalised support/services available.

12. Our contracts and service level agreements are based on priorities and direction outlined in the commissioning strategy.

13. We manage and monitor contracts and service level agreements effectively and regularly within our sectors

14. We use the outcomes of monitoring and review to help set priorities and inform future plans and commissioning priorities.

1.5 Wider stakeholder engagement and communication

The Strategic Planning Group undertook a series of workshops during 2015 to develop the draft strategic plan and develop a credible joint strategic commissioning plan which reflected the shared priorities of key stakeholders and set out the direction for future commissioning decisions and service redesign and development.

The group worked actively with the people of Moray to ensure their feedback was gathered about what is important about integration of services and this contributed to the development of the strategy.

Other activities included undertaking Health needs analysis, service mapping analysis, review of existing strategies and national policy research

Staffs across all sectors, and the wider population were kept up to date and their views sought on the content of the strategic plan. The draft strategy was developed in Nov 2015. A 12 week period of consultation then followed.

A range of communication methods have been used including committee reports, briefings, meetings, workshops, web information, newsletter and consultation events, survey monkey.

Wider stakeholders included :

- The general public, including adult and older people community representatives
- Wider network of community groups for adults and older people
- Area forums
- Unpaid carers
- Community Health and Social Care Staff
- Independent Care Sector
- Primary Care wider GP population
- Acute sector staff
- Voluntary sector
- Current service users/patients
- Community planning partners (police, fire and ambulance service)
- Elected members
- Housing, including sheltered housing and extra care housing
- Respective committees across all agencies

1.6 Feedback from local consultation and engagement events

A full range of consultation and engagement events were held. These were promoted through a variety of methods, including the Moray Council website, local media and invitations to voluntary organisations and community focused groups.

Moray Engagement Events:		
4 November 2014	Moray Wider joint Commissioning Group	Lesson learned and planning for the future – change fund review facilitated by Institute of Public Care (IPC)
June 2015	Operational Leadership Team	Development of strategic priorities
8 July 2015	Workforce Stakeholders	Workforce integration event
3 September 2015	Primary Care Stakeholders	Primary Care Integration Event
22-30 September 2015 • Fochabers • Tomintoul • Forres • Elgin • Buckie • Rothes • Lossiemouth	Locality Stakeholders, including the public and elected members	Health and Wellbeing Locality Engagement Events (x8)
14 August 2015 11 September 2015 30 October 2015 27 November 2015 03 March2016	Strategic Planning Group workshops	Understanding demand Understanding supply Identification and testing of the strategic options Development/finalisation of the draft plan
October – December 2016	Integrated Strategic Planning Workshops (NHS Grampian)	Acute delegated services
November 2015 – 10 November (Elgin) 11 November (Lossiemouth) 12 November (Dufftown) 16 November (Buckie) 17 November (Fochabers) 18 November (Forres) 19 November (Keith)	Community planning engagement meetings	Health & Social care integration
14 December 2015	Members Briefing Moray Council	Draft Strategic Plan
14 January 2016	NHS Grampian Board seminar	Draft Strategic Plan
12 February 2016	Workforce Engagement Event	Creating change through better communication
22 April 2016	Workforce Engagement Event	Making a difference in localities

24 June 2016	Workforce Engagement Event	Topic to be confirmed
23 September 2016	Workforce Engagement Event	Topic to be confirmed
25 November	Workforce Engagement Event	Topic to be confirmed

A newsletter was produced in October 2015 to provide information to staff groups and the wider public.

The following pages provide the feedback from the above events. Further event feedback and consultation will be added as they are completed. This document is a working document and will include all feedback /consultation/comments that are gathered which have informed the development of the Strategic plan.

June 2015: Operational Leadership Team – Developing Strategic Priorities

Summary of Key Points of Discussion:

What is important?

- Intermediate Care/Community Hospitals – balance between early intervention/prevention(reaching crisis)
- Mental Health
- Learning Disability
- Primary Care and Locality Planning
- Engagement with contractors
- Community and Locality
- Linkage – Interdependencies and relationship to resourcing
- Use of technology
- End of life – Cancer/Long term conditions

Intermediate Care/Community Hospitals & Dr Grays – for Moray

Community Hospital Strategy What is our model?

- Leadership/culture (local)
- What does slow stream rehab mean?
- Public/workforce belief
- Degree of comfort with status quo
- model should be more socially based than medically based
- Broader definition of intermediate care
- Tiered model
- 170 profiling beds in the community
- Demedicalise it
- Contractors' engagement

Mental Health

- Within Tier 2 – Cognitive Impairment, dementia
- Lack of a recovery process
- Link to employment/active citizenship
- Access to services if you don't have a serious mental health problem
- Crisis Intervention (rescue model)
- Tier 2 plus Tier 1
- Good peer support etc.

Actions

- Feedback to be returned for collation
- Future Tier Model to be drawn up and develop common language

4 November 2014: Joint Commissioning Group - Review of Moray Change Fund Lessons learned and Planning for the future

Purpose of event

To discuss with a range of stakeholders including health and social care commissioners, practitioners and providers, and older people:

- What have we achieved in three years of Change Fund?
- What lessons have we learnt?
- How should we draw on these lessons, and otherwise plan to deliver national outcomes in Moray?

Successes and lessons learnt

Groups discussed a range of successful initiatives which had taken place over the course of the three year programme, and identified key characteristics of success as including:

- The change in culture involved in moving away from service interests to working together towards a shared aim.
- Multi-disciplinary and multi-agency approaches and meetings.
- Collaborative working.
- Drawing on community assets and building on volunteering capacity.
- Having the willingness and resources to test approaches and learn from them.

Challenges included:

- Building sustainability and/or having robust exit strategies.
- The importance of listening to what individual people say they want or need, and not making assumptions/generalisations.
- Become less risk adverse.
- Having measures which reflect local priorities and issues, and are meaningful.
- Being aware of unintended consequences of particular initiatives.
- Being able to manage balance between resources directed at maintaining people with more complex needs in the community, and resources directed at supporting people with lower levels of need and having preventative approaches.
- Making use of the whole system (differently) to deliver outcomes.

What do we need to do next?

Theme	Stop	Improve	Start
Commissioning	Putting more attention on small amounts of money Being shy of stopping core funding to enable re-allocation Not being clear	Implementation = area of weakness Prevent disjointed actions that stray from plan Better co-ordination Apply co-production consistently Improve evaluation	Implement the full commissioning cycle for all services Agree priority areas Shift to SDS amongst older people Understanding what already exists in wider community to enable more focus on complex needs
Co-production and engagement	Repeating approaches without consultation	Listening and communication Understanding population change Review process Support for self-management	Speak to the wider population Local dialogue and ongoing discussion Ways for people to feed in to the process Assessments in the home
Delivery of change	Duplication and pilots Fragmented approaches Reacting to crises rather than planned approaches	Being honest and realistic Whole system approaches Communication Wider consultation Collection of data to support planning	Joint planning sessions Bringing systems together
Monitoring and reviewing performance	Reporting on everything Need national indicators but focus on meaningful local data Stop using rates – use numbers for local data	Development of meaningful measurement Leadership group steer needed Whole system focus Introduce individual review eg multiple	Agree top priorities across system and how to measure them Move to an outcome focus Evaluation audits Drill down on key

	admissions	areas
	Improve evaluation	Share results

The Moray "Top 10" For next 12 months

How we plan and deliver	Improve leadership and direction Consistent approach to co-production Increase capacity of the third sector Recruitment and retention of key workforce Improve multi-disciplinary team working Revamp basket of measures to align with local strategy Actively evaluate and respond to measures Develop and implement information sharing standard protocol
What we do - general	Consistent approach to assessment across all settings Comprehensive geriatric assessment in A&E Improve out of hours – knowing who to turn to 24/7, sharing ACPs Better shared understanding of high risk people Improve early intervention and prevention Improve rehab/re-enablement in hospital settings
What we do - specific	"Instant" care package Increase step up/step down Extend day for acute care in virtual medical ward Dementia friendly communities Multi-disciplinary link with care homes Learning disability accommodation review Reduce polypharmacy – engage with community pharmacy

For next three years:

Working together	Make co-production a core business activity Shared information systems Integrated systems One patient record Workforce development planning Community planning and working Self-directed support – patient design Use of technology to improve communication and free up time Develop strong community hubs
Promoting independence	Design of sheltered/supported housing Consider transport links and access to services

Look at use of step up/down beds
Invest in primary preventative mental health services
Use of technology eg home monitoring
Strengthen health improvement and preventative approaches

8 July 2015: Workforce Stakeholders - Workforce Integration Event

The Moray workforce event highlighted several positive messages:

- There is enthusiasm to progress the integration agenda
- Good examples exist of co-ordinated, multi-agency working and multi-disciplinary care
- Several examples were given of already integrated teams, with some co-location.
- Staff are "signed up" to putting the person/service user/patient at the centre of their care
- High levels of staff skill exists
- Our smaller size is an advantage – there are often strong personal and professional relationships which help "get the job done"

There were also an equal number of areas identified where we "could do better" and details were documented of the challenges facing operational teams (see table).

The workshop break out groups focused on how we build strong integrated locality teams and the responses fall broadly into 3 strategic themes:

- Build the right workforce for quality care
- Ensure positive leadership and accountability
- Create shared processes across sectors and professions

Build the right workforce for quality care

- Importance of developing appropriately skilled and competent workforce
- Importance of building capacity and developing the staff of the future

Staff suggested we need to:

- Build on existing good practice
- Have clarity on roles/remit, including work shadowing opportunities
- Create an emphasis on equal respect and on professional responsibility across all staff groups
- Share staff training / Develop joint training needs analysis

- Empower staff to work autonomously and collaboratively
- Maintain professional development and “play to staff strengths”
- Maintain specialist skills and knowledge
- Develop shared approaches and integrated workforce planning tools
- Investigate the possibility of new or generic roles – flexible and “blended” roles
- Develop new training if needed including “apprenticeships”
- Look at different skill mix
- Develop innovative plans to recruit and retain future workforce
- Develop innovative ideas to encourage career progression, succession planning and to recruit high calibre staff to management/leadership roles
- Allow sufficient time to build new teams and manage change

Ensure positive leadership and accountability

- Importance of developing a positive culture with strong leadership.

Staff suggested we need to:

- Define leadership structures and have good leadership at locality level
- Develop “true autonomy within localities”
- Give localities “permission to try something different”
- Nurture team working
- Empower managers and team leaders to flexibly direct budget and resources to meet local need
- Set a shared vision and goals
- Set clear and realistic objectives
- Agree robust governance arrangements
- Maintain professional supervision and professional networks
- Have clear professional accountability
- Speak a common language

Create shared processes across sectors and professions

- Importance of standardising local procedures, policies, pathways as well as assessment and risk management approaches.
- Simplify!

Staff suggested we need to:

- Streamline process and avoid duplication of assessment and paperwork, including referral processes – “process is dominating the interaction”
- Minimise excessive assessment and eligibility arrangements
- Simplify documentation and processes
- Create an integrated IT strategy, a shared information system or at the very least empower staff to be confident to share information safely
- Develop joint robust risk management processes
- Develop shared tools and protocols and share good practice
- Consider co-location, or where not practical, ensure good liaison
- Reduce bureaucracy
- Better use of technology
- Create more effective communication arrangements
- Speak in plain language

Other comments

There were also a number of comments around:

- Good examples of carers support
- Good examples of building community resilience
- The need to embed the health promotion agenda
- Community and public expectations and the need for services to be clear about what we can and can’t provide

Key messages from groups

- More co-location – people working in the same buildings and talking to each other. Co-location of staff in the localities, not always effective for small teams
- Shared understanding of people’s roles
- Shared training including workforce planning, succession planning for a quality, skilled and competent workforce
- Streamline how budgets are allocated and access to resources
- Data sharing – how we all access the information we need when we need it
- Integrated IT systems – systems that are fit for purpose
- Communication – increasing opportunities for contact face-to-face and by phone; decreasing use of email
- Access to information for all team members

- Prevention and pre-emptive management of patients
- Increase accessibility of service users/patients/public to services
- Integrated teams with generic support workers
- Single service-user held record – information systems that can talk to each other
- Communities that support themselves
- Third sector preventative work

- Simplify and work as a team - how can we simplify things to make it easier for everyone?
- Professional relationships; understanding each other better; have value and respect for each other
- Giving teams the tools to work differently
- How do you understand what is available to you?
- Requires to be person- centred, MDT care where people have the capacity to take charge (using SDS)
- Knowledge of skills of others' roles within the team and knowledge of community groups, resources etc. What's accessible; what to direct people to
- Better communication – sharing good practice, regular opportunities to discuss complex cases as a learning experience for what can be done differently, what went well
- Involvement of person and their carer in planning care. Support and manage expectations and encourage active participation in finding solutions. Promoting the idea that they may be the solution
- Named person role to co-ordinate the care
- Listened to and trust (relationships) should be the core values for improvement?
- GP doesn't need to be the 'named person' to contact
- Services should be created/delivered at the smallest unit i.e. locality/community level
- There is a role for centralised services which are devolved to community level
- We need to ensure a friendly voice at the end of the telephone line. We need to think how we can more effectively use admin as a cherished and scarce resource

Workshop 1: Building stronger teams – in terms of working together, what works well for you? What doesn't work well? What gets in your way?

ISSUE	WORKS WELL	COULD BE BETTER	CHALLENGES
Staff	Motivation and enthusiasm Like working together – see this when interacting with the workforce Goodwill Signed up to having the ability to put the person in the centre Get the job done, "can do attitude" Flexible High level of staff skills Manageable size – professional networks good – easier to find people and make contacts Moray is small and we retain staff. This means strong personal/professional relationships are formed Personal relationships means we can get the job done in one phone call Willingness to improve and integrate is there Someone who knows someone around who can help	Lack of understanding about role/remit – changing job titles Recruitment and retention – limited pool of workforce Succession planning Opportunities for professional development – career development and management Some professionals unable to let go (tribalism) – other professionals could take on the tasks and be supported Processes have often been compromised because of the strength of personal relationships Training Bureaucracy – need to be approved by lots of committees, time wasted Different professions and organisations have different views on risk/risk management. Governance different Some hierarchy Issues when folk not fully focussed Lack of co-ordination and bureaucratic barriers e.g PVG Expectations about home visits vs clinics	Understanding of roles and models Changing expectations Community resilience Preventative working More confident in professional identities Grade appropriate. Time/space to redesign – done by staff on the ground. Appreciate other people's roles Skill mix – good supervision etc. – innovative recruitment Acknowledge that still need some specialist (i.e. not everyone needs to be generic. Ok to have specialists) Sometimes we don't get the flow of new staff and ideas that makes a partnership vibrant. This is across all areas, including GPs Needs good leadership at local level Need to create opportunities to resolve
Teams	Co-location MDT working Single access – works well Community hospital system – natural hub for integrated teams	Work in silos (but effectively) Too compartmentalised Limited by resource. Barrier – focus on own tem Processes (response	More co-location Step in and out of silos – responses Lack of overview of system Break out of crisis management; firefighting

ISSUE	WORKS WELL	COULD BE BETTER	CHALLENGES
	Lossiemouth GP Practice – co-locating council LD team Smaller teams/good MDT links D&A – co-location works well – extended teams e.g. Police People you work with get to know the team and recognise you as a team Stability of teams Co-location has a number of different disciplines Existing integrated teams – co-located, multi-disciplinary, multi-agency Extend to all areas, current good basis to expand, need to acknowledge/respect each profession, can just talk to each other and signpost on Access point seen as a positive asset between geriatric and social work Moray Coast – integrated – GPs, nurses, mdt community care with GP meetings Maryhill involved in forward planning to get patients home sooner LD – multi-disciplinary – sharing expertise – pro-action No barriers or hierarchy – equal partners (except ward 4) Some good examples of whose need/expectation and response are matched How advanced we already are at keeping people at home Pitgaveny team – health care assistants Good when all focussed on a complex case	priorities) Different responses, different responsibilities Shared understanding Variation in motivation Person centred v organisational objectives Over medicalise Social work in community hospital, practice Competing priorities between teams and organisations Access point risks undermining relationships between staff in LD The size of Moray means we could spread ourselves too thinly. There is a balance between centralisation and locality Services stretched, lack of resources	will continue to be a challenge for locality working Creating space and time for development e.g advanced clinical skills Role of community less clear in e.g. Elgin – how do we take this forward
Information systems	Being familiar with system Trust the system Good cross-system working	Information sharing – needs must Different recording systems - ACPs,	Standard referrals OOH – ability to get info Challenge of time person-facing v paperwork

ISSUE	WORKS WELL	COULD BE BETTER	CHALLENGES
		emergency care summaries The usual systems not talking to each other Sharing information – staff still frightened about sharing data Multiple assessments – collecting similar/same info IT systems don't speak to each other Sharing information – staff still frightened about sharing data IT systems and records	IT systems 1 case file Better access to other people's assessments So many different pieces of info not connected, not presented. Are we maxed out with the right things? Process could be dominating the interaction
Communication	Access team – communicate with primary care Good communication across teams/localities Informal communication good (worker to worker) Good communication about patients and about working together	Is it? Patchy? Phones not answered (call handling – accountability?) Need more information	Digital solutions – better awareness, better use, communication Communication between hospital and community services – better co-ordination/planning Mistakes when communication is poor Common language
Other	Support at councillor/board level Health promotion clubs e.g. BALL group, LEG club (Aberlour) Cameron Gillies material helpful and bulletins Leaflets that parents get re activities, toddler groups Ideas about asset maps Awareness of what is available – Buckie and Elgin Quarriers support around carers. Carers assessment	Children – different thresholds for need and response A & E $\rightarrow$ community Community resilience Transport Lack of budget allocation The size of allocation Which organisation pays for what – wrangling	Work between children and adult services – transitions Better understanding of people's disengagement – could locality connection improve this? How to help people gain better access Helping carers to see selves as carers New challenges and expectations e.g. targets, families Need to get communities to point where they can respond and deal with

ISSUE	WORKS WELL	COULD BE BETTER	CHALLENGES
			need and set tone for expectation and celebrate when it works

Workshop 2: Imagining the future: working in localities, what should good look like? What do we need to do to make it happen?

What does the future look like?	How do we make it happen?
Generic support worker in each locality Single point of access – triage – signpost Service user held records – chip Single IT operating system Health and social care out of political playing field Community-run fund Common language Health promotion – conversation re future planning Continuity of care for the punter Access to services in locality area – digital if required Care when you need it then home quickly Further co-location of teams • Health and community care teams • Flexibility of teams • Ease of communications • Working together/huddle/MDT • Ability to prioritise together e.g. palliative care • Centralised care plan • Time for people • Continuity • Common language First thing checked, are you well? Third Sector delivery Prevention Connectivity Transport that works Beyond the services – local community networks Digital	Permission to try something different Confidence To talk to people/blether Time to develop as a team Connections Target and influence Simplify More effective communication Professional identity and understanding of role – value and respect for one another Giving people tools to assist – can we have the bus? More co-location, hubs etc. Joint management Shared understanding of roles Joint resources (all aspects) Technology (data and sharing) Agreed strategic plan/locality plans Play to staff's strengths/flexibility of staff Shared training including workforce planning and succession and professional development = quality workforce Different recruitment e.g. pool of staff across organisations All staff access to records True autonomy within localities i.e. ability to make local changes even if it makes local service different to a neighbouring area

What does the future look like?	How do we make it happen?
Shared priorities (including compromise where able) and shared vision of core business Shared understanding of roles etc. Be clear on where we can compromise versus what is statutory/government directive – what we can control and be flexible on Confident and knowledgeable workforce (including proportionality/difficult conversations) Where possible continuity of same staff involved with service user Access to records/patient/client info, ideal shared records Shared, plain language Wider than just health and social care – credible and robust alternatives to signpost to if not our services Good crisis intervention including anticipatory care plans – including out of hours support Population understanding what we will/won't provide Happy staff Access to services in locality area – digital if required Care when you need it then home quickly Further co-location of teams • Health and community care teams • Flexibility of teams • Ease of communications • Working together/huddle/MDT • Ability to prioritise together e.g. palliative care • Centralised care plan • Time for people • Continuity • Common language First thing checked, are you well? Third Sector delivery Prevention Connectivity	Robust alternatives for non NHS/social work input – resilient

What does the future look like?	How do we make it happen?
Transport that works Beyond the services – local community networks Digital Shared priorities (including compromise where able) and shared vision of core business Shared understanding of roles etc. Be clear on where we can compromise versus what is statutory/government directive – what we can control and be flexible on Confident and knowledgeable workforce (including proportionality/difficult conversations) Where possible continuity of same staff involved with service user Access to records/patient/client info, ideal shared records Shared, plain language Wider than just health and social care – credible and robust alternatives to signpost to if not our services Good crisis intervention including anticipatory care plans – including out of hours support Population understanding what we will/won't provide Happy staff	

3 September 2015: Primary Care Stakeholders Primary Care Integration Event

Group Discussion:

- Strategic objectives, strategic plan and Vision.
- What are the key opportunities around integration that could impact positively for the population within the primary care context?
- Locality Planning, what challenges and opportunities does this present to improve outcomes and what needs to change?
- How do we scale up good initiatives and support change within primary care?
- What would a bid for the primary care transformation fund look like for Moray?

Suggestions for improving what the health and social care partnership do?

- More detailed discussion around the formal structure and setting up of the localities – if we want to involve everyone in the locality in these discussions we need to start now.
- Move on now with locality planning.
- Set up strategic groups of multidisciplinary members to feed in ideas and share back out.
- Need greater public engagement with process.
- Quick move to clarifying localities to progress working on bid for Primary Care Transformation Fund.
- "Hot Topic" forums to facilitate best practice pathways/problem solving.
- Time to attend is the biggest challenge.
- Advertising and looking at the commercial sector.
- Use Protected Learning Time to increase engagement.
- Move on to next step – facilitate the formation of locality groups and build on discussing at this level.
- Integrated Community is the key.
- Patient cards can be access by all in the care team.
- More advertising for the public and professionals (from Government too).
- Ensure sharing of good practices locally.
- Working with Government – need to steer away from the "GP" term
- Public need to identify with "health care provider" and more time investment into signposting patients to appropriate services.
- Transparency – Clarity of action plans
- Education and empowerment of patients
- Good consultation among services
- Having a similar model within Adult Services that Childrens' Services have i.e. "Wellbeing Wheel"
- Using SHANARRI wording with named person and lead person

- To have a health care team/s rather than GP Practices (DNs, Emergency practitioners, GP, Physio, OT, Optician, etc)
- Slides – print out or to be sent through email (presentations)
- Work on PR for joint integration by visiting GP Practices to discuss strategies and opportunities ("same faces" tend to be seen at events, more buy in needed from other GPs)
- Repeat event in near future
- Continued engagement with Primary Care (all aspects)
- Out of Hours to be a priority
- Support innovations proposed
- Provide information on what is the locality structure
- Improve information sharing e.g. between GPs, secondary care, community pharmacies, optometry and social care, including Vision 360 and data sharing agreements.
- Try and address the issues of inconsistencies around OOH services e.g. frequently no Marie Curie nursing services available and doctors are then being asked to carry out "nursing" tasks that they're not trained/competent to carry out.
- Early days, lots of rhetoric – as always we need specific initiatives that are likely to make a difference. Huge potential to was resources if not properly planned/implemented.
- Have same type of meeting but in localities.
- Focus on communications are key issues
- I am interested to see how this would take off – sounds good! Watch this space
- To send out an email with outcomes from questions/discussions so next time our email addresses could be collected.
- Please come to talk to the Forres locality and support us with a plan of how the locality should meet/operate.
- Thanks, thoughtful discussions / Thank you comments.

Comment from a GP:
"There was a good turnout of a broad spectrum of folks which was very encouraging. Hopefully people will have at least some degree of engagement to take back to practices and discuss next steps, especially for locality discussion."

Other comments

- The national outcomes are so woolly that any project bid from any sector can tick all the boxes and be politically correct yet still be a complete waste of money!
- For mini-localities to work well the GP's need to drive the show. Best done through agreeing and defining a specific locality based frontline clinical project first then building in how community nursing, community care, AHP, third sector,

private sector, pharmacy etc can all be engaged appropriately and effectively to make the project work. This will prevent a series of tandem and unlinked projects utilising funding in a non-joined up way (as per S's table question). Localities can agree on principles and practices can still deliver operationally in a way that best suits circumstances.

- Whilst mini-localities are key I still think there is room for individual practice innovation, but this can't be simply as "let's give everyone an additional nurse practitioner or physician assistant" at the same time there needs to be opportunity for testing.
- There also needs to be room for pan-moray projects involving all 4 sectors working together in a joined up way, again this needs to come as a project first such as "how do we provide crisis intervention and prevent admission" (or "how do we promote safe discharge") then have all 4 sectors involved in joined up thinking to create a sustainable solution.
- We need to be very careful about championing any of the ideas for innovation at G's table question without trying to address potentially unlooked for consequences. As a GP pointed out, practice based triage seemed a great idea to cope with the workload demand, however for many practices it has become a monster that needs continual feeding and now provides instant access repeatedly for self limiting problems. Ideas such as engaging consultants in virtual clinics or telephone contact sound great in theory but need to have proven efficacy. It may be just me but 99% of what I deal with every week doesn't need consultant engagement and the current system of phoning the duty consultant for clinical advice if necessary seems to work fine.
- There is a political correctness to patient engagement and education that for me completely misses the mark. Having been a keen patient educator and adopting a person centred philosophy most of my 26 GP years (and written a book on Persuasion in Clinical Practice) it is like trying to push water uphill. For example, my nurses all have behavioural change training but still find it a huge challenge trying to get type 2 DM patients to take self responsibility. At the risk of being politically incorrect I think we need to develop processes that automatically channel patients in the right directions rather than spend lots of money and time on trying educating to take responsibility. We have tried to do that in so many guises in the past.
- Following on from the previous point, we need to find robust mechanisms to deal with tier 1 issues and prevent them coming unnecessarily through the practice door to take up an appointment and be further signposted again by GP's. Pharmacy, third and private sector have a role to play here though any project needs to have a robust mechanism of ensuring that this workload is dealt with differently. I have no easy solutions here but wonder if e.g. TSi and pharmacists need to be directly engaged in local solutions with each practice.

- Will be useful to get a handle on how we apply for the National monies and if that is to be a Moray bid just how we get some joined up thinking on a practical project. Maybe this should be something along the lines of immediate access to a crisis intervention service.

Group/Question 1 (Pharmacy)

- e-Signatures on prescriptions
- Better advertisement of current services
- Upskill clinical skills
- Process for LTC – Shared IT access (read only, intranet access), shared records, sharing good practice → Methadone, FP, Etoll(?)
- Redirection / Signposting i.e.Triage
- Community Medicines Management:
  - Home visits
  - Common MAR
  - Training for carers
- Polypharmacy:
  - use clinical mailbox
  - what services are being provided
  -availability of items (suggest alternatives) (?? Care)
  - Access to NHSG Formulary
  - Sick Day rules (dosette)
- Rationalising/Syncing Prescriptions
- Carer Training
- Working more closely with carers
- Discharge planning
- Med-rec:
  - De-prescribing with practice team
  - Use practice pharmacy to train
  - Med review
  - Request blood
  - Shared care protocols (DMARD Guru)
- IT
- Upskill for Unscheduled Care
- Medicines Management

Group/Question 2 – Modernising Primary Care

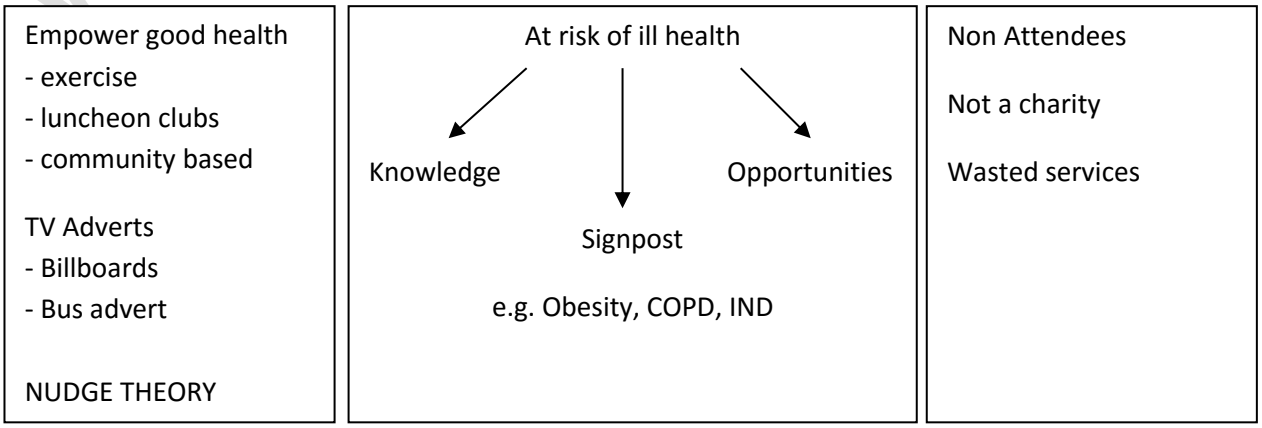
- Promote messages about health care.
- Take the GP out of the explanation – use the health care provider – rebranding
- Access to services for mild/moderate mental health problems e.g. counsellors
- Access to secondary care via email – advice

- Access to PC as a person
- Need to get out of fire fighting to a new place – how do we increase capacity in the system?
- Optometry – still opportunities for increasing public understanding
- Changing skill mix
- Public engagement / conversation with the individual
- Political influence
- Educating/assisting public to understand
- Identify frequent flyers and test how we can influence them in a positive way.
- Locality level – practices working together to deliver in-hours
- Access to info – query use of other services
- Access to Third Sector
- Healthpoint embedded in Practice Team
- Services in-hours / out of hours – are we accessible at the right time
- Waiting times – no visibility of where people are
- Who responds to tests carried out by different parts of the system
- Website design that assists in Triage

Group/Question re patient / health professional relationship

PATIENT – HEALTH PROFESSIONAL

Change Relationship



Change the relationship between public and health care

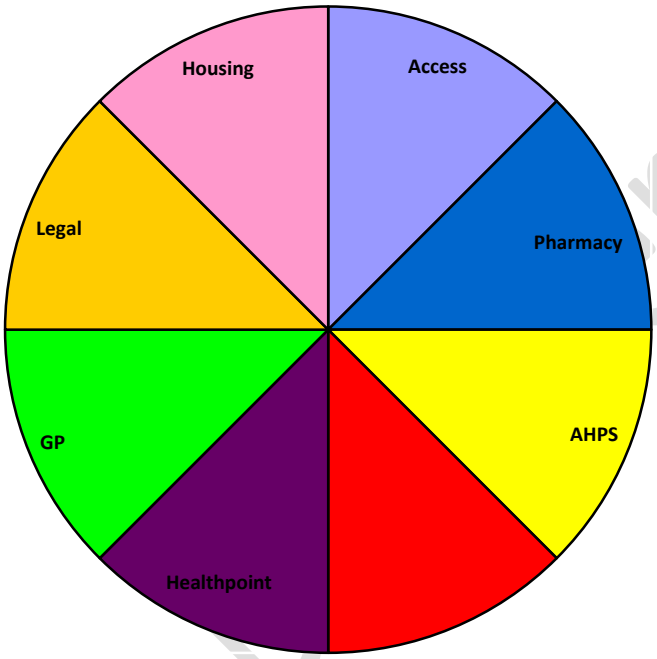
Move away from GP led Primary Care to a service delivered by a mix of Health Care Professionals

Group/Question 3

- Easier access to services
- Opportunity to deliver a new message
- Locality Planning is powerful
  - Delegated budget
  - Equitable – i.e. per head of population
  - Responsive to local need – services deployed more efficiently
  - More effective delivery
- Broader range of options rather than habitual referring practice
- Promotes innovation
- Greater ability to manage complex cases at home and out of hospital
- The public has a voice re options for intervention
- Career pathways and progression in alternative roles
- Co-location → solidarity
- Alternative options need to be real to shift public choice
- Patient education enhanced
- Public trust in alternative to GP
- Shared budget
  - less divisive
  - more options
- Delivering care closer to home – acknowledging local differences / culture
- This redesign is a necessity rather than an opportunity
- Giving responsibility back to the patients
- Shared learning and shared philosophy
- Influencing community planning processes → e.g. dementia friendly communities
- We are worried about the challenges around succession planning but integration offers us an opportunity to consider one workforce and one workforce plan → community capacity building e.g. providers.
- Start planning for old age early
- Managing patients expectations

Group Question - What is care and what is a patient?

We are all people.



Person is at the centre

Group/Question 5

- Hot topic focus group 1/12? - virtual group?
- Time to think/communicate needed
- Practice staff to meet and share
- Virtual clinics
- Resource to create time to change
  - spend to save
- Cascade work/demand down to low cost staff!
- GPs to refer patients to Pharmacy
  - Well Being – Well North?
- Patient Education +++, not babysitting!
- Self reform (physio, smoking, etc)
- Consultants visit practices – discuss patients with staff, improve overall care.
- Consultants to refer to dentists (care homes, dom visits)
- Directory of services – not all aware of whats out there

- Link worker / IT system (up to date info)
- More use of telephones
- PLT REQUIRED!
- More ANPs
- Regular communications MTNs
- GPs to consultant direct line/communications
- Possible telephone reviews more/less
- Training capacity, to support practices, advance skills
- Consultants to support training practice staff (resource required!)
- Evidence based work practice
- Cost/benefit of any actions/changes
- Post change evaluation - Use tools as intended (not as tick box exercise)

Group/Question re locality planning

- How do we engage?
- We need to influence and change the current mindset/culture/behaviours stop working in silo`s, start thinking and doing bigger than the "practice", but smaller than Moray-wide.
- Communication systems between professionals
- Sharing of information – keeping everyone informed
- No backfill or locums to help primary care professional take locality planning forward
- Currently don`t know boundary lines
- How this will affect me/my team (when boundary lines are confirmed)
- No community hospital model/service in Elgin
- Workforce development/recruitment and retention/training/succession planning
- Out of hours services – how do we address this?

Opportunities

- Find out what services the community needs
- Scope for cross-fertilisation of good ideas across GP practices
- Innovation sharing
- Scope for patients to better understand and acknowledge budget limitations
- Opportunity to be more honest about what can or can`t be done
- Strengths in current cohesive teams

Theme(s)

- What`s next, how do we do this? Support is needed from the MH&SCP and a` toolkit`.

- What is community planning? A lack of knowledge and understanding of the role, function, systems and infrastructure and of Moray 2023.

- Increasing concerns on what community planners are agreeing to/supporting e.g. housing developments with no consideration re: GP practices, schools, transport infrastructure etc; no engagement nor consultation with GP practices etc.

Other Points

- High number of questions were asked by participants on locality planning, participants were unaware that they will have roles and responsibilities to co-ordinate and manage locality planning within their respective GP practices/teams/communities

Event Feedback (28 Questionnaires completed)

Question	**Yes**	**No**	**Unsure**	**Not completed**
Do you have increased understanding of the opportunities and challenges that exist around the modernising of Primary Care?	22	2	4	0
Did you feel able to participate and give your views and concerns?	26	0	2	0
Do you feel informed as to where Moray is with integration?	21	2	5	0
Do you find the presentations/discussions interesting and well prepared?	22	0	5	1
Do you feel it would be useful to have the presentations made available so they can be accessed by all staff?	20	4	4	0
Do you think the venue was appropriate and well laid out?	27	0	1	0
Do you think that holding this event in an evening was beneficial to a good turnout?	26	1	1	0

22-30 September 2015: Locality Stakeholders - Health and Wellbeing Locality Engagement Events x 8

Our vision for integration

To enable the people of Moray to lead independent, healthy and fulfilling lives in active and inclusive communities, where everyone is valued, respected and supported to achieve their own goals.

Introduction

This document is a record of a series of eight community engagement events held between 22-30 September and which brought together over 60 members of the public and elected members of The Moray Council.

The purpose of the events was to raise awareness of the integration of health and social care in Moray and engage with stakeholders to inform the development of the draft Strategic Plan.

It was also an opportunity to recognise the contribution of communities in supporting health and wellbeing and share information on small grants funding streams from the Integrated Care Fund.

The engagement events were designed and facilitated in partnership by tsiMoray and the Moray Health and Social Care Partnership.

Summary

Participants at the engagement events expressed overwhelming support for the Moray vision for integration and the national health and wellbeing outcomes, with a strong desire to see the words put into action.

The recurring theme at all discussions was **active and inclusive communities.**

Almost all participants were involved in groups in their communities and strongly advocated the important role groups and their activities play in terms of prevention

and early intervention by providing opportunities for people to stay socially connected and enabling them to maintain and improve their health and wellbeing.

The challenge of sustainability in terms of limited finances and active volunteers was highlighted along with a desire for continued community capacity building.

Background

The Moray Health and Social Care Partnership, under the governance of the Shadow Integrated Joint Board, is currently preparing a three year draft Strategic Commissioning Plan.

This plan will set out how the partnership will achieve its vision, deliver on the nine national health and wellbeing outcomes and meet the local Moray priorities identified and agreed by listening to and involving all stakeholders.

The draft plan will be consulted on in January and February 2016. It must be finalised by the end of March to allow the Joint Board to assume full responsibility for the planning and delivery of integrated health and social care services in Moray.

Event format

The events looked to provide people with an opportunity to engage with health and social care integration and identify priorities for the draft Strategic Plan.

The first part consisted of a PowerPoint presentation which introduced integration in terms of legislation, the national health and wellbeing outcomes, progress in Moray and the next steps.

Information on the small grants funding opportunities for community groups/projects from this year's Integrated Care Fund was presented by tsiMORAY.

Each session ended with participants asked to suggest the priorities they want to see addressed by the plan.

Questions and open discussion was encouraged throughout the events and comments noted to provide a record of the conversations.

The key discussion points from each event are summarised in this report and will be shared with the Strategic Planning Group as part of the process to develop the draft plan.

The draft newsletter on integration was circulated and this highlighted opportunities for continued involvement.

This report will be shared participants who provided their contact information and through the integration section of The Moray Council website www.moray.gov.uk/integration.

They will also be invited to attend the series of engagement events in November 2015.

The events:

Fochabers – Public Institute, 22 September
Community. Importance of social interaction. Communities are fragmented nowadays and people need opportunities to come together. People enjoy coming together and it's good for their health and wellbeing. Lack of confidence stops people going. Lots of work goes in to promoting activities but people still feel they don't have enough information.
Expectations placed on community groups: Community groups should be seen as complementary to services, not a replacement. Volunteers are not professional support staff. They can become over-burdened, particularly as many in groups don't want to take on organisational responsibilities. Individuals only have so much capacity.
Engaged workforce: Have to get it right at the coal face. Achieving the first seven national health and wellbeing outcomes relies very much on an engaged workforce and effective resource use. Many people have had positive experiences of kind and dedicated staff. A lot will also be down to external service providers and this seems to be an issue in home care.
Shared information/single record. Services at the moment are disjointed. People are told they need equipment for medical reasons and then have to fight for it. There should be one record or central database which everyone can see so no one can argue about what's been said. People should be able to get the help they need.
Role of GPs. GPs not signposting patients to support such as CLAN. More social prescribing needed.
Local services. Difficulties caused by having to travel to Aberdeen for appointments. Dr Gray's turning into a "cottage hospital".
Mental health. Shortage of help for people with mental health issues and their families.

Tomintoul – Richmond Hall, 23 September
Community. People would benefit from more opportunities for social interaction, including inter-generational interaction and with animals. This would reduce feelings of loneliness and depression.
Independent living. Need to get self-directed support (SDS) working well for everyone. People enjoy the flexibility it offers.
Strategic Plan. Need to get all age groups involved, particularly younger people.

Forres – Forres House Community Centre, 23 September
Community. Following bereavement people can lose their community connections which can impact on their mental health.

Wellbeing, early intervention and prevention. Prevention is not mentioned in the health and wellbeing outcomes. How do we ensure children grow up to be healthier? Prevent people going into hospital. Recognition is needed of the benefits to health and wellbeing of non-health and social care services such as the arts and sports. Sporting and physical activity are important in terms of maintaining and developing wellbeing. We have the knowledge to support people locally.
Unpaid carers. Importance of carers. Now and again they need a break and have to fight for respite. Carers don't realise they need it.
GP involvement. Can see the potential for integration but it will only work if GPs throw their weight behind it.

Elgin – Elgin Town Hall, 24 September
Community. No such thing as community any more; people don't knock on your door to make sure you're OK. How do we get back to where we were? It's a particular issue in rural communities and for older, isolated people. What is the definition of community – it might mean different things to different people. What prevents people from getting involved in their community? Particular issue with men. Need for community connectors/ village agents both in person and online. Transport is a key aspect to enable activities to happen.
Early years. Not in scope but a crucial aspect of strong communities. Good foundations for physical and mental health and wellbeing for young people start with their parents. Provide more support to parents and families as a way of supporting/investing in the community of the future.
Unpaid carers. Lots of couples in their 70s and 80s who are caring for each other without any outside help until something goes wrong. You can't force them to accept help but it's important they realise help is available. People in their 50s and 60s now caring for ageing parents and their spouses/siblings.
Partnership working. Health and social care should be more open to sharing resources and to improving relationships with the third sector. Lot of things being done by health and social care professionals could be done by others which would be more effective and efficient. The third sector is able to do more for less. Health and social care could then focus on Tier 3, those with complex and long term care and support needs. Make more use of expert patients, not just what a service can do but looking at peer support. Third sector organisations have to be better at networking. More funding should be directed to the grassroots. Huge network of strong voluntary organisations doing phenomenal work.
Keith – Longmore Hall, 29 September
Community. We have a changing society where you no longer speak to your neighbours every day. People don't think about looking out for each other. People lead independent and isolated lives then during times of crisis don't know how to get help. Need to create opportunities to bring people together. Lots of ways of supporting community connections such as through local radio.
Improving health and wellbeing. Everyone has a role to play, not just professional staff. People need to be involved in all aspects of nutrition, activity etc. Concerns over alcohol being too socially acceptable and the harm not recognised.
Independent living. Provision of home care is key for many people. Home carers seem to be focused on personal care and there is little help with domestic tasks such as shopping and cleaning. Could others be employed just to do the domestic

Elgin – Elgin Town Hall, 24 September

tasks? Admission to a care home isn't always a negative, particularly for those who are socially isolated and struggling at home. Need to remember this is not just about older people.

Unpaid carers. Develop more befrienders in the community to provide respite for carers.

Early years. Importance of educating children in health and wellbeing but this needs to be supported at home by the parents.

Buckie – Fisherman's Hall, 30 September

Community. The importance of community groups in enabling people to live in good health for longer has to be supported. It is not just about the activities they run but the wider social connections made. Replacing equipment is costly and increasing hall charges are a concern. Always seem to talk about community activities for older people but young mums can be just as isolated. People need information about what's available in their community using a variety of means to get messages out such as local radio as not everyone has internet/Facebook.

Independent living. Elderly people want to stay in their own homes but don't want to be stuck at home, seeing no one. There is an issue with a lack of care at home and particularly with external providers not being able to deliver on contracts. Need to look at all issues of recruitment, pay and conditions for home carers.

Unpaid carers. As the population ages so do carers. People in their 70s may still be caring for their parents in their 90s. They need support. Respite care is very hard to get. Provision needs to be looked at, particularly emergency respite.

Mental health. Suicide is an issue in Buckie, particularly among young men.

Local services. People who are sick and in pain are having to travel through to Aberdeen and appointments are made for 9am. People with an AB postcode have to pay for accommodation at the CLAN centre but those with an IV postcode don't, even though it may be just as far for someone to go from their home to the A96 first to get a bus. More use should be made of technology and telemedicine.

There was no public attendance at the events in Lossiemouth (25 Sept) and Rothes (29 Sept).

14 August 2015: Strategic Planning Group - Development of Strategic Plan

Aims of workshop

- Reaffirm our vision statement, purpose and principles for the care and support of adults in Moray.
- Describe the approach being taken in Moray
- Share existing headlines for analysis
- Share existing strategic priorities from strategies
- Agree the strategic priorities and identify any gaps

What one thing do you want to see achieved within the strategic plan?
Recorded on post it notes

- Support people to self-manage long term health conditions
- Reduce stigma & increase understanding of dementia
- Engaged & motivated workforce (that is dementially person centred)
- We are able to deliver the right services required for the people of Moray
- A vision that supports people feeling confident that they can access Health & Social Care services when they need to throughout their lives (In short a strategy plan that inspires confidence)
- Understanding of roles and responsibilities across the board and accountability across all sectors
- Crossing boundaries / breaking down barriers
- Recognition of the resources assets that is in localities , Strengths, Opportunities, Ambition, Results, Techniques, realised
- Support us to provide a first class service for partners with dementia

- Working together acknowledging each other's contributions to promote independent living
- The right thing easy to do to benefit staff and the people
- Simpler communications
- Steam lined & patient focused pathways of care pre & post acute services
- Many conditions are life (Huddle AM)
- Living well with multiple conditions
- To be sure that Health & Well being of older people that they are linked together
- A strategic plan based on need which sets out our priorities
- Flow – in right place for you, not convenience of service , i.e need acute hospital bed? Her in Elgin , not Aberdeen unless you need their support
- Ready for home? Don't hang around
- Co-production make wording more accessible
- To ensure independence but with proper support for Older People
- To be allowed to have a voice be listened to as an equal
- Wider understanding of the three tier model bit not just at a superficial level – more about what is really means for the service you manage or might use
- To ensure community pharmacists are involved in strategic planning from early on in the process to maximise the services they can offer
- A clear commitment to engagement with stakeholders
- One plan – One direction – One implementation process – Outcomes not Silos
- Being able to quantify the positive difference to individuals, clear, concise and simple
- In light of projected shortfall of GPs, how are we going to support the future reform / development of Primary Care
- Commitment to supporting lable free accessible wellbeing led by communities, less silos / empowering choice / resilience / asset based / human rights approach seeing people as individuals with different needs

Vision and Principles

- Broad and not contentious therefore all in support
- However - does our selection of strategies encourage a system of 'silos' rather than a holistic approach
- Professional Focus - where is my voice my choice
- Is it self affirming rather than challenging – what is real transformation?
- Vision does not convey risk and human rights approach
- Vision reaffirmed
- Need strong culture change & strong vision to support (current is not strong enough)
- Independence – word in vision statement
- Inter-dependence is a more recovery orientated goal. We are not actually aiming for independence (support is vital)
- Independence – as a word is limiting – ie may not be a word I might use for self – so what is Older People to us ?

- Not independence but we need to support and receive support as part of life long wellbeing & teaching life goals
- Focus should be on not what but how – human rights approach / respect for individuals
- Revisit “principles”

Principles / Priorities

- Human rights approach – responding to individual needs – this will require empowered public and services. A common language – mutual acceptance of risk
- How do we challenge the norm when we are the norm?
- If we take this approach how do we ensure face to face access in an equal partnership. Mutual respect should prevail – breeds confidence
- A pragmatic approach on both sides – goals are shared and understood, boundaries are shared and understood

Strategic Priorities

- Identify, deliver and sustain locally provided community based services for scheduled and unscheduled care
- Incorporate a focus on carers
- Recovery, re-enablement
- Prevention
- “open source” knowledge
- Move away from professional hierarchy
- Increase in peer support
- Increase in people / patient involvement
- Coproduction
- Widening of professional roles
- Less protectionist
- Less directive
- Provision of tools / skills to enable autonomy / independence
- To enable the people of Moray to lead independent healthy & fulfilling lives in active & inclusive communities where everyone is valued, respected & supported to achieve their own goals
- Recovery – involvement of people who use services keeping you well - Add to values or somewhere else?
- Prevention
- Three Tier Model – invest in language of recovery / self help / independence / communication
- Communities – respect resources people have / resilience
- Recovery – how do we articulate it? Use the five chime – Connectedness, hope & optimism, identify, meaning in life, empowerment
- Golden thread – Nine outcomes and how we implement them for all individuals

Health & Wellbeing Outcomes

- Healthier Living – Choice & Control, self management, enabling prevention
- Does Health & Social Care impose their perception of what tier people fit into when they might consider themselves to be T1. Person being confident to challenge care professionals. Care package to be person-centred
- Effective resource use – Address shortfall in GPs / Right skills matched to need / Forres Health Centre model / Support people to access lowest – level "services"
- Independent living
- Individuals ability to communicate their needs
- T2 & 3 Signposting / Awareness of T1
- National Priorities
- GP's
- Community Resources
- Prevention needs resource

Other

- Be clear about the person's responsibility as a team member
- Define Health & Wellbeing – person specific
- Tangible link between strategic plan to implementing plan Needs not Wants
- Hip Fracture Pathway is a tracer condition
- Develop a single assessment process
- Develop seamless service through written, verbal and IT & joint documentation (Protocol)
- Communications process need to be open and person centred – Person held

11 September 2015: Strategic Planning Group - Development of Strategic Plan

Aims of workshop

- Update on the development of the plan and the time line
- Shared feedback from last workshop
- Shared feedback on workshop engagement event
- Shared newsletter and communication plan
- Further explore our strategic priorities

Summary of key points

A number of key themes emerged from the four tables of multidisciplinary, multi agency including service users and public representatives:

- Improving the health and wellbeing of our population
- Carers continuing in their caring role
- Investing in a seamless workforce which meets the needs of the population
- Carers

Group one feedback

- Workforce have the skills to meet the needs of the population
- The population will look after themselves. The community with partnerships will respond to support individual outcomes
- Transform the culture and philosophy of care from reactive services provided to people towards preventative, anticipatory and co-ordinated care and support people at home with people
- Transform relationships to open, honest, fair, equal – public/third sector/statutory services
- Supporting carers implies hierarchy

Strategic Outcomes

- More people will live well in their community
- Carers can continue their caring role whilst maintaining their own health and wellbeing
- The population will be responsible for their own health and wellbeing. The community will respond to support individual outcomes
- Relationships will be transformed to be open, honest, fair and equal

Group Two

Strategic Outcomes

- Community Resilience
- Workforce
- Carers and families
- Service redesign

- Health and Wellbeing
  - Together we will build ,healthier resilient communities
  - Community in the widest sense, self care
  - We will build an engaged workforce, who are connected, confident, valued and able to respond well to their community
  - Unified ethos
  - Carers and families are consistently recognised as partners, valued and receive practical support and choice
  - pre crisis *contingency planning/anticipating carer needs (including short term)
  - People experience choice and are recognised as partners in every contact with health and social care
  - seamless, person centred, holistic not looking at one condition, co-designed, choices – support and guidance not dictation, not medical model, flexible not one size fits all
  - We will work together with all partners to deliver sustainable services and to promote positive health and wellbeing
  - Philosophy, change and impact, system improvement, connecting with partners e.g. community planning, transformational, cultural change in society and services, sustainability, affordability/value, positive, needs led, within resources available.

Group Three

Strategic Outcomes

- Provide carers with choices that enables them to maintain their wellbeing and continue their caring role
- Invest in a seamless workforce and ensure that skills. Competency, confidence to match the requirements to enable individuals to maintain their wellbeing
- Provide choice and increase personal responsibility to encourage and enable individuals to maintain their own wellbeing making person centred care a reality
  - Where possible, despite challenges, together make it happen
  - Personal Responsibility – support to ask
  - Vision Statement “Aye but”
  - Tell us once
  - Competency against confidence
  - Give respect and autonomy to professionals to do their job properly
  - Allow people to make connections that will maintain their wellbeing
  - Person choice, availability, access, seamless
  - Joined up approach – one stop shop

Group 4

Strategic Outcomes

- Right Time right care right place
    - Contribute to Vision?
    - Possibly just shifts demand elsewhere to equally pressured services
    - People living at home reduce pressure on hospitals but increases on the community services
    - Shift is not resourced in advance – no transfer of resources with demand
    - Expressed better?
    - Be specific about personal health approach (self Care) and self management
    - Need to fit with national policy e.g. easy to get paracetemol prescriptions from GP rather than self responsibility
    - How its applied and communicated – more detail for individuals to work it through

- More carers supported to continue in their caring role
    - Right for Moray?
    - Moray census indicated low rates of self assertion as carers. Important therefore to find and engage with people how? Difficult. Moray carers survival plan needed
    - Expressed better?
    - Need to capture carers in an anticipatory way so their health is valued (by self and services) early on

- More Carers are identified and supported and valued in their caring role – partners in care
    - Health and social care services reflect the demography and needs of the population
    - Right for Moray?
    - Rurality factor importance of locality planning to be right
    - Culture – expectations of standards/quality is consistent everywhere but ability to meet that is variable across Moray (small settlements)
    - Expressed better?
    - Does it address every need or imply that every need will be met?, does it address inequalities?
    - Does it reflect the need to keep up with the changes e.g. migrant workforce, need for non English communications include the words “current” and “future”
    - Add to end – and address inequalities

Workforce Event feedback

- Health and social care services reflect the demography and needs of the population and address health inequalities
- Very short notice but well attended. Valuable to note that it is important to workforce
- Who was missing/not invited, not enough clinician
- Good to get dates out for future events
- Roles – need to be flexible to "fix things" without recovering but valued specialist skills too – how will we do this?
- Co-location – very important to shape relationships and trust – not rely on eminent faceless communications. People are willing to travel-committed

Feedback on the Project Plan

- Record the localities
- Will be good to see confirmed localities on map so we can begin to divvy things up
- Content will be what be measured against so of timeis everyone aware of that
- Good at plans – are we good at implementation and review
- Not clear how it will come together
- More focused on plan than people
- How do we know what each locality wants
- Needs to include an indication where we will be in a years
- Point 7 re workforce – expand it to include work stream about staff/change management/direction of travel/new philosophy service user as partners
- Communication plan – expand this action listening + two way
- Useful indicators of real communication not "just telling"
- NB fire service has gone through similar process. Can we meet with their strategic team

Feedback on Consultation Plan

- Training events – include service user perspective from service user perspective. Respect/behaviour
- Agree with PG 7 of workforce event
- Specifically discussion with existing service user groups/disability groups, local groups and talk to services users e.g. visit Moray resource centre
- Empower people to have their say and not be afraid to "rock the boat"
- Include third sector health and social care forum (multi-organisational)

Feedback on Integration Newsletter to staff and public

- Looks fine
- Jargon around multimorbidities

- At last
- Useful to give staff and public same information, consistent message

30 October 2015: Strategic Planning Group - Development of Strategic Plan

Aims of Workshop – Exploring our strategic outcomes

- Update on the development of the plan and Timeline
- Commissioning Activity Updates Share feedback from GP event
- Share feedback from Workforce event – three tier model
- Share results of Service Mapping

Group 1 - Headlines at 1 Year

- Transformational Programme for Inter Service approved
- TMC Homecare now providing 1st response Service
- IT agree categorically to allow us to do our job
- Implementation Plans
- VC
- Online Appts
- Telehealth
- Locality / Co-location planned

Group 1 - Headlines at 3 Years

- Holistic view of one person across multiple agencies (MAV) careview
- Fully mobile working – access to live data
- Managing expectations around confidentially etc
- Information co-produced
- Increased securing – rather than paper
- Locality co-located working
- Taking assessments to patient
- Include VC
- Online appointments
- Telehealth

Group 2 - Headlines at 1 Year

- Scotish Govt launches consultation on Nat Curriculum for Care
- Stakeholder survey on needs for a One Stop Shop (H & SC). Feasibility study on One Stop Shop. Business case completed & funded by IJB
- Practices survey their population on facetime / Skype appts. Two practices to test virtual appts
- Public, local Moray consultation on time banking. Local businesses identified to support – Hopeman Pathfinder

- Partnership with Private Sector to test digital “Backpack” of Personal Med Records of people with COPS
- 1yr birthday for Nurse led Health Clinic in Asda
- “One stop Shop for Support “
- Virtual Doc appts outnumber Face 2 Face appts
- Party at the Community Living Centre
- Community Partnerships replace local Auth & NHS
- Rare NHS ID Badge goes on Ebay for £1m
- New Currency Launched – Community Coins – Time banked and bartered
- Housing boom due to Sandwich Generation
- Facebook marriages on the rise among Octogenarians
- Medical records embedded under the skin microchips
- Mixed age care on single site
- Community care on the curriculum
- 30% of working week delivered “At Home” – more choice for work / life balance
- Tax reduction for workers who volunteer
- Neighbourhood health watch

Group 2 - Headlines at 3 Years

- National Quals & curriculum include care (inc SVQ at college & Apprenticeships)
- New career path for Care
- Test of “One Stop Shop in Moray” Access to Health & Social Care on a drop in basis
- Pt choice of real or virtual appt with GP
- Test of time banking in Locality with rewards
- CHI No & Record in Apple Passbook” Digital Health Passport” for people with LTC

Group 3 - Headlines at 1 Year

- Cohesion for housing planning & provision
- Jubliee cottages showcases benefits of technology
- Focus – savings realised
- Online GP bookings available throughout Moray
- Prospect of time banking explored
- In Buckie open community wellbeing meeting

Group 3 - Headlines at 3 Years

- Power of attorney update now at 80% in Moray
- Conversations on future crisis now the norm for H & SC workers

- Moray gets partners in Care
- Suicide & Self Harm rates at all time low

Group 3 - Headlines at 10 Years

- GP retiral demographic time bomb overfed
- Social isolation a thing of the past with Moray
- Innovative timebank scheme
- Embracing in immigration boom for Moray's Wellbeing - Culture health and happiness rated top in Scotland
  - Expectations
  - Responsibility / rise
  - Choice & change
  - Technology

Group 4 - Headlines at 1 Year

- No reduction in demand for Beds – Health Chief hopes for no repeat of 2015s "Winter from Hell"
- Workforce seven day flexible working redesign announced
- Gowans promises Moray Strategic Plan will be finished by this Christmas
- A meeting of the IJB yesterday announces 8% pay rise for all volunteers
- Plans finalised for New H & SC facility in Keith
- Carer Recognition
- Social Care Careers Pathway in development
- Spynie Closes Doors - Team relocated to .....
- Ave GP appt now 11 ½ Mins
- OOH Promary Care Redesign process announced
- Local Vol Orgs round planning table to develop patient peer support

Group 4 - Headlines at 3 Years

- Repeat follow-up appointments as a routine "check-up" now replaced by "Community connections" – huge media campaign was needed to win public opinion
- Polyclinic Plans – Finalised for Keith
  - 7 day service provision
  - 'Virtual ' appointments
  - One Stop location for range of Public services, Vol orgs, beds, community centre
- Tapping our greatest asset – people with long-term conditions supporting others to live well after diagnosis
- Risk from privatisation of services highlighted "Two Tier service "
- Community Planning Partnership Planning – economic development locally

Group 4 - Headlines at 3 Years

- 50 Euros Buy Digital Diagnoses iWatch
- Order Custom Grown Organ replacement
- U.H.I & The 3rd Age – PHD courses in caring enrolling now
- No Crashes this year – since Google cars become common
- Pension Age raised to 95 in line with increased life expectancy
- No Beds , Bike Sheds – Dr Grays to close with opening of Cycle – through diagnostic and treatment centre in derelict former hospital site
- Last Gasp – Morays final smoker died yesterday
- Vaping cafe to take over WRVS role in Asda Health Centre
- First Minister Ross proposes raising town care speed limits back to 10mph
    - Cyclist outrage
    - Lord Corbyn condemns
- Health Manager goes for Gold
- GM today picks his 50 Year Service Award for work with Health Scotland
- Single set of personal information seamless care – tell us once but will be digital
- Driverless cars (replacing dial-a-bus)
- Community what's app
- Increase in connected communities – enable via Social networks etc
- Sharing skills helping each other
- Dilution of volunteering – Increase in those participating
- Activity / prevention in home – virtual interaction (where appropriate) the norm
- Integration review find Moray truly integrated
- Co-location at Community level showing benefits
- Careview providing holistic view of patient / client journey – and not viewed as a number but a profile
- Online appointments reduce no-shows
- Virtual appointments save MHSCP £Millions!
- I haven't been in the office for 6 months – yet I'm supporting more people MHSCP Worker
- Increased Adoption of preventative telehealth supporting patients & carers
- Virtual GP flashmob goes viral & pushes for Dementia Cure to be financed in Moray
- Smart Patients fully chipped
- CH retires on Implementation of Dial-A-Drone
- Apple adopt SIRI What's Apps
- Census reports massive increase in volunteer in Moray as a result of connected community

Group 4 - Headlines at 10 Years

Digital

- Human MOTS pioneered through chip technology
- Waiting times disappear as robots replace surgeons in Dr Grays
- Portable CT scanner moves diagnosis closer to home
- Last few remaining people with COPD attend their pulmonary rehab class linking in with Singapore. Everyone else has had their disease eliminated due to successful health improvement interventions

Community News

- Moray residents move into their self sustaining, energy efficient housing scheme, designed by their local communities with virtual links to health and social care
- Moray management team go on holiday safe in the knowledge that people will look after themselves. The team have been following a Mediterranean lifestyle with good food and an afternoon siesta
- Joint equipment store closes as people become more independent
- Supermarkets close as communities vote with their feet and access local produce
- Plans are available for viewing for the smaller version of Dr Gray's

Vacancy Bulletin

- New Chief Officer appointed. Joe Bloggs started his career as a home carer in Moray in 2015
- Young people choose to live and work in Moray pursuing careers that support local communities

Achievements

- MM a 23 year old Moray resident with ALD has just sold a piece of art for £1 million at auction. M studied art at the UHI
- Moray Partnership achieves its budget for the 9th year running
- Moray sweeps the board at this years' Scottish golden games
- Psychiatric admissions at an all time low due to community care initiatives
- 100% of people in Moray have a choice in their lives through self directed support

27 November 2015: Strategic Planning Group

Aims of Workshop

- Does the strategic plan reflect what we have agreed?
- Review content
- Are there any gaps?
- Is the plan readable to the public?

This meeting was used for an overview and consolidation of the progress to date. The group finalised and prepared the strategic plan prior to public consultation.The group went through the document chapter by chapter and identified terms for the glossary and final amendments. The outcomes of this workshop were incorporated into the final version of the plan, post consultation.