MORAY STRATEGIC PLAN

2016-2019

A Strategic Commissioning Plan for the adult population of Moray developed and agreed in partnership with Health, Social, Voluntary, Independent sectors, and the public. It describes how the new integrated partnership intends to improve the health and wellbeing of adults in Moray through the design and delivery of integrated services.

Moray Integration Joint Board (MIJB)

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FOREWORD

"The landscape for the future delivery of health and social care for adults in Moray is changing. The new legislation progressed through the Scottish Parliament in April 2014; The Public Bodies (Joint Working) Scotland Act 2014 set a new legal framework for the future of these services. For Moray this means that the Health and Social Care Partnership known to people will continue but under the direction and operation of the Moray Integrated Joint Board (IJB).

The IJ B is a new public organisation that from the 1st of April 2016 will be responsible for the planning and delivery of services. The board is a partnership arrangement in the broadest sense in that it is expected to work with voluntary and private sector partners alongside communities to improve the quality and effectiveness of services as well as supporting people in our communities to keep well and live independent and fulfilling lives in their own right.

It is important to say that this new organisation will continue to work in sync with the Moray Council and NHS Grampian, as well as being a partner in the Community Planning Partnership arrangements for Moray. It is also important to say that children's services will continue to work together with adult services in the interests of families and building our future generations.

The current situation in Moray is a very positive one, with the majority of people living well and already caring well for themselves and their families. We need to build on this together. The future of services and our ability to future proof Moray in a way that means there is a strong emphasis in helping people to help themselves will determine our ability to have the right services available to meet your needs when you really do need help of a more complex nature. So when I say together I mean together, the people of Moray whether you are a professional working in public, voluntary or private sector service, a paid or unpaid carer or a member of the community.

The new arrangements have brought the need for the development of a strategic plan for Moray which will set the direction of travel and hopefully convey the spirit in which we want to move forward. Extensive consultation and engagement has informed this plan, people from all walks of life have been involved in a variety of discussions over the past year in relation to pulling this strategy together.

This Strategy sets out our ambitions for Moray in terms of achieving good health for us all and responsive, supportive services when you need them. Where ever you sit in Moray we have a

great opportunity to improve on how we all work together and share our knowledge and experiences to improve. We want to gather the talent and enthusiasm which in the end will benefit us all. We do have a challenging time ahead with financial constraints but the level of challenge will be less if we work through things together and maximise our potential by drawing on the strengths and assets of our communities. "

Pam Gowans, Chief Officer, Moray Health and Social Care Partnership

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PART ONE: INTRODUCTION What's the strategy about and how did we develop it?

1.0 Introduction

This is the first Moray Integration Joint Board (MIJB) Strategic Plan to be developed since the evolved Partnership was established in accordance with the provisions of the Public Bodies (Joint Working) (Scotland) Act, 2014.

In Moray, the Partnership has been established as a Body Corporate – i.e. a separate legal entity from either the Council or the Health Board, with responsibility for its governance resting with the Integration Joint Board (IJB).

It has responsibility, primarily, for a range of health and social care functions relating to adults and is responsible for the strategic planning of integrated services, together with monitoring of the corresponding service delivery. The Act places a duty on IJB's to develop a "strategic Commissioning Plan" for all adults in the area.

This Strategic Plan describes how the MIJB intends to improve the health and wellbeing of adults in Moray through the design and delivery of integrated services and achieve the national outcomes.

- It will describe how the integrated partnership will make changes and improvements to develop health and social services for adults over the coming three years.
- It will explain what our priorities are, why and how we decided them and how we intend to make a difference by working closely with partners in Moray.
- The Plan is underpinned by a number of national and local policies, strategies and action plans. It will provide the strategic direction for how health and social care services will be shaped in Moray in the coming years and describe the transformation that will be required to achieve our vision.

1.1 Purpose

The main purpose of Integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. Its core aims are:

- To improve the quality and consistency of services for patients, carers, service users and their families;
- To provide seamless, integrated, quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so; and
- To ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

1.2 Scope of the Strategy

This strategy covers all adults18+ who use our health and social care services which are agreed as in scope of integrated services (**Appendix 1**). This includes existing service user client groups - older people, physical and sensory disabled, learning disability, autism, mental health, drug and alcohol and unpaid carers.

1.3 A Shared Approach

Moray Health and Social Care Partnership is a mature partnership with a proven record of partnership working with other agencies such as the third sector and independent sector. Communication and engagement with patients, service users and the wider public is embedded in our shared approach to strategic commissioning in the development of a suite of joint strategies which link directly to the Moray Single Outcome Agreement.

Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. The output of the strategic commissioning process is the strategic plan.

Building on the strong partnership relationships, we established a Strategic Planning Group (SPG) made up of a broad range of people, professionals and partners. This includes local clinicians and professionals from across health and social care, including GPs. Patients, service users and unpaid carers along with staff from the third sector and the independent sector are also on the group. The group co-produced the plan using their combined knowledge, expertise and experience.

A range of commissioning activities was carried out to inform this plan. This included a health needs analysis, service mapping of what is in scope, review of existing strategic priorities, review of finance, review of national and local policy/guidance, a robust staff and public consultation and engagement plan, a series of workshops at key points in the development of the plan. These are detailed in the accompanying appendices.

1.4 Stakeholder Engagement and Communication

The partnership acknowledges that supporting the health and wellbeing of adults needs to involve more than health and social care sectors e.g. the population itself ,housing , transport, leisure, community support groups and the independent sector and third sector all have a role to play if we are to achieve the national outcomes and redesign our services.

A wide range of communication and engagement activities have taken place in the development of this plan. This includes staff and public newsletters, website updates, a series of locality events, a series of staff workshops and draft plan questionnaire. Working Together (**Appendix 2**) details the findings which have informed the plan.

1.5 Equalities and Diversity Impact Assessment

The Strategic Plan has been Equality and Diversity Impact assessed to ensure that consideration of the needs of our local equality and diversity communities are an integral part of the way we operate. The 9 “protected characteristics” of equality as defined by the Equality Act 2010 are: Race, Disability, Age, Sex (male or female) Sexual orientation, Gender reassignment, Pregnancy and maternity, Marriage and civil partnership, Religion or belief. The assessment is detailed in **Appendix 7.**

1.6 Housing Contribution Statement

Housing are fully engaged in the strategic planning process, the housing contribution statement describes the role of the Council as Strategic Housing Authority, as a social landlord and the role of local social housing providers in achieving the outcomes required by the Moray Strategic Plan. The full statement is available in **Appendix 8**.

1.7 Timescale and Review

This Strategic Plan sets the direction of travel for future commissioning decisions and service redesign and development over the next three years (2016-19) and will be subject to monitoring and review on an annual basis in line with government policy around the Act. This will ensure it

continues to respond to emerging needs and expectations of adults through future locality planning arrangements, local and national policy and emerging priorities.

This is not a static document. It is a live strategic plan and as such we look forward to engaging with all those with an interest in health and social care to deliver on our plan between now and 2019.

PART TWO: BACKGROUND TO THE PLAN Why do we need to change?

2.0 Introduction

'Separate - and sometimes disjointed - systems of health and social care can no longer adequately meet the needs and expectations of increasing numbers of people who are living into older age, often with multiple, complex, long-term conditions, and who need joined up, integrated services." (Scottish Government 2012 analysis report integration of health and social care)

Over the last decade there has been growing recognition that services for the population in Scotland will need to change. Demographics, economics, increasing care complexity and people's expectations are driving a rethink about what kind of health, wellbeing and social care services are needed, and about the way in which services are planned and coordinated to be effective in securing the best possible outcomes for the population.

2.1 Policy Context

Two main National documents have influenced this strategy:

The Christie Commission on the Future Delivery of Public Services (2011) recommended radical changes to the way public services are designed and delivered if they are to be sustainable and capable of meeting the needs and expectations of individuals and communities. It sets out four objectives which must shape a programme of reform;

- Public services are built around people and communities, their needs, aspirations, capabilities and skills and work to build up their autonomy and resilience;
- Public service organisations work together effectively to achieve outcomes;
- Public service organisations prioritise prevention, reduce inequalities and promoting equality; and
- All public services constantly seek to improve performance and reduce costs and are open, transparent and accountable.

The 2020 Vision (Healthcare) and The Healthcare Quality Standards Strategy NHS Scotland (2010) identified quality ambitions to support the delivery of person centred, safe and effective

care and emphasises the need to support people to manage their own conditions as far as possible. The strategy detailed 3 quality ambitions:

- Beneficial partnerships between patients, families and those delivering care which respects individual needs and values, demonstrates compassion, continuity, clear communication and shared decision-making.
- There will be no avoidable injury or harm to people from healthcare they receive and an appropriate clean and safe environment will be provided.
- The most appropriate treatments, interventions, support and services will be provided at the right time for everyone who will benefit and wasteful or harmful variations will be eradicated.

The 2020 Vision augmented this and sets out the Scottish Government's strategic vision, and specifies 12 area of improvement (one of which is integrated care) for achieving sustainable quality in the delivery of healthcare services:

By 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

"We will have a care system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission."

From a local perspective this document overarches our existing suite of joint commissioning strategies for older people, mental health, learning disabilities, physical and sensory disabilities, drug and alcohol, carers and dementia. Recurring themes within these strategies are community capacity building,prevention and early intervention, co-production, rehabilitation, reablement and recovery, person centred and outcomes focused care, care at home, use of technology to enable care and workforce development. **Appendix 3** further details the national and local policy context

2.2 Moray Health Profile and Changing Demand

Moray tends to have an overall health profile that is better than the Scottish national average. However behind this lies evidence of variation in health status, with some communities reporting

greater levels of health problems than others (**Appendix 5** Health Needs Analysis). Overall Moray has:

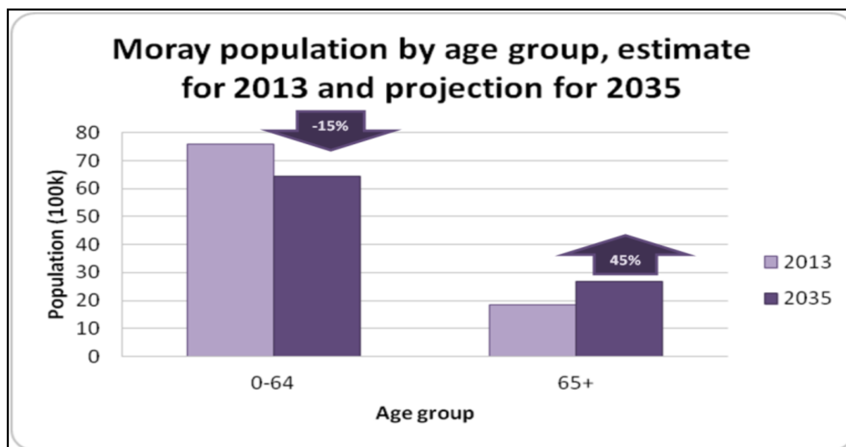
- high life expectancy
- above average educational attainment, employment, income
- below average crime, homelessness, alcohol-related mortality and hospital admissions
- average smoking rates
- health condition prevalence rates that are similar to, and often lower than, the national average; some emergency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

Within and across Moray, not all communities are exposed to the underlying causes of health equally, and health condition prevalence and emergency hospital admission rates show observable variation by geography.

Predicted growth in older adult population over next twenty years, suggests expectation for increasing service demands, reduced working population, increase in multiple long term conditions

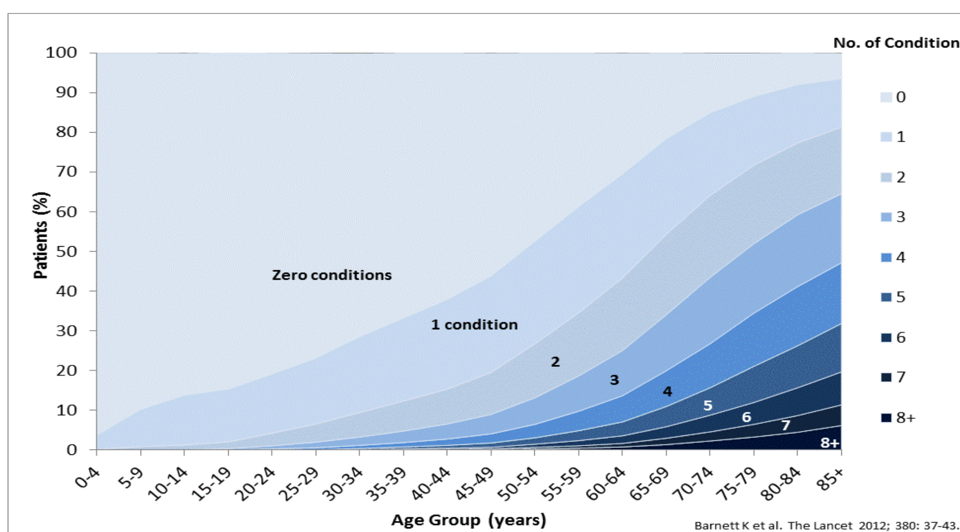
Moray tends to score well for the social and economic factors that underpin good health, when compared to the Scottish national average. However, its rurality is a known issue that can cause people difficulty in accessing services, and despite high average employment and low overall income deprivation, moray has a higher proportion than average of households reported to be living in fuel poverty. Moray also has an above average level of road traffic accident casualties in Scotland.
Moray's population is ageing, consistent with national trends. Increasing life expectancy is to be celebrated. Population projections show a 45% increase in the over 65 population and a reduction

of 15 % in the under 65's in the next twenty years. Not only does this suggest an increase in service demands, it may also impact on the available workforce.



With increasing age there is also a rise in the number of people living with long term conditions which includes people with enduring mental health problems who are likely to have increased care and support needs. The mental health needs of people can generate significant problems for them, their families and carers. Addressing these needs can make significant demands on services. Mental health is a crucial part of our health and wellbeing.

The prevalence of long term conditions will increase with the ageing population, and increase the burden on health and social care services in the community setting and the use of emergency beds if not managed well in the community. There are clear links between long term conditions, deprivation, lifestyle factors and the wider determinants of health. The chart below shows the number of long term conditions which can be accrued as people age.



2.3 Current Service Structures

Services in Moray are primarily delivered through the NHS and Local Authority in partnership with communities and the voluntary and independent sectors.

There are many community and voluntary organisations and groups in Moray that also contribute to people's health and wellbeing, this type of work is hugely varied.

Moray has a population of approximately 88,560check (ISD General Practice Populations data) and stretches across approximately 860 square miles of predominantly rural landscape.

Most people live in the natural communities/main towns of Elgin, Lossiemouth, Buckie, Forres and Keith. Other smaller communities are also scattered throughout Moray e.g. Hopeman, Burghead, Cullen and Aberlour, Dufftown, Fochabers, and Tomintoul in remote and rural locations.

The town of Elgin hosts the acute services at Dr Grays hospital; a 129 (122 acute assessment beds and 7 assessment beds) bedded District General Hospital which provides acute services to the greatest density of the Moray population.

Five community hospitals exist in Moray in the towns of Forres, Buckie, Aberlour, Dufftown and Keith providing 79 inpatient beds in total delivering a range of acute and intermediate care services for local areas.

Community health and social care services are built around the community hospitals with community based teams co-located where possible.14 GP services are arranged in practice clusters around the natural communities. Teams in Elgin are aligned to GP practices.

Mental Health services in Moray are delivered primarily through the NHS and local authority in partnership with communities and the voluntary and independent sectors. Responsibility and resources for planning and delivering these services will move to the IJB.

Interim management arrangements around these services have been in place since September 2015, Work is underway to refine and understanding the requirements of the ongoing management structure to take us forward.

2.4 Key Service Developments in terms of integration and national outcomes,

Our developing relationship with **tsiMORAY** will support us to continue the development of a moray based third sector forum focused on health and wellbeing in our communities; enabling and empowering smaller groups and organisations in the delivery of priorities identified; facilitating and

connecting to make and improve relationships and engaging with partners; further developing their participative role in the process of integration as the culture of **collaborative** and **co-productive** practice continue to be developed.

This strategy recognises the enormous and valuable contribution that communities and volunteers can make in the areas of promoting health and wellbeing

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

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

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

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

Improvement Programmes currently underway in Moray include: **Modernisation of Primary Care, Focus on Dementia, Self-Directed Support, Unscheduled Care, Older People in Acute Care, Patient Safety Programme, Long Term Condition Action Plan**

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

2.5 Current Performance

MHSCP can demonstrate sustained and improving performance in relation to a range of key national and local measures that form the "basket of measures" for older people.

This includes; reducing emergency inpatient days rates for people aged 75+, increases in the proportion of people 75+ living at home with an anticipatory care plan shared with the out of hours service, an increase in the number of clients receiving more than ten hours of care with a corresponding reduction of clients moving to long term residential care.

The Partnership is also recognised as being in the top quartile in terms of the number people experiencing delayed discharge. We can also demonstrate an increase in both the delivery and flexibility of respite provision based on local demand.

These improvements have been instrumental in reshaping care for older people and shifting the balance of care from institutional settings to community settings. However, as demand continues to increase the following issues are emerging:

- The number of total emergency acute hospital admissions is not reducing
- The number of delayed discharges from hospital remains a challenge
- The number of people from Moray who readmitted to hospital within 30-days of discharge has been increasing, with the exception of Dr Gray's Hospital where the rate is reducing
- The availability of home carers in some areas is cause for concern

2.6 Financial Framework

One of the principles underlying The Public Bodies (Joint Working) (Scotland) Act 2014 is that the Integration Joint Board will, through the Strategic Plan, be able to allocate resources within the integrated budget and to prioritise and agree transfers in order to meet the goals as specified in the Strategic Plan. The ability to plan within the overall resource for a defined population and user groups and to use budgets flexibly is one of the advantages of integrated care.

This Strategic Plan incorporates a 3 year financial plan for the resources within the scope. These resources comprise:

- The payment made to the Integration Joint Board by The Moray Council for the adult social care services that have been delegated;

- The payment made to the Integration Joint Board by NHS Grampian for the delegated healthcare services; and
- The amount set aside by NHS Grampian for large hospital services used by the population of the Integration Joint Board.

The 3 year Financial Plan outlines the indicative resources available for the years 2016/17 to 2018/19 and is detailed at **Appendix 4**. The Integration Joint Board assumes responsibility for these resources as of 1 April 2016.

Strong leadership, effective planning and performance management are essential elements for successful integration. Accordingly, an effective assurance framework is required to identify and minimise the associated risks. Financial governance is an essential element to the assurance process and has been embedded into the process thus far through the Integration Scheme and will continue to be monitored through a range of documents underpinning this Strategic Plan.
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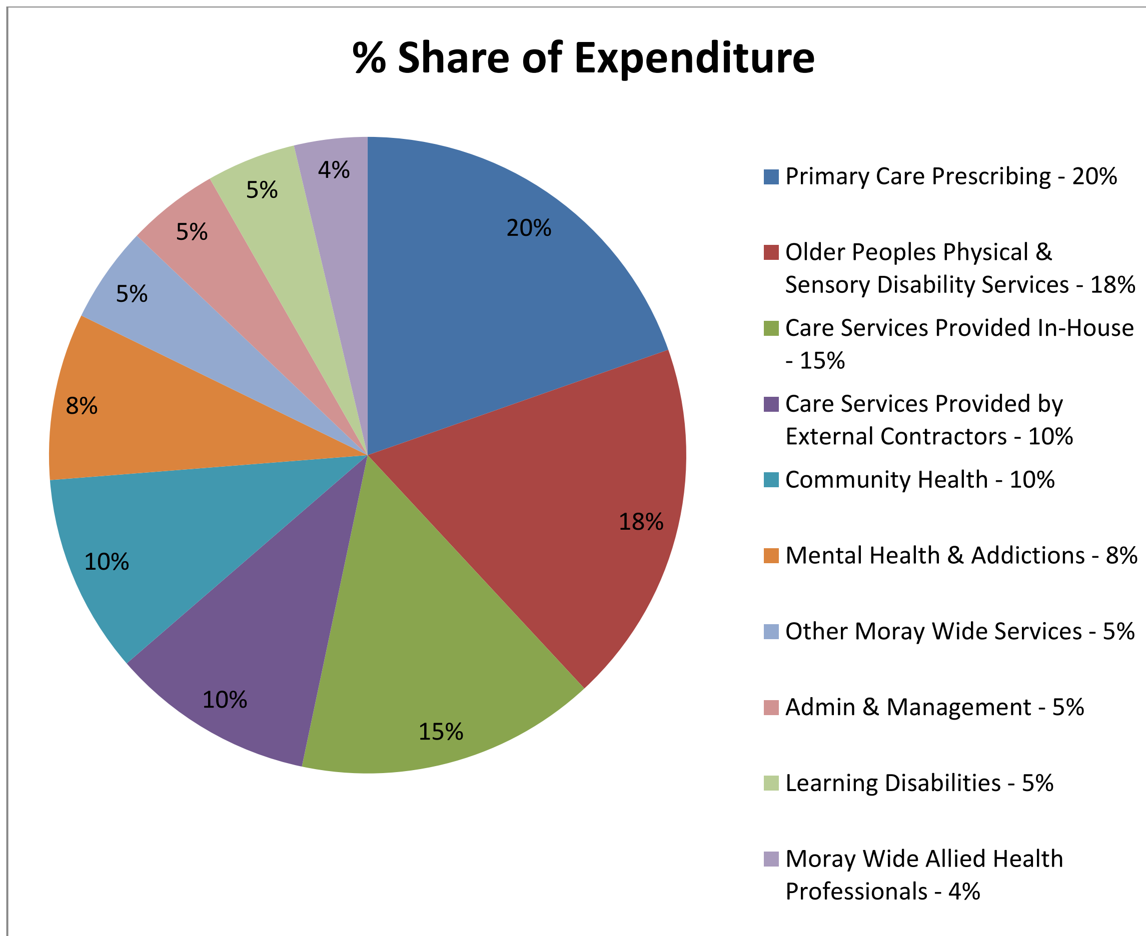
In 2014/15 the total spend for The Moray Health and Social Care Partnership amounted to £86m. The top 5 cost areas were primary care prescribing (£17m; 20% of total costs), the older peoples physical and sensory disability services (£16m; 18%), care services provided in-house by Moray Council (£13m; 15%), care services provided by external contractors and commissioned by The Moray Council (£9m; 10%) and community health services (£9m; 10%). Of the £86m, the split of health to social care was split equally with £43m on each arm of the budget.

The following chart shows the consolidated expenditure for 2014/15 across Health & Social Care:



2.7 Estimating Future Demand on Resources

When population projections are applied to the current financial position, it confirms that current ways of working are not sustainable. There is a shared understanding across the IJB that increasing demand on health and social care services will have financial implications if services continue in their current form. The IJB is committed to ensuring the fullest use of all the available resources in order to improve the health and wellbeing of the community. There is a need for efficiencies, smart solutions and new ways of working in this new integrated environment.

2.8 Conclusion

We believe that the Case for Change is unassailable. It highlights the pressures currently faced by our health and social care system and the demands that will be placed upon it in the future. If we

continue to deliver services as we currently do they will not meet the needs of our population and will not be sustainable for the years to come. Changes are needed to meet future health and social care needs.
Consequently Moray cannot insulate itself from the need for change and this Strategic Plan presents an opportunity to consider a more integrated model for the health and social care system that allows us to deliver an excellent and equitable service to the population.

We must ensure that the Strategic Plan for Health and Social Care builds on the achievements to date and seeks to challenge the system further towards building community resilience and community engagement that has the community and services working together to maximise the opportunities for all.

The partnership acknowledges that supporting the health and wellbeing of adults needs to involve more than health and social care sectors: the population itself housing, transport, leisure, community support groups and the independent sector and third sector all have a role to play if we are to achieve the national outcomes and redesign our services.

Sustainable change requires the longer term transformation and integrated working that will be enabled by joint strategic commissioning and integrated resourcing.

PART THREE: OUR STRATEGY What are we going to do?

3.0 Introduction

This section sets out our three year vision statement, our values and principles, and our strategic outcomes. These are all designed to deliver progress and continuous improvement against the national and local outcomes, which are set out later in section 4.

3.2 Our Shared Vision

"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."

A vision developed by listening to the views of people who use health and social care services, unpaid carers and those who deliver services in Moray and the wider community.

3.3 Our Values and Principles

Through "Working Together " with all partners including patients, unpaid carers, service users and their families, we will promote choice, independence, quality and consistency of services by providing a seamless, joined up, high quality health and social care service.

Supporting people to live independently at home or in a homely setting for as long as possible will always be our default position.

We will strive to ensure resources are used effectively and efficiently to deliver services that meet the needs of an increasing number of people with longer term and often complex care needs; many of whom are older.

We will always work to support people to achieve their own quality outcomes and goals that improve their quality of life.

We will always listen and treat people with respect and value the support and contribution provided by unpaid carers.

We will respect our workforce and give them the support and trust they need to help them achieve positive outcomes for the people of Moray

3.4 Our Strategic Outcomes

Our shared vision for change will be achieved through the delivery of **6 key strategic outcomes** and a wide range of related improvement actions. They were informed by a process of community consultation and analysis of available data about health (including mental health) and social care needs of the population. This included best practice and national evidence of 'what works' in delivering integrated care and addressing positive health and wellbeing. The priorities were agreed and developed at a series of workshops with the Strategic Planning Group and reflect the areas that people felt important.

- More people will live well in their communities - the population will be responsible for their own health and wellbeing – the community will respond to individual outcomes
- Carers can continue their caring role whilst maintaining their own health and wellbeing
- Relationships will be transformed to be honest, fair and equal
- Investment in a seamless workforce to ensure that skills, competencies and confidence match the needs to enable people to maintain their wellbeing
- Technology enabled care considered at every intervention

3.4 Our Commissioning Framework

Commissioners will be important across the health, wellbeing and social care sectors over the next few years. Working with their colleagues across the public, independent and third sectors they will be reconfiguring services to ensure that they meet the needs of the population. They will be change agents working with managers, professionals, service users, patients and carers to ensure that services are increasingly outcome focused, self-directed and effective in helping people live as long as possible in a homely setting.

Strategic commissioning will demand new skills and new practices, and a new level of maturity in the partnership as we try to ensure that every penny spent from the public purse (and by individual service users) is used wisely and effectively, and that services are cost-effective, of good quality and sustainable into the future.

The following table describes the key elements of integrated approaches to commissioning within the practice matrix which we aspire to in the future (extract from IPC and JIT learning development framework, joint commissioning practice matrix).

Areas	Integrated Approaches
	Commissioning plans, decisions and actions are arrived at through a single organisation or network
Purpose and Strategy	• Inclusive planning and decision process as an integral partner • A transparent relationship between integrated bodies • Single agency with one commissioning function
Needs and Market Intelligence	• Single projects undertaking needs and market analysis and using these to inform commissioning and contracting priorities • Single research analysis, public health teams
Partner Engagement	• A single team is responsible for systematic engagement to inform a single strategy • Partners are closely involved in sharing intelligence

We will commission outcomes focused services that deliver high quality care and support and can evidence a positive quality of experience for the individual and their carer. We will develop a quality driven approach that promotes and protects human rights and which seeks the appropriate involvement of people and their carers in the commissioning process.

3.5 Commissioning Intentions

Our commissioning intentions are outlined in the following pages within our strategic outcomes.

1. More people will live well in their communities – the population will be responsible for their own health and wellbeing – the community will respond to individual outcomes

Moray has a clear intention to **build community capacity** in order, amongst other things, to facilitate earlier intervention and a preventative approach and to achieve a real shift in the balance of care.

The recognition of the resource and assets already in localities and building community resilience is key to working in partnership with people in their communities. Together we will build, healthier resilient communities – community in the widest sense.

Co-production and community capacity building will involve working with people who use our services, their carers and the Third Sector to build an approach to providing care, based on co-production principles, develop new community driven models of care provision, and to help people maintain their independence wherever possible.

We aim to have supportive local communities which have the capacity to provide care and support with and for people. Growing community capacity that focuses on early intervention and a preventative approach will reduce isolation and loneliness, enable participation, improve independence and wellbeing and delay escalation of dependency and need for more complex care and support.

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

It should be recognised that people living with multiple conditions can benefit greatly from peer support, either in person or online, and that this can help them to self-manage and build their personal resilience.

Examples of activities (next 1-3 years)

- Strengthen health improvement and preventative approaches
- Develop locally provided community based services
- Reduce stigma of mental health
- Invest in activities that promote positive mental health and wellbeing
- Raise awareness of contribution that housing services and adaptations can make
- Develop a consistent approach to “working together” (co production)
- Increase the capacity of the Third Sector
- Signposting people to access “help to help yourself” services and information
- Support label free accessible wellbeing led by communities
- Support people to make connections that will maintain their wellbeing
- Rights based approach to define responsibilities

- Develop Dementia Friendly Communities
- Increase access to peer support to promote recovery
- Support people to self-manage long term conditions
- Improve information about what is available in the community
- Develop seamless service across the system
- Focus on recovery in mental health
- Develop networks to facilitate peer support locally in partnership with the third sector
- Embed Self Directed Support

What does it mean for you?

I am offered emotional and psychological support from my peers, local community or professionals

I am given information and advice on opportunities to stay well and be physically active

I'm supported to do the things that matter most to me

My local community gets the support and information it needs to be a safe and healthy place to be

2. Carers can continue their caring role whilst maintaining their own health and wellbeing

Supporting carers to continue in their caring role will be key to providing care and support for the people in Moray. We must work with carers as partners and encourage and support families to provide a caring role.

Providing unpaid care for someone with multiple conditions can also have a significant impact on the lives of those caring, who are often elderly. Carers and their families should be consistently recognised as partners, valued and receive practical support and flexible respite.

Examples of activities (next 1-3 years) development areas

- Provide carers with choices that enables them to maintain their health and wellbeing and continue in their caring role
- Refresh and Develop Moray Carers Strategic Plan fit for the future
- Unpaid Carers must be considered in locality plans i.e. rurality factor
- Early identification of carers to support early intervention and prevention approaches
- Flexible respite options

What does it mean for you?

I feel I get the support I need to keep on with my caring role for as long as I want to do it

I am happy with the quality of my life and the life of the person I care for

I can look after my own health and wellbeing

Staff knows if I have a carer and my carer feels supported

3. Relationships will be transformed to be honest, fair and equal

Developing more equal and reciprocal relationships between health and social care professionals, people currently receiving help, and their families, neighbours and communities will not happen without specific commitment from both the individuals concerned and those professional working to support them.

We will build on and improve our existing engagement with service users , patients, families, carers and the public in general to actively work with communities in localities to ensure their needs and expectations are understood and responded to. This will include working with localities to co-design future services.

People in Moray should expect, for themselves and those they care for , to be listened to, to be involved not just in deciding upon the packages of care they receive, but as an active participant in how it will be delivered: and to enjoy better health and wellbeing within their homes and communities as a result.

We will work together acknowledging the challenges and identifying solutions with all partners to deliver sustainable services and to promote positive health and wellbeing acknowledging each other's contributions to promoting independent living and where possible despite the challenges together make it happen.

Examples of activities (next 1-3 years) development areas

- A clear commitment to engage with localities
- A new relationship where goals and boundaries are shared and understood
- Managing expectations
- Communication process need to be open and person centred
- Mutual respect shall prevail which breeds confidence
- Invest in a language of recovery
- Communication and engagement with communities in localities opportunity to deliver a new message will be responsive to local need, more effective delivery more effective use of resources, will acknowledge local differences and culture
- Transform relationships to be open, honest, fair, equal – all sectors
- People experience choice and are recognised as partners in every contact
- Provide choice and increase personal responsibility to
- Build on engagement with general practitioners and acute hospital doctors
- Clear communication structures across the partnership
- Develop and embed "Moray Partners in Care" approach and framework with teams across localities as a tool of empowerment with individuals

What does it mean for you?

I am offered emotional and psychological support from my peers, local community or

Services and support help me to reduce the symptoms that I am concerned about

I develop my own "thinking ahead" Anticipatory care plan

My choices are respected in making decisions about keeping me safe from harm

I have a single agreed point of contact for my community health and care team

4. Invest in a seamless workforce to ensure that skills, competencies and confidence match the needs to enable people to maintain their wellbeing

People who manage a range of conditions are commonly affected by a range of emotional and psychological issues which include pain, fatigue, depression, anxiety, low self esteem and distress. Wider issues which can have an impact include employment, caring responsibilities, family relationship and social life.

Within our new plan success has as much to do with shifting our attitudes, expectations and aspirations in the community of Moray as it has about shifting resources, care institutions, providers and workforce.

Achieving these aims will require all of us to **work together**, to resolve our differences and transcend traditional boundaries; to recognise our shared aspirations and responsibilities; to share our skills, talents and resources; and to familiarise ourselves with an exciting new dynamic where we are all both contributors and beneficiaries alike. A **unified ethos** and philosophy of care will be required which takes a holistic approach to individuals. **Culture change** will be supported by the development of a positive ethos and working environment.

Examples of activities (next 1-3 years) development areas

- Improved focus on local issues from a needs and delivery perspective
- Build the right workforce for quality care, co-location where possible
- Build and improve positive leadership and accountability
- Create shared processes across sectors and professions
- Workforce development planning
- A holistic approach should be taken when supporting people to address issues - Conversation at the heart of everything we do
- Transform the cultures and philosophy of care from reactive services provided to people towards preventative, anticipatory and coordinated care and support people at home with people
- “Right thing easy to do” If not me who, if not now when
- Develop an assessment mechanism that reduces duplication where possible
- Embed three R’s Reablement, Rehabilitation and Recovery in practice
- Give respect and autonomy to professionals to do their job properly
- Set up mechanism for sharing good integrated practice
- Improve information sharing e.g. between GP’s, secondary care, community pharmacies, optometry and social care
- Develop easy access to service information across Moray
- Improve multidisciplinary team working by supporting the establishment of locality implementation groups across the five communities identified within our locality plans

What does it mean for you?

I feel that I get the support and resources I need to do my job well

I feel that the outcomes that matter to me are taken account of at my work

Engaged and motivated workforce that have the confidence to match the requirements to enable the population to maintain their wellbeing

I feel my views are taken into account in decisions

I feel that the services I am using are continuously improving

5. Technology enabled care considered at every intervention

We acknowledge that technology enabled care is vital to the delivery of the 20:20 vision for health and social care and will contribute to achieving the national outcomes. It should be seen as a mainstream and integrated part of care planning at a strategic and operational level.

Technology has the power to radically transform the way we deliver healthcare by enabling all patients to take a more active role in their own health and increase prevention through supported self-care. We believe that by embracing rapidly emerging mobile and health care we can empower people to own their own care and transform the way we plan and deliver services.

By capitalising on new and emerging technology we have the opportunity to provide a modern model of continuous, coordinated care centred on the individual, with professionals acting in partnership with the person to improve their health and wellbeing.

Telehealth and telecare is here and already working, supporting people in or close to their home. It can reduce the hospitalisation rate of older people with multiple conditions significantly, and improve outcomes for patients who can find it difficult to travel or those who can self-manage their condition.

There is a wide range of potential benefits of technology in relation to health and wellbeing from community alarm, medication prompt, bed sensors to video conferencing to a consultant clinic. Technology is ever changing; home self-monitoring is now available to support people managing conditions at home.

Proactively managing a patient’s health in this way can lead to much better outcomes for them, reducing the risk of being hospitalised, and thereby also reducing the pressure on our acute care sectors.

Keeping people connected using technologies i.e. mobile phone, tablet, access to libraries also have a role to play in reducing social isolation and loneliness.

Examples of activities (next 1-3 years) development areas

- Prepare application for Technology Enabled Care Fund
- Increase the use of NHS video conferencing facilities to other partners, increasing the numbers and range of users and the level of clinical consultations
- Increase use of home monitoring
- Scale up use of digital information, remote monitoring and consultation
- Develop and implement information sharing standard protocol
- Develop shared information systems
- Explore “one patient record” concept
- Use of technology to improve communication, free up time
- Use of technology e.g. home monitoring
- Explore the use of Apps

What does it mean for you?

I can look after my own health and wellbeing

I am able to stay safe and monitor my conditions at home using everyday technology

My GP shares my Key Information Summary and Emergency Care Summary with the emergency teams

My GP, local pharmacist and I receive a summary within 48 hours of my discharge from hospital

6. Infrastructure and redesign

We need to challenge ourselves to seek to ensure we are properly equipped to take health and social care into the future conducive with a modern system. This redesign is a necessity not an opportunity.

Examples of activities (next 1-3 years) development areas

- Review current community hospital model in terms of delivering intermediate care
- Agree the definition of intermediate care in an integrated environment
- Community medicines management – working in partnership
- Develop a consistent approach to assessment across all settings
- Invest in preventative mental health community services
- Improved access to services
- Scope joint estate to maximize team working
- Develop implementation plan to improve information sharing protocols
- Clear route map of implementation to ensure success

What does it mean for you?

Services and support are available to when I need them

The right care for me is delivered at the right time

I feel resources are used appropriately

I feel that I get the support and resources to do my job (staff)

PART FOUR: DELIVERING OUR STRATEGY How are we going to know we are achieving?

4.0 Introduction

Achieving our long term vision for this strategy requires that people, communities, unpaid carers, staff from a range of different public services, the third and independent sectors will need to come together to design and deliver future services that achieve the best possible outcomes we possible can for adults in Moray. It is acknowledged that this requires a whole systems approach, partnership working and involvement of the whole community.

The integration planning and delivery principles are the lens through which all integration activity should be focused to achieve the national health and wellbeing outcomes. They set the ethos for delivering a radically reformed way of working and inform how services should be planned and delivered in the future.

The main purpose of the integration planning and delivery principles is to improve the wellbeing of service-users and to ensure that those services are provided in a way which:

- Are integrated from the point of view of service-users.
- Take account of the particular needs of different service-users.
- Takes account of the particular needs of service-users in different parts of the area in which the service is being provided.
- Take account of the particular characteristics and circumstances of different service-users.
- Respects the rights of service-users.
- Take account of the dignity of service-users.
- Take account of the participation by service-users in the community in which service-users live.
- Protects and improves the safety of service-users.
- Improves the quality of the service.

- Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care).
- Best anticipates needs and prevents them arising.
- Makes the best use of the available facilities, people and other resources.

4.1 Governance

The IJB will be a statutory partner in the Community Planning Partnership and as such a member of the community planning board and will therefore report with the other partners to the community planning board, although the relationship is not hierarchal.

As part of their remit to prepare and implement a Strategic Plan the IJB established a Strategic Planning Group April 2015. To date the group has focused on developing and consulting on the Strategic Plan and gaining a shared understanding of strategic commissioning. Moving forward it will:

- Oversee the implementation plans for each work stream of the Strategic Plan through a focus on each of the strategic priorities;
- Support the development of locality planning and engagement ; and
- Ensure alignment between the Strategic Plan and the plans of the three health and social care partnerships within the Grampian area.

Membership of the Strategic Planning Group is in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. A complete list of the Strategic Planning Group membership is included in **Appendix 2**.

The IJB will create such Committees that it requires to assist with the planning and delivery of integrated services such as a "Clinical and Care Governance Group". The role of the Clinical and Care Governance Group will be to consider matters relating to Strategic Plan development, governance, risk management, service user feedback and complaints, standards, education, learning, continuous improvement and inspection. It will:

- Provide assurance to the IJB, the Council and NHS, via the Chief Officer, that the professional standards of staff working in Integrated Services are maintained and that appropriate professional leadership is in place.

- Review significant and adverse events and ensure learning is applied.
- Support staff in continuously improving the quality and safety of care.
- Ensure that service user/patient views on their health and care experiences are actively sought and listened to by services.

4.2 National Health and Wellbeing Outcomes

National Outcomes		
1	Healthier living	People are able to look after and improve their own health and wellbeing, and live in good health for longer.
2	Independent living	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. *This outcome aims to ensure delivery of community based services, with a focus on prevention and anticipatory care, reducing emergency admissions to hospital. It recognises that independent living is vitalto improving health and well-being.*
3	Positive experiences and outcomes	People who use health and social care services have positive experiences of those services, and have their dignity respected. *It is important that health and social care services take full account of the needs and aspirations of the people who use services. Person centred planning and delivery of services will ensure that people receive the right service at the right time, in the right place, and services are planned for and delivered for the benefit of people who use the service.*
4	Quality of life	Health and social care services are centred on helping to maintain or improve the quality of life of service users. *Everyone should receive the same quality of service no matter where they live.*
5	Reduce health inequality	Health and social care services contribute to reducing health inequalities. *This outcome is focusing upon the role of services in seeking to reduce the gap in health inequalities.*
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.
7	People are safe	People who use health and social care services are safe from harm. *In carrying out our responsibilities, we must ensure that the planning and provision of health and social services supports protects individuals from harm.*
8	Engaged 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.
9	Resources are used effectively and efficiently	To deliver Best Value and ensure scarce resources are used effectively and efficiently in the provision of health and social care services.

The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. This Strategic Plan is intended to achieve the National Health and Wellbeing Outcomes prescribed by Scottish Ministers.

In order to record progress against the new Health and Wellbeing Outcomes, the Scottish Government has developed a core suite of integration indicators for Partnerships to report on.

The first set of national indicators is based on survey feedback from existing surveys, to reflect the importance of personal outcomes and user feedback.

The second set of indicators are derived from organisational/system data most of which are already collected for other reasons.

4.2 Performance Management and Monitoring

Performance monitoring and evaluation is a key component of the commissioning cycle, it drives improvement and the future development of services. Monitoring impact of services and analysing the extent to which they have achieved the purpose will be key in achieving the national outcomes.

Joint Performance is already in place within the Moray HSCP in the form of the Joint Performance Management Group. The suite of core indicators has been adopted and the group is currently revising the previous reporting against the future reporting to inform an Integrated Performance Framework. All performance, targets and improvement measures will be produced and in place for IJB come April16 with regular reporting in place.

The Integration Joint Board will publish an annual performance report which will set out progress towards the National Health and Wellbeing Outcomes. The report will include information about the core suite of indicators, supported by local measures and contextualising data to provide a broader picture of local performance.

Appendix 9 Cycles and flow in the performance framework illustrates the complexities of monitoring the performance of the whole system. It maps potential pressure points and the range of points that we measure.

It is acknowledged that there needs to be more outcome focused measures particularly around service user/patient experience, there may also be some local measures specific to Moray localities to be developed.

4.3 Workforce Development

Moray, like many areas, faces major challenges in recruiting and retaining staff and there is a continuing need to train and develop skills as the nature and demands of jobs change. Staff are our most valuable resource. Without staff, at all levels, the changes required across health and social care will not happen. Supporting informal carers and volunteers and ensuring a flexible, well-trained, motivated and highly-valued workforce will be pivotal in the delivery of this strategy. This strategy will enable new roles and new ways of working to be explored.

We will be working with staff to develop further opportunities to engage, equip and inspire our workforce. Workforce development will focus on the whole health and social care workforce exploring cross-sector opportunities for learning and development.

Our Older People's Strategy summarised our long term goal for the workforce.

"A health and social care workforce that reflects demography and need, increasingly community-based and less focused than at present on acute and unscheduled care: with changes delivered via training, education and career paths: knowledge, skills and attitudes: with more people working in teams and away from hospitals: and making maximum use of emergent IT and other technology for example Telecare."

This long term goal still stands however within our new plan success has as much to do with shifting our attitudes, expectations and aspirations in the community of Moray as it has about shifting resources, care institutions, providers and workforce. Achieving these aims will require all of us to work together, to resolve our differences and transcend traditional boundaries; to recognise our shared aspirations and responsibilities; to share our skills, talents and resources and to familiarise ourselves with an exciting new dynamic where we are all both contributors and beneficiaries alike.

We are working towards a joint approach to developing our future workforce and will continue to invest in support for cultural change in Moray, with organisational development activities to support the transformation of the whole system within our partnership organisations.

A series of Workforce Engagements in Moray highlighted several positive messages:

- There is enthusiasm to progress the integration agenda
- Good examples exist of coordinated, 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”

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

1. Build the right workforce for quality care
2. Ensure positive leadership and accountability
3. Create shared processes across sectors and professions

The IJB will develop an Integrated Workforce Plan which will be aligned to develop and support the workforce to achieve this major reform.

4.4 Locality Planning

The Act requires each authority to subdivide in to a minimum of two localities; the purpose is to provide an organisational mechanism for local leadership of service planning, and to feed upwards into the IJB Strategic Plan – localities must have real influence on how resources are spent in their area.

Localities refer to the group of people in these areas who must play an active role in service planning for the local population, in order to improve outcomes.

Localities must:

a) Support the principles that underpin collaborative working to ensure a strong vision for service delivery is achieved. Robust communication and engagement methods will be required to assure the effectiveness of locality arrangements.

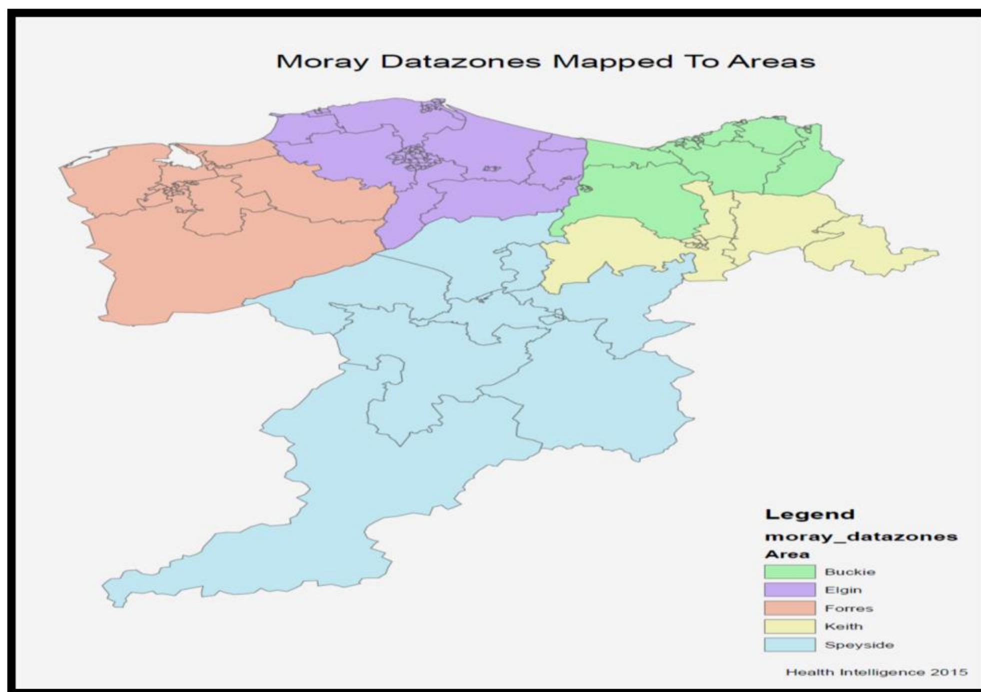
b) Support GPs to play a central role in providing and co-ordinating care to local communities, and, by working more closely with a range of others – including the wider primary care team,

secondary care and social care colleagues, and third sector providers – to help improve outcomes for local people.

c) Support a proactive approach to capacity building in communities, by forging the connections necessary for participation, and help to foster better integrated working between primary and secondary care.

After extensive engagement and consultation **two** locality areas were identified in the partnership **Moray East** and **Moray West** using area data zones. These will be used for organisational purposes. Locality Planning will operate within these localities in five natural communities.

Moray East	**Moray West**
• **Buckie/Cullen**	• **Elgin/ Lossiemouth**
• **Keith**	• **Forres**
• **Speyside**	



There is however acknowledgement that there is a requirement to work with natural communities at as local a level as possible. In addition there may be occasions when “communities of interest” are considered on particular issues which means the configuration of a community may differ from groups of people to geographical areas, when it comes to service design and community resilience.

Strategic and locality level planning must work together to create the best possible working arrangements and to enable them to take account of local, and often deep rooted, issues, such as inequalities and poverty.

Localities exist to help ensure that the benefits of better integration improve health and wellbeing outcomes by providing a forum for professionals, communities and individuals to inform service redesign and improvement

APPENDICES

Appendix1: Services in Scope

Appendix 2: Working Together

Appendix 3: Policy Context National and Local

Appendix 4: Financial Plan

Appendix 5: Health Needs Analysis

Appendix 6: Glossary

Appendix 7: Equality Impact Assessment

Appendix 8: Housing Contribution Statement

Appendix 9: Cycles and Flow in the Performance Framework