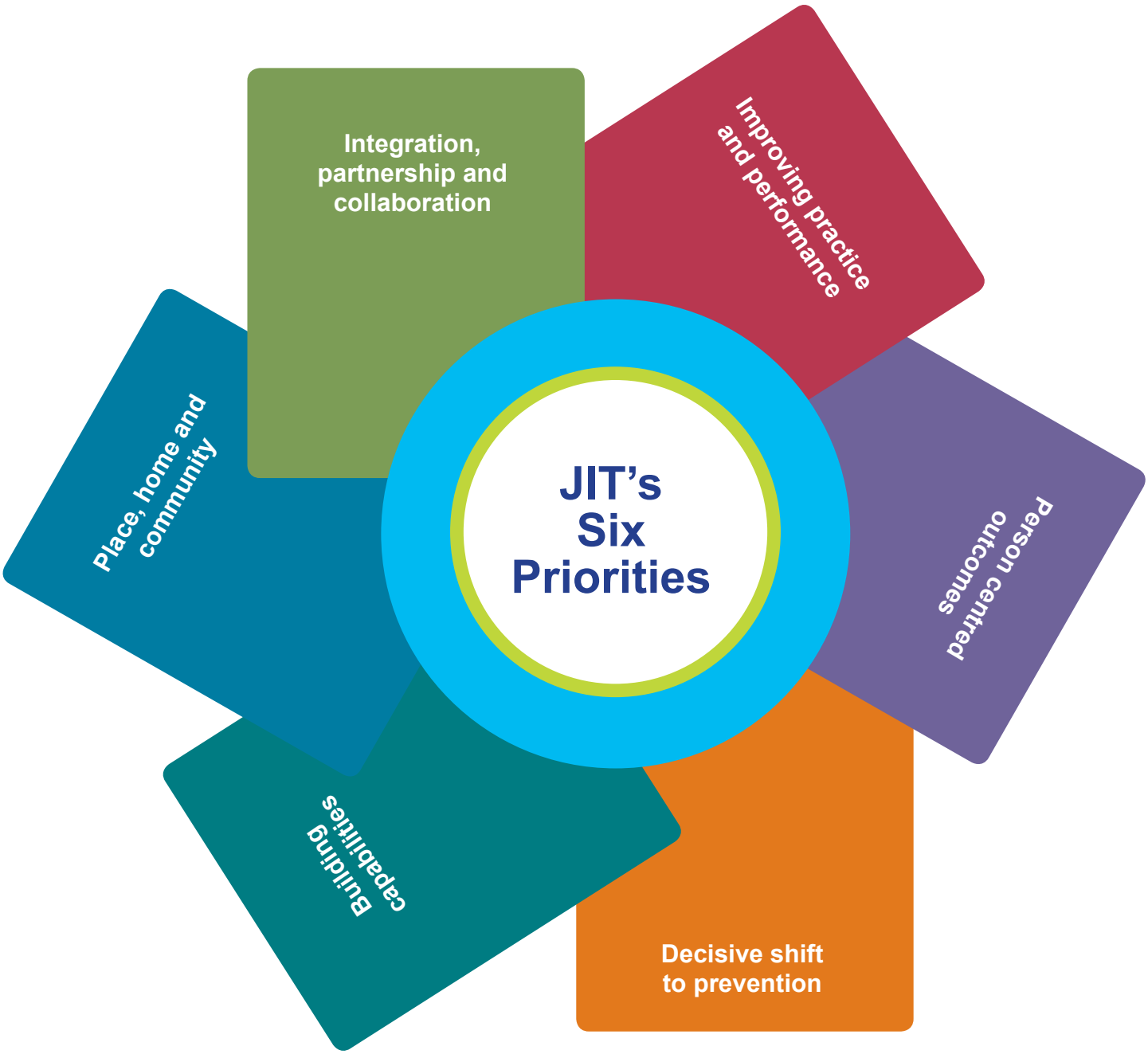
joint improvement team
creativity, collaboration and continuous improvement

Strategic Plan 2013-16



JIT is a strategic improvement partnership between the Scottish Government, NHS Scotland, CoSLA, the Third Sector, the Independent Sector, and the Housing Sector.

Foreword

"None of us is as smart as all of us". That's written on the marker board on the JIT Director's office wall, and it neatly sums up the ethos of the newly formed Joint Improvement Partnership Board. The Board was established in April this year, and it brings together chief officers from across the Scottish Government, CoSLA, NHS Scotland, the Third, Independent and Housing sectors. I am privileged to have been given the opportunity to be the first Chair of the Partnership Board.

The Board's role is to strengthen the position of the Joint Improvement Team to work with others to accelerate the pace of transformation within health and social care partnerships and support the delivery of integrated health and social care.

The Board provides high level strategic governance for the JIT's work by challenging and supporting the JIT Director and her team - a model similar to the one used by the JIT in its work with partnerships.

The Board will encourage greater ownership of the joint improvement and integration agenda by all of the national partners, as well as a greater willingness by local partnerships to engage with the JIT to take advantage of the resources it provides.

The establishment of the Board comes at a time of great change and challenge for public service delivery in Scotland, but that in itself creates a momentum for change that can be harnessed.

This Strategic Plan is an ambitious statement of how JIT will capitalise on that momentum for change by working with all of the national partners to support their efforts to deliver new models of public service and integrated health and social care.

Professor
Jim McGoldrick
Chair
Joint Improvement
Partnership Board

Preface

It is a great pleasure for me, as Director of the Joint Improvement Team, to set the scene for our new three year Strategic Plan. The plan is highly ambitious and sets out a series of challenging aspirations for the team, working alongside local and national partners, between now and 2016.

Improving outcomes for the people who use health, social care and housing services is at the heart of our ambition and everything we will do throughout the period of the plan will be geared towards achieving this.

Our approach will create the conditions for change in localities so that partners are enabled to deliver the decisive shift towards prevention envisaged in the drive towards public service reform.

Greater integration, partnership and collaboration will characterise how local partnerships approach the challenge of meeting the needs of a growing and ageing population whilst managing reductions in the availability of finances. JIT will support partnerships to innovate, to learn from success and to respond creatively to the needs of their communities.

We will increase our focus on the importance of place, home and community to support a further shift in the balance of care and a reduced reliance on forms of institutional care than has been the case until now.

Challenging the cultural barriers to success will be a top priority for JIT and our work with local partnerships. We will support them to move beyond traditional ways of working that restrict their ability to improve outcomes, support them to build their capacity for change and build their capability and resilience.

Throughout the period of the plan we will challenge our own performance through continuous improvement of our strategic management systems and processes to ensure we remain capable of delivering our strategic objectives.

We recognise that in the current financial climate there is a need to ensure that all resources are used as efficiently as possible to deliver best value. Both the Joint Improvement Partnership Board and JIT will work in partnership with other improvement agencies to ensure we maximise the impact of our collective resources whilst highlighting the need for additional investment required to meet the aspirations set out in this ambitious strategic plan.

Dr Margaret Whoriskey
Director
Joint Improvement Team

The Joint Improvement Team

The Joint Improvement Team (JIT) is a unique partnership between the Scottish Government, CoSLA, NHS Scotland, the third, independent and housing sectors, tasked with accelerating the pace of local change and improvement in the quality of Scotland's care and support services.

The JIT was established in 2004 under Circular **CCD12/2004** to promote joint working between local authorities and NHS Scotland. JIT's role has been re-affirmed with the establishment of a Joint Improvement Partnership Board in April 2013, comprising senior representatives of the Scottish Government, CoSLA NHS Scotland, and the Independent, Third and Housing sectors. The JIT Director will be accountable to the Board for delivery of the Strategic Plan through members' scrutiny at Board meetings and the Board's Annual Review process.

The JIT remit as set out in the Memorandum of Understanding is to support partners to:

- Achieve the outcomes and targets agreed by the national partners;
- Provide leadership in the delivery of health and social care reform to drive local change and improvement;
- Improve performance by developing sustainable solutions to challenges that inhibit the provision of best value and best quality care and outcomes;
- Develop more integrated approaches to the redesign, commissioning and delivery and evaluation of health, housing and social care services;
- Embed the use of preventative spend, and preventative approaches in general;
- Adopt an assets-based approach such as co-production, and embed a personal outcomes approach.

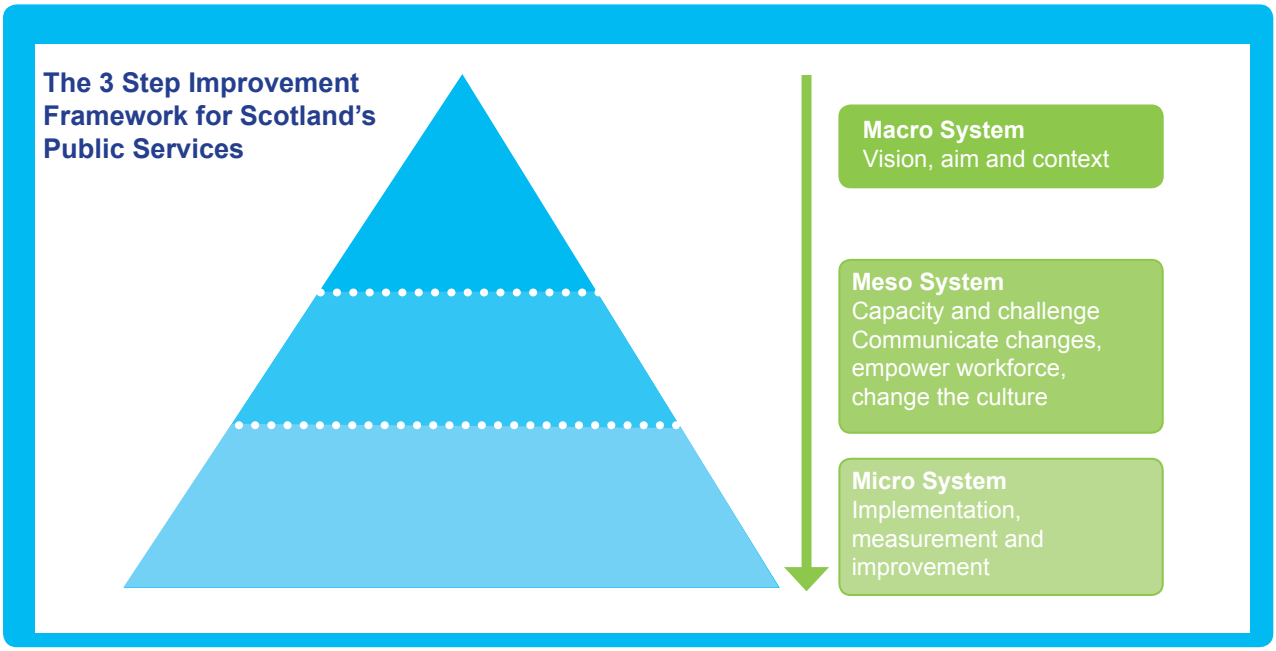
The JIT has a flexible and responsive business model. We have a core team based within the Scottish Government's Health and Social Care Integration Directorate. This team is supported by a small group of Associates/ Leads, who work with the JIT on a part-time basis or through a secondment from their employing organisation. The Leads all have strong delivery experience in the health, social care, housing or voluntary sectors. The JIT Action Group is a pool of subject experts, who are available to support specific pieces of work as and when required. This model enables the JIT to provide a balance between planned and responsive support and advice and critical challenge designed to create the conditions for partnerships to improve outcomes for the public.

Looking forward, JIT will play a key role in supporting the reform of public services and supporting Community Planning Partnerships to deliver their ambitions for health and social care reform within their Single Outcome Agreements.

The JIT is one of a number of improvement agencies with a focus on supporting effective change in public services. We recognise the value of collaboration in combining the skills from across the range of improvement bodies. During the period of this plan, we will seek to extend, embed and systematise this collaboration with the range of improvement bodies supporting public service reform and improvement in Scotland.

Our approach

EXHIBIT 1



We work in partnership with local health, social care and housing providers, service users, patients and carers. Our role is to support local partners to improve outcomes and deliver national and local policy. We do this by creating the conditions for improvement though:

- **Constructively challenging** those we work with to consider different approaches, to draw on good practice and so to achieve more for the same resource;
- Helping partnerships to **successfully transfer practices and approaches** - shown to be effective elsewhere - to their local context;
- Advising on **changes in local policy** and practice, based on an in-depth understanding of the local issues;
- **Building capacity and developing skills** amongst partnerships by ensuring that what we do is informed by high quality knowledge and expertise;
- **Synthesising and reflecting back experience of local delivery**, so that it can support realistic and achievable policy development at national level;
- Improving the ability of partnerships to **identify the root causes not the symptoms**, thereby shifting local systems towards sustainable solutions;
- **Nurturing innovation**, including the adoption of new technology, so that new approaches can be tested and the learning shared across Scotland;
- **Sharing knowledge** about effective practice at policy, strategy and delivery levels;
- Supporting partnerships to use local and national health, housing and social care information well, **to continually improve outcomes through effective analysis, benchmarking and needs assessment.**

Resources

The JIT is funded by the Scottish Government. Core programme funding is supplemented by income from across other Scottish Government Divisions on a non-recurring basis. This stream of income is used to deliver work on key priority programmes such as joint commissioning, intermediate care, co-production, integration and dementia.

Demand for JIT's support is increasing and as such there is a more strategic role to be played by the team, and the need for all partnerships to engage with JIT and derive the benefits available from it especially as we move towards integration and the opportunities that this will create.

The Minister for Public Health and CoSLA Health and Wellbeing spokesperson, in a letter to all partnerships and national organisations on 1st February 2013, stated that JIT will address the implications for local partnerships that arise from the consultation processes related to Bill. This will include ensuring capacity to respond flexibly and rapidly to the need for improvement support as well as provision of developmental and improvement support in a planned and proactive way. It is recognised by the national partners that early consideration will be given to the resources needed by JIT to deliver future priorities and commitments.

The Strategic Plan is ambitious, and over its lifetime, we will seek opportunities to enhance and consolidate our core programme funding to enable us to deliver on the priorities it sets out. The Strategic Plan is accompanied by a Management Plan that details the actions we will take during each of the three years, and this will be reviewed annually with the Board to take account of the resources we have available.

The Joint Improvement Partnership Board and the JIT will work in partnership with other improvement organisations and boards in order to ensure best value from the collective national improvement capacity and resources to support progress on the full range of strategic improvement priorities for health and social care.

JIT Strategic Plan 2013-16

This strategic plan sets out our programme for the next three years, and supports implementation of key policies including:

- Renewing Scotland's Public Services
- Route Map to the 2020 Vision for Health and Social Care
- Reshaping Care Programme and the associated Change Fund
- Age, Home and Community, Scotland's national strategy for housing for older people
- Telehealth and Telecare Delivery Plan
- Dementia Strategy
- Community Planning Statement of Ambition and revised SOA guidance
- Strategies in relation to particular groups or approaches e.g. Self-Directed Support, Carers, Learning Disability, Mental Health

In particular, our approach and priorities contribute to delivering the four pillars of successful public service reform:

1. A decisive shift towards prevention
2. Greater integration of public services at a local level driven by better partnership, collaboration and effective local delivery
3. Greater investment in the people who deliver services through enhanced workforce development and effective leadership
4. A sharp focus on improving performance, through greater transparency, innovation and use of digital technology

JIT Core Priorities

We have identified, in discussion with our national partners, stakeholders and local partnerships, six core priorities. Our priorities are mutually reinforcing and provide the best opportunities for us to support local partnerships to continue to improve outcomes for their local populations.

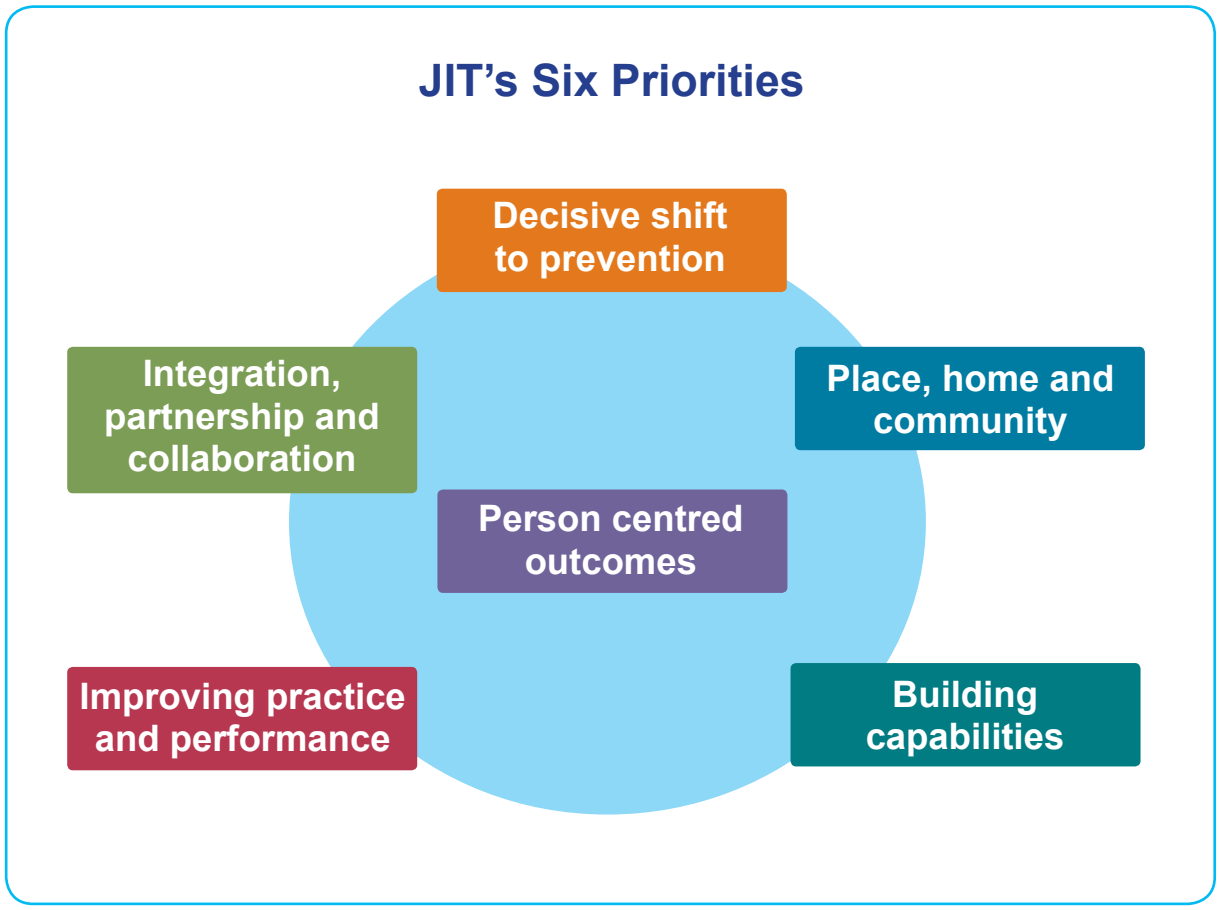
All of our work aims to support a reshaping of our care and support to meet ***person-centred outcomes*****.**

In line with the public service reform agenda, we will give priority to achieving a ***decisive shift to prevention***, and to improving ***integration, partnership and collaboration***. In addition, given the importance people place on their homes, we will give priority in this strategy to improving the ***place – home and community*** – in which people live. These take forward nationally agreed aims and ambitions.

The JIT exists to provide practical support and assistance to local health, housing and social care partnerships across statutory, voluntary and independent sectors. This practical support is centred on ***improving practice and performance*** and ***building capabilities*** of those who provide these public services.

JIT Core Priorities

EXHIBIT 2



While much of the focus of our work to date has centred on reshaping care for older people, during the life of this plan we will increase our contribution to other adult population groups. This is in line with the proposals for health and social care integration, which encompass all adults, but also reflects that much of our work has wider relevance, not only to all adults, but, equally to children's services. This has become particularly relevant in relation to joint strategic commissioning, but is also evident in requests for our support in other areas. The JIT approach and resources are as applicable across all population groups including the range of specific work streams, e.g. Telecare, Talking Points, Intermediate Care, Reablement, Community Capacity and Co – Production.

Strategic Outcomes

Between 2013 and 2016 we will have supported partners to achieve the following outcomes:

Person-centred outcomes

- All partnerships have achieved a step-progression towards embedding and mainstreaming a personal outcomes approach in local health and care systems.
- Increased awareness and use of co-production approaches is evident in partnership service planning and delivery models, and workforce and organisational development activity.
- Local partnerships are developing and integrating SDS within their commissioning and service delivery models for health and social care.

Decisive shift to prevention

- All partnerships have delivered a year-on-year shift of Change Fund investment to upstream, sustainable prevention.
- All Partnerships provide a core menu of effective alternatives to emergency admission for people with complex needs, enabling a return home from hospital, or closer to home, without delay.
- Telehealth and telecare has enabled choice and control in health, care and wellbeing services for an additional 300,000 people, with the use of telehealth and telecare proactively demanded as positive options.
- The 8 pillar model of community support for people affected by dementia has been adopted by local partnerships, and effective pathways and support are evident.
- All partnerships will have a better understanding of the financial impact of reablement and the most effective delivery models will be in operation

Strategic Outcomes

Integration, partnership and collaboration

- All partnerships have implemented effective governance and associated arrangements, including locality planning, for health and social care integration.
- All partnerships have agreed joint strategic commissioning plans for adults and older people's services, which set out long term plans for investment and disinvestment to achieve national and local outcomes and priorities.
- The housing sector's relationship with the new health and social care partnerships has been defined, has secured support, and is being implemented.
- All partnerships are reporting progress on the National Integration Outcomes and associated measures.

Place, home and community

- Increased focus in all partnerships on place based approaches to build resilient and healthy communities with the principles of co-production embedded throughout.
- Fit for purpose, sustainable models of housing with care have been identified, and form part of current or forward plans in all local partnerships.
- Exemplars of integrated, outcome focused and person-centred housing adaptations systems have been developed.

Strategic Outcomes

Improving practice and performance

- National targets are being met by all partnerships in relation to:
  - reducing maximum delays to discharge to 4 weeks from 2013, and to 2 weeks by 2015;
  - trajectories for reducing rates of 75+ emergency inpatient bed days;
  - providing post-diagnostic support to people affected by dementia.
- All partnerships are actively using integrated, fit for purpose information to support planning, decision-making and performance improvement.
- Health and Social Care Partnerships will have been established and will be utilising and reporting on the suite of Integration Outcomes and associated measures.
- We will have a clear understanding of the contribution of the third sector to the preventative agenda.

Building capabilities

- Partnerships will have benefited from a comprehensive programme of improvement techniques and events.
- Partnerships will be equipped to maximise the opportunities arising from the integration of health and social care.
- Community Planning Partnerships will be fully engaged with the integration of health and social care.

How we will measure success

Our approach to measuring JIT's effectiveness reflects the complexity of attributing improvements to our individual contribution. Our approach will be **proportionate**, so that we avoid costly research or information gathering; it will be **focused**, so that we identify ways in which we can use our skills and resources more effectively and it will be **forward looking**, in order to help us and our partners to identify future challenges and opportunities.

We will use a combination of indicators and sources of information which will include

- **Activity monitoring – we will monitor delivery of this strategy and the detailed work plans.**
- **360° stakeholder and partner survey - conducted annually to a standard format, we will seek feedback on the effectiveness of our contribution from our stakeholders, and our partners.**
- **Thematic evaluations – some approaches and services, particularly tests of change and early implementers, will be evaluated in detail to inform effective development and support strategies.**
- **Partnership: Review of impact and improvement – undertaken with individual partnerships to review outcomes against agreed programme of work**
- **Progress against national targets & indicators – we will set information and feedback from other sources within the context of performance on national indicators and outcomes.**

In addition, we may commission an external review to evaluate delivery of key objectives as has been undertaken to date by the University of Stirling in 2006, IRISS in 2011 and more recently, in the review undertaken by Colin Mair from the Improvement Service in 2012.

Delivering our Plan

This section of the plan provides a summary of how JIT will take forward each of our core priorities during the life of this plan. This will be reviewed on an annual basis to take account of developments, emerging issues and resources available to JIT.

Priority

Person centred outcomes

A focus on person-centred outcomes, making sure that public services are designed to deliver what people want, is a central plank of national and local policy, set out in the Christie report, the Scottish Government's response, and the Route Map to the 2020 Vision for Health and Social Care

Shifting systems and services to a focus on personal outcomes is complex, and requires changes in the design of services, in the skills of people working in them, and in the culture of organisations that deliver them. Enabling people to meet their personal outcomes often requires cross sector collaboration beyond health and social care alone.

The JIT has led the way in Scotland in promoting a person-centred outcomes, supporting the development of Talking Points, a user designed approach to identifying people's personal outcomes that inform the design and review of care and support services. Person-centred outcomes approaches are now being used in all partnerships but the extent to which this is embedded as standard practice varies considerably.

We will continue to promote the adoption of Talking Points across all partnerships as a key component of personalising support and care and delivering the outcomes that are important to people.

EXHIBIT 3

Talking Points: Outcomes Important to Service Users

Quality of Life	Process	Change
Feeling safe	Listened to	Improved confidence
Having things to do	Having a say	Improved skills
Seeing people	Treated with respect	Improve mobility
Staying as well as you can	Treated as an individual	Reduced symptoms
Living where you want/as you want	Being responded to	
Dealing with stigma/discrimination	Reliability	

Priority

Person centred outcomes

A core focus of our work will be on extending and embedding co-production. Statutory partners cannot deliver the change required alone, and co-produced services are more effective and acceptable, while policy emphasises the importance of working together with people who use services. This agenda has particular importance in the context of a shift to prevention and to community-based services and support. JIT has in place dedicated expertise and resources to support partners to deliver co-produced services, and to provide practical support to make it a reality. This includes supporting the contribution of the third and independent sectors in local Change Plans, supporting the sectors to develop and build local capacity, and co-produce local services.

With others, we have been supporting the development of Self-Directed Support (SDS), including contributing delivery experience to policy and guidance associated with the new SDS legislation. We will support partnerships to embed SDS within their local systems, alongside support for reablement, self-management, co-production, community capacity building, and local activities focused on prevention.

Central to enabling people to achieve their person-centred outcomes is that they know about the options and choices they have. Independent information and advice are integral parts of SDS. There are however, other information and advice requirements, and Age, Home and Community has identified information and advice about housing options amongst five main areas for improvement.

***Over the three years of this Strategy*, our approach to improving the focus on personal outcomes will be through providing practical support to partners to:**

- **Design, commission, deliver and review services using a person-centred outcomes approach;**
- **Embed co-production as mainstream practice in the design, commissioning, delivery and review of services;**
- **Realise the potential of Self Directed Support, Reablement and self-management to enable people to manage their long term conditions;**
- **Empower service users and carers by providing comprehensive, accessible and relevant information and advice.**

Priority

Person centred outcomes

WE WILL SUPPORT PARTNERS TO:	WE WILL DO THIS BY:
Design, commission, deliver and review services using a personal outcomes approach	• Supporting partnerships to embed and mainstream Talking Points into service design and delivery. • Providing expert support to NHS Education for Scotland (NES) and the Scottish Social Services Council (SSSC) to develop capabilities of the workforce in relation to person-centred outcomes. • Working with the Quality Alliance Board and The Health and Social Care ALLIANCE to support the use of person-centred outcomes measures across different settings and care groups • Ensuring alignment with the Person Centred Health and Care Programme.
Embed co-production as mainstream practice in the design, commissioning, delivery and review of services	• Providing expert support and challenging partnerships to adopt co-production, so that it becomes integral to the decision-making of health and social care partnerships. • Building capacity in partners from the third and independent sectors so that they are able to contribute their full potential to reshaping care, joint strategic commissioning, and health and social care integration. • Working with the Third Sector Division and the Quality Unit within the Scottish Government to build a strategic approach to engaging with the third sector.
Realise the potential of Self Directed Support, reablement and self-management to enable people to manage their long term conditions	• Supporting the work of policy leads for Self Directed Support and Self-Management. • Providing expert support on information resources including measures derived from the Indicator of Relative Need (IoRN), Resource Allocation Systems (RAS) and Talking Points in the development of SDS, including during the SDS Bill stage. • Providing support to local partnerships to embed SDS within their approach to procurement of care and support and joint strategic commissioning. • Providing expert support to identify workable models for those with complex care and support need
Empower people by providing comprehensive, accessible and relevant information and advice	• Supporting local partners to developing information and advice on housing options – building on existing housing option hubs. • Identifying models for making available comprehensive information and advice, across health, housing and social care.

Priority

Decisive shift to prevention

We must achieve a greater emphasis on prevention, focusing on the root causes of problems rather than the symptoms. Redesign of our systems towards prevention requires a long-term commitment and a clear strategy to shift systems and services upstream.

There are particular opportunities over the next two years through the Change Fund. JIT will provide support and challenge to partnerships to maximise the leverage of the fund and embed effective approaches to support this decisive shift to prevention.

Currently, partnerships are investing more than 50%% of their Change Fund on preventative, anticipatory and proactive community based services to support people to live at home or closer to home. This is a significant investment and is primarily represented by a shift away from hospitals and long-stay care homes towards spend on upstream preventative and anticipatory care. As part of this process we will work with partnerships to ensure this stream of preventative spend is properly aligned with Community Planning Partnerships' Prevention Plans.

There are challenging targets to meet over the period of this plan in preventing avoidable or premature admissions to hospital or long term care amongst older people and reducing delays in their discharge. A key strand of our work will be to support partners to put in place a range of safe and effective ***Intermediate care*** alternatives to emergency hospital admission and enable an earlier return home or to provide care closer to home. We will work to support the further spread of Reablement approaches to support people to regain and maintain their independence as far as possible.

EXHIBIT 4

Change Fund investments Reshaping Care Pathway

SCOTLAND	Preventative and anticipa-tory care	Proactive care and support at home	Effective care at times of transition	Hospitals and long stay care homes	Enablers
	%	%	%	%	%
2011/2012					
Change Plans	19	27	24	23	7
2012/2013					
Change Plans	23	25	28	16	8
2012/13 projected spend at Mid-Year	**25**	**27**	**24**	**12**	**12**

Priority

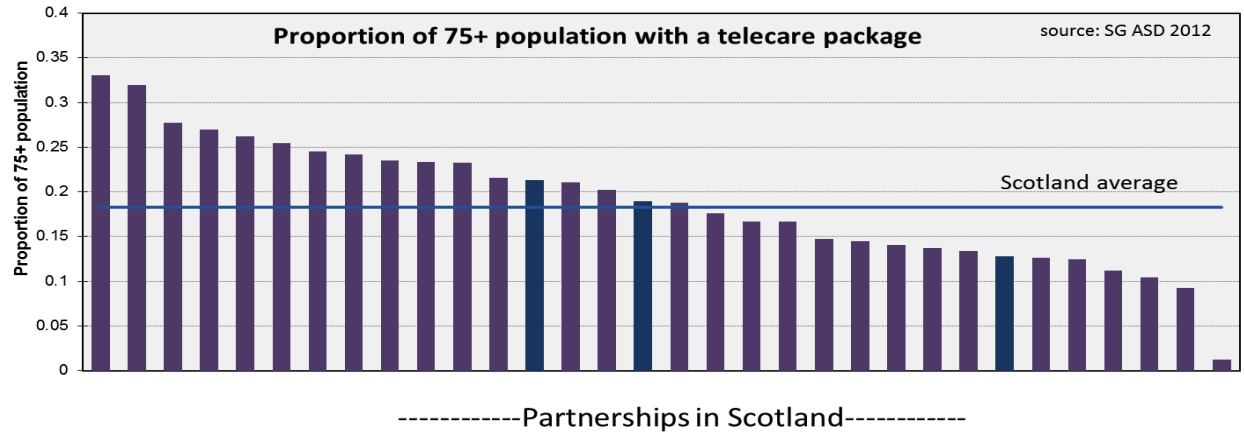
Decisive shift to prevention

We will work with partners at national and local levels to extend upstream, ***preventative support***, building on the assets of older people, their families and local communities. We will promote active and healthy ageing across sectors, with contributions by local communities, housing organisations, leisure and recreation as well as health and social care services.

Scotland is a pathfinder in Europe in its use of ***telecare and telehealth,*** and has secured significant funding to further develop services through the Technology Strategy Board's DALLAS programme for 'Living it Up', and through the European SmartCare and United4Health Projects. We will work in partnership with the Scottish Centre for Telehealth and Telecare (SCTT), hosted by NHS 24, to support the implementation of the National Telehealth and Telecare Delivery Plan[3], and to extend adoption of telecare and telehealth by health, housing and care services and by the wider public by helping to enable greater choice and control in health, care and wellbeing services.

EXHIBIT 5

Provision of telecare varies significantly across local partnerships



Telecare (mainly community alarms) is now provided to most people who receive home care and to an even larger number of older people who do not receive home care.

[3] A National Telehealth and Telecare Delivery Plan for Scotland to 2015: Driving Improvement, Integration and Innovation

Priority

Decisive shift to prevention

Growing numbers of people will be affected by ***dementia*** and improving the support they and their families receive is a major national priority. The JIT has played a central role in the Demonstrator Sites and Post Diagnostic Sites to identify effective approaches that can be adopted by all partnerships. Achieving the ambitions set out in the new Dementia Strategy will be complex and challenging, requiring multi- agency and multi-sector collaboration. Our approach to support this agenda will be equally wide-ranging.

The contribution of ***informal carers*** is key to helping older people to maintain their independence and wellbeing. The Scottish Government has made a major commitment to improving support for informal carers, including a Ministerial commitment to increase investment to improve support for informal carers (at 20% of the Change Fund). Our initial focus will be on challenging and supporting partnerships to use this Change Fund investment to maximum effect, and then to ensure that investment in further improvements are taken forward through joint strategic commissioning.

Over the three years of this Strategic Plan, **our approach to driving a decisive shift to prevention will be through providing practical improvement support and challenge to partners to:**

- **Maximise the impact and leverage of the Change Fund in achieving a shift to prevention;**
- **Provide seven day access to a core menu of Intermediate Care services;**
- **Adopt and scale key preventative approaches;**
- **Increase use of telehealth and telecare technology;**
- **Improve support to people affected by dementia;**
- **Deliver the commitment to carers;**
- **Develop their approach to Reablement**

Priority

Decisive shift to prevention

WE WILL SUPPORT PARTNERS TO:	WE WILL DO THIS BY:
Maximise the impact and leverage of the Change Fund in achieving a shift to prevention	• Supporting and challenging partnerships to focus on root causes not symptoms in developing their plans for change. • Providing expert support in identifying strategies and approaches to shift systems and investment towards prevention, maximising the Change Fund's leverage. • Supporting partners, particularly in the third, independent and housing sectors, to contribute effectively to the re-design of local systems to shift towards prevention.
Provide 7 day access to a core menu of Intermediate Care	• Promoting, testing and spread of 'Hospital at Home' and a menu of Intermediate Care for people with complex care and support needs. • Encouraging and supporting partners to adopt effective practices in terms of: – Establishing a single point of contact for Intermediate Care; – Introducing productivity tools so that capacity is increased in community hospitals, and home care and community rehab teams.
Adopt and scale key preventative approaches	• Identifying and providing practical support on re-design or introduction of services and approaches that focus on prevention and release resource; • Supporting and challenging local partnerships to have put in place a local Active and Healthy Ageing implementation plan, and to have made identifiable progress in its delivery; • Improving prediction of those at risk of emergency admission, in particular by: – Working with ISD so that the enhanced SPARRA tool is routinely used by GP practices and community teams; – Promoting use of risk prediction tools in acute care, housing and care homes. • Working with national partners so that Anticipatory Care Planning is being delivered at scale.
Increase use of telehealth and telecare technology	• With SCTT, supporting delivery of the European United4Health and SmartCare Programmes. • Supporting pathfinder local partnerships to expand innovative models through the Scottish Government and Technology Strategy Board's DALLAS programme – Living it Up.

Priority

Decisive shift to prevention

WE WILL SUPPORT PARTNERS TO:	WE WILL DO THIS BY:
Increase use of technology	• Supporting partnerships, local communities and providers to reduce digital exclusion. • Engaging with key stakeholders and local partnerships to provide improvement support and challenge in delivering the actions in the National Delivery Plan. • Supporting partnerships, local communities and providers to reduce digital exclusion. • Supporting partnerships to implement the key priorities in the Telehealth and Telecare Delivery plan • Engaging with key stakeholders and local partnerships to provide improvement support and challenge in delivering the actions in the National Delivery Plan.
Improve support to people affected by dementia	• Providing expert improvement support to the Dementia Demonstrator sites, and the Post Diagnostic Support Demonstrator sites. • Co-Leading the National Dementia Improvement Programme, sharing learning from the dementia demonstrators of effective approaches, and supporting uptake across Scotland. • Building capacity within the housing sector to provide housing-based solutions for people affected by dementia.
Deliver the commitment to carers	• Supporting and challenging partnerships to embed support for carers as a key focus in their planning and delivery of services and support, and to meet national requirements to spend at least 20% of their Change Fund allocation on supporting carers. • Working with national partners to meet improvement and support needs of GPs in their role to identify carers. • Providing support to carer organisations so that they can contribute effectively to local partnerships.
Develop their approach to Reablement	• Working with the Scottish Community Care Benchmarking Network to improve understanding of the flow of money and impact of Reablement on budgets. • Piloting new training materials for Care at Home workers, produced with Alzheimer Scotland and Stirling University (NES and SSSC), in three partnerships in Scotland. • Further development of Telecare and Telehealth linkages. • Further analysis of the impact of turnover in Reablement particularly in relation to different type of models.

Integration, partnership and collaboration

During the three years of this plan, we will build on our success in promoting effective collaboration and facilitating improvement in the new context of health and social care integration. As set out in the Memorandum of Understanding, we will provide leadership in the delivery of health and social care reform to drive local change and improvement. We will support partnerships during the transition period and work with all of the new health and social care partnerships at strategic and operational levels, and with their local housing, third and independent sector partners, to support and challenge them to take full advantage of the opportunities to deliver a step-change in the pace of improvement.

The ***integration of adult health and social care*** is a central component of public service reform. Integration tackles the disconnects that exist currently between health and social care, and aims to accelerate improvement in both the quality of services and the outcomes achieved. The JIT will facilitate strategic engagement and partnership development and provide local partnerships with advice and practical support in building their readiness for integration, and we will challenge partnerships to develop and deliver local integration plans. JIT will support partnerships in their efforts to reshape practice and tackle the cultural shifts that will be needed to deliver on integration.

We carried out an enquiry on progress with Health and Social Care Integration in local partnerships earlier this year. The outcome from this exercise was reported to the Health and Community Care Delivery Group and Ministerial Strategic Group in April 2013. The report set out progress made by partnerships to date and highlighted examples of good practice which partnerships would be willing to share and identified support needs going forward.

Our work has clearly demonstrated that health and social care partnerships need support to undertake ***joint strategic commissioning***. The scope of the support required is substantial: increasing the understanding of the role and contribution of joint strategic commissioning; enhancing local skills and capability; and building implementation capacity. The JIT will lead an improvement programme involving all national improvement and support partners. The JIT's specific contribution will be on driving a focus on strategic (rather than operational) issues and approaches within the process.

Priority

Integration, partnership and collaboration

The JIT will also support and facilitate improvements in the connections with strategic housing planning, with an initial step being the development of a Housing Contribution Statement as part of the Joint Strategic Commissioning Plans. The opportunity to consider the wider joint commissioning agenda to collaborate with childrens' services will be an area for further work during the first year of this plan.

The JIT's experience in supporting partnership and collaboration means that we are asked to contribute to other ***cross-sector programmes***. In the initial period of the plan, this will be in relation to improving healthcare for people in police custody.

***Over the three years of this Strategy*, our approach to improving integration, partnership and collaboration will be through providing practical support to partners to:**

- **Build partnerships' readiness for health and social care integration at both strategic and operational levels and support the implementation of national policy on integration and associated outcomes;**
- **Develop and deliver local joint strategic commissioning plans for adults and older people, and support joint commissioning for children's services;**
- **Spread learning across wider, cross-sector programmes.**

Priority

Integration, partnership and collaboration

WE WILL SUPPORT PARTNERS TO:	WE WILL DO THIS BY:
Build partnerships' readiness for health and social care integration at both strategic and operational levels and support the implementation of national policy on integration and associated outcomes	• Identifying the changing improvement and support required by leaders of local partnerships, and putting in place supports and tools to address these at strategic and operational levels. • Providing customised support for individual partnerships, who want to improve their effectiveness. • Providing expert support to the housing sector to reach local agreement on their role, contribution and relationship with the new health and social care partnerships. • Organising and facilitating events at national, regional and local levels to support local partnerships to address particular issues, as they occur and facilitate shared learning.
Develop and deliver local joint strategic commissioning plans for adults and older people, and support joint commissioning for children's services	• Leading the development and delivery of the National Improvement Support Programme for Joint Commissioning with key stakeholders. • Leading the development and roll out of the National Learning Framework and facilitating its use by local partnerships. • Providing 'critical friend' support to the development of local joint strategic commissioning plans. • Guiding and mentoring partnerships during the transition years 2013-15 in order to ensure alignment between their commissioning arrangements, and integration plans. • Supporting partnerships to commission care homes • Providing expert support to partnerships in developing their adult joint commissioning plans and Children's Services commissioning plans.
Spread learning across wider, cross-sector programmes	• Providing expert support to partners in housing to improve alignment of strategic housing planning and joint commissioning, particularly through the Housing Contribution Statements. • Providing expert support to the team leading the development of a new framework for the healthcare of people in police custody. • Providing expert support to emerging cross-sector programmes and Change Funds – e.g. police and health; drugs and alcohol; early years. • Providing advice and support to policy development by reflecting back experience of local delivery to support realistic and achievable policy development at national level

Place, home and community

Our strategy for reshaping our care services needs to incorporate and address the importance of the place in which care is provided: people's homes, the local community and the wider environment.

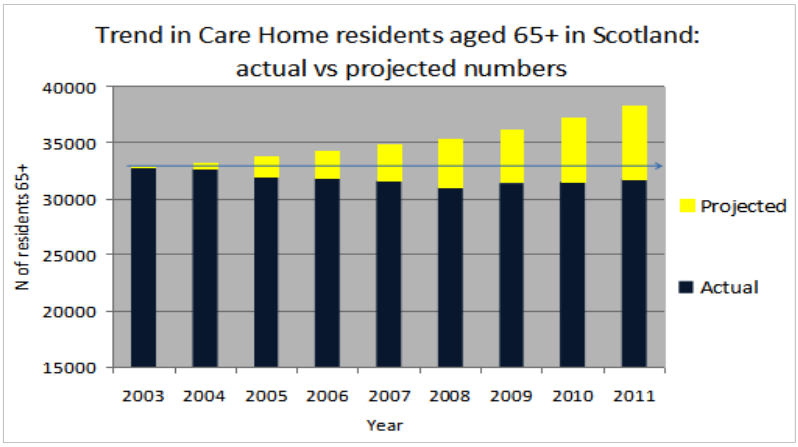
Building the capacity of local communities is an integral part of achieving a shift in the balance of care and support, and meeting many specific objectives, such as healthy and active ageing, improving support for people with dementia, meeting the commitment to carers, and enabling service users to have greater control.

There is a wider recognition of the contribution that ***housing and the housing sector*** can make, through its relationships with local communities, the work of the social rented sector in areas of deprivation, and the care and support services provided by many housing organisations. The integration of health and social care offers particular opportunities to develop more effective working relationships at both strategic and operational levels.

The JIT has an established record in nurturing ***innovative practice***, sharing the learning, and encouraging other areas and partners to adopt approaches found to be effective. During the course of this plan, we will focus on supporting innovation in relation to community-based and community-controlled services. We will also explore ways in which local communities can provide opportunities for volunteering.

EXHIBIT 6

More older people are living in housing, rather than in care homes.



By the latest time point on the chart (2011) the actual number of residents is 17% below the projected number based on the 2003 rate. The difference between the actual and the projected is a reflection of changes which must have occurred in the period: for example, changing thresholds regarding admission to a care home; changing preferences of older people (and their families); the availability of a wider basket of options which enable people to live longer in their own homes may be a critical factor.

Priority

Place, home and community

Age, Home and Community, the national strategy for older people's housing, sets out a substantial programme of change. The JIT has played a major role in supporting the development of that strategy and will continue to support its delivery. New building programmes will play a part in providing suitable housing options, but the great majority of people will live in housing that already exists. Making best use of that housing stock is essential and housing repairs and adaptations to support the 20/20 vision ambition of people staying in their own homes is essential. An early priority will be identify ***housing with care*** models that provide fit for purpose housing in local communities, are affordable and support the wider objectives to enable older people to remain at home for longer.

The JIT has highlighted the contribution of ***equipment and adaptations*** in supporting people to retain their independence. National guidance issued in 2009 was accompanied by a programme of support from the JIT to local partnerships to undertake service improvements. The programme has achieved important improvements in community equipment services, and this support will continue over the course of this plan. More recently, the Adaptations Working Group's final report has recommended major reform of the current arrangements for housing adaptations. The JIT will continue to support the next stage of the reform of housing adaptations.

Care homes will remain a key part of local health and social care systems, providing a particular form of care and support. The development of intermediate care, the emphasis on rehabilitation and Reablement, and a person-centred outcomes approach have clear implications for service design and delivery in care homes. There may be wider opportunities to extend the contribution that care homes make to the wider local community. JIT will continue to support care home providers to respond to the challenges and opportunities of health and social care integration and the reshaping care programme.

Over the three years of this Strategy, **our approach to improving the focus on place, home and community will be through providing practical support and challenge to partners to:**

- **Build on local assets and increase community capacity to develop resilient and supportive communities;**
- **Ensure that home and housing issues are integral to re-design of care and support;**
- **Nurture new models and approaches to community, and home-based care and support;**
- **Increase the range of suitable housing options available to older and disabled people;**
- **Re-shape equipment and housing adaptation services;**
- **Enhance the range and quality of supports offered by care homes.**

Priority

Place, home and community

WE WILL SUPPORT PARTNERS TO:	WE WILL DO THIS BY:
Build on local assets and increase community capacity to develop resilient and supportive communities	• Promoting the contribution that community capacity building, and its links to co-production and assets based approaches, makes to improving personal and system outcomes. • Supporting the role of communities, including faith communities, in developing resilience in individuals and neighbourhoods and building their confidence to co-produce solutions to their own care. • Extending the contribution that housing providers make as community anchor organisations, and in building community capacity.
Ensure that home and housing issues are integral to re-design of care and support	• Extending the understanding of the housing sector's role and contribution to health and social care agendas. • Supporting the housing sector to contribute to its full potential in Reshaping Care, and the development of local joint strategic commissioning. • Illustrating the range of contributions that social housing providers can make to reshaping care.
Nurture new models and approaches to community, and home-based care and support	• Promote and support innovative provider models such as social and community enterprises/co-operatives/community ownership. • Develop and encourage "supported volunteering" which integrates with contracted /commissioned care.
Increase the range of suitable housing options available to older and disabled people	• Sharing learning across Scotland about re-modelling existing housing to provide a range of housing options – such as extra care housing, and community hubs with outreach support. • Identifying opportunities for wider use of existing housing and facilities to support community activities.

Priority

Place, home and community

WE WILL SUPPORT PARTNERS TO:	WE WILL DO THIS BY:
Increase the range of suitable housing options available to older and disabled people	• Reviewing advice on design standards at modernisation and upgrading to reduce the risk of accidents and to improve people's independence.
Re-shape equipment and housing adaptations services	• Providing expert support to Partnerships to review and improve Community Equipment service provision, in line with established good practice. • Supporting a major review of the organisation and funding of housing adaptations – and follow on implementation.
Enhance the range and quality of supports offered by care homes	• Extending the contribution made by care homes in providing intermediate care and short breaks. • Share learning across Scotland about palliative and end of life care in care homes.

Improving practice and performance

The JIT provides practical improvement support to local health and social care partnerships to deliver national targets and improve outcomes.

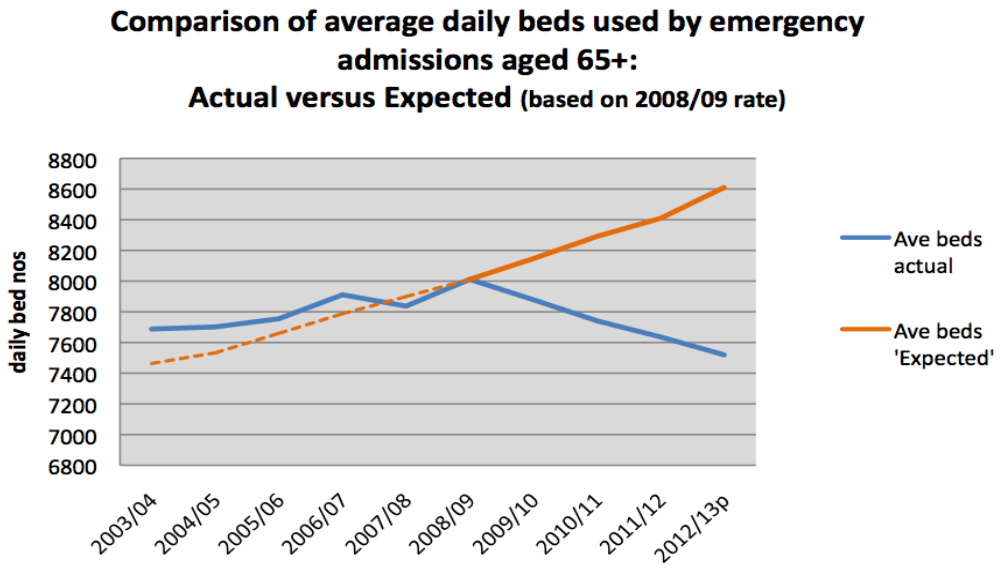
National HEAT targets include a specific focus on reducing the rate of 75+ **emergency bed days and delayed discharges**.

National targets to reduce the levels of emergency bed days and delayed discharges are intended to enable partners to release capacity to re-invest in prevention and support at home, are at the heart of the 20:20 vision for health and social care in Scotland.

Supporting partnerships to deliver these targets will continue to be a key priority for the JIT. We will build on the success achieved to date and help partners to release resources for re-investment through re-design of their system with an emphasis on prevention.

EXHIBIT 7

Older people are spending less time in hospital following an emergency admission.



The number of beds used on average by people aged 65+ who had been admitted as an emergency has gradually risen in the period from 2003/04 until 2008/09. From 2009/10 until 2012/13 the number has consistently fallen year on year. This contrasts with the 'expected' number of beds (orange line) which would have been used had the 2008-09 age-related rate continued in step with the growing age profile of Scotland's population.

Priority

Improving practice and performance

The JIT, in collaboration with QuEST (Scottish Government Quality Efficiency and Support Team), will support the delivery of the ***Post Diagnostic Support*** HEAT target as a key element of the national Dementia Strategy 2.

Improving practice and performance requires access to, and use of, relevant, ***improvement-related information***. The major programme of change, particularly an outcomes approach, the shift to prevention, and joint strategic commissioning, all place new demands on information to support improvements in practice and performance. The JIT is supporting the development of a single suite of outcome indicators and measures for health and social care integration, which will underpin the new integrated health and social care partnerships. We will also continue to support and challenge partnerships to strengthen their use of improvement-related information, with a particular focus on identifying the impact and effectiveness of preventative approaches, the use of personal outcomes data, and reporting of benchmarking data in collaboration with the Scottish Community Care Benchmarking Network (SCCBN).

***Over the three years of this Strategy*, our approach to improving practice and performance will be through providing practical support to partners to:**

- **Deliver their 75+ emergency bed day targets and delayed discharge targets;**
- **Deliver the Post Diagnostic Dementia target;**
- **Strengthen the analysis and use of performance improvement information**

Priority

Improving practice and performance

WE WILL SUPPORT PARTNERS TO:	WE WILL DO THIS BY:
Deliver their 75+ emergency bed day targets, and their delayed discharge targets	• Leading the HEAT target support group for emergency admission bed days in partnership with ISD, ASD, QuEST and the Improvement Network. • Supporting the delivery of the 4 week and 2 week targets and the implementation of the recommendations of the Delayed Discharge Expert Group. • Supporting and challenging partnerships to make progress against their trajectories for reductions to 2015. • Supporting and challenging NHS Boards and their partners to identify the variation and productive opportunities associated with delayed discharges and avoidable emergency admissions. • Working with QuEST to support a whole system approach to demand, capacity and flow.
Deliver the Post Diagnostic Support target	• Working with QUEST to support delivery of the post Diagnostic Dementia HEAT target.
Strengthen the analysis and use of performance improvement information	• Coordinating the development of a single suite of outcome measures for health and social care integration. • Trialling systems for capturing comprehensive and coherent partnership level information, to enhance strategic joint commissioning and investment. • Realising the potential of Talking Points in capturing service level outcomes and informing service improvement. • Supporting development of joint performance improvement frameworks in parallel with health and social care integration. • Identifying the role of contribution analysis in achieving outcomes – including testing in three national demonstrator projects. • Supporting the 'Stitch in Time' evaluation of the third sector's contribution to the preventative agenda

Priority

Building capabilities

A key component of the reform of our public services is the importance of building the capabilities of those who are involved in the delivery of these services.

We will support partners to ***share learning*** and to adopt practices and approaches found to be effective in improving performance, productivity and outcomes. We have built a significant library of resources on the JIT website, including evidence summaries from research, local experience from case studies and practical improvement toolkits. These will be reviewed, maintained and updated throughout the period of the plan so that we can continue to provide partnerships with useful material that encourages and supports local improvement.

The ambitious programme of improvement involved in the integration of adult health and social care, and the reshaping care programme will demand ***increased capacity*** from those working in health and social care. The JIT's Improvement Network will provide support to sharing learning and providing challenge to partners across health and social care practice and performance. The Network has become an established and popular source of information for local partners in health and social care, and other sectors. It has an ambitious and wide-ranging programme, using WebEx, e-bulletins, national and regional events, and a regional support network.

Effective ***community planning*** arrangements will be at the core of public service reform, driving an increased focus on prevention and continuous improvement. An important element in the response to the recent review of Community Planning Partnerships (CPPs) will be to ensure that CPPs have the skills and capacity to deliver improved outcomes for their communities. The JIT is a key partner in the programme led by the Improvement Service to improve the capacity of CPPs. The JIT will have a particular focus on governance, achieving an outcomes approach, supporting integration and promoting co-production.

***Over the three years of this Strategy*, our approach to improving our strategic management will be through:**

- **Share learning across partnerships about practices and approaches effective in improving performance, productivity and outcomes;**
- **Build capacity to support reshaping and improving services;**
- **Support capacity building in relation to community planning.**

Priority

Building capabilities

WE WILL SUPPORT PARTNERS TO:	WE WILL DO THIS BY:
Share learning across partnerships about practices and approaches effective in improving performance, productivity and outcomes	• Coordinating improvement and support activity in relation to reshaping care and health and social care integration. • Building capacity and developing skills amongst partnerships to share knowledge about effective practice at policy, strategy and delivery levels. • Improving knowledge management across all improvement programmes, through reviewing and updating of JIT website, case study collection, and links with other improvement websites. • Providing relevant, up-to-date tools to support partnership improvement and to build capability for successful integration. • Encouraging and challenging partnerships to build on learning, spread local improvements, and increase the pace of change; and maximise the impact of the range of local and national improvement support available.
Build capacity to support reshaping and improving services	• Deliver a programme of events through the Improvement Network to share and explain effective approaches across all improvement programmes. • Work with NES and SSSC to support Action Learning in partnerships as a vehicle to build local capability for integration. • Improve the quality of key skills in leadership and governance; management; partnership; production in joint commissioning.
Support capacity building in relation to community planning	• Working with other improvement and support bodies in relation to: – governance, accountability and operation of CPP boards; – outcomes based resourcing and co-production; – outcomes based organisational design and management.

Improving our own performance

During the next three years we will improve and develop our strategic management systems and processes to ensure they are capable of supporting delivery of the strategic plan, and can provide the appropriate levels of accountability to the Joint Improvement Partnership Board, Scottish Ministers and CoSLA.

JIT has a strong brand image and equally strong reputation in Scotland. We want to build on this success by developing new ways of communicating with our partners and stakeholders. We will complete the redesign of our website in 2013, and the process of re-badging JIT taking account of the new strategic partnership represented by the Joint Improvement Partnership Board.

We will continue to improve our planning and budget management systems and processes to enable a clear line of sight between what we intend to achieve and how we will fund it.This will provide the reassurance that our strategic commitments are financially viable. However, there will be a requirement to identify opportunities for additional resources to respond to the ambitions and expectations of national partners and stakeholders.

This plan sets out an ambitious improvement programme, which is likely to grow during the coming three year period. It is essential therefore that we provide opportunities to develop our team to ensure we have both the capacity and capabilities required to succeed.

ANNEXE 1

Members of the Joint Improvement Partnership Board

Professor Jim McGoldrick	Chair	
Angela Leitch	Chief Executive	East Lothian Council,
Angiolina Foster	Director, Health and Social Care Integration	Scottish Government
Annie Gunner Logan	Director	Coalition of Care and Support Providers in Scotland
Cathie Cowan	Chief Executive	NHS Orkney
Colin Mackenzie	Chief Executive	Aberdeenshire Council
Fiona Mackenzie	Chief Executive (to October 2013)	NHS Forth Valley
Ian Welsh	Chief Executive	The Alliance
Kenneth Hogg	Director for Local Government and Communities	Scottish Government
Martin Sime	Chief Executive	Scottish Council for Voluntary Organisations
Mary Taylor	Chief Executive	Scottish Federation of Housing Associations
Ranald Mair	Chief Executive	Scottish Care
Rory Mair	Chief Executive	CoSLA
Ian Crichton	Chief Executive (from October 2013)	National Services Scotland

Notes

Notes

joint improvement team
creativity, collaboration and continuous improvement

Strategic Plan 2013-16

For further information about JIT check our website on www.jitscotland.org.uk

Follow us on twitter: @jitscotland