



REVIEW OF THE JOINT IMPROVEMENT TEAM

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KEY OBSERVATIONS AND RECOMMENDATIONS

The Joint Improvement Team was established as a partnership between the Scottish Executive, CoSLA and NHS Scotland at the end of 2004. Its remit is to support the 32 health and social care partnerships in Scotland to deliver effective outcomes. This review was commissioned in response to a request from the former Director General of Health, Dr Kevin Woods, and draws on the responses to questionnaires and interviews with key stakeholders, on analysis of reports and other materials, and on discussions with core members, Associates and Action Group members from the Joint Improvement Team.

OBSERVATIONS

- The Joint Improvement Team has established a model of intensive partnership support across health, housing and social care which is highly valued by partnerships for its facilitative and enabling approach. The model can be resource intensive in terms of the extent and duration of engagement but appears to be effective in terms of embedding the learning within the partnership.
- The support received by partnerships has been very effective in driving down the delayed discharge figures over the last decade from over 2000 individuals at the peak to on recent occasions near zero.
- The Team has led on a number of key innovations, most particularly telecare, reablement and a personal outcomes-based approach, which have the potential to transform the provision of support.
- The creation of the Team as a three-way partnership between Scottish Government, CoSLA and NHSScotland both provides a powerful governance structure and facilitates communication with the essential stakeholders.
- The creation of a highly experienced group of Associates, each well grounded in the experience of partnership working, has provided a skilled resource additional to the core team members and well respected by partnerships.
- Action Group members have contributed in different ways to themed and partnership work, some taking a key lead role, others having only occasional input. The range of backgrounds and skills amongst Action Group members provides a rich resource to support and develop capacity within partnerships.
- The calibre of leadership provided by Mike Martin is widely recognised; the need to ensure such leadership is replaced following his retirement was highlighted by many respondents.
- There is little appetite either for merging the Joint Improvement Team with other bodies such as the Improvement Service or Improvement Support Team or for moving the Team outwith its Scottish Government location. There is however a lack of awareness and some inaccurate perceptions within some parts of the Government as to the role and functioning of the Team.

- The focus for much of the work of the Team can be considered to be driven by current policy directives, facilitating partnerships to respond to the priority agendas relating to outcomes and integration. This may be perceived as overly constrained - ‘it is about here and now problems rather than “where the hell are we going”’. However, the JIT has promoted a number of strategic developments including Telecare, Talking Points (Personal Outcomes Approach) and the Reshaping Care for Older People Programme. The recently issued Change Fund Guidance provides an opportunity to support partnerships over the longer term alongside shorter term improvement priorities.
- There is a tension in providing intensive partnership support between focusing on specific elements and looking at the broader strategic framework. To some extent a similar tension is replicated within the operation of the Joint Improvement Team itself, responding on demand to particular requests or working to a more strategic plan.

RECOMMENDATIONS

The following recommendations are put forward as a result of this review.

- A body known as the Joint Improvement Team should continue; it is an identity widely valued by local partnerships and offers a unique model of support.
- The tri-partite sponsorship by Scottish Government, CoSLA and NHSScotland should also be retained and the Team should retain its location within Scottish Government and build on established links with COSLA. The Team should take steps to raise greater awareness of its activities within other Divisions and Directorates of Scottish Government and to develop internal alliances and champions.
- The structure of core team members, Associates and Action Group should be retained. However the numbers in the Action Group should be limited and should be restricted to individuals contributing to partnership or themed work on a regular basis. Those with a less substantive input can be directed to interest groups and communities of practice.
- The Team should continue to adopt an enabling role of ‘critical friend’. It should however seek to proactively engage partnerships facing challenges who do not seek support on their own initiative.
- The experience and expertise of the Team should be used to promote and develop integrated and outcomes focused care and support with local partnerships including supporting the delivery of the Integrated Resource Framework, lead commissioning and integrated working arrangements. The Team should also contribute to work around shared services.
- For the next few years the Team should adopt the mantle of Reshaping Care for Older People and related work as its leading focus. This does not necessarily preclude the application of generic principles to other areas of partnership

working but having a robust core identity is of major importance both practically and presentationally.

- The Team should continue seeking to raise the profile of the role of housing alongside health and social care, both within local partnerships and across national agencies.
- The Team should capitalise on its knowledge and experience in translating an outcomes-focused approach into practice and should seek opportunities to embed this knowledge within other improvement agencies.
- At the same time it is suggested that the Team should continue to take the initiative on promoting future models of working, creating new ways of working rather than solely responding with existing practice.
- JIT should build on work underway with other Improvement Services and Programmes, such as Releasing time to Care and dementia demonstrators, to ensure a coherent approach to improvement support and effective use of resources and expertise.
- Greater attention should be paid to locating the individual partnership and themed work within a coherent strategic framework. This is not in any way to recommend the introduction of increased bureaucracy; rather to ensure that engagement with projects and partners remains focused and targeted.
- Consideration should be given to adopting new technologies, both to reduce the need for extensive travel and to share knowledge and experience across partnerships through the development of networks.
- Careful succession planning is needed to ensure continuation of the political and strategic leadership that has contributed to the achievements of the Joint Improvement Team.

SECTION ONE: CONTEXT

This review of the Joint Improvement Team seeks to assess the extent to which the Team has been successful in delivering its main aims and objectives, namely:

- To help health and social care partnerships to improve services through partnership working
- To provide support to improve joint working between organisations through partnership working while taking into account local circumstances
- To support local service developments which may be suitable for wider development across the country.

The specification for the review detailed a number of questions to be addressed; these underpin the discussion below and will be summarised in the concluding section. Key issues to be addressed by way of recommendations were also specified.

BACKGROUND TO THE JOINT IMPROVEMENT TEAM

The Joint Improvement Team was established as a partnership between the Scottish Executive, CoSLA and NHS Scotland at the end of 2004. Its remit, as highlighted above, is to assist the 32 partnerships working across health, housing and social care to work effectively together to deliver appropriate outcomes for individuals receiving care and support and their carers. The initial team comprised a core of three seconded core staff, supported by internal administrative staff. The team also recruited individuals with specific expertise to an Action Group¹, available to provide sessional input and embracing around 40 individuals. This built on the model of the Change Agent Team developed south of the Border.

The Team took an early decision that they wished their approach to be facilitative rather than interventionist. It wished to work with partnerships on the basis of negotiation rather than direction and sought to adopt the role of 'critical friend'. This was very much the decision of the core team members and has persisted as the dominant ethos. In part it was adopted as an approach distinctive from what has been characterised as the more prescriptive approach of the Joint Future Agenda and in particular the Ladder of Support and Intervention (CCD12/2004) proposed as an element of the Joint Performance information and Assessment Framework (JPIAF) (CCD1/2003). Support for partnerships under the current approach is delivered through two main streams of work: generic partnership support, working with individual partnerships in order to

¹ The Action Group is a mix of clinicians/practitioners and managers currently working in local health, housing and social care partnerships; user and carer representatives and independent experts. People can be drawn in to provide direct capacity and expertise to local partnerships in a very flexible and responsive way and contribute to JIT development programmes.

achieve specific goals, and themed work, addressing at a national level a number of key initiatives and challenges.

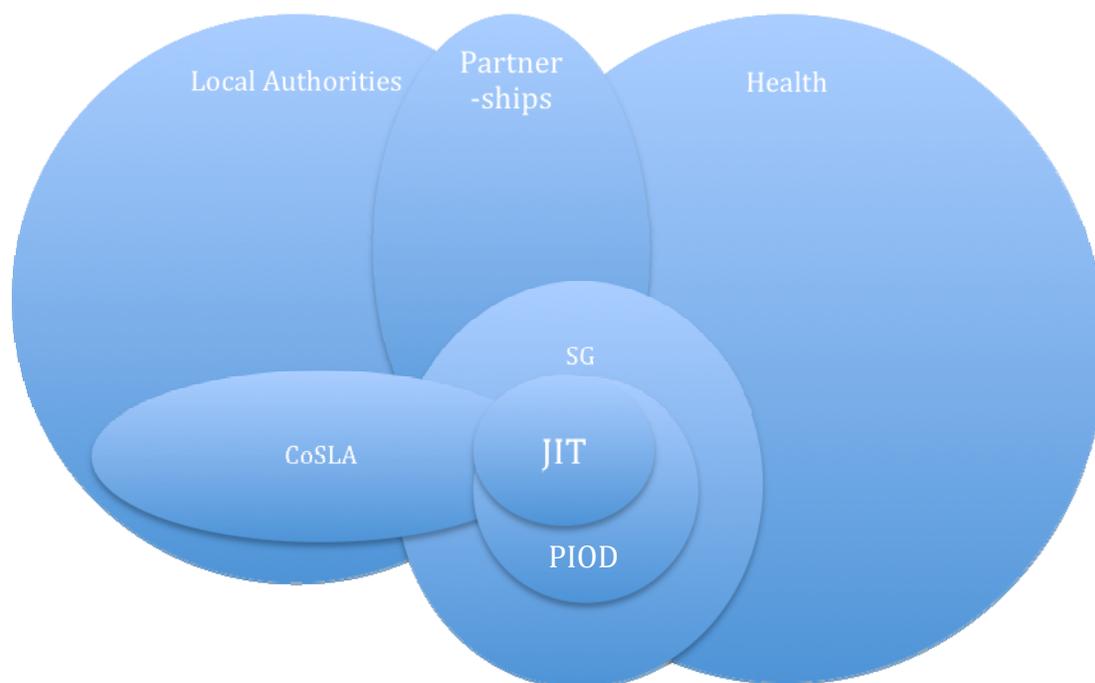
Following an external evaluation of the Team (Ball and Forbes, 2006) it was decided to recruit a number of Associates (currently eight)² who would take a lead role alongside the core team members in providing support to partnerships or in taking a lead on national initiatives.

There have also been changes in the internal arrangements for the Joint Improvement Team within the Scottish Government. For its initial eighteen months the Team was relatively free standing, jointly reporting to the NHS Scotland Chief Executive and to the Chief Executive of CoSLA. Following a restructuring, a new Primary and Community Care Directorate was established and the Joint Improvement Team located within it. The Directorate in turn created a new Division, the Performance, Improvement and Outcomes Division (PIOD) with a twin focus on improvement and on outcomes by linking the Joint Improvement Team with other partnership-focused activities. Although a three-way partnership, the involvement of both the wider Directorate and of CoSLA tends to have been relatively 'hands-off', affording considerable autonomy to the Team.

PIOD now embraces two core teams, the Joint Improvement Team working alongside the lead for delayed discharge, and a second team (formerly the Joint Future Unit) focusing on outcomes. The former lead for the Joint Improvement Team (Mike Martin) now has responsibility for the whole Division, while Margaret Whoriskey acts as the immediate lead for the Joint Improvement Team. This structure allows for a degree of synergy between the two parts of the Division, particularly in respect of themed work. For example the work on Delayed Discharge and Community Care Outcomes bridges the interests of the two teams, while the Joint Improvement Team has been able to promote and support application of the 2009 Guidance on the Provision of Equipment and Adaptations (CCD5/2009) developed within the other half of the Division. Most recently Mike Martin has taken the lead for the *Reshaping Care for Older People* initiative.

The diagram below seeks to locate the Joint Improvement Team within its immediate environment and to emphasise its role in facilitating partnership working. As can be seen, the Team is located at the heart of a system which seeks to promote the work of health and social care partnerships within the context of both national and local agencies. A range of other organisations contribute to the wider environment within which the Team operates including NHS QIS, NHS Education Scotland (NES), Scottish Social Services Council (SSSC), Social Work Inspection Agency (SWIA) and the Improvement Service.

² One of the two Assistant Directors appointed when JIT was set up had left and a decision was made not to recruit but to develop a model of associates



Subsequent to the review being undertaken the Scottish Government –Shaping Up review has concluded and JIT will continue as an entity within the Primary and Community Care Directorate, reporting to the Director and taking a Directorate wide role in support of the integration and joint working agendas

COSTS

The cost of the Joint Improvement Team is modest. The core budget for the most recent year, 2010-2011 was £974,000, with an additional allocation for this year only of £500,000 under the Shifting the Balance of Care Programme Funding. Efficiency savings of £106,000 resulted in a net budget of £1,368,000.

Expenditure against this budget comprised £376,000 on secondee and core staffing; £280,000 on Associates; and £712,000 on direct support to partnerships. This sum

includes events, activities, Action Group support, partnership development work and themed development work.

In addition to the above the Joint Improvement Team manages the National Telecare Programme of £4 million capital. From this total approximately £3.8 million is allocated to partnerships, with the remainder supporting development and learning activities and materials, the programme manager and evaluation. The current year, 2010-11 is the final year of a four year funding programme.

The Team contributes towards improvements across Scotland in the areas referred to below, and as set out in more detail within its own business plan and in other parts of this Review. The following estimates may help to set in context the funding of £974,000 provided to the JIT to carry out this improvement work.

In the area of delayed discharges from hospital around 4% of Scotland's inpatient hospital beds are occupied by people who are clinically ready to be discharged somewhere else (October 2010 ISD census). The cost associated with these delayed discharges can be estimated as being in the region of £56 million. The cost of emergency admissions of older people to hospital is estimated at around £1.4 billion.

Councils in Scotland currently spend around £600 million per annum on housing older people in care homes and a further £380 million on care at home. A total of £4.5 billion was spent on health and social care for older people in 2007/08.

A detailed cost effectiveness analysis was not conducted. Nonetheless, within the health and social care context the Team can be considered as highly cost effective, with a modest expenditure producing a range of effective outcomes as detailed below.

BROADER POLICY CONTEXT

The Team has operated against a backcloth of a number of major policy initiatives. Soon after it was established, the Kerr Report on a national framework for service change in the NHS in Scotland was published (Scottish Executive, 2005) while the following year the local authority role was addressed in *Changing Lives: Report of the 21st Century Social Work Review* (Scottish Executive, 2006). A focus on older people was introduced with *All Our Futures: Planning for a Scotland with an Ageing Population* (Scottish Executive, 2007).

With the advent of the new Scottish Government in 2007, five strategic objectives were adopted that underpin its Purpose – 'to focus Government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth'. These five Objectives describe a Scotland that should be: wealthier and fairer, smarter, healthier, safer and stronger and

greener. These are translated more specifically into the 15 elements of the National Outcomes Framework which include, for example 'we have improved the life chances for children, young people and families at risk', 'we live longer, healthier lives' and 'our public services are high quality, continually improving, efficient and responsive to local people's needs'. Progress on the National Outcomes is tracked through forty-five National Indicators, for example to Increase the percentage of people aged 65 and over with high levels of care needs who are cared for at home.

For health, the Action Plan *Better Health, Better Care* (Scottish Government, 2007) set a number of priorities for a five-year period. These included a key role for Community Health Partnerships in providing better community care services and shifting the balance of care; investment to support Carer Information Strategies; use of a risk prediction tool (SPARRA) to identify those at greatest risk of emergency admission or readmission to hospital; the development of a three year Long Term Conditions Collaborative and a Mental Health Collaborative; electronic sharing of information for Single Shared Assessment by 2009; support for the Scottish Centre for Telehealth; and introduction of maximum 18 week waiting times. The Action Plan also made a commitment to dementia being a national priority from 2008. The National Dementia Strategy was launched earlier this year (Scottish Government, 2010). In addition 2010 also saw the publication of the NHS Quality Strategy as the key overarching strategy underpinning all developments across the NHS and its approach to care and treatment.

The HEAT performance management system (Health Improvement, Efficiency, Access, Treatment) provides the framework against which the activity of NHS Boards is monitored. As part of the Action Plan HEAT targets now have a greater emphasis on health improvement, mental health, efficiency, anticipatory care and patient experience and are to link more closely with other performance management approaches in the public sector. For example the target of increasing the level of older people with complex needs receiving care at home has been one of the treatment targets for the last three years.

As part of the Concordat agreed between the new administration and CoSLA in 2007 on the relationship between central and local government, agreement was reached on a Single Outcome Agreement (SOA) structure for performance reporting by local authorities and community planning partnerships. This allows local authorities to determine their local priorities within the context of the 15 National Outcomes and reflects the shift in emphasis towards outcome-focused delivery. An evolving menu of local outcome indicators is available to assist with the identification and measurement of these local priorities.

The Single Outcome Agreements can draw also on the Community Care Outcomes Framework, developed in 2007 to demonstrate how joint working between NHS and local authorities improves community care services. The framework comprises four national outcomes – improved health; improved well-being; improved social inclusion;

and improved independence and responsibility - together with 16 performance measures. These address six themes: satisfaction; faster access; support for carers; quality of assessment and care planning; identifying those at risk; and moving services closer to users and patients. The specific measures embrace, for example, the proportion of service users satisfied with opportunities for social interaction and the proportion of carers who feel supported and capable to continue in their role as carer. It is acknowledged that not all of the measures address outcomes; a number focus on inputs, outputs and process. There is an element of read across to certain of the Concordat National Indicators and the HEAT targets. The Framework is also aligned with the National Minimum Information Standards and with Talking Points (see below). It has provided the focus for the development of the Community Care Benchmarking Network. The Joint Improvement Team has been heavily involved in the design, development and implementation of the Community Care Outcomes Framework and Talking Points approach.

A range of other policy documents and strategies contribute to the context within which the Joint Improvement Team operates. These include the work on Shifting the Balance of Care which followed *Better Health, Better Care*, the focus on Reshaping Care for Older People and the current five associated workstreams, the NHSScotland Quality Strategy (Scottish Government, 2010), the recently updated Carers Strategy (Scottish Government, 2010) and most recently the National Strategy on Self-Directed Support (Scottish Government, 2010). Shifting the Balance of Care has spawned the Integrated Resource Framework (IRF) with the aim of developing a flexible approach for partnerships to realise the full benefits of integration across organisations. The Framework seeks to identify the cost and quality implications of local decisions about care, understanding variation in spend, activity and outcome as close to the individual as possible, and allowing inappropriate variations in practice and outcomes to be reduced. Four IRF test sites have been identified, Highland, Ayrshire and Arran, Lothian and Tayside. At each site the key populations in the area are being identified, together with the spend across the groups. The opportunity to move resources for locally agreed priorities can then be explored.

The Joint Improvement Team is of course also working in an arena, that of partnership working and integration, where there is an extensive literature. This explores a range of related issues: what is meant by partnership working and what is meant by integration; how can they be progressed; what is the evidence base; what is the impact in terms of outcomes. Glasby and Dickinson (2008) provide a general overview; Dowling, Powell and Glendinning (2004) highlight some of the key debates around evidence; and Curry and Ham (2010) offer the latest conclusions – ‘evidence from North America and Europe shows that integrated health and social care systems for older people demonstrate positive results on many indicators’ (p vii). A series of reports focusing on evidence and Partnership Working to support local Partnerships has also been developed (JIT Partnership Briefing Notes).

APPROACH TO THE REVIEW

Data was collected from a range of sources in autumn 2010 as part of this review. The Joint Improvement Team distributed questionnaires to three key groups: lead individuals from local partnerships; individuals involved with aspects of themed work within partnerships; and individuals from within other divisions of Scottish Government and from a number of cognate organisations. Respondents were asked to comment on the style and approach of the Joint Improvement Team, on its strengths and weaknesses, on its potential to contribute to emerging policy and delivery priorities, and of its fit with other improvement agencies. They were also asked to assess the impact the Team had had on various aspects of the partnership.

	Distributed	Responses	Response rate
Partnership leads	59 ¹	29 ²	49.2%
Themed work	26	9	34.6%
Scottish Government	21	8	38.1%
	106	46	43.4%

¹ to 21 partnerships

² from 17 partnerships; while questionnaires were sent to two or three people in each partnership, in some cases a response was on behalf of the partnership

Interviews exploring key issues in greater depth were conducted with ten individuals from partnerships (five particularly associated with specific themed work), eight from Scottish Government and other organisations including CoSLA, SSSC, NES, QIS and IS, and ten from the Joint Improvement Team itself (including Associates) and the wider Performance, Improvement and Outcomes Division (PIOD). Interviews were agreed with a further three individuals from partnerships but could not be completed due to availability. Four individuals failed to respond to the interview request, two partnership leads, one from the themed work, and one from Scottish Government.

Summary and evaluative reports produced as a result of work with the partnerships were appraised, together with a number of independent reports evaluating specific aspects of the work of the Joint Improvement Team. These include commissioned evaluations on Telecare and on the implementation of reablement in Edinburgh. The Joint Improvement Team applies the PEAT tool (Partnership Enhancement Assessment Tool) at the conclusion of a programme of partnership work and PEAT scores were examined alongside the reports on the engagement with each partnership.

A guided discussion was held at a session with the Associates; this group was also asked to complete a form recording their key areas of work and where they considered they

had had the greatest impact. Members of the Action Group also participated in a feedback session which included discussion of the achievements of the Action group, of challenges they had encountered, and of potential solutions.

Finally, early findings were presented to a group of individuals who had earlier responded by questionnaire or interview. Invitations were extended to all those from partnerships who had already participated, either by completion of the questionnaire or through interview. From the 46 invited, nine individuals attended this session, together with three individuals associated with the Joint Improvement Team. A video link for an island participant had to be cancelled at the last minute due to an enforced change of venue. The group used four 'straw dog' futures scenarios as the basis for exploration of potential directions in which the Joint Improvement Team might wish to move. Initial conclusions were also presented for validation.

SECTION TWO: KEY FINDINGS

This discussion draws across the range of sources to identify predominant themes. Where the material is predominantly qualitative in nature it seeks to reflect the relative strength of the range of responses.

Prior to a discussion of the key themes emerging from the questionnaire and interview responses, a brief review of the nature of the work with individual partnerships is provided.

THE NATURE OF INTENSIVE PARTNERSHIP SUPPORT

Engagement with the Joint Improvement Team is often described as a process of negotiation. Particularly in the early years of the Team, an initial scoping report would precede the development of an agreed action plan for the partnership. Involvement from the Team would typically involve two or three core team members or latterly Associates, supported as appropriate by Action Group members, working closely with partnership leads and other relevant individuals and groups over an initial period of perhaps twelve to eighteen months. Contact might be at least weekly to two or four days every six to eight weeks. The action plan includes identification of priorities and desired outcomes and agreement of resource commitments from the partnership and from the Joint Improvement Team. During the implementation of the action plan there is regular monitoring and progress reporting together with a more formal review and evaluation at the end of the support period.

CASE STUDY ONE: Improving delayed discharge figures

Poor performance against delayed discharge targets led to involvement of one community health and social care partnership with the Joint Improvement Team. 'The invitation to bring the JIT in was to get effectively some independent facilitation, direction, coaching, mentoring in to all that we were doing, and also to try and learn from good practice that was happening in other places, whose performance was evidently a lot better than ours.' Monthly performance review meetings had been established around the community care agenda, structured around a six item action plan. With involvement of the JIT, attending the review meetings and facilitating workshops, 'we began to see that the whole wider community care agenda was important'. The facilitation, mentoring and direction from these individuals, 'observations on our working practices, our kind of context, our kind of dialogue', 'enabled us to get a grip of the agenda'. Their advice on what was happening elsewhere and what would make a difference had enabled the partnership both to achieve the target of zero delays and to

reach the stage where they felt confident in addressing the broader agenda without the need for further support. 'We now have an Action Plan, we have a very clear vision of where we want to be, we have a very clear performance management strategy now around community care – and if my chairman phones me today or tomorrow and says "how are things doing around your ratio of home care to institutional care?" I can tell him, because I now have statistics and information. So life has just changed considerably I think, not only in terms of our command of the topic, but also our ability to improve things for our patients and our clients'.

The partnership lead reflected on the success of the engagement: 'I think that mutuality of Scottish government thinking "these guys need a bit of support", and us saying "yes, we agree, we do need support". We started with the right attitude that we were going to embrace all the advice and all the help that we could get from them. So I think this is strike one. I think strike two, the way in which they did their work, quite often in a more kind of coaching, encouraging, evidence-based approach, was again readily acceptable, rather than what could have been was a team coming in and saying "well, you know, what are you doing here is not hitting the mark, this is what you have got to do". Most importantly, 'there was evidence of results, evidence of progress'.

Looking across the activity reports from intensive partnership working, a number of scenarios can be highlighted. For those less familiar with the detail of the activities of the Joint Improvement Team this should hopefully convey the breadth of the agendas they are involved in.

- A work plan focusing in one partnership on five key elements: a strategic governance and management framework; local joint management; joint service redesign and redevelopment; project management; and delayed discharge management.
- Another partnership where the Action Plan identified as key objectives governance and leadership; strategic planning and resourcing; management of the requirements for the Single Shared Assessment process and Care Management guidance; measurement of the achievement of agreed outcomes; development of telecare, community equipment and an out-of-hours service; and improved cross stakeholder communication.
- Activity within four specific areas: review of Geriatric Orthopaedic Rehabilitation Units; reviews of in-house residential care homes, with a focus on dementia; home care review, focusing on out-of-hours provision; and opportunities to extend housing with care.
- A second round of engagement prompted by challenges meeting delayed discharge targets; this followed earlier participation around commissioning and Talking Points.

- Engagement to support a partnership to meet and sustain delayed discharge standards through delivery of effective care pathways.
- A collaboration that embraces sustaining the delivery of delayed discharge standards; supporting redesign of care at home including intermediate care, reablement and reduction in continuing care beds; application of telecare solutions and development of telehealth care; contributing to the sheltered housing review and options appraisal; extending the use of Single Shared Assessment and supporting the application of Talking Points; and supporting the implementation of the joint commissioning strategy for older people.
- A comprehensive programme addressing joint governance; capacity planning and joint commissioning; personalised services for people with learning disabilities; mental health improvement plan; and implementation of the outcomes based joint performance framework.
- Development work focusing on Shifting the Balance of Care; intermediate care and rehabilitation; housing and public services; delayed discharge; service redesign; and outcomes and Talking Points.

CASE STUDY TWO: Improving relationships

Three members of the Joint Improvement Team ‘helped us crack the nut’ in a partnership where there had been a history of troubled relationships. Strengths and weaknesses and the opportunities for joint working were explored, good professional relationships were developed and a model for working was established. ‘They were extremely skilful and enabling, and professional at the level of not getting involved. So they didn’t get dragged into the local scenarios, they kept very much on the higher plain.’ Success was also attributed to their independence and to their ability to offer a national overview. Subsequent work within this partnership has focused on discharge planning and discharge programming, on developing joint community care services and resources, and on social care provision out of hours in rural areas. Reflecting on their experience, the partnership lead concluded ‘I suppose to a degree we have become more self-resourceful, you know, as we are looking to do as much as possible in-house, or within local resources as possible, and we had been doing that even before the squeeze on budgets, and just trying to up-skill our own managers and getting them to work jointly with health and looking to do as much as possible in-house. And the baggage of poor relationships has been left behind, people are popping their head up and more able to focus on the job instead of being distracted by nonsense.’

The examples of activities within partnerships demonstrate both the breadth and the diversity of the engagement. Detailed plans specifying lead responsibilities and timescales would work out the specifics of the support arrangements. Intensive

partnership support has primarily focused on the delivery of health and social care for adults. The final case study relates an account from a partnership of extending involvement into children's services.

CASE STUDY THREE: Involvement in children's services

Aware of the Joint Improvement Team involvement in community care activities within the partnership, the Head of Children's Services approached the Team to establish whether it would be willing to engage with children's services. This was prompted by the prospect of applying its expertise and knowledge to joint activity at both a strategic level and for locality based service delivery; by a desire to learn from their knowledge of models elsewhere; and by the desire for involvement in the performance and audit subgroup.

Involvement over twelve months of a JIT Associate in the subgroup has resulted in an integrated performance framework for children's services, signed up to by both the strategic group and by operational groups across education, health, social work and others. A cross cutting contract and commissioning team has also been established.

A number of key questions were identified by the reviewer in the course of this scrutiny of the detail of intensive partnership working. These will be addressed in the course of this review but include:

- How should involvement with a partnership be triggered?
- How should the focus for involvement be defined, allowing roles to evolve without losing focus?
- How should exit from partnership work be negotiated?
- Should resources be allocated to partnerships which are reluctant to engage?
- How can the appropriate balance between support and dependency be attained, ensuring that appropriate skills are embedded and owned within partnerships?
- What is the appropriate balance between progressing individual components compared to the whole system?
- At what level of the partnership – strategic, operational, front-line - is support best targeted?
- How should the Team balance offering national lessons as against local solutions?
- What should be the balance between short-term deliverables and longer-term strategy?
- Should the skills of the Team in partnership working be extended to children's services?

PARTNERSHIP ENHANCEMENT ASSESSMENT TOOL (PEAT)

The Partnership Enhancement Assessment Tool (devised by Professor Bob Hudson³) provides the opportunity for a summary evaluation on three key aspects of the engagement with the Joint Improvement Team. Completed at the conclusion of a period of intensive support it addresses three key dimensions: style of support and intervention, partnership awareness, and partnership impact. Respondents are asked to select from 'strongly agree', 'agree', 'disagree' and 'strongly disagree' in respect of 18 statements, six for each dimension. For example the statements in respect of partnership awareness read:

The contribution and support of JIT has helped the local partnership to:

- Develop a partnership agenda that may not otherwise have emerged
- Better prioritise the local partnership challenges
- Promote changes in behaviour that contribute to a positive culture of partnership working
- Accept that engagement in partnership working is a legitimate call on staff time and resources
- Be more aware of where money is being spent across the locality
- Accept that improved service delivery needs a whole system approach across the locality

Scores on these three dimensions are then added together to provide a summary score. The suggested interpretation for these overall scores (presented as percentages rather than a total potential score of 72 as in the original formulation) is:

83.3-100	JIT support has been highly effective and the partnership shows a significant capacity for enhancement and sustainability
69.4-83.2	JIT intervention has had some beneficial impact and there is evidence to show enhanced partnership capacity and some likelihood of sustainability amongst the local partners
55.5-69.3	The effect of JIT intervention remains unclear. Although achievements to date have been limited there are some plans and some evidence of capacity to improve
55.4 and less	Despite JIT support this partnership does not seem able to demonstrate enhanced capacity and its sustainability is in doubt

Schedules of this type provide of course only a partial story and summary scores should be treated with caution. In particular the number completing the PEATs during the feedback sessions in partnerships was often small. Moreover, most specifically in

³ Honorary Professor in the School of Applied Sciences at the University of Durham

respect of 'impact', the threshold for scoring highly is challenging. Completion of the PEAT scores was embedded within a wider discussion of the value of the partnership engagement led by a member of the Team not previously involved with the partnership; these summary reports were overall very positive, more critical reflections often referring to their own internal activities and responses. One partnership for example reflected that the involvement of the Team had been key in building trust and joint working between the council and the health board, ensuring that the appropriate priorities were addressed. Another reported that the involvement had been 'enormously helpful', moving senior managers to implement partnership working rather than just talk about it.

Available scores following work with individual partnerships are listed below.

		Style of support	Awareness %	Impact	Overall
	returns	%	%	%	%
Argyll + Bute	2	89.6	79.2	85.4	84.7
East Lothian	5	83.3	74.2	69.2	75.6
Edinburgh	48	81.3	65.0	69.7	72.0
Fife	10	84.2	69.2	67.9	73.6
Grampian	13	74.0	58.7	63.9	65.5 ¹
Inverclyde	?	91.3	79.2	71.9	80.8
Orkney	11	84.2	76.0	73.3	78.6
Stirling	7	77.5	75.8	70.0	73.8
Western Isles	8	80.8	72.4	63.5	72.0

¹ These scores can be broken down into Aberdeen City (3) 60.7; Aberdeenshire (6) 66.4; Moray (1) 74.0; pan Grampian (3) 60.9

The summary scores for the style of support and intervention are strong, all but two in the top grouping, characterised as 'the experience of working with JIT was highly positive and brought significant gains to the local partnership'. In respect of partnership awareness following the engagement, the majority of scores (all but two) fall into the second category: 'understanding of the nature and benefits of joint working has improved in some important ways following JIT support'. In terms of impact, the summary for all but one is 'some limited change in joint service outputs can be identified as a result of JIT support'. The challenges of demonstrating impact will be explored further within the section below. In terms of the overall scores, only in one area (Grampian) was there uncertainty as to whether the intervention of the Joint Improvement Team had been beneficial overall. A number of confounding factors locally are likely to have influenced this assessment.

Other partnerships carefully weighed up the overall strengths and weaknesses. For example one highlighted the strengths and weaknesses as follows:

Key Strengths	Least Helpful Aspects
<ul style="list-style-type: none"> ▪ Advice and support and JIT's ability to act as 'critical friend' has been enhanced by the credibility of JIT Associates ▪ Materials and approaches such as commissioning workbook process ▪ Programme developed a better understanding of the benefits of joint working and of the changes required ▪ JIT offers the opportunity to transfer learning from other partnerships ▪ Objectivity and strategic skills ▪ Additional resources such as SSA post 	<ul style="list-style-type: none"> ▪ Need for more practical and hands on support ▪ Some aspects of the programme seemed disjointed eg telecare developed in isolation ▪ Failure to really get housing on board ▪ Tendency towards 'one size fits all solutions' – JIT may need to be more selective about how models and approaches used elsewhere are applied ▪ Teams might have challenged more on issues haven't progressed ▪ Joint financial planning/budgeting has not really happened

In reviewing the work of the Joint Improvement Team, there is a key distinction between the *process* of engagement, the style and acceptability of interaction, and the *outcome* of the engagement with the Team in terms of impact. The key element, impact, will be considered below. Nonetheless, the importance of the engagement process should not be underestimated. The discussion below highlights a number of key themes emerging across the various respondents, followed by a couple of observations specific to particular groups.

PERCEIVED STRENGTHS

There was widespread recognition and appreciation of the skills, knowledge and personalities of those delivering support on behalf of the Joint Improvement Team. This included both members of the core team, Associates and individuals from the Action Group.

Expert and credible

Much of the validity and respect afforded to the role of the Team stemmed from an acknowledgement that those involved had themselves wrestled with similar challenges

and were highly skilled - 'strategic thinking, intelligence, rigour, tools and methods and linkage to central strategic planning' (partnership).

'One of the strengths is they can parachute people in who have got particular knowledge or expertise – say on facilitation around creation of joint teams, on community development, on how you build a strong joint management team.' (partnership)

'The use of JIT Associates has been very helpful in encouraging change at the local level because they are people of seniority and 'gravitas' who bring a wide range of practical experience and expertise to bear and are respected in their field. That practical knowledge of the challenges and difficulties at the local level is invaluable. The ethos of encouraging development and working alongside partnerships in a supportive way rather than being seen as the Government 'hit squad' sent in to tackle underperformance seems to me to be very important to their influence and success, as is the fact that it is a joint COSLA/Scottish Government initiative.' (SG)

Participatory, facilitative, constructive

In addition to the personal skills of team members, respondents spoke at length about the constructive style of engagement. A key element is the careful negotiation of the potential tension between a directive and possibly critical approach and one that seeks to enable those within the partnership to develop their own skills and strengths – 'what would you say, outside looking in, you know, and being able to comment and make observations which are non-judgemental, but clearly giving pointers as to potential areas of weakness and strength' (partnership).

'Not kind of directing and managing it, but sitting round the table, providing advice, providing coaching and mentoring, ... evidencing good practice, telling us where we can go to get evidence of good practice, and indeed bringing that good practice to the table. They also have helped the development of action plans, and then sat, if you like, in the background as we monitored those action plans, but giving us comments and observations on how we have been working.' (partnership)

'The way in which they did their work, quite often in a more kind of coaching, encouraging, evidence based approach, was again readily acceptable, rather than what could have been was a team coming in and saying "well, you know, what you are doing here is not hitting the mark, this is what you have got to do". I think we went through that period of developing approaches that were no doubt being put in our minds by the Joint Improvement Team, but there was a sense that we were coming up with these ideas and making progress from within our organisations rather than as a consequence necessarily of the Joint Improvement Team being with us. But clearly the Joint Improvement Team had quite a significant influence in that.' (partnership)

'They will listen to any proposals, problems, ideas, creative ideas that you might have, and then they will think about how they can help. And they are very good at streaming in associates or identifying a key person who might be able to work with you on it, in terms of development or problem solving.' (partnership)

Practical approach to achieving better outcomes

The common driver for partnership working should be its anticipated role in achieving better outcomes for those on the receiving end of care and support. A role of the external agent is to reinforce this driver, to prevent partners becoming embroiled in local barriers, and to move the players towards delivery – 'that's the thing that JIT, I think, are very good at – is taking people, or changing people's hearts and minds as they go' (partnership).

'JIT have made a significant difference to the way of working across the partnership resulting in measurable improved outcomes for service users/carers as well as efficiencies.' (partnership)

'They come in with a completely fresh view, and again my experience is that they are non-judgmental, but they ask really good, relevant and searching questions.' (partnership)

'There was quite a bit of "them" and "us" at that point and I think JIT helped to cut through the crap and get to the nub of the problems – and not banging heads together, it wasn't quite as brutal as that, but clearly helping us to recognise where the barriers were and how we required to take steps to overcome them'. (partnership)

A key element of this outcomes-based approach is the capacity and capability of the team to develop tailored support. Again this is well expressed by one of the respondents.

'JIT style of working with teams "where they are" is important. Work alongside local leaders on things that are both locally and nationally relevant. They are supportive but challenging – they can do this because they have invested in building a relationship with us.'

Two-way flow of information

A further feature of the involvement of the Joint Improvement Team appreciated by a number of individuals was its ability both to inform the local context from the wider national policy agenda and to disseminate local good practice more widely.

One partnership outlined how they had used the Team to check out their local development of telecare against the national policy.

‘We used JIT in that particular area of work, more as a kind of sounding board – because there were things happening right across Scotland, and we had got some money, some funding, and it was really just to kind of check that we were not going wildly out of line with what was happening elsewhere. They were quite good for kind of giving us feedback on what they thought of our plans, our schemes. I think what we have developed in X they saw as being a good scheme, and they used our model and our report to share with other local authorities. So it was kind of a conduit for information sharing, a way of reflecting on what we were planning to do, and trying to get some sort of national perspective, and some sort of confidence that they felt we were on the right track and I guess they gave us support in that. So it was a very soft, if you like, level input that we had with them on that piece of work.’ (partnership)

Respondents particularly welcomed an understanding of broader policy drivers and valued learning how other partnerships had navigated similar challenges – ‘I think the essence of it for me is a combination of that two-way flow of information, with a particular emphasis on the coordinating information from around the country, in terms of experiences’ (partnership).

‘It’s a bit about relationships, it’s a bit about discussion and it’s a bit about two-way discussion ... I actually feel that I am understanding that agenda very clearly, and while I am talking to them, that they are hearing and listening to what we are saying from X in terms of our experience of taking those and trying to work with them – they are actually listening and hearing. And you can see the impact and the change happening over time as the new sort of round of advice or guidance comes out. And I think that is a really positive thing.’ (partnership)

‘Well placed especially as a conduit to government, to ensure that potential barriers from policy agendas that are not always mutually supportive are clarified and reframed appropriately. Ability to help partnership priorities and understand how best to work through the community care maze. No other group exists to support this networking into action context.’ (themed)

The importance of learning from experience elsewhere is increasingly recognised in a context of financial constraint - ‘the potential to bring together in one place a diversity of good practice experience and development, with the ability to share across partnerships – help to avoid reinventing wheels’.

‘We won’t have the time, we won’t have the resources to spend lots of time developing answers that have already been developed and have been seen to be working in other places. And I think what JIT has done for us is, they have brought

some of that stuff, and because they have been working with us, almost part of our structure, we have kind of accepted and embraced some of the stuff that they have brought to us, without having to spend a lot of time developing it ourselves.’
(partnership)

For one partnership the guidance on the national perspective was combined with some targeted requests for financial support.

‘I think the strength has certainly been their supporting us gain a national perspective on what we were trying to do at a local level, and guiding us to other areas, advising us of other areas that we are trying to do, or other local authority areas that are doing similar work, the same work, and putting us in contact with people – that is certainly a strength. Providing us with some feedback, you know, just kind of reflective practice that we would be involved in. Giving us some sort of comment on their perspective of what we are trying to achieve would be another strength, it would be a sort of an independent objector sometimes, you know, view on things. And I suppose, to be honest, we often saw them as a source of kind of guidance towards government money and things – I am being absolutely blunt here, about the kind of practical help we were given. That was always something “maybe the JIT will have some money to contribute”, and sometimes they did. Always very much appreciated.’ (partnership)

Tenacity

The tenacity of the Joint Improvement Team in sticking with a consistent agenda was recognised by a number of the partnership respondents.

‘The JIT team work hard, are tenacious and somehow remember what the project plan is for each area they work in. Their style is nonjudgmental but they advise where appropriate in a sensitive way’. (partnership)

‘The in-depth knowledge by JIT of the partner organisations, plus a tenacity of approach have been key characteristics of the success. I find all the team approachable with very relevant skills and experience. They are the most value adding element of the Health Department’. (partnership)

‘I just think that the mix of how they have approached things has just been right – that when they have needed to be assertive, directional, you know, bit cheeky, they have done it – and when they know ... when they have seen that that approach is getting people’s backs up, they have just backed off and come at it from a different perspective. So I don’t know, my experience of the Joint Improvement Team, I think has been as good as I have had with a number of teams that have come in to do work, and I am assuming ... well my assumption is it’s because they have been effectively sponsored by the Scottish Government, and they are coming in

genuinely, not to perpetuate their own existence – they are coming in genuinely for a very clear remit in terms of improving performance around our community care.’ (partnership)

PERCEIVED WEAKNESSES

The number of more negative comments was much more limited, whether from questionnaire or interview respondents. The most negative comments tended to be made by others within Scottish Government; these will be discussed in the context of this specific group of respondents. From partnerships five particular issues can be highlighted.

Competing local priorities

A number of partnership respondents spoke of the tensions that could arise between the agendas and timescales being proposed by the Joint Improvement Team and the demands to deliver ‘the day job’. Smaller agencies were particularly likely to flag the pressures of responding to the agendas set for completion between visits. For some this suggested perhaps a failure to acknowledge the centrality of the priorities; from others there was a recognition on reflection that the need to prioritise was necessary.

‘JIT were demanding and expected us to work towards the timescales and objectives we had agreed with them – made sure we remained focused. This was difficult when we had so many other competing priorities and did cause tensions at times but the end result was worth it!’ (partnership)

Distance from the local context

There were a couple of instances only where respondents felt that perhaps those from the Team were not fully primed on local circumstances - ‘better if they spent time establishing a better understanding of the respective positions and issues before working with us’.

Strategic planning

A number of individuals commented that whilst the flexibility and responsiveness of the Team was a major strength, there could usefully at times be a more strategic approach across the work of the Team as a whole.

‘I think maybe they are involved with quite a number of work streams, and I am not sure that always the big picture and the context for these work streams is as clear as it might be.’ (partnership)

Response times

Two or three partnerships suggested that on occasion they had not been able to access support as rapidly as they would have wished - 'I think sometimes by the nature of how they work with various partnerships across the land, it's difficult to get them when you need them at times'.

Conflicting policy frameworks

Finally, a couple of respondents expressed frustration that despite their location within Scottish Government the Joint Improvement Team had not been able to resolve separate policy frameworks across Government.

'I had hoped that they would be able to influence policy at the very highest level to promote a more joined up approach across Scottish Government and NHSScotland. We are still beset by two policy frameworks and directives.' (partnership)

Responses from specific groups

The few less positive responses tended to come from those working elsewhere within Scottish Government. These often expressed frustration at their lack of awareness of the activities of the Team: 'my team are continually asking what it is, who are the associates, and what legitimacy they have in terms of cross-cutting policy work'; 'the JIT is more concerned with communicating with the outside world than the internal one';

'It is questionable whether the support service to local authorities is needed as many have their own senior management team whose function is to provide leadership. The themes chosen by the JIT are not always negotiated with policy colleagues and this gives the impression of cherry-picking at times. The recruitment of associates is not transparent which affects credibility.' (SG)

Such perceptions were not always accurate. For example the recruitment of Associates is governed by Scottish Government procurement regulations. Another Scottish Government respondent however, offered a possible explanation for such negativity

'I think there is a great deal of benefit to be gained from the kind of very flexible working, fast on their feet, able to re-form and re-form themselves into all kinds of different shapes to address all sorts of different problems. It does create a certain amount of tension with the more established bits of the system, it seems to me, where people are inclined to ... in present circumstances in particular, look slightly resentfully at the apparently large resources that the JIT has available at its command. And there is also, I think, a certain amount of low level grumbling, at a more personal level, because people have a perception that individual members of the JIT Action Teams may be doing very well on their daily rates and so on.

Although I don't see any of the grumblers queuing up to put themselves into that position, it has to be said! And it is low level, I am not wanting to make a big deal out of that, but it's there.' (SG)

Members of the Action Group were given the opportunity to explore specific challenges that they encountered in their work for the Joint Improvement Team and to suggest potential solutions. A range of issues were identified, summarised in the table at the Appendix. These can be grouped into four key areas: communication, engagement, operation and utilisation. They highlight in particular opportunities for better communication strategies to share both information and experiences and the need for careful management of the process of engagement.

SECTION THREE: THEMED WORK

In addition to the intensive work with individual partnerships, the Joint Improvement Team has been involved in work around a number of major themes. There are specific listings on the website for care at home, commissioning, delayed discharge, equipment and adaptations, governance and management, housing, integrated transport with care, intermediate care, managed care networks, performance improvement, Reshaping Care for Older People, rural and remote, Talking Points and telecare. A number of these are discussed below; some have been the focus of independent evaluations and these are referenced.

REABLEMENT

The concept of reablement has emerged as a key driver in recent years. In England the Care Services Efficiency Delivery Programme (2008) led the promotion and evaluation of the model, building on positive evidence of cost effectiveness from a number of early initiatives (for example Kent et al, 2000; Newbronner et al, 2007). Currently the Social Policy Research Unit (SPRU) is examining longer term impact (Jones et al, 2009; Rabiee et al, 2009). In Scotland the Joint Improvement Team has taken the lead in the development of reablement. This has built on the initial work in Edinburgh which has been the focus for an external evaluation funded by the Team. An individual initially involved in the Edinburgh development as an external consultant has subsequently taken the lead in his role as a JIT Action Group member together with an Associate in delivering workshops and support to partnerships across Scotland.

Unlike England where the initial focus of reablement has tended to be a time-limited service focused on those being discharged from hospital, the model developed in Edinburgh has sought a more wholesale transformation across homecare delivery. The emphasis was to be one of supporting individuals wherever possible to undertake tasks themselves rather than performing tasks for them. The vision for modernising homecare was for a personalised service, working with individuals to achieve agreed goals and outcomes in a way which promotes independence rather than dependence. Initial development focused on those who were new to services, 46 per cent referred from hospital, 54 per cent from the community. An incremental implementation plan was put in place across the six localities, supported by a communications strategy including focus groups and monthly newsletters and a two day training programme. Older people's forums within the city were also engaged in discussions as to what was planned.

The reablement service was introduced to the first locality in Edinburgh (the South East) in October 2008 and the evaluation reported by McLeod and Mair (2009) focuses primarily on the initial eight months experience within this area. The initial focus was

on six weeks of reablement input, comparing outcomes for the target group with those for a control group from elsewhere within the city. Hours of input were also tracked for a further three months. Findings confirmed those from earlier studies. For example the total hours of care for those receiving the reablement service were reduced by 41 per cent over the six week period. Amongst the control group there was a small increase in care hours. Sixty per cent of the 90 individuals receiving support reduced their requirement for care hours over the period and almost two thirds required no further support at the end of the reablement period. Those referred from the community showed a greater reduction in care hours (46%) than those from hospital (39%).

Those receiving the reablement service were also positive about it; they were satisfied with the reduction in hours and pleased at the speed with which equipment was provided. The evaluation reports that a common response was that the service had 'allowed them to get back on their feet'. The views of social care staff were also positive, both at the front line and amongst co-ordinators. The need for clarity at transfer to an independent provider was highlighted, a finding common also to the SPRU study. Initial costs of the reablement service were higher, primarily due to increased management input. Further detail would be required on the costs and savings emerging beyond the initial three month period to draw more substantive conclusions on the cost effectiveness of the Edinburgh implementation.

The favourable reports emerging in respect of reablement led to an existing plan for the production by the Joint Improvement Team of an Action Plan for Care at Home being revised to a focus on reablement. In December 2008 the Into the Spotlight conference provided the first national opportunity to discuss reablement and in the course of 2009 many local authorities visited Edinburgh to explore their experience. The Joint Improvement Team started to promote the model around the country, to a variety of responses. Some areas adopted the model wholesale (for example Stirling, East and Midlothian, East Dunbartonshire, Perth and Kinross); others disliked the terminology; others debated the potential for a model more immediately integrated with health. Three partnerships are currently seeking to progress a unified rehabilitation and reablement service.

Whatever the model, those supporting the development of reablement argued that the essential components for any framework were details of the baseline, vision, capacity, process, financial benefits, costs and communication strategy. A series of regional workshops in autumn 2010 have provided details and offered support to partnerships across the country. More detailed engagement will be progressed around details such as the role and involvement of intermediate care, of anticipatory care and of complex care. In progressing the roll out of reablement in partnerships across Scotland, the Joint Improvement Team is taking the lead in transforming one of the most critical areas of support provision.

TELECARE

The Joint Improvement Team has provided the lead for the National Telecare Development Programme, launched in August 2006 with an initial budget of £8.35 million to allocate to telecare development projects across the 32 partnerships. The initial business case was subject to revision in the early months; revised estimates suggested the £8.35 million investment would generate net benefits of £40 million by March 2010. An evaluation of the initial two year programme (York Health Economics Consortium, 2009) introduced quarterly monitoring returns and explored the extent to which the eight objectives of the Programme had been met:

- Reduce the number of avoidable admission and readmissions to hospital
- Increase the speed of discharge from hospital once clinical need is met
- Reduce the use of care homes
- Improve the quality of life of users of telecare services
- Reduce the pressure on informal carers
- Extend the range of people assisted by telecare services in Scotland
- Achieve efficiencies from the investment in telecare
- Support effective procurement to ensure that telecare services grow as quickly as possible.

Despite extended lead-in times in a number of partnerships, positive progress was reported for a majority of partnerships on each of these objectives. Older people had been the main beneficiaries initially, with a recognition of the need to promote and sustain the necessary culture change. Overall it was estimated that an additional 4000 individuals were able to maintain themselves at home as a result of the initial two year programme. Estimates suggested that 137,000 were already in receipt of some form of telecare prior to the Telecare Development Programme.

Further funding of £8 million was allocated to the programme under *Seizing the Opportunity: Telecare Strategy 2008-2010* (Joint Improvement Team, 2008). The £4 million for 2008-9 was allocated on the basis of an assessment within each partnership of the progress to date. Nine partnerships were judged to have made 'slow progress' (and were offered an external review prior to any further funding); 17 to be 'progressing', and six to be 'progressing well'. For 2009-10, partnerships were required to add matched funding to the allocation. Seven core elements for the two years were detailed:

- Extend telecare services to at least 7500 additional people
- Enhance innovation and telehealth/care convergence
- Ensure all aspects of telecare proviso are delivered to recognised standards
- Improve the assessment process for service users that could benefit from telecare

- Provide care staff with the skills they need to incorporate telecare within care packages
- Increase awareness of telecare amongst service users and carers, and the general public
- Identify and contribute to international good practice in telecare innovation and implementation.

Drawing on the reviews of partnerships where progress was slow, support was provided in the form of an action guide (Boddy and Henderson, 2009).

The latest review of the development of telecare (Newhaven Research, 2010) assesses the extent to which the aspirations of *Seizing the Opportunity* have been achieved and the degree to which telecare has been mainstreamed as a result of the dedicated programme. Results from the ongoing monitoring suggest that the funding has provided telecare to an additional 29,000 people over the four-year period, at least 2,000 known to have a diagnosis of dementia. Fifty-five per cent received a basic service (a hub unit with pendant and smoke alarm) whilst 45 per cent received an enhanced package. The review estimates that the provision of telecare allowed 1,500 hospital discharges (target 1,800) and prevented 6,600 hospital admissions (target 3,800) and 2,650 admissions to care homes (target 3,025).

There is a degree of uncertainty associated with such forecasts and assessments. Nonetheless the review provides further estimates: savings of 346,000 care home bed days (anticipated 188,000); 65,000 hospital bed days (anticipated 80,000); 35,000 overnights (anticipated 55,000); and 411,000 home check visits (anticipated 615,000).

With regard to embedding telecare as mainstream within partnerships, a self assessment survey suggests that seven partnerships consider this has been achieved, 20 judge that they have made solid progress, while for the remaining five major progress is still required. A number of demonstrator projects have been developed, three focusing on supporting individuals with long-term health conditions, three focusing on housing and care, and three targeted on an integrated approach to falls and fracture prevention. The housing demonstrators and to a lesser extent the health demonstrator got off to a slow start. Attention has also focused on the future of call handling arrangements and training, on partnership accreditation under the standards framework of the Telecare Services Association (TSA), and on recognition of telecare by the Care Commission, the Social Work Inspection Agency (SWIA) and the Scottish Social Services Council (SSSC) within their respective registration and inspection regimes. Work with telehealth and the Scottish Centre for Telehealth (established 2006 and from April 2010 part of NHS 24) also needs to be aligned. Current proposals focus on support for individuals with COPD in their own homes and on mental health

Overall the review, supplemented by information from an internal report (Joint Improvement Team, 2010), concludes that there are a number of key issues impeding

progress. These include lack of engagement from stakeholders and limited commitment from senior management, lack of integration of the telecare role within other policy agendas, the need for more innovative resource management, and for local performance management systems. Nonetheless almost 60 per cent of local partnerships are reported as having some form of telecare strategy document, 63 per cent of partnerships report ongoing committed capital funding and 78 per cent core revenue funding. A telecare learning network has been established to provide peer support, exemplars from elsewhere, and working groups. The network is co-ordinated from the Dementia Services Development Centre and meets on a quarterly basis.

The developments still to be achieved should not detract from the considerable success of the Telecare Development Programme since its inception in 2006. The Joint Improvement Team has provided vigorous leadership through the Programme Manager and through its chairing of the Telecare Development Board. Co-ordination with the more generic programme in input to a specific partnership can enhance effectiveness. The review concludes:

In sum therefore, a great deal has been achieved in a short space of time. Most local partnerships in Scotland are on the way to delivering telecare as a mainstream service, there are recognised and accepted standards for this service, and increasing awareness of the power of telecare to transform lives as well as working practices. (Newhaven Research, 2010:30)

The achievements of the Programme also underpin much of the ambition of *Reshaping Care for Older People*. A final year of telecare funding of £4 million has now been provided for 2010-11; the aspiration is that following this final allocation telecare will be firmly embedded within core provision.

HOUSING

One of the observations of the most recent assessment report on the telecare programme is the need for further development of the housing role in telecare provision. In terms of housing more generally, the Joint Improvement Team has sought to highlight its essential contribution to the partnership agenda; for one of the Associates this has been their key focus, building from the initial establishment of the telecare programme. A current assessment would be that there are good connections and awareness at a national level. Respondents from the Housing and Regeneration Directorate valued the contributions which had been made to the Wider Planning for an Ageing Population Group - 'we would not have made the progress we have without her input'. This had involved the development of a framework for the housing workstream of *Reshaping Care for Older People* (Scottish Government, 2010), including a summary report for consultation and an action plan. Input from the Joint Improvement Team was

able to act as a catalyst, for example in proposing that housing be included as an element within the Integrated Resource Framework being piloted in Highland.

Outwith the housing demonstrators (West Lothian, Inverclyde and Highland), there has been less systematic engagement of housing at the local level. Further work appears to be needed before housing is seen as an equal priority within local partnerships. This cannot of course solely be the responsibility of the Joint Improvement Team. The role of housing needs to be equally recognised and promoted within national strategies, for example the Dementia Strategy, if it is to generate commitment and investment amongst partnerships.

TALKING POINTS

Another key area in which the Joint Improvement Team has taken a leading role is in the promotion of a personal outcomes-focused approach to the delivery of support. Building on a well-established evidence base detailing the outcomes valued by individuals who use care and support and by unpaid carers, members of the Action Group have led a sustained programme of work designed to embed an approach based on this culture in routine practice.

As outlined on the website, promoting the approach has involved developing a range of tools, guidance and resources in order to:

- Support a focus on outcomes at assessment, care planning and review
- Place the person at the centre of a more personalised approach
- Enable information on service user and carer outcomes to be systematically gathered during assessment and review processes
- Support organisations to use this information to improve outcomes at individual service and organisational levels.

The development of Talking Points has been well documented and a range of background documents can be accessed via the website (for example Joint Improvement Team, 2009a; 2009b; 2009c). These range from the initial work with the early implementers, for example Orkney, Stirling, East Renfrewshire and North Lanarkshire to a range of accessible resources targeted at specific interests. A suite of digital stories has been developed and a Learning and Action Group has been established. There has also been discussion with the Care Commission of how Talking Points and the National Care Standards can be used in tandem.

Work on Talking Points has been ongoing since 2006 and reflects extended and consistent engagement designed to achieve the necessary cultural change that

underpins an outcomes focus. A number of the respondents from partnerships spoke warmly of the support they had received:

‘We were taking a slightly different angle on Talking Points and we wanted to talk it through and make sure that it was in keeping with the sort of spirit of what they were trying to do, and testing it out in an appropriate way... We did an initial discussion in terms of teasing out the sort of purpose and scope of the pilot, and then she came back down as part of a pulling together of the information post pilot. So there was very hands on support at that time around Talking Points... it was the very live sort of input into what we were doing was very helpful.’ (partnership)

COMMISSIONING

Initial work on commissioning by the Joint Improvement Team focused on the challenges of demographic and service forecasting and creating a framework to support the development of joint commissioning strategies by local partnerships based on the ‘Catalyst for Change’ programme developed by the Change Agent Team in England. Detailed workbooks were produced in respect of older people and individuals with learning disabilities (Joint Improvement Team, 2007; 2008), with an extensive range of cost and activity tables for completion. The data requirements for these workbooks were challenging and for many partnerships their use was problematic. The equation of the Joint Improvement Team with a requirement to tackle these workbooks as part of the commissioning process was not necessarily helpful in promoting the identity of the Team, although the workbooks were always projected as being but one part of the process alongside substantial stakeholder engagement activity. More recently specification of two core datasets has been provided: Capacity for Change – Commissioning Effective Services for Older People. Alongside this the Joint Improvement Team was asked to lead work on preparation of guidance for social care procurement in the context of some high profile social care tendering exercises. This intensive piece of work was undertaken with the Scottish Government Procurement Directorate (SPD) and through a stakeholder Reference Group and resulted in substantial official guidance being published in September 2010. The guidance has been well received and the Team is now co-ordinating along with Scotland Excel and SPD a programme to support implementation of the guidance.

The nature of the commissioning process is not necessarily well understood or developed. Although the detailed specification of service provision can be useful, it does not necessarily lend itself to a broader understanding of the inter-related nature of strategic planning and commissioning across the health, housing and social care system. In recent months there has been a shift in emphasis from the Team in their approach to work on commissioning. Specific proposals for the future direction of work around commissioning are currently under discussion, designed to promote a greater

integration between the specifics of local service redesign and the broader strategic context of which these individual elements are a part.

The evolving role of the Team in respect of the commissioning agenda perhaps illustrates in microcosm an ongoing tension in any approach to engagement, the balance between a proactive and a responsive strategy. Seeking to avoid an interventionist approach, the offer of toolkits that assist with immediate demands can open partnership doors. Yet realisation of the need to tackle the interconnected nature of the various challenges may suggest the need for a somewhat more directive approach from Associates and others. If such an approach is attempted prematurely, however, early gains may be negated and progress may be reversed. The performance improvement framework and the focus on outcomes may have assisted with an increasing recognition of the need to plan for the whole system and a greater confidence from the Team in drawing the connections between different strands of activity.

Development of the Integrated Resource Framework with its focus upon the mapping of activity, understanding of local variation and development of the means to deliver effective joint investment decisions has resulted in a revitalisation of partnerships focus upon joint commissioning. Ensuring the close alignment of Joint Improvement Team commissioning work with the Integrated Resource Framework, particularly around planning, service re-design and option appraisal, will be key to ensuring that partnerships receive effective support in moving ahead with their Re-shaping Care plans.

OTHER AREAS

In addition to the areas explored above in the course of the review, as listed at the beginning of this section the Joint Improvement Team has worked across a range of other areas. In order to provide a complete account the following summaries outlining the focus in these areas have been provided by members of the Team.

Intermediate care

Development of intermediate care has included the funding of five demonstrator projects (Fife, Edinburgh, West Glasgow, Perth and Kinross and Borders). Each demonstrator project focused on different aspects of intermediate care and in five very different partnership contexts. A lesson from all sites was the realisation of the lead time and capacity required to change culture, approach and practice.

At least two of the projects had experienced challenges endemic to short-term project funding: difficulties with staff recruitment and concerns about long-term sustainability. This provoked the comment:

'the JIT has always had money to resource new ideas, but we all know it takes a lot more than that to get a new idea going. And I think we had a frustration in X, and I have felt it here, that there isn't the resource from the Joint Improvement Team to have someone just come in and roll up their sleeves alongside you and work with you.' (partnership)

However in general the Joint Improvement Team funding, critical friend support and buddying was valued by all demonstrators - particularly in making connections with other areas and expertise (for example evaluation methodology; use of Talking Points; workforce training and development; and integration across staff groups and agencies using the Capability framework). One of the partnerships has had a peer reviewed article on their demonstrator accepted for publication in the Journal of Integrated Care (Mitchell et al, forthcoming).

Remote and rural

The work of the Joint Improvement Team in this area has focused upon the implications for the delivery of formal health and social care services in remote and rural areas for their geographical location. It has comprised:

- Support to the Remote and Rural Implementation Group programme to ensure effective links with the partnership aspects of service planning and delivery in remote and rural areas
- Scoping of service development and innovation in rural and remote areas
- Review of integrated resource worker role implementation
- Review of out-of-hours services
- Support for guidance on the development of obligate networks in particular the establishment of a mental health obligate network between NHS Orkney, NHS Shetland and NHS Grampian which has been independently evaluated
- Support to the University of the Highlands and Islands/Scottish Agricultural College (SAC) research programme looking at how best to embed evidence-based learning and development of dementia services in rural and remote Council areas
- Support to SACs Knowledge Exchange programme as it relates to health and well-being in rural and remote areas.

The principal objectives of the remote and rural work thus far have been to:

- Ensure a joint/partnership perspective is fully reflected in planning, developing and delivering health, housing and social care services in rural areas
- Investigate, identify and disseminate information about effective and innovative approaches in remote and rural areas

- Support two-way knowledge exchange between health/social care/housing and the rural sector in order to develop greater appreciation of the place-based approaches that are already established in rural policy.

In the context of Reshaping Care and the recently announced Change Fund, future objectives might also include:

- Exploring the particular challenges and solutions that emerge from local partnership initiatives to shift the balance of care in rural areas, with a particular focus upon issues relating to scale, sustainability and integrated, multi-purpose provision
- Exploring the use of the Total Place concept in a rural context in order to build upon the broader rural experience of community development, integrated approaches and alternative delivery mechanisms such as housing and land ownership trusts and social enterprises
- Investigating, identifying and disseminating information about community capacity building in remote and rural areas with a particular focus upon building social capital to deliver improved health and well being and what makes for effective relationships between communities and statutory commissioners
- Support to the Joint Improvement Team's dedicated community capacity building staff through wider programmes and direct support strategic/delivery rural and remote initiatives.

Integrated transport

Since its inception the Joint Improvement Team has contributed to work towards improving transport coordination and making better use of existing transport resources to improve the quality, range and outcomes of services for those who need transport with care. With health and social care provision increasingly shifting from hospitals, care homes and other institutional settings to care in the home and self directed models of support in the community, the role of transport solutions in enhancing people's independence and quality of life has been brought into sharper focus.

Providing safe, efficient transport for older and disabled people is one of the key challenges facing the Reshaping Care agenda currently being pursued in partnership by the Scottish Government, COSLA and NHSScotland. There is a shared recognition of the strategic importance of ensuring adequate access to transportation as key to quality of life and in meeting key outcomes for service users, including being safe, seeing people and having things to do, and an essential element in rebalancing health and social care provision towards people's support needs rather than institutional models, particularly where health and social care settings exist in increasingly dispersed locations. The aim is that people from all parts of Scotland should be able to access safe, reliable and efficient local transportation services where they want, and when it is needed.

The Joint Improvement Team believes there are major opportunities to make better use of existing transport resources to improve the quality and range of services of those who need transport with care. This would take the form of an integrated transport system that cross-cuts public transport and community transport structures as well as health and social care services provided by local authorities and health boards. It would require agreement on a shared, collective vision which makes sense to people across Scotland, and defines how best to put ideas into practice. It also requires sensible and fruitful collaboration where this is possible between different statutory and voluntary agencies on matters like sharing fleets and servicing, routing and planning services. The aim is not only to avoid unnecessary duplication and waste but, crucially, to provide people with the means to access both universal, and health and social care, services leading to the best possible outcomes.

The Team has worked closely with the Scottish Ambulance Service and a number of local partnerships in local pilots to help towards creating local integrated transport with care services in order to optimise resources and create efficiencies.

Experience from three pilots supported by the Joint Improvement Team, the Scottish Ambulance Service, local Councils in Perth and Kinross, Dumfries and Galloway, and the City of Glasgow, working with Passenger Transport Authority partners and community transport providers has shown considerable potential to transform the nature of services through sharing best practice, shared booking and vehicles, integrating services, and partnership working. The pilots demonstrated the need to work with service providers within transport settings and with community services to fine tune and personalise the interface between them, resulting in the potential redirection of available transport resources to the wider benefit of localities. The pilots worked in different ways and in differing contexts – rural and urban, and required different approaches. The results demonstrated that significant progress with good outcomes could be made, alongside releasing capacity within existing systems.

Governance and partnership working

One of the challenges presented in the course of partnership support programmes has been effective partnership working itself. As a result of this, one of the themed areas the Joint Improvement Team has focused on is Governance and Partnership Development. Specific support has included development work with partnerships to assist them in arriving at the best structural solutions for them, or in identifying actions necessary to achieve more effective working from existing partnerships. This has also included, at times, providing more ‘hands on’ support in implementing solutions. The Team has also responded to specific requests from partnerships in providing information and supporting development events on a range of topic areas to assist partnerships in meeting partnership challenges and in achieving the most effective future arrangements.

The Joint Improvement Team has reviewed the evidence base on partnership working referred to earlier and developed a series of 'briefing notes' for managers and practitioners aimed at helping members of health, housing and social care partnerships to understand and apply the evidence of best practice in partnership and as a tool for development. The notes are short and practical guides, with review questions for each section to help in applying the main messages to individual partnerships. The Notes have been externally peer reviewed by Professor Bob Hudson of the University of Durham.

In addition, support in the development of Joint Performance Frameworks has been provided to some partnerships, resulting in the provision of a focused development programme which can then be offered to other partnerships. To assist some of this work, the Team has also developed POPIT (Partnership Outcomes Performance Improvement Tool), a four section self-assessment tool designed to support partnerships in assessing their readiness for outcomes based performance improvement which is supported by further resources and which is also used to inform development events where appropriate. Increasingly the Team can be called upon to play a role in a diverse range of initiatives, most recently the dementia demonstrator projects and the releasing time to care programme.

SECTION FOUR: IMPACT

Evaluation of the effectiveness of support delivery to complex organisations, the core business of the Joint Improvement Team, presents significant challenges for attribution of impact. Is it possible for example to identify that it was the input of a particular element of partnership support that led to successful implementation of a specific strategy. Likewise, however exemplary the external input by way of advice or mentoring, factors internal to the local partnership may preempt the achievement of a specific objective. A pragmatic approach has to be taken, making judgments and attributions on a 'most likely' basis and acknowledging that certain factors are outwith the control of the Team. A further consideration is that many of the goals of partnership working are both long-term and ill-defined and more immediate and surrogate measures may be appropriate. This will have an obvious influence on the rating of impact in the PEAT scores.

Notwithstanding these caveats, a number of observations can be made in terms of impact. Firstly there are the questionnaire responses from individuals in the three groups as detailed in the table below.

'In your opinion what impact has the JIT had on your area of work ' 1=no impact; 5=a very high impact

	1	2	3	4	5
Partnerships (n=29):					
The challenges faced by your partnership in delivering quality services + improving outcomes for service users	-	10%	35%	38%	17%
Achieving and sustaining external targets set by quality or scrutiny bodies and/or the SG	7%	7%	41%	38%	7%
Governance and accountability arrangements within your organisation/partnership + the relational aspects of partnership working	-	17%	38%	38%	7%
Cost savings or efficiency gains for your organisation /partnership	7%	38%	42%	10%	3%
Themed work (n=8)					
In your opinion what impact has the JIT had on your area of work	-	-	38%	38%	25%
SG (n=8):					
In your opinion what impact has the JIT had on your area of work	-	25%	25%	25%	25%

These tend towards the upper end of the scale and suggest that the perceived impact on their work or on various aspects of the partnership operation is not inconsiderable.

Some indication of impact has also been given in terms of specific areas of activity in the previous section. The Joint Improvement Team has been the major player in promoting both reablement and telecare, initiatives already demonstrated elsewhere to be cost effective in terms of outcome delivery. It is likely that these examples of broader cost effectiveness are not necessarily reflected in the responses given to the category of 'cost savings or efficiency gains' above which are likely to focus on immediate local elements. The Joint Improvement Team has also taken a key role in progressing an outcomes-based focus and in working with partnerships to understand the process that underpins a Talking Points approach. They have worked to resolve particular partnership challenges in a number of areas and can point to the development of specific integrated frameworks and governance arrangements.

Perhaps most dramatic, given the initial impetus for the Team, has been the continuing reduction in delayed discharge figures. Figure 1 on the following page from the latest quarterly review of the figures is included to demonstrate this visually. Delayed discharge numbers had already been halved by the time the Team was created and therefore the Team cannot be credited alone. Nonetheless the figures have continued on a steadily downward trajectory over the ensuing period, with zero returns for the first quarters of 2008, 2009 and 2010.

A particularly positive respondent provided an overall summary:

'I do not know of any other Scottish Government department/agency which has made such an impact on change and outcomes for service users or staff which has been sustained. The leadership and structure of JIT is an exemplar. The JIT is also providing national leadership with Talking Points, telehealthcare and Reshaping Older People services and has a UK excellent reputation in these fields.'
(partnership)

Another comment reflects on the complexity of the challenge that underpins the role of the Joint Improvement Team, one where impact is recognised in decades rather than years.

'A fundamental seismic shift towards genuine strategic planning, sharing of resources and service delivery between the NHS and local authorities still hasn't been achieved, despite the JIT's best initiatives on integrated resource frameworks and supporting local development activity within partnerships etc. One could argue that suggests the JIT hasn't worked, but that seems to me a harsh conclusion. Cultural and system change of that nature is a massive and complex challenge, and ultimately unless Scottish Government Ministers are willing to move towards greater

use of pooled budgets between the NHS and local authorities based around mutual accountability for the delivery of shared outcomes, with penalties for non participation and under achievement, the JIT will always face an almost impossible task. Any assessment of progress or weaknesses has to be set against that background and, on that yardstick, they have chipped away at the mountain face to significant and useful effect.’ (SG)

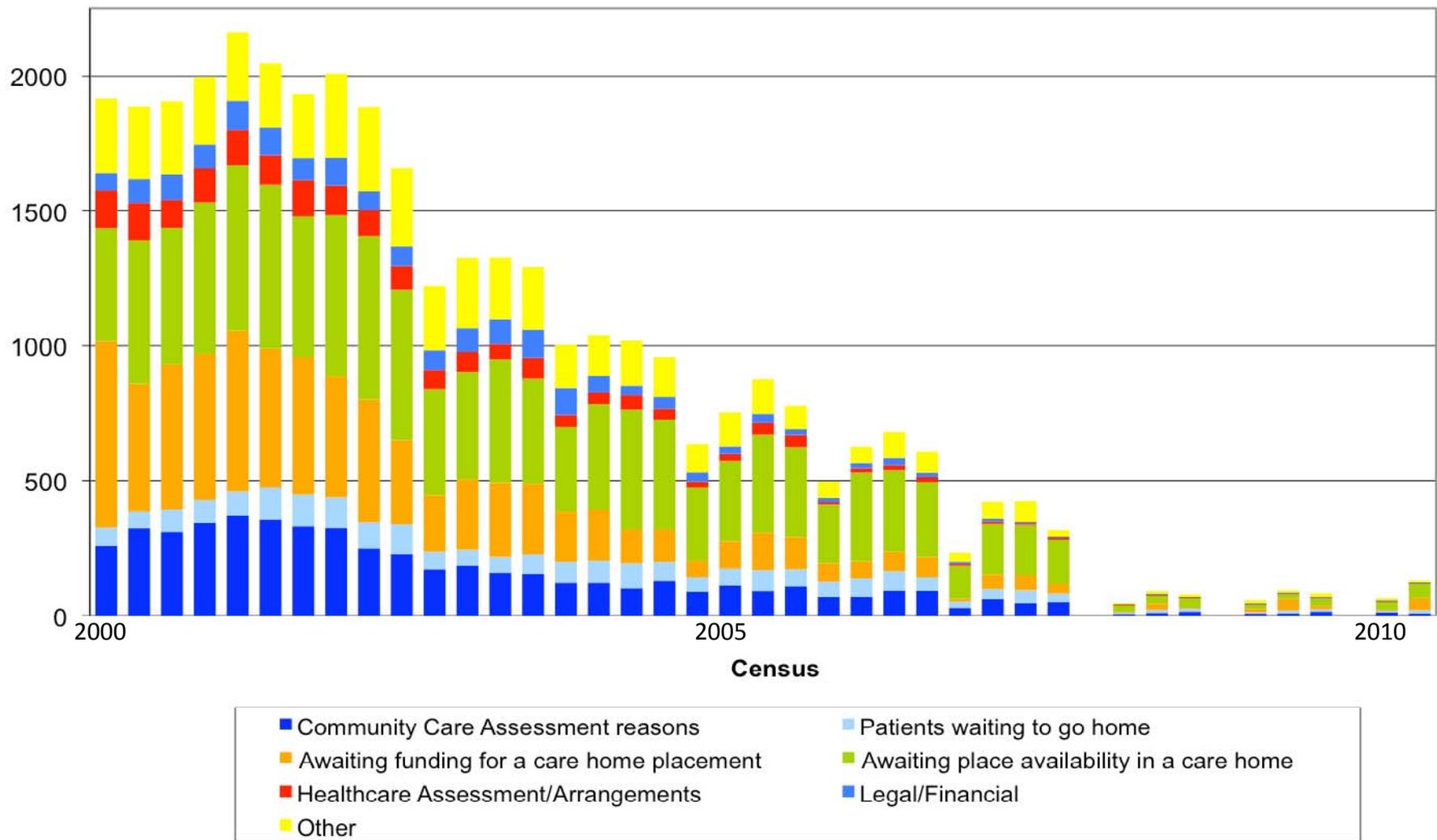


Figure 1: Delayed Discharge Figures Sept 2000 to Oct 2010

Source: ISD

SECTION FIVE: LOOKING FORWARD

It is useful to characterise the Joint Improvement Team as evolving through three phases. Phase one was the initial response to the trigger of delayed discharge, while phase two has been the recognition and implementation of the whole partnership response. Phase three will take the Team forward following the internal Shaping Up review completed within Scottish Government. The options outlined below derive from discussion with interview respondents on their ideas for future identities for the Team and from the scenario discussions with the 'futures group'.

This group worked around four 'straw dog' options, designed through the discussion of positives, negatives, challenges and issues to identify preferred activity for the future three to five years. The emphasis was primarily on the focus for the work of the Joint Improvement Team rather than the specific structures or governance within which it should be located.

Scenario A suggested a focus on generic features of partnership working, embracing for example children, equalities and well-being agendas. Considered a big change in role, potential positives of this scenario were the opportunity to be an external catalyst at planning level; the provision of a one-stop shop with a consistent overview; the opportunity to act as a refreshing perspective or driver; and being valued from being close to the real issues. A negative was the potential to be spread too thinly. Particular issues included who would act as commissioner or lead agent and considerations of objectivity and governance.

Scenario B posited a focus for the activity of the Team around Reshaping Care for Older People. The positives identified for this scenario were its imperative as a key national challenge; the building on existing work in terms of relationships and expertise; the depth, breadth and coherence of the older people's agenda, of a significance to merit a core focus; the opportunity to bring a focus on partnership to the themed areas of the Reshaping Care agenda; the style and approach to change management; and the opportunity to frame Reshaping Care to have wider applicability and benefits. Conversely, the identified negatives included the potential to lose focus on other elements and aspects; themed approaches having wider applicability which could be lost to other areas; concentration on those over 65 would exclude those under 65 living in deprived communities for whom there is a big partnership agenda; and potential impact on the skill mix. Challenges that were highlighted included 'spreading the jam too thinly'; losing the focus on partnership working between the NHS and local authorities; embracing the wider agenda of older people and long term conditions; and coherence with other improvement services and agencies.

Scenario C offered the prospect of a focus on promoting themed work, currently for example telecare, intermediate care, Talking Points, but identifying similar opportunities in the future. Positive aspects identified for this option included it being easier to locate expertise, and operating as a mechanism to highlight best practice. More negatively it could re-enforce and repeat silo behaviour. Potential

challenges include balancing agendas and priorities, and marrying the ‘big picture vision’ with developing delivery mechanisms.

Scenario D focused on trouble-shooting in local partnerships and building local capacity. Positives from this scenario included the opportunity for a more targeted, bespoke focus; the response to locally identified need and locally identified projects leading to more acceptance by partnerships; the potential for short pieces of work on a ‘pick and mix’ basis; and a more effective link up with other Scottish Government areas. More negative was the reactive nature and the likelihood of ‘short-termism’; being driven by government; the label of trouble-shooting rather than continuous improvement; the potential for fragmentation with ‘too many irons in the fire’; and the danger of diluting the approach from being a change agent for the whole system. Challenges could include how to frame the trouble-shooting role; the danger of doing too many different jobs; and any potential conflict between the role of the Joint Improvement Team as ‘expert’ versus its role in collecting and disseminating knowledge and intelligence.

The function of these particular scenarios was to act as a trigger for debate. Those participating in the futures exercise selected different options in terms of a range of indicators, for example most feasible (B), most complex (A), most responsive (C), most effective (B), most flexible (A), and most impact (B).

FUTURE CONFIGURATION

In considering the future configuration of the Joint Improvement Team, a number of key questions can be identified in addition to the primary focus for the work. These include:

- is the Joint Improvement Team best located within Scottish Government?
- what is the relationship between the Joint Improvement Team and the other improvement agencies?
- how might the Joint Improvement Team relate to the new regulatory agencies?
- is the current workforce structure of Associates and Action Group the most appropriate?

Related agencies

The Improvement Service (IS) is a partnership between CoSLA and SOLACE (Society of Local Authority Chief Executives). Established in 2005, it has the strap-line ‘supporting Scottish local government and its partners to deliver better outcomes for communities’. It plays a lead role in respect of the Single Outcome Agreement. It differs from the Joint Improvement Team in being located independently outwith a central or local government department. The Improvement Service occupies common territory in working with local authorities and their partnerships, albeit usually with a broader focus than health and social care integration. Nonetheless,

‘it raises an interesting question of the degree to which the issues within social care are issues of leadership, culture, system architecture and design, that are not actually dissimilar to issues that arise within economic development, children’s services and so on, and whether a broader approach to a council and its partnerships is one way in...’

From the perspective of the Improvement Service, the Joint Improvement Team operates as a policy driver within a division of government, ‘an internal driver within the health system’.

‘I think they have done some both original and important work, but I think they do it within the parameters of the system as designed and policy as designed, and don’t seem to step outside that. So for example they have done interesting things around how we empower clients, how we get personalised budgeting and so on – but it has reflected, I think, a fairly cautious Scottish stance on that in comparison to what has happened down south.’

This comment appears to underestimate the extent to which the Team has led on initiatives such as telecare and Talking Points which have been key in focusing on improved outcomes for individuals.

The nearest equivalent to the Improvement Service for health is the Improvement and Support Team located within the Health Delivery Directorate of Scottish Government. This leads on supporting the delivery of national improvement programmes that support the HEAT targets. Current priorities include the Long Term Conditions and Mental Health Collaboratives, the National Efficiency and Productivity Programme, the Lean Transformation Programme and the 18 Weeks Service Redesign and Transfer. JIT is working in collaboration with IST in relation to Long-term Conditions, Releasing Time to Care (community services) and Dementia Demonstrators.

Respondents were asked to reflect on how the role and contribution of the Joint Improvement Team fitted with these and other improvement agencies. With only one or two exceptions, people favoured the distinctive partnership identity of the Joint Improvement Team and recognised its value in bringing together CoSLA, Scottish Government and NHS Scotland – ‘the other bit of the Joint Improvement Team that I think works well is that it instils a level of confidence from all of the partners – so Scottish government, local authority community, but also the NHS’ (cognate agency). Preference for the facilitative approach of the Joint Improvement Team was also reiterated.

‘I have also experienced the teams that come in, I’ve had experience of the waiting list hit squad coming in from Scottish government and that wasn’t a particularly pleasant experience, because they had a very – when I say “hard approach”, I don’t have a problem with hard approaches, but there wasn’t so much of a kind of coaching, evidence-based, mentoring, facilitative approach – it

was more about “well we’re in because you have got a problem – this is what you have got to do – just go away and do it and we will be back in two weeks and see how you are getting on”.’ (partnership)

There was also a common assessment that the Team would lose considerable leverage if it were to be located outwith Scottish Government. The opportunity to be able to link to agendas internally but at the same time be able to retain an element of independence was regarded as invaluable – ‘having the authority of Scottish Government without being constrained by the usual limits of convention’. It was also acknowledged that at times the Team could be used as a conduit for asking questions internally.

‘I think the partnership focus is vital and the partnership focus probably within St Andrews House, I think that’s important that we keep that basic structure where you have the Joint Improvement Team supported by government, sponsored by local government, national government and the NHS, but make sure that there is a foot in all of those camps to learn. So that basic structure, that basic relationship I think must continue to be respected. So in other words, if the Scottish government decided “well let’s fire this out as some sort of independent”, I don’t think that would be nearly as effective.’ (cognate agency)

There was however a recognition of the need for the Team to engage with emerging structures, for example HIS (Healthcare Improvement Scotland) and SCSWIS (Social Care and Social Work Improvement Scotland).

CONCLUSIONS

‘JIT has a key role in changing and challenging times, a rare if not the only arena for mature and meaningful debate that ensures best practice is supported in a value driven context.’ (partnership)

Reflecting on the interviews with a range of respondents and drawing on elements from earlier in this report a number of conclusions can be drawn. These will then be translated into potential recommendations for future development.

- The Joint Improvement Team has established a model of intensive partnership support across health, housing and social care which is highly valued by partnerships for its facilitative and enabling approach. The model can be resource intensive in terms of the extent and duration of engagement but appears to be effective in terms of embedding the learning within the partnership.
- The support received by partnerships has been very effective in driving down the delayed discharge figures over the last decade from over 2000 individuals at the peak to on recent occasions near zero.

- The Team has led on a number of key innovations, most particularly telecare, reablement and a personal outcomes-based approach, which have the potential to transform the provision of support.
- The creation of the Team as a three-way partnership between Scottish Government, CoSLA and NHSScotland both provides a powerful governance structure and facilitates communication with the essential stakeholders.
- The creation of a highly experienced group of Associates, each well grounded in the experience of partnership working, has provided a skilled resource additional to the core team members and well respected by partnerships.
- Action Group members have contributed in different ways to themed and partnership work, some taking a key lead role, others having only occasional input. The range of backgrounds and skills amongst Action Group members provides a rich resource to support and develop capacity within partnerships.
- The calibre of leadership provided by Mike Martin is widely recognised; the need to ensure such leadership is replaced following his retirement was highlighted by many respondents.
- There is little appetite either for merging the Joint Improvement Team with other bodies such as the Improvement Service or Improvement Support Team or for moving the Team outwith its Scottish Government location. There is however a lack of awareness and some inaccurate perceptions within some parts of the Government as to the role and functioning of the Team.
- The focus for much of the work of the Team can be considered to be driven by current policy directives, facilitating partnerships to respond to the priority agendas relating to outcomes and integration. This may be perceived as overly constrained - 'it is about here and now problems rather than "where the hell are we going"'. However, the JIT has promoted a number of strategic developments including Telecare, Talking Points (Personal Outcomes Approach) and the Reshaping Care for Older People Programme. The recently issued Change Fund Guidance provides an opportunity to support partnerships over the longer term alongside shorter term improvement priorities.
- There is a tension in providing intensive partnership support between focusing on specific elements and looking at the broader strategic framework. To some extent a similar tension is replicated within the operation of the Joint Improvement Team itself, responding on demand to particular requests or working to a more strategic plan.

SECTION SIX: RECOMMENDATIONS

The following recommendations are put forward as a result of this review.

- A body known as the Joint Improvement Team should continue; it is an identity widely valued by local partnerships and offers a unique model of support.
- The tri-partite sponsorship by Scottish Government, CoSLA and NHSScotland should also be retained and the Team should retain its location within Scottish Government and build on established links with COSLA. The Team should take steps to raise greater awareness of its activities within other Divisions and Directorates of Scottish Government and to develop internal alliances and champions.
- The structure of core team members, Associates and Action Group should be retained. However the numbers in the Action Group should be limited and should be restricted to individuals contributing to partnership or themed work on a regular basis. Those with a less substantive input can be directed to interest groups and communities of practice.
- The Team should continue to adopt an enabling role of 'critical friend'. It should however seek to proactively engage partnerships facing challenges who do not seek support on their own initiative.
- The experience and expertise of the Team should be used to promote and develop integrated and outcomes focused care and support with local partnerships including supporting the delivery of the Integrated Resource Framework, lead commissioning and integrated working arrangements. The Team should also contribute to work around shared services.
- For the next few years the Team should adopt the mantle of Reshaping Care for Older People and related work as its leading focus. This does not necessarily preclude the application of generic principles to other areas of partnership working but having a robust core identity is of major importance both practically and presentationally.
- The Team should continue seeking to raise the profile of the role of housing alongside health and social care, both within local partnerships and across national agencies.
- The Team should capitalise on its knowledge and experience in translating an outcomes-focused approach into practice and should seek opportunities to embed this knowledge within other improvement agencies.
- At the same time it is suggested that the Team should continue to take the initiative on promoting future models of working, creating new ways of working rather than solely responding with existing practice.
- JIT should build on work underway with other Improvement Services and Programmes, such as Releasing time to Care and dementia demonstrators, to ensure a coherent approach to improvement support and effective use of resources and expertise.
- Greater attention should be paid to locating the individual partnership and themed work within a coherent strategic framework. This is not in any way

to recommend the introduction of increased bureaucracy; rather to ensure that engagement with projects and partners remains focused and targeted.

- Consideration should be given to adopting new technologies, both to reduce the need for extensive travel and to share knowledge and experience across partnerships through the development of networks.
- Careful succession planning is needed to ensure continuation of the political and strategic leadership that has contributed to the achievements of the Joint Improvement Team.

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APPENDIX

Action Group responses

	Challenges	Solutions
Communication	No induction; working out the JIT structure	Managed induction; information sheets; contacts
	Communication	Communication strategy required – regular, committed, managed; circulate presentations, materials, minutes; members only section of website for info, questions; community of practice; knowledge sharing amongst the AG
	Keeping up to date within the AG	Monthly e-mail bulletin; regular lists of new policies and strategies; better use of website; ensure right people get updated on-going projects
	Maintaining contact with other JIT colleagues; personal and professional support	Create ‘critical friendship partnerships’ for AG and Associates
	Language – people meaning different things by terms such as anticipatory care; use of acronyms	Ensure use of consistent definitions across JIT and other departments
Engagement	Securing the time and space when partnerships have multiple priorities; fatigue of partnership	Link work clearly across main streams eg Reshaping Care
	Lack of clarity re role	Guidance on how to ensure good engagement with partnerships: role clarity; reporting arrangements; supervision/support
	Getting the right people involved	Giving the AG member locus to identify/follow indicated priority
	Managing expectations at partnership level	Clear but flexible brief; focused and time limited; clarity about exit strategy
	Defining the breadth and scope of work – mission creep	Create time for discussion and debate; create outcomes focus for JIT activity and review/check back
Operation	Appearing competent/legitimate; having authority/mandate with the partnership	Matching the AG member with needs of the partnership; tolerate uncertainty of role
	Balance between supportive input/facilitation and providing additional resources	Ensure partnerships are fully aware of the role of AG member
	Managing pace and timescales	Ensure initial scoping and time to agree outcomes and timescales
	Letting go of initial work to others	Ensuring roll out and general

		ownership eg Talking Points
	Exit Strategies	Flexibility is positive; review and evaluation is a shared responsibility; alternative media to support improvement
	Time for joined-up working agenda and approach	Support for early tie-in with key local partners
	Organisational learning from the AG experience	AG forum – influence policy direction
	Use and distribution of feedback	More info on evaluations
	Dealing with conflict and personality differences; local politics	Leadership input; more formal opportunities to discuss issues
	Competing pressures for AG members between JIT and 'home job'; pressures on home organisation could lead to reduction of AG resource	Articulate personal development benefits that are also of value to the organisation
Utilisation	Extent of use of AG members	Ensure opportunities to all are available as appropriate; encourage links between leads for work and appropriate AG members