

Changing times

Improving services for older people

*Report on the work of the health and
social care change agent team 2003/04*



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Social Care Change Agent Team 2003/04*

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Foreword

a service user's story

“My mother, Margaret Alice Parker, is 86 and in 2002 lived alone in a warden-controlled property. She was very frail, with poor mobility as a result of arthritis, and walked with a stick.

In April 2002 Margaret fell and cut her head. Prior to her fall her state of mobility and general health and well-being had been deteriorating – she wasn't eating as well or moving about as much as she had been. She is rather stubborn and wouldn't rally or listen to me encouraging her to eat and move about more.

As she lived in a warden-controlled property, she called the warden using the signal cord. The warden called the paramedic team who responded within five minutes, followed almost immediately by two rapid response nurses. She was taken to the local hospital A&E department. Within the hour she had been stitched and given a thorough medical examination, and was then kept in hospital for a further five days and monitored.

On discharge from the hospital she was assessed as needing a period of rehabilitation to enable her to return home to live independently. She was moved to a nursing home near her home for two weeks rehabilitation.

I visited my mother daily and have no complaints about the standard of care she received. Unfortunately, as my mother's state of health has now deteriorated, I am not able to ask her how she personally felt about the experience.

However, she did settle well into the nursing home and made steady progress back to better health. With their support she became more mobile, was encouraged to eat to build up her strength, and appeared relaxed and comfortable there.

When she was fit enough to return to her home, she was provided with various apparatus by the occupational therapy team, which included a Zimmer frame, food trolley, kettle swing frame and toilet aid frame, all of which enabled her to maintain her independence in her home.

I cannot speak too highly of the rapid response system which operates in this locality – had it not been for them and the warden control system she might not have been here today.

The support and care she was subsequently given in the nursing home enabled her to return to sufficient mobility and state of improved health, both physically and mentally, to return to live independently at home and was 'stronger' than prior to the accident in many ways.

Unfortunately, my mother's health has now deteriorated to such a level that she has recently been accommodated in residential nursing care. I believe, however, that if it had not been for the rehabilitation care she received the year before, she would not have been able to return home following her fall in 2002."

David Parker

2004

Introduction

2002

“Given its newness, we were not able to assess the impact of the Change Agent Team but we welcome its establishment. Its findings will need to be widely disseminated at the earliest opportunity.....”

**Health Select Committee,
Third Report of the
Session 2001/02 on
Delayed Discharges**

This is the second annual report of the Health and Social Care Change Agent Team (CAT). It sets out the work carried out by members of the team, our associates and expert group members in 2003/4. It is meant to be a useful source of practical information and examples of ‘what works’, not just a historical account of past activity.

In our first year we based our initial work on the premise that delayed discharges happen when services fail to provide people with the right care, in the right place and at the right time – for most organisations, tackling delays by simply trying to ‘hit the target’ is to miss the point. Neither are ‘quick fixes’ the answer, hence the emphasis we have placed on providing practical help to assist all parts of the local system achieve sustainable improvements in services. What is significant about Margaret Parker’s story is how different parts of the health, social care and housing sectors together made it possible for her to return home and live independently for as long as possible.

2004

“The approach and achievements of the Change Agent Team provide a powerful endorsement of what can be achieved through a managed, properly resourced and skilled support team.”

*All Change Please:
Evaluation of the Change
Agent Team, Melanie
Henwood, February 2004*

In most places, older people are the biggest users of health and social care services – we include some of their experiences in this report. They are the ‘core business’ of the NHS and this means that getting it right for older people means getting it right for everyone. Our work to help local organisations achieve this, and the values which underpin it, have borne fruit in our second year. The independent evaluation of our work to date has shown that:

- 90% of organisations judged that CAT had been helpful;
- In more than half the sites, the help turned out to be better than expected;
- More than 80% thought that the change achieved would be enduring (reflected in continuing local and national progress in sustaining reductions in delays);
- The continuing support provided by CAT – not simply arriving, delivering a report and moving on – was highly valued by organisations.

In summary, in 2003/4 we have:

- Worked with a further eight health and social care communities, involving a total of 15 councils, 29 PCTs, 20 hospital trusts and 6 other trusts;
- Delivered a dedicated programme to support the introduction of reimbursement under the Community Care (Delayed Discharges etc) Act 2003;
- Produced a further range of development and support products on commissioning and other good practice themes;
- Begun to plan and implement new work on supporting improvements in mental health services for older people (jointly with the National Institute for Mental Health in England) and establishing a new learning and improvement network on better commissioning; and
- Contributed to 67 national and regional events, and directly organised 24 events

We have now begun our third year of work, based on a broader remit to support the implementation of wider aspects of the National Service Framework for Older People, working closely with the National Clinical Director, Professor Ian Philp. The recently published NHS Improvement Plan, with its fresh focus on supporting people with long term conditions, public health and new thinking about the future of adult social care services, reflects many of the issues with which CAT has already begun to grapple in its third year, for example, our work on the contribution of community hospitals, the development of extra care housing and telecare.

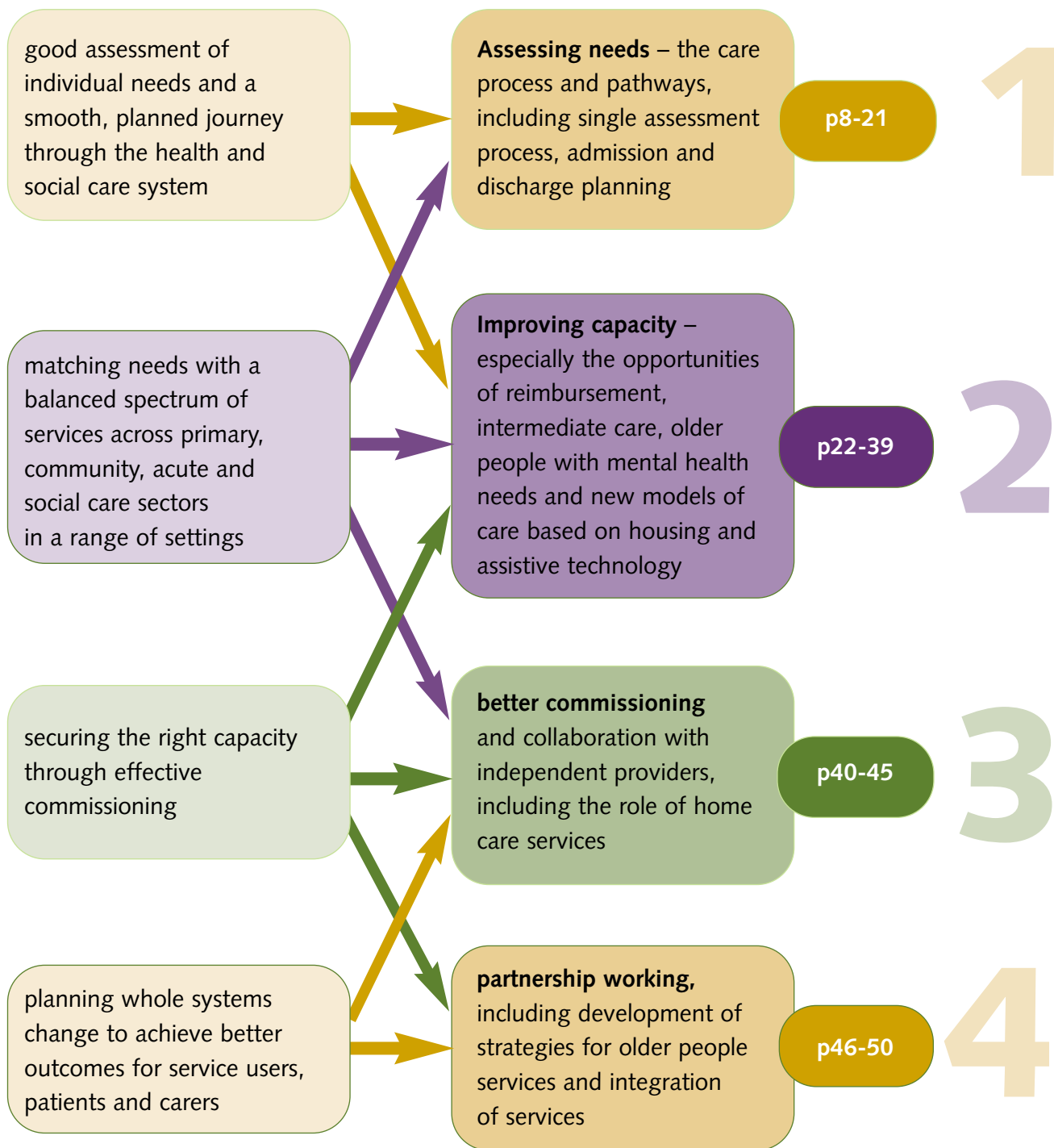
Helping to translate policy into practice – as experienced positively by service users, patients and carers – has been a distinctive feature of our expertise; we want to be even better in 2004/5.

Richard Humphries

Director

The right care in the right place at the right time – what the Change Agent Team has done

During 2002/03, the Change Agent Team's work on reducing the numbers of people delayed in hospital involved working across health and social care organisations, looking at how partnerships work at the very top of organisations, as well as how the processes work for the individual patient. Integration has been a common theme, with a particular concern as to how mental health services for older people are integrated with general hospital and community services. CAT has focused on commissioning services, especially with the independent sector, and on services that offer an alternative to acute hospital care, such as intermediate care and extra care housing.



1

Assessing needs: The care process and pathway

“Five days later I was contacted by an occupational therapy assistant who enquired if I was managing OK. I explained about my difficulties and she arranged for me to have a trolley with wheels. ...She apparently knew all about my home circumstances, but how she came upon this information I do not know, as neither myself nor my husband were party to any such discussions.”

Ina Acres, service user
(See Appendix E page 75 for the full story)

The single assessment process

The single assessment process (SAP) is one of the requirements of the National Service Framework for Older People (standard 2 – person-centred care). The aim is to ensure that older people's needs are assessed and evaluated fully, with professionals sharing information appropriately and not repeating assessments already carried out by others. This requires a high degree of mutual trust, robust systems for information-sharing, and a clear understanding of respective roles and responsibilities.

The service user must be at the centre of the assessment, contributing fully to the gathering of information and the formulation of the care plan. A crucial element of SAP is the development of shared information systems. Ideally these should be electronic, and local systems must ensure that SAP is included in the local service provider's specification under the Department of Health national programme for IT. However, systems should not lose sight of the fact that the key principles of SAP hinge on how people work together and communicate with each other around individual older people.

What works

- Involving the user/patient fully throughout the process to develop a care plan that is needs-led rather than service or professional-led;
- Open communication and sharing of information with all organisations involved, with the user/patient's consent;
- Having agreed information-sharing protocols in place;
- Shared notes – that is, one single set of notes that everyone involved uses;
- User-held notes/summary/care plan. This does not always need to be the full medical notes. A suitable summary and care plan with all the relevant information on it is often enough to start with – we've found that patients like this;
- Integrating SAP into arrangements for supporting people with long-term conditions (chronic disease management) and

preventive programmes to ensure appropriate and timely exchange of information;

- Using SAP in conjunction with a reimbursement Section 2 Notification to identify the likely needs of the patient and to ensure that assessment against the criteria for NHS-funded continuing health care is carried out before the notification is sent.

Examples of good practice

In **Bedfordshire** and **Luton**, person-held records have been developed, initially as a mechanism for sharing assessment information, but now as an inclusive style of working, which is appreciated by users. Older people are encouraged to take their record with them to GP and hospital appointments. The ambulance service is charged with ensuring that the record accompanies the user in any emergency attendance at A&E, potentially helping avoid unnecessary admissions.

For further details contact: Alan Armitage, Bedfordshire County Council social services department, at alan.armitage@bedscc.gov.uk

In the **West Midlands** an effective regional group is working across three strategic health authorities to achieve co-ordinated and collaborative implementation. Together they have funded and produced a SAP training video, developed a joint approach to working with the local provider for the national programme for IT, and are producing a set of cross-boundary agreements.

Contact: Angela Nichols at angelanichols@wrath98.freerserve.co.uk

In **Hertfordshire** an interim system has been developed, pending electronic information sharing, for 'flagging' when an assessment has been started in one part of the system, so that other professionals know that they do not need to start from scratch, and to avoid information already available being sought again.

For further details contact: David Robinson, Hertfordshire County Council adult care service, at David.Robinson@hertscc.gov.uk

What CAT has done

Since our inception, we have promoted the single assessment process (SAP) as fundamental to achieving the genuinely person-centred care and integrated services envisaged in the NSF for Older People. It became clear during 2003 that localities were at very different states of readiness for implementation of SAP in April 2004. Recognising the professional and practical challenges involved, CAT was engaged to work closely with Department of Health colleagues and other experts to develop and extend the range of practical support available to help localities achieve workable implementation for the April 2004 milestone and beyond.

This support programme has included:

- Five regional roadshows offering information updates and implementation workshops;
- Follow-up 'surgeries' for organisations which wanted to discuss their particular issues and concerns;
- A revamped and updated SAP website with further checklists and advice, including an extended question and answer section;
- Learning and development materials including examples of SAP protocols and good practice, provided on the website through a resource base commissioned from the Centre for Policy in Ageing;
- Advice from a business analyst on issues related to information-sharing, IT solutions and the relationship with developments in the national programme for IT;
- Development work on-site in some localities; and
- Sponsorship of projects to develop good practice for dissemination.

Where to find out more

The Department of Health has details of SAP at www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/SingleAssessmentProcess/fs/en

In order for SAP to be implemented effectively, it is essential that localities can share information about good practice. The Department of Health has commissioned the Centre for Policy on Ageing (CPA) to collate these examples of good practice, and other useful reference materials about SAP. CPA has a website which exclusively holds documents about SAP – go to www.cpa.org.uk/sap. This has been

found to be extremely useful, both as a reference point for materials on SAP, and as a focal point for discussions about SAP implementation.

Developing care pathways

Care pathways are a way of demonstrating how well systems work – or don't work – together. Care pathways have traditionally been developed to describe the journey of a patient with a specific condition through a system, or a part of it, as they sometimes neglect to make the vital connection with the next step in the journey when care transfers to another organisation.

Care pathways can be a means of jointly agreeing an ideal service and identifying gaps in the current services, or, for more operational purposes, to ensure that people move smoothly from one part of the service to another. They can be based on specific conditions, such as stroke or fractured neck of femur, and set out the anticipated milestones for the patient and professionals working with them.

What works

Developing a care pathway needs to include:

- Representatives of staff working at all levels in the organisations involved, including GPs, hospital doctors and the independent sector;
- Involvement of ambulance transport and housing services;
- Representatives of people using the system, including carers;
- Clear agreement at the outset of the purpose of the care pathway;
- Individual groups to tackle sections of the pathway, which can then be brought together;
- Links to the Older People's NSF local implementation team;
- Follow-up of the initial work to develop the detail;
- Feedback to all the contributors;
- Incorporating the findings into strategic frameworks and local development plans.

Examples of good practice

The **Dudley** health and social care community has developed a discharge care pathway which has been thoroughly road tested by frontline staff to ensure its practicality.

For further details contact: Tony Ivko, Dudley directorate of social

"My experience of the emergency services was very good. The ambulance arrived quickly and I was given pain relief immediately. I was seen very quickly in A&E and constituted a 'trolley wait' for only an hour or so while a porter could be found to take me to the ward. I had my operation the next day and even watched it on TV."

Ina Acres, service user

services, at tony.ivko@dudley.gov.uk

In **Sheffield** a care pathway for falls has been developed, with accompanying patient information and assessment forms.

For further details contact: Rosemary Lawson, Sheffield South West PCT, at Rosemary.Lawson@sheffieldsw-pct.nhs.uk

In **Northumbria**, one of the stroke beacon sites has created both an acute and community multi-disciplinary pathway, including patient-held records and patient/carer educational support.

For further details contact: Norma Tindle, Northumbria Healthcare NHS Trust, at Norma.Tindle@northumbria-healthcare.nhs.uk

Boston Pilgrim Hospital, part of United Lincolnshire Hospitals Trust, has developed care pathways for elected orthopaedic (neck of femur) surgery, which have resulted in patients receiving a pre-assessment visit, a three to four day hospital stay and then being moved to intermediate care – either at home or within another care setting.

For further details contact: Alison George-Jones, United Lincolnshire Hospitals NHS Trust, at alison.george-jones@ulh.nhs.uk

In **Cornwall** and the **Isles of Scilly** a shared care pathway for people with dementia has been developed by Cornwall Partnership NHS Trust and Cornwall social services using health action zone (HAZ) funding. The pathway is a guide for professional and care staff, service users and carers. It stresses a needs-led person-centred approach and the need for ongoing objective assessments. There is an active training programme which, so far, has concentrated on health and social care staff. It is intended that the pathway will form a central part of other training programmes.

For further details contact: Mike Langshaw, Cornwall social services, at mlangshaw@cornwall.gov.uk

Stroke Northumbria is one of the stroke beacon sites and has created both an acute and community multidisciplinary pathway, including patient held records and patient/carer educational support.

Contact Norma Tindle at norma.tindle@northumbria-healthcare.nhs.uk

What CAT has done

CAT has used the approach outlined above with health and social care systems across **Dorset** to develop a generic view of older people's services, identifying what needs to be in place to ensure that patients and users move smoothly from one service to another.

In **Bolton** we have helped health and social care organisations to review their discharge planning processes and develop a discharge care pathway.

In **Hertfordshire** we have funded a post to co-ordinate discharge planning and build on the work carried out in orthopaedics to review the care pathway through a process redesign event.

For further details contact: Mary Jamal, Watford & Three Rivers PCT, at mary.jamal@watford3r-pct.nhs.uk

Where to find out more

The Department of Health guidance on commissioning to support implementation of an integrated falls service, *How can we help older people not to fall again*, is available at

www.dh.gov.uk/assetRoot/04/01/94/78/04019478.pdf

The Stroke Association has extensive information on developing stroke pathways. Find at www.stroke.org.uk

Process mapping

Process mapping details what happens to people when they access health and social care. By analysing detailed flows of the patient journey/process across the whole system, it allows participants to see bottlenecks, duplications and wasted processes in the current system. It also means that frontline workers, who understand how things work in the system, are able to influence change.

This information then forms the basis of identifying opportunities to change these systems by improving on good practice, removing or reducing 'hand offs' and freeing up bottlenecks to the benefit of users of the services. Such improvements do not necessarily require additional resources, but instead are often based on changing the way people work.

"Margaret fell and cut her head.....she called the warden using the signal cord. The warden called the paramedic team who responded within five minutes, followed almost immediately by two rapid response nurses. She was taken to the local hospital A&E department. Within the hour she had been stitched and given a thorough medical examination, and was then kept in hospital for a further five days and monitored."

David Parker, carer

How process mapping can be used.

In **the Wirral** process mapping led to:

- A signed agreement by the chief officers of all agencies to work across the whole system to reduce the number of emergency medical admissions leading to a reduction in the number of hospital medical beds;
- The appointment of an Admissions Avoidance Co-ordinator to develop health and social care services in the community as opposed to a planned Admissions Avoidance Unit at the hospital;
- Plans to bring together the various intermediate care schemes under one umbrella with a single point of contact to assist with admissions avoidance and earlier hospital discharge.

In **Hertfordshire** CAT facilitated a two-day process redesign event focusing on the journey of elderly orthopaedic patients in the West Herts NHS Trust. The whole system was represented, including the ambulance trust and the voluntary sector. The outcome of the event was:

- Many staff who thought they knew the detail of the total patient journey were surprised, once they had the whole picture, to learn what actually happens to people;
- Some very creative thinking about how to remove or reduce blockages in the process and make better use of resources;
- Further CAT funding on work to broaden the learning from the orthopaedic pathway into discharge planning across the whole of the Acute Trust.

What CAT has done

We regularly use process mapping to:

- Increase understanding of the value of partnership working;
- Improve user experience of hospital discharge;
- Reduce the numbers of delayed transfers in the health and social care system;
- Reduce the number of people admitted to hospital inappropriately; and
- Reduce the number of people who are prematurely admitted into long-term residential and nursing home care.

Process mapping has been successfully used on several sites and has resulted in better discharge planning, reductions in inappropriate hospital admissions and more effective use of resources.

Where to find out more

A practical guide to process mapping and service design, and further information on CAT's approach, can be found at www.changeagentteam.org.uk

The Modernisation Agency has produced a guide to process mapping, available on its website at www.modern.nhs.uk/improvementguides/process.

Developing a 'choice' policy

Revised guidance on the National Assistance Act 1948 (Choice of Accommodation) Directions 1992 ('the Directions') was issued for consultation in September 2003 and finalised in January 2004. This guidance sets out how systems should promote choice in securing long-term care in nursing or residential homes and how interim placements, while awaiting a placement of choice, can be arranged. Approximately 10% of delayed discharges arise because people are awaiting their home of choice. The revised Directions support the need to have a policy in place to ensure that patients do not remain in an acute hospital bed but move to an appropriate interim placement.

What works

Key elements should include:

- Adopting a policy that no patient should go directly to a long-term placement in a nursing or residential home straight from an acute hospital ward;
- Providing a variety of interim placements where assessment and recuperation can continue in a more appropriate setting;
- Firmly embedding a choice policy, which sets out a process and timescales for moving patients who are delayed awaiting a home (or care) of their choice, within local health and social care discharge policies;
- Allowing time for assessment for eligibility for NHS-funded

continuing health to be carried out so that the patient's potential for recovery can be gauged before decisions are made;

- Identifying a senior person within each organisation (acute trust, PCT and social service department) as the lead, who will be responsible for responding to any complaints that may arise;
- Agreeing the policy at board or committee level;
- Supporting the choice policy with information for patients/carers about options available if the patient cannot return home straight from hospital, including specific information on eligibility for continuing health care and the rights of appeal. Ensuring this information is given to patients and their carers on admission to hospital. Further leaflets should set out the responsibilities of the patient and carers to find suitable accommodation within given timescales and to accept an interim placement if the first choice is not available within these time limits.

All staff, including clinicians, will need training in implementing the policy.

Examples of good practice

Peterborough Hospitals NHS Trust employs a full-time senior nurse to help self-funders choose a future nursing or residential home that meets their assessed needs, through working closely with the older person and their family, with the homes and with the social services department.

For further details contact: Julie Stokes, Peterborough and Stamford Hospitals NHS Foundation Trust, at julie.stokes@pbh-tr.nhs.uk

Lincolnshire County Council has dedicated assessment beds within residential homes where patients are transferred for a full assessment with the aim of getting them home and/or giving them sufficient time to find a suitable placement.

For further details contact: Jean Lammie, Lincolnshire County Council social services directorate, at jean.lammie@lincolnshire.gov.uk

Suffolk County Council has a joint protocol with local PCTs and acute trusts which not only lays out procedures but has a clear definition of what is a reasonable alternative. Social services will also pay transport costs for relatives if necessary, for up to 12 weeks.

For further details contact John Such, at john.such@socserv.suffolkcc.gov.uk or john.such@ipswich-pct.nhs.uk

What CAT has done

We have produced a checklist to help local health and social care systems implement the Direction on Choice of Accommodation.

As part of CAT's London and South East Programme, a one-day workshop was held at Gatwick for organisations in Kent, Surrey and Sussex to help develop local policy and identify good practice.

In **Herefordshire**, CAT has supported the development of a discharge from hospital booklet, including guidance on the Directions, and funded it to be written in plain English.

For further details contact: Tracy Hill, Hereford County Hospital, at Tracy.Hill@hhtr.nhs.uk.

Where to find out more

The CAT supplementary checklist on implementing the Direction on Choice of Accommodation, *Discharge from hospital: A matter of 'choice'*, is available from www.changeagentteam.org.uk.

Discharge planning

Ina's story illustrates that we still have a long way to go to achieve a smooth discharge for all patients leaving hospital. Sometimes there is still an absence of multidisciplinary or integrated working and a lack of awareness of what is possible. Ward staff under pressure may refer patients to several services or teams in the hope that at least one of them will respond and do something.

Pressures on acute beds may mean that appropriate alternatives to residential care or nursing home admission are not fully explored and that older people are rushed into making significant decisions about their future care. Despite being a priority group, older people at risk of long-term care may not be offered intermediate care prior to a final decision being made about their future. Discharge is still regarded in many places as a medically-led process and the full

"My discharge home was frenetic and unplanned. The consultant decided I was fit in the morning and I was home later that same day. Within minutes of being discharged, the physiotherapist visited me again to show me how to use sticks on the stairs and how to get into the car. Unfortunately, the lesson did not extend to showing me how to get out. I was given a scruffy bit of paper about using the stairs which was passed off as an information sheet. Shaky but home!"

Ina Acres, service user

resources and skills of other professions are not used. Many systems are now moving towards integrated discharge planning services.

What works

A good discharge planning service should include:

- A mix of professionals (social workers, nurses, therapists) working and located together in the same team;
- A single line manager or a co-ordinator;
- An agreed multi-agency discharge policy including when and how to assess for eligibility for NHS-funded continuing health care;
- Early referral so that planning for discharge starts as soon as possible;
- Early identification of an estimated discharge date that is communicated to all key people, including patients and carers;
- Ward-based co-ordinators who can oversee the discharge process both for the 80% of patients whose discharge is straightforward and the 20% who have more complex needs; and
- Active involvement of patients and carers in the planning and decision- making processes.

The advantage of integrated working is that different professionals learn from each other, share skills and make best use of the total resource. Integration cuts down on duplication and multiple referrals, while enabling individual members of the team to retain and utilise the core skills from their professional training.

Examples of good practice

The Royal Shrewsbury Hospital, Shropshire social services and Shropshire County PCT have brought social workers, discharge nurses and therapists together in a single **Shropshire** joint hospital 'interface' team.

The team diverts patients in A&E and the medical assessment unit into intermediate care services, tracks patients through the system ensuring appropriate transfers and minimising lengths of stay, and enables patients to leave hospital as soon as possible either by going home with appropriate support, or by transferring to an intermediate care or transitional care bed.

For further details contact: Andy Rust, Shropshire County PCT joint commissioning team, at Andy.Rust@shropshireha.wmids.nhs.uk

In **Coventry**, the health and social care discharge teams based in University Hospitals Coventry and Warwickshire NHS Trust are working towards an integrated team model and have developed joint policies for practice including a single point of referral. Much of the associated staff training and development is run jointly and multi-disciplinary working arrangements have increased significantly. The current hospital avoidance team (REACT) is a good example of an integrated discharge team and is likely to be adopted as the integrated model.

For further details contact: Margaret Greer, University Hospitals Coventry & Warwickshire NHS Trust, at margaret.greer@uhcw.nhs.uk

Mersey Care NHS Trust provides a liaison service for older people with mental health needs to the acute hospital trusts in Liverpool by means of a team approach. The teams consist of registered mental health nurses, social workers, occupational therapists, support workers and domiciliary support staff, with input from doctors on a sessional basis. They provide an assessment and advice service and are able to facilitate people's early discharge from hospital by accessing mainstream and specialist services as needed.

For further details contact: Barry Owen, Mersey Care NHS Trust, at barry.owen@merseycare.nhs.uk

What CAT has done

We have published a good practice guide, *Discharge from Hospital: pathway, process and practice*. Further learning materials have been developed around the practice guidance, especially to help managers and practitioners plan and deliver improved services for adults with complex discharge needs. The package is designed to be used by multi-disciplinary groups of health and social care staff who normally work together.

The training modules (details below) cover topics such as involving patients and carers, agreeing a discharge co-ordination approach at ward level, setting a discharge date, risk sharing, resolving conflict, developing an integrated discharge service, and emergency care. We

provide training for facilitators in conjunction with strategic health authorities.

In **Portsmouth** and **South East Hampshire**, CAT has sponsored a project across the whole health and social care system to support good practice in discharge planning, identifying local obstacles and progressing homegrown solutions.

In **Coventry**, we facilitated a series of workshops with staff from acute, primary health and social care to help them work out the best model of an integrated discharge and intermediate care service for their needs. Coventry also acted as a pilot site to test some of the modules in the learning materials.

Where to find out more

The discharge planning training materials are web-based and can be copied onto CD Rom from www.dischargetraining.doh.gov.uk. They include slides and facilitator notes. The good practice guide can be downloaded from

www.publications.doh.gov.uk/hospitaldischarge/index.htm.



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2

Improving capacity: Matching needs to services

A variety of specific grants and initiatives have begun to make a difference to improving capacity within the system. These include the building capacity and partnership in care agreement grant, intermediate care capital funding, access and systems capacity and delayed discharge grants. Some localities have used these grants to introduce new services or extend existing provision, such as rapid response teams to maintain people at home during or after a crisis. Some new specialist beds have been built or re-provisioned, for instance, for intermediate care. Other systems have passed on the benefit from specific grants to improve fee levels in independent provision to stabilise the market.

Despite these developments we have still found examples of resources not being used to their best advantage. Some systems have had empty intermediate care beds at the same time as a red alert in the acute hospital. Others use their community hospitals as a means of emptying acute beds without proper care planning or an agreed care pathway for individual patients.

By looking at the whole system and how one part impacts on the rest, local health and social care communities have been able to improve the journey for the patient at the same time as freeing up resources for others – getting the right care in the right place at the right time.

Reimbursement: Incentives for investing in older people's services

Reimbursement was introduced in January 2004 as a way of ensuring that the cost of people being delayed in hospital was recognised. Additional funding was given to social service departments to reflect the costs of their responsibilities, and in particular to encourage them to invest in services to prevent delays.

“The reimbursement programme had enormous potential to go very badly. It was characterised by: a highly controversial and high profile policy territory accompanied by considerable ministerial involvement; an absence of any established models of good practice; and a wide range of conflicting stakeholder interests. The fact that it was possible to turn the programme into something highly focused, extremely productive, and of immense value to the field, is testimony to the skills of those most closely involved.”

Melanie Henwood, All Change Please: An independent evaluation of the Change Agent Team

Reimbursement is closely linked to:

- **Good hospital discharge planning**

Discharge planning is covered in detail in Section 1 of this report.

- **A whole system approach to investment**

Many local systems have agreed, as partners, that the delayed discharge grant is an opportunity to increase capacity and extend the range of services in the community by upfront investment and offsetting reimbursement liability.

- **'Mature' systems**

These are systems which have sorted out the basic tasks for reimbursement and moved on a level in terms of understanding the links with other initiatives – such as the strategic direction for older people's services, good practice on the single assessment process, discharge planning, data collection, and investment and risk-sharing. The diagram below outlines a typical structure.

This diagram outlines the necessary interaction between strategic and operational staff in successfully implementing reimbursement.



Examples of good practice

In **Birmingham** and the **Black Country** joint protocols for delayed transfers of care and reimbursement have been drawn up across all the organisations in the strategic health authority area with the objective of developing consistency of approach in data recording and definitions of transfers of care from an acute hospital setting. For further details contact: Tony Ivko, Dudley social services, at Tony.ivko@dudley.gov.uk

The **Waltham Forest** whole systems investment protocol has secured agreement between Whipps Cross University Hospital NHS Trust, the London Borough of Waltham Forest, and Waltham Forest PCT on investment planning for reimbursement. It covers annual planning of the investment of the delayed discharge grant, monitoring expenditure compared to the agreed plan, and re-prioritisation of planned expenditure and the total financial liability that would be paid for reimbursement had there been no tripartite investment agreement.

For further details contact: John Flood, London Borough of Waltham Forest, at john.flood@soc.lbwf.gov.uk

In **Camden** there is a joint risk-sharing agreement that details action to be taken between Camden PCT, Camden social services, University College London Hospitals NHS Trust, and the Royal Free Hospital to make use of the delayed discharge grant. The aims of the agreement are to identify, manage and balance the risk for all the organisations involved. They have agreed that the reimbursement monies should be used to develop additional intermediate care and community-based services.

For further details contact: Pamela Jones, Camden PCT, at Pamela.Jones@Camdenpct.nhs.uk

What CAT has done

CAT worked closely with the Department of Health policy colleagues to provide focused and practical support for the implementation of the Community Care (Delayed Discharges etc) Act. Local health and social care systems have been encouraged to use the legislation and the delayed discharge grant as a chance to strengthen discharge

planning and to improve the range of local services to minimise reimbursement.

Support available from CAT has included:

- A website with material to support reimbursement;
- Advice on investment of reimbursement funds in services;
- Guidance materials, including frequently asked questions, protocol checklists and examples of notifications;
- Roadshows and local workshops held around the country;
- Sponsorship of pathfinder projects, outlined on the practice innovations section of the website.

Where to find out more

The reimbursement website can be found at www.dh.gov.uk by searching for 'introduction to reimbursement'.

For more details of a whole system approach using the delayed discharge grant, search the Department of Health website at www.dh.gov.uk with 'using reimbursement funds to increase capacity'.

Intermediate care

Intermediate care has been defined as:

'Care and support which is targeted at people who would otherwise be likely to be admitted to hospital or long-term care in residential or nursing homes or would otherwise remain in a hospital bed when this is not clinically necessary.'

Intermediate care is a vital part of the jigsaw of whole systems working. It provides the opportunity to develop a person-centred service that bridges the gap between all parts of the system. To do this it is essential that it is developed as a flexible adaptable service that can meet the variety of needs of older people including those with dementia.

In many places intermediate care is still not delivering all that it could because of over-tight criteria and fragmented services. It is often

"She settled well into the nursing home and made steady progress back to better health. With their support she became more mobile, was encouraged to eat to build up her strength, and appeared relaxed and comfortable there."

David Parker, carer

perceived as a specialist service with separate resources rather than part of a spectrum of services which people can access as their needs change. The challenge for the coming year is to make intermediate care part of mainstream services.

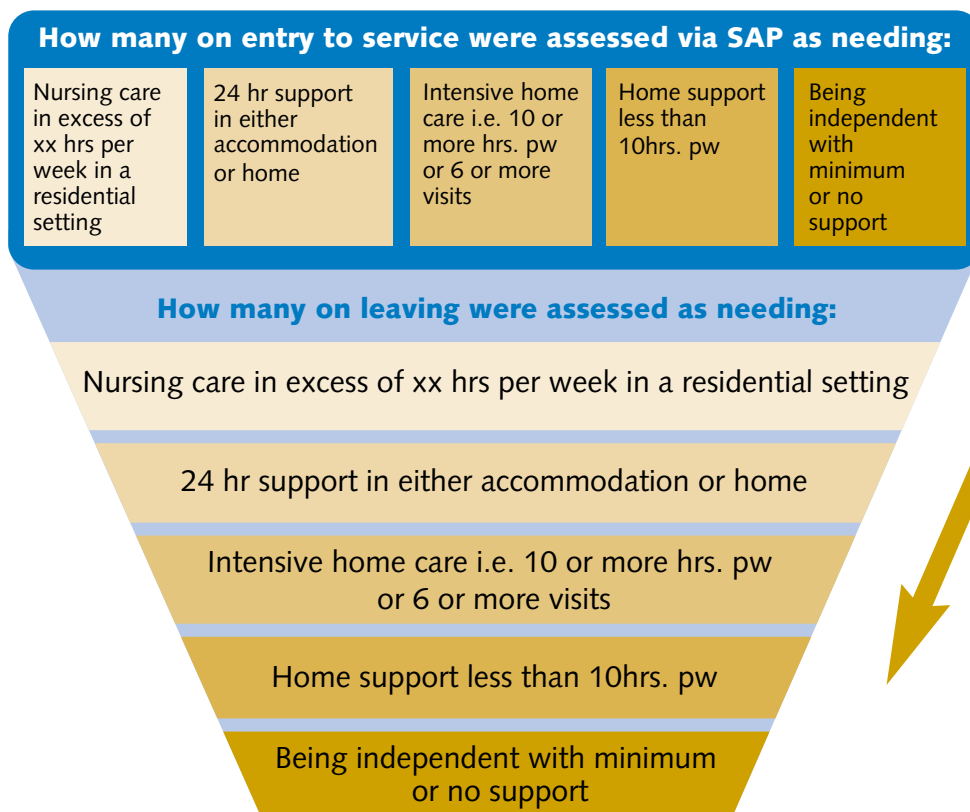
Where intermediate care is working well it increases capacity across the system by supporting older people to move through the continuum of care with the level of support that meets their needs. This is altering the 'balance of care' (reducing dependency on acute and long-term institutional care and increasing options in the community), from a reliance on institutional settings to a system where more people are supported in their own homes.

What works

- Strong strategic leadership and vision at executive level;
- Links to implementation of single assessment process – (see Section 1 page 8);
- Use of Health Act flexibilities;
- Inter-disciplinary working;
- Range of provision – through one access point;
- Increased focus on prevention of admission;
- Increased focus on providing assessment after acute admission in a non-acute environment;
- Provision of service in an older person's home is considered the best environment and reduces transfers between care settings;
- Continuous review to ensure length of stay in bed-based services is kept to a minimum;
- Housing-based services (see page 37-8 on the housing learning improvement network);
- Links to mental health services to support people with dementia;
- Clarity of outcomes expected from intermediate care;
- Monitoring and evaluation of outcomes (see outcome funnel below).

The development of services for long-term conditions, particularly case finding and case management will offer new opportunities for intermediate care. Planning and development of these new services needs to consider the connections to intermediate care.

Intermediate care outcome funnel



The drive is in this direction. Note however successful outcomes are delivered at all levels

The Outcome Funnel is a means of assessing the effectiveness of an intermediate care intervention. Before receiving the service, the user is assessed for which level of on-going care they might need at that point. Following the intervention, the user is reassessed to identify whether they would need a less dependent service, 'lower down' the outcome funnel. Not all users will reach full independence but the level of the support now required should ideally be less than when first assessed.

Examples of good practice

At Poppyfields, St Neots, **Cambridgeshire**, a new 34-unit extra care housing complex has been developed in partnership between Huntingdon District Council, Hanover Housing, Cambridgeshire County Council and Huntingdonshire PCT. Three of the units have been developed to support older people unable to return directly to their own homes. General 24-hour care is provided with additional rehabilitation provided by services from the PCT. The aim of the unit

is to reduce admissions to residential care and raise awareness of the housing options available to older people.

For further details contact Sharron Cozens, Huntingdonshire PCT, at Sharron.Cozens@hunts-pct.nhs.uk

In **Hampshire** and **the Isle of Wight** taking forward the intermediate care workforce is a major role redesign project for intermediate care, which is being led by Eastleigh & Test Valley South PCT on behalf of the PCTs and social services within the strategic health authority area. The project includes the full range of registered practitioners and rehabilitation assistants (associate practitioners) working in intermediate care services developing new ways of working.

For further details contact: Jane Barnacle, Eastleigh & Test Valley South PCT, at jane.barnacle@etvspct.nhs.uk

The **Manchester** health and social care community have agreed a city-wide framework for intermediate care. This sets out essential features of service that all three sectors are expected to achieve, while recognising that some services will develop differently depending on local need. It includes the important principle that any older person identified as likely to need residential or nursing home care should be offered the opportunity to benefit from intermediate care before the final assessment is completed.

For further details contact: Pete Gosling, Manchester City Council children, families and social care department, at pete.gosling@notes.manchester.gov.uk

In **Knowsley**, the community older people's team provides a single point of access for older people to reduce duplication and remove the barriers to accessing services, and has a strong admission prevention approach. The team includes social workers, therapists and therapy assistants, district nurse assessors, home safety advisers, pharmacists and podiatrists. District nurses can commission small packages of care. Intermediate care is represented by the clinical lead and a community independence team supporting hospital discharge.

For further details contact: Barbara Riddell, Knowsley social services, at Barbara.riddell@knowsley.gov.uk

The **City of Sunderland** intermediate care service (winners of the 2004 Health and Social Care Intermediate Care Award) with the local NHS community provide a range of rehabilitation facilities. 73% of people discharged continue to remain at home after six months and there has been a fall in long-term admissions to residential care.

For further details contact: Sharon Lowes, Sunderland City Council, at sharon.lowes@sunderland.gov.uk

In **Nottingham** there is a well developed and evaluated A&E 'front door assessment' and care team (FACT). This multi-professional rapid response team provides full functional and social assessment for older people attending the emergency department. Their aim is to prevent unnecessary hospital admission by providing safe discharge and link closely with intermediate care services to promote follow-on rehabilitation.

For further details contact: Debbie Welton, FACT, Queen's Medical Centre, at Deborah.welton@mail.qmcuh-tr.trent.nhs.uk

In **Bournemouth**, Christchurch Hospital, part of the Royal Bournemouth and Christchurch Hospitals NHS Trust, uses its day hospital to provide a rapid and comprehensive multi-disciplinary assessment for older people as an alternative to hospital assessment, and then to refer them on as necessary to other services, including rehabilitation within the day hospital itself.

For further details contact: Brenda Butcher, Royal Bournemouth & Christchurch NHS Hospital Trust, at brenda.butcher@rbch-tr.swest.nhs.uk

At the Welland Resource Centre in **Lincolnshire**, Lincolnshire Partnership NHS Trust (winners of the 2004 Health and Social Care Team Award), in consultation with older people, offers crisis intervention within two hours, treatment at home to hospital standards, outpatient clinics, and help and support to residential and nursing homes through an integrated community mental health team linked to voluntary sector partners.

For further details contact: Rachel Wright, Lincolnshire Partnership NHS Trust, at rachel.wright@lpt.nhs.uk

What CAT has done

In **Birmingham** we have developed a template to enable Eastern Birmingham PCT to evaluate its intermediate care services so that it can identify any gaps or areas for improvement.

In **Medway** and **Swale** PCTs, CAT funded a project to research the need for intermediate care to inform the commissioning process.

"We intend to undertake significant redesign of our community hospitals to enable delivery of more chronic disease management services to more patients for the same level of investment. New services will be delivered through a proactive and radical approach to reconfigure the bed base, workforce and the range of community diagnostic and treatment services that are provided both within the walls of the community hospitals and in the wider community."

Carol Williams, Central Cornwall PCT



Where to find out more

The report *Developing the intermediate tier: Sharing the learning* (ISBN 1 903475 43 0) outlines a development programme involving 25 PCTs and their partners in West Yorkshire, North and East Yorkshire, and North and West Lincolnshire. The programme was devised and co-ordinated by the Nuffield Institute for Health in partnership with representatives from older people's services in all participating localities. The report can be downloaded from www.nuffield.leeds.ac.uk/downloads/lilc_intermedtier_report.pdf

Developing community hospitals

The issue of how to make the best use of community hospitals has arisen in many places where we have done intensive site work. Systems recognise the valuable resource they have in their community hospitals, but are frustrated that they are not being used as effectively as they could be. Some hospitals are seen primarily as a place to move patients while they are awaiting placement in a nursing or residential home; others are limited in use by rigid access criteria, often geographical. Some places have tried to modernise the use of their local community hospitals but have been inhibited by local resistance to change.

Recognising the considerable resource that can be tied up in community hospitals, and their contribution to the capacity of local health and social care systems, CAT has joined with the Community Hospitals Association to develop a web-based guide for PCTs, social services, acute trusts and others wanting to develop the way they use their local community hospitals and related services. A multi-agency reference group supports the project.

The guide will advise what information systems need to be available before embarking on any changes, and what options there are for using community hospitals in different ways. It will also offer advice on involving the public and media. There will be extensive examples of good practice. The guide is due to be completed by December 2004.

Where to find out more

The CAT web site at www.changeagentteam.org.uk will be updated with progress of the project and requests for help in reviewing the material.

Mental health services for older people

Judith McMillan's experiences as a carer highlight the real challenges faced by staff in an acute ward when caring for people with dementia – and the risk of a lack of understanding of the needs of older people in a confused or demented state.

“The hospital did not cater for people suffering from senile dementia. My dad used to wander up and down the ward and on a few occasions he wandered off the ward. On one occasion, he left the hospital in his night clothes and slippers and walked up to my sister's house, half a mile from the hospital.”

Judith McMillan, carer
(See Appendix E page 77 for the full story)

What works

Older people with mental health problems can quickly become even more disorientated and distressed in unfamiliar surroundings. The following approaches can help:

- Rapid assessment of the person in their own home to explore alternatives to hospital admission and whether treatment and support can be provided at home;
- Patient-held records that give a clear picture of how the person is normally supported and how they usually manage;
- Early identification of the person's mental health difficulties once they are admitted to hospital and checks on whether the person is already known to specialist mental health services;
- Responsive multi-disciplinary liaison services that do not rely solely on consultant-to-consultant referral;
- Access to intensive home support services so that the person can be returned home from hospital quickly once their acute illness is under control; and
- Access to mainstream intermediate care services for people with mental health needs whose primary need is for physical rehabilitation, with staff trained in mental health.

Examples of good practice

Shore Green is a purpose-built partnership development between **Manchester** social services and Irwell Valley Housing Association. It aims to promote independence on a very individual basis by supporting each tenant in the identified areas that have caused them to become unsafe or distressed and have led to the need for a move.

The residents have chosen to develop their skills and work towards increasing or maintaining independence levels for as long as possible. Support staff and care staff work side-by-side in constant assessment of a tenant's changing needs.

For further details contact: Mali Pocsai, Irwell Valley Housing Association, at Mali.pocsai@irwellvalleyha.co.uk

In **Nottingham**, a specialist dementia home care service has been developed to provide long-term ongoing support. The service is supported with intermediate care funding and is delivered by specifically trained and empowered staff. It links into mainstream intermediate care that is an integrated health and social care service. For further details contact: Joan Gavigan, Nottingham City Council social services department, at Joan.gavigan@nottinghamcity.gov.uk, or Shirley Smith, Nottingham City PCT, at shirley.smith@nottinghamcity-pct.nhs.uk

In **Bristol** a new model of intermediate care for people with dementia has been developed by a mental health trust and a local voluntary sector provider (Brunelcare). Ten beds in a home for people with dementia have been allocated for intermediate care with an appropriately skilled team. The beds are mostly used for intensive intervention to prevent an acute admission, or following a stay in acute care. Almost all the patients transferred to the facility are perceived on referral to be in need of elderly mental illness (EMI) nursing home care, but an evaluation of the first six months of the project showed that of 53 clients, 46 were discharged home rather than transferred to nursing home care.

For further details contact: Niall Moore, Avon and Wiltshire Partnership Trust, at niall.moore@awp.nhs.uk

South Gloucestershire's assertive in-reach project provides short-term intensive support to clients with acute mental health crises which might otherwise result in admission to hospital or transfer of care to another home. It can also provide intensive support if transitional difficulties are anticipated when a person with dementia is discharged from hospital to a care home.

For further details contact: Andrew Baker or Beatrice Godwin, andrew.baker@awp.nhs.uk or beatrice.godwin@awp.nhs.uk

“Extra care housing offers another choice to the individual; a choice based on security, rights and control... to reflect the lifestyles that people want and expect. It must be a community solution and to make it work requires the full commitment of housing, health and social care agencies.”

**Stephen Ladyman MP,
Parliamentary Under-Secretary of State for
Community, July 2003**

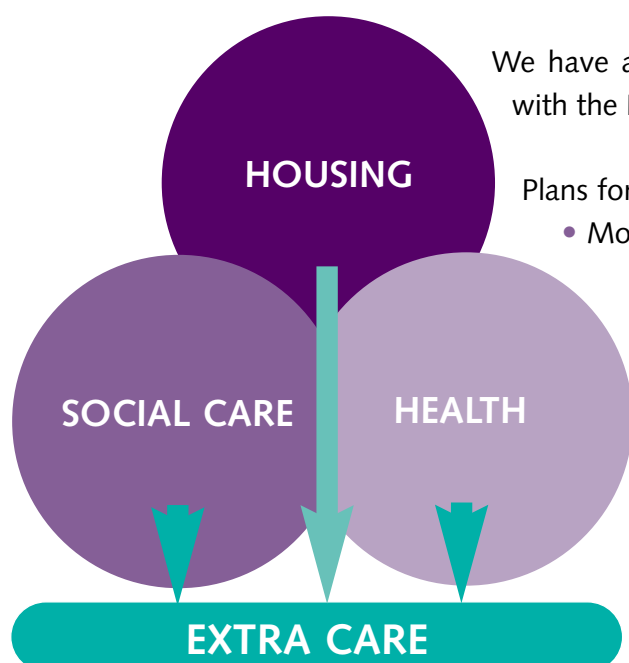
What CAT has done

- We have developed support materials on moving people with dementia into acute settings, and on discharge planning for this group, and have ensured that the material produced to support reimbursement reflects the needs of people with dementia.
- We have held a series of conferences on intermediate care and dementia which have highlighted practical examples of effective approaches.
- We have carried out intensive site work in localities where older people with mental health needs emerged as a key issue during the initial diagnostic stage.
- We contributed to the ministerial summit on older people with mental health needs in October 2003.
- We have contributed to the audit carried out by strategic health authorities as a response to the Commission for Health Improvement report on Rowan Ward, which investigated allegations of abuse by staff of older people with mental health problems.
- We have worked with policy colleagues in the Department of Health on mapping services for older people with mental health needs and developing a performance indicator for services for this user group.

We have also launched a joint work programme on older people with the National Institute for Mental Health in England (NIMHE).

Plans for 2004/05 include:

- More work on developing good practice for older people with mental health needs in challenged organisations;
- Guidance on commissioning services;
- Links with members of CAT’s commissioning learning and improvement network;
- Further intermediate care and mental health events; and
- Increased efforts to ensure that older people with mental health needs become part of the mainstream.



Where to find out more

Health and Social Care Change Agent Team checklist – *Discharge from hospital: Getting it right for people with dementia* at www.changeagentteam.org.uk

The National Institute for Mental Health in England (NIMHE) has a useful web site at www.nimhe.org.uk.

CAT associate change agent Professor Jane Gilliard is a specialist in dementia and older people's mental health. She can be contacted at Jane.Gilliard@hd.gsi.gov.uk

Building capacity with housing and assistive technology

Extra care housing is a style of housing and care for older people that falls somewhere between established patterns of sheltered housing and the accommodation and care provided in traditional residential care homes.

In July 2003, the Department of Health made available £87 million through the access and systems capacity grant to be spent within financial years 2004-2006 to develop up to 1,500 new extra care units of accommodation. £29 million was allocated for year one and a further £58 million for year two of the programme. The aim of the fund is:

- To develop innovative housing with care options;
- To stimulate ongoing strategic links between health, social care and housing; and
- To develop partnerships between a range of agencies, including housing associations and the private sector.

The Department of Health received an overwhelming response, with more than 200 bids totalling over £330 million made for year one funding, a tenfold over-subscription to the fund. Funding was approved for 19 bids, with a further three receiving joint funding from the Department of Health and the Housing Corporation, which is responsible for investing public money in housing associations. A further 44 extra care housing schemes have been solely funded by

“When she was fit enough to return to her home, she was provided with various apparatus by the occupational therapy team, which included a Zimmer frame, food trolley, kettle swing frame and toilet aid frame, all of which enabled her to maintain her independence in her home.”

David Parker, carer

the Housing Corporation under their two-year approved development programme.

What works

Extra care housing is not a replacement for good quality residential care or sheltered housing. However, in many areas it is a realistic alternative and provides extra choice within the housing, care and support options for older people. Option appraisals have demonstrated that extra care housing can:

- Provide a base for out-of-hours services with mobile and peripatetic support to older people in the community;
- Provide a normal and supportive living environment for people with dementia, particularly with the added benefits of assistive technology;
- Offer a lifestyle choice across a range of tenure options;
- Provide communal space and facilities and well-being services for use by the wider population. Such services could include GP surgeries, clinics and therapy services, exercise and leisure facilities, shops, libraries and IT suites.

Assistive technology can also contribute to independent living, by enabling people with certain disabilities to counteract isolation and give people greater privacy and dignity. For example:

- Some technology is designed to enable or overcome a physical or sensory limitation (from simple gadgets to a fully automated house);
- Communication orientated IT makes it easy to keep in touch with others (e.g. video phones, cameras linked to computers);
- A variety of devices have been developed that can prompt people, remind them to do things or how to do things automatically (e.g. verbal prompt to turn gas off or close a door, complete instructions, visually and spoken, on how to cook a meal);
- Social alarms have for a long time played a part in summoning help, but have developed greatly (e.g. fall detector, staff alert to 'wandering', intruder alarm, medication monitor).

Examples of good practice

In **Durham**, the Southfield Lodge extra care scheme provides older people with their own flats alongside communal areas, and staff are on-site to provide 24-hour care and support when needed. The

scheme, which won the Older People Health and Social Care Award 2003, has made a positive difference to the lives of all Southfield Lodge's tenants. They are more independent, have more privacy and can take more responsibility for their own care.

For further details contact: Duncan Callum, Durham County Council, Social Care and Health, at duncan.callum@durham.gov.uk

Crystal Fountain Retirement Village in **Gloucestershire** is a new private sector development. This purpose-built village is set within 25 acres of its own grounds in a valley setting, and comprises one, two and three-bedroom apartments and houses, a residential care home and a broad range of on-site leisure facilities and support services.

For further details contact: Steve Critchell, Care Village Group, at stephen.critchell@carevillagegroup.co.uk

Rowan Court is an extra care facility in **Eastleigh**, Hampshire, for older people with dementia. It was converted from a traditional 'bedsit' sheltered housing scheme into an extra care scheme, which provided the opportunity to utilise assistive technology tailored to meet the needs of individual tenants and as a supplement to staff care and support. All flats have a heat sensor and flood detector. Cabling is also in place to add extra functions on an 'as required' basis following an assessment of need.

For further details contact: Nick Craik, Fernhill Care Ltd, at Nick.craik@fernhillcare.co.uk

What CAT has done

The CAT housing learning and improvement network (housing LIN) has raised awareness and knowledge of extra care housing, including within the independent and private housing sectors. Membership of the network has increased to over 230 members, representing 130 statutory and non-statutory organisations.

To enable members to participate more fully, the housing LIN has worked with all stakeholders to establish regional forums and an easy-to-use web-based discussion forum. At the height of the 2003-2004 bidding round for Department of Health funding, 400 enquiries a week were posted on the discussion forum for further advice, information and assistance.

"The housing learning and improvement network is playing a vital role in helping providers and agencies develop services that more effectively meet the future needs of older people. This is leading to a significant growth in the number of units of extra care housing, which is transforming the lives of older people, and will in the future."

John Payne, partnership director, ExtraCare Charitable Trust

"Trafford Metropolitan Borough Council has benefited enormously by being part of the housing LIN. The joint work on extra care housing has really helped us to clarify our thinking in the area, and will make a big difference to the lives of elderly people in the borough."

Mushtaq Khan, Trafford Metropolitan Borough Council

“The opportunity afforded by the housing LIN to exchange ideas, good practice and information about a range of housing and support options across so many diverse organisations is clearly resulting in new, innovative and creatively designed services for older people.”

Jenny Tuck, East Sussex County Council

“As a developer and operator of extra care housing projects in the independent sector, we have found the housing LIN of essential importance. Their efforts to promote awareness of extra care as an option to regional authorities have greatly assisted our efforts to introduce ourselves when opportunities arise without having to fully explain our activities. The web site is also a source of very valuable information as are the regional conferences. We are very grateful for all the housing LIN has accomplished.”

Nick Sanderson, Audley Court Estates Ltd

Since the announcement of the successful year one submissions, the housing LIN has provided feedback on all the bids and delivered a series of roadshows to offer tailored advice and information to support and encourage bids for the next bidding round. These roadshows have been heavily over-subscribed and demonstrate the enthusiasm of the housing, health and social care sector to further enhance the housing-with-care choices of older people in their localities.

The housing LIN has been extremely active in working with local and regional LIN and CAT groups in raising the profile and understanding of housing-with-care for older people, and building the capacity to develop extra care housing strategies.

This includes specific site work/events in East Sussex, Hampshire, Cornwall, Cheshire and Stoke-on-Trent. A series of regional events and thematic masterclasses have also taken place on:

- Strategic commissioning of extra care housing;
- Building capacity with the private sector;
- Developing retirement housing villages;
- Understanding the health dividend of extra care housing; and
- The Supporting People programme of housing-related services: making the links with capital and revenue.

Where to find out more

The housing LIN has published two documents to help commissioners develop clear strategic objectives when planning for and developing extra care housing. These are *Extra Care Housing for Older People: An introduction for commissioners* and *Developing and Implementing Local Extra Care Housing Strategies*.

It has also produced a series of factsheets, covering related topics such as assistive technology, provision for older people with a learning disability, and retirement housing communities.

The housing LIN worked with ICES (Integrating Community Equipment Services) to help develop *Getting Ahead With Telecare*, a good practice implementation toolkit (www.icesdoh.org).

These materials can be downloaded from the CAT website at www.changeagentteam.org.uk. For details of the housing LIN contact associate change agent Jeremy Porteus at jeremy.porteus@dh.gsi.gov.uk



3

Better commissioning: Securing capacity through collaborative working

The Commission for Social Care Inspection...greatly welcomes the launch of the Learning Improvement Network for better Commissioning. As a body with an explicit statutory remit to improve social care services across England, and with the ability to track services for users from the commissioning process through to service delivery, CSCI strongly supports activity to drive up the quality of the commissioning of social care for older people. We hope the LIN proves a successful development.

David Walden, Commission for Social Care Inspection

Although independent markets remain quite fragile in some areas, there is increasing evidence from the work of the Change Agent Team around the country that service provision is being realigned to meet new service needs. This can be an uncomfortable process that requires constructive and honest dialogue between providers and commissioners about the need for change to different service models and for improved quality. This is particularly important in areas where there are shortages of resources for people with specific needs, for example older people with mental health needs, those from black and ethnic minority groups and particularly for those whose preference would be to remain supported at home.

We therefore have to be more imaginative in commissioning services that offer a variety of services and real user choice. This will include developing more services that promote independence and support people at home for as long as possible – such as enabling home support, good quality housing with extra care, adapted housing, proactive nursing support for people with long-term conditions – rather than producing more of the same. The focus on commissioning for longer-term support will be crucial as the government's agenda of developing services to support people with long-term conditions unfolds.

Many areas have reported problems in providing complex care packages for people at home because of the serious difficulties in recruiting and retaining staff. This is not helped by competition between and within different sectors. There are opportunities here for collaborative working across health, social care and independent providers. Social services and PCTs can provide practical help with recruitment and training. Workforce strategies across health and social care can introduce career structures for support staff which enable localities to 'grow their own' by giving people opportunities to move on to professional training if that is what they want.

What works

Communication

- Talking regularly to providers about policy changes and plans;
- Ensuring smaller providers particularly are supported to attend meetings as for them time really is money;
- Newsletters, bulletins, emails etc can supplement regular liaison meetings but should not replace them;
- Maintaining good working relationships by tackling mistrust between sectors as soon as it is recognised.

Collaboration

- Sharing ideas for developing new services as soon as plans are developed, or shortfalls in services are identified, helps providers feel part of the solution and know what services will be needed in future;
- Sharing planning information and data on purchasing intentions and available budgets;
- Using costing and pricing models to help agree fee structures;
- Engaging service users in service design, delivery and evaluation to ensure the user's experience is positive.

Mutuality

- Recognise that a statutory and independent market for care is mutually dependent, which should lead to more principled commissioning;
- In a culture of mutual dependency, each party should accept responsibility to overcome difficulties that threaten a service, such as the consequence of an acute staff shortage. Offsetting recruitment costs, shared training programmes (and budgets) with joint efforts to raise the profile of care work as an attractive career opportunity will help.

Fairness

- Under-Secretary of State for Community, Stephen Ladyman, has challenged health and social care commissioning practices to meet his four tests of fairness – fairness to service users, to providers, to commissioners and to taxpayers. Systems which do not develop fairer practices risk being unable effectively to influence local markets over the quality and range of local services.

Examples of good practice

In **Shropshire**, Section 31 Health Act Flexibilities have been used to:

- Agree the use of Reimbursement monies between acute trust, primary care trust and social care and health. The monies have been used to invest in and develop a range of community services to support the prevention agenda avoiding unnecessary admissions, facilitating speedy discharge to services supporting people in their own homes and offering extra bed provision from independent providers.
- Develop community-based intermediate care involving health and social care, independent and voluntary providers, such as The Red Cross and Age Concern including intensive home care support and intermediate care beds in independent homes.

Contact Karen Jackson at karen.jackson@shropshireha.wmids.nhs.uk

In **Hillingdon** there is a jointly commissioned nursing, intermediate and continuing care resource in which care is provided by an independent care provider under contract from local commissioners. It is made up of 12 PCT-purchased continuing care beds and 10 intermediate care beds. The borough council has contracted for 11 intermediate care beds and, in a joint agreement with the PCT, 33 nursing beds. Specialist medical cover is provided by the acute trust. For further details contact: Mike Boyle, London Borough of Hillingdon social services, at mboyle@hillingdon.gov.uk.

In **Hampshire** Blackwater Valley and Hart PCT and Hampshire Social Services together are considering closer partnership working for commissioning for older people's services. They are working towards a joint performance management model which is acceptable to both agencies and the use of which is affordable and sustainable.

Contact Chandra McGowan at chandra.mcgowan@bvhpct.nhs.uk or Claire Forman at claire.foreman@hants.gov.uk

In **Tameside**, work is particularly advanced as a modelling and forecasting tool has been adapted to meet local needs, to enable the acute trust, the PCT and social services to jointly tackle a number of challenging local issues.

For further details contact: David Jones, Tameside Metropolitan Borough Council social services, at david.jones@tameside.gov.uk

What CAT has done

CAT has developed several approaches to improving effective commissioning across whole systems, particularly those that provide a range of services as an alternative to acute care. We have promoted the role of independent providers in service improvement to provide more opportunity for them to partner statutory commissioners in identifying solutions to service shortfalls and to reshape the contracted services.

Commissioning checklists and workbook

One such approach has been drawing up a commissioning checklist, *Commissioning and the Independent Sector*, which enables commissioners to check their compliance with the requirements of the building capacity and partnership in care agreement. CAT is publishing a checklist, *Fair Commissioning*, to help systems assess whether they meet the Minister's four tests for fairness challenge. We have also produced a commissioning workbook, *A Catalyst for Change*, which is facilitated on-site by CAT-trained facilitators. It aims to help systems assess the effectiveness of their commissioning and it guides them through successive levels, encouraging them to think differently about their commissioning arrangements and strategy.

In two areas in the South of England, we have developed 'brokerage' schemes where CAT has funded, or part-funded, the appointment of an independent person to act on behalf of local independent providers in negotiations with the statutory agencies on service development and the improvement of partnership arrangements.

Supply and demand modelling of services for older people

Most health and social care communities have problems trying to project how much and what type of services they need to provide in the future to meet the needs of a growing diverse population, who have changing medical and support needs and increasing expectations.

CAT has been working collaboratively with the Department of Health Economic and Operational Research Unit (EOR) and policy colleagues, refining a systems dynamics tool to assist organisations with capacity planning. Experience reveals that organisations,

UKHCA supports the development of the Commissioning Learning and Improvement Network. It is an opportunity to foster greater understanding of the concerns expressed by independent home care providers, which are primarily commissioning issues. It is hoped that the Commissioning LIN will also support the implementation of more meaningful relationships between commissioners and statutory and independent organisations providing care at home.

Lesley Rimmer, Chief Executive, United Kingdom Home Care Association

typically, plan independently without estimating how activity in one part of the system impacts on another, nor what unintended consequences may result from unilateral decisions. The modelling and forecasting tool rehearses scenarios to help foresee and avoid problems occurring in the future.

CAT has established a number of pilots in several parts of the country, which have been using this tool to examine a range of issues, including reducing the number of hospital admissions, delayed discharge figures, average length of stay in social care, and occupancy levels in hospital.

London and South East programme

CAT's London and South East programme has also championed the development of home care as a real alternative to bed-based solutions. It has undertaken a major national survey into the range and nature of commissioning domiciliary care services and is producing a series of papers on market conditions directly affecting the development of home care services, which will be available online.

As commissioning practices are extremely varied, and in all cases could benefit from learning from better practice elsewhere, we have set up a better commissioning learning and improvement network (the commissioning LIN) to address the needs that organisations have identified. These include:

- Exploring how different practices work elsewhere;
- Sharing problems and problem-solving with other systems; and
- Learning what works well and what can be 'imported' into their own systems.

Where to find out more

A dedicated website has been set up for the better commissioning learning and improvement network through the CAT website at www.changeagentteam.org.uk. For specific queries or additional information email catcommlin@eac.org.uk.



4

Partnerships for progress: Delivering change through a whole systems approach

“There was no discharge planning, no single assessment, no carer’s assessment, no intermediate care and no community care. In fact, I did start to wonder if the NSF had been a figment of my imagination.”
Ina Acres, service user

More and more systems are recognising the value of integrated working, both at the most senior level and at field work level...but as Ina’s story suggests, it is still not working as well as it might in some places.

Working in partnership

What works

Where a chief officer takes a lead in bringing all the organisations in a system together, the system, at all levels, seems to work better. We recognise the enormous complexity of some whole systems, involving several social service departments, PCTs, NHS trusts, emergency care services and out-of-hours services, but the first step is recognising that it is a ‘whole system’ with inter-dependence of each organisation on the others. There are some things that can only be tackled successfully across the whole system, such as delayed transfers of care, the single assessment process, NHS funded nursing care and continuing care.

A good local partnership for older people should involve:

- A strategic forum (director/chief executive level) that sets the agenda, and where broad agreements about the development of services for older people, and decisions in principle about the use of finance such as the delayed discharge grant and reinvestment of charges, are reached;
- A representative of those caring for older people with mental health needs as part of the strategic forum;
- A system-wide operational/development group that implements the ‘big picture’ and makes policies work;
- Active participation by older people and their carers in planning, reviewing and monitoring services;
- The involvement of the independent sector as full partners at all stages; and
- Regular informal contact between chief officers from the key health and social care agencies to discuss issues of mutual interest and develop an understanding of each other’s pressures.

Examples of good practice

Peterborough City Council's Adult Social Care Department integrated with North Peterborough and South Peterborough Primary Care Trusts in April 2004 to form the Greater Peterborough Primary Care Partnership. The pooling of resources, both staffing and financial, has led to better health and social care provision and has improved the capacity to develop new services jointly, particularly in the area of preventive services.

For further details contact: Ian Anderson, Greater Peterborough Primary Care Partnership, at ian.anderson@greaterpboropcp.nhs.uk

The **Manchester** health and social care community has established a chief executives' strategic forum, chaired by the city council's deputy chief executive, to agree the broad principles and direction of travel for older people. Below the forum sits a citywide policy and development group that turns the 'big picture' into operational detail and tackles the operational issues to implement policy.

For further details contact: Pete Gosling, Manchester City Council children, families and social care department, at Pete.gosling@notes.manchester.gov.uk

In the **Wirral**, the director of social services and the chief executives of the two PCTs and NHS trust have agreed a joint vision for modernising older people's services. A joint commissioning post was created, accountable to the lead chief executive for older people's services on behalf of the partnership. One of the first successes of the post was a one-day event, involving health and social care practitioners, managers and the lead chief executive, to develop a plan for integrating 22 different service teams that provide intermediate care, rehabilitation and home care services. CAT facilitated the day. While it was agreed that the aim would be for a single point of access, initially six teams were merged and the lessons learned will inform further integration.

For further details contact: Mike Rose, Wirral Hospital NHS Trust, at Mike.Rose@whnt.nhs.uk

The NHS chief executives, director of social services and director of education in **Cornwall** have agreed a statement of intent for a new whole systems partnership, which includes consideration of how the wider health and social care community and the general public will know that they are working in a different and more constructive way. The five NHS trust boards and the local authority cabinet committees will be asked to endorse this approach to provide a foundation for more effective working together.

For further details contact: Carol Tozer, Cornwall County Council social services directorate, at Ctozer@cornwall.gov.uk, or Antek Lejk, West of Cornwall PCT, at Antek.lejk@westprimcare.cornwall.nhs.uk

What CAT has done

We have funded a project in the **Birmingham** and the **Black Country** strategic health authority area to develop protocols for delayed transfers of care and reimbursement. The work involved six local authorities, 12 PCTs and 13 NHS trusts that all signed up to the final version of the protocols. Representatives of the various organisations reported that during implementation of reimbursement the protocols gave them the basis to resolve difficulties that arose within their local system. One representative described the protocols as 'a godsend' because of the co-ownership across the whole system.

For further details contact: Tony Ivko, Dudley social services, at tony.ivko@dudley.gov.uk

We have recommended the setting up of a chief officers' strategic forum in east **Dorset** and helped facilitate the early meetings.

In **Hillingdon**, the partners in the health and social care system acknowledged that some lines of communication and the remit and functions of top level meetings were not fully understood by staff nor effective in the way decisions were disseminated. These have been clarified and streamlined. A regular meeting between council leaders and chief officers and health service board chairs and chief executives, oversees all joint and collaborative arrangements and steers system activities towards corporate goals.

For further details contact: Hugh Dunnachie, London Borough of Hillingdon social services, at hdunnachie@hillingdon.gov.uk

"Partnership arrangements were fragile, to say the least, and we had no strategic forum where all the different agencies could come together to plan, make decisions and commit resources for older people. With CAT's help and advice we have put an infrastructure in place that should mean we can work together constructively in a planned way and also deal with any unexpected difficulties or problems that may arise."

Val Beese, Heart of Birmingham PCT

CAT has funded a member of its expert group to work with a system wanting to improve the relationships between the chief officers.

Where to find out more

The Modernisation Agency has produced a series of improvement leadership guides to assist organisations improve services and systems, including through collaborative working. They can be downloaded from www.modern.nhs.uk/improvementguides.

Working at the highest level

Members of CAT have met with senior nursing and therapy policy leads in the Department of Health and together have come up with four key messages to assist professional leaders, commissioners and practitioners in improving the experience of older people using health and social care services. Aspects of these messages have been shared widely with the nursing and therapy professions through core communications and professional networks, including the Chief Nursing Officer's business meetings with PCT and NHS trust nurse directors.

The four messages are, briefly:

- A person's home is as important a health care setting as the hospital and surgery. There are 3.5 million older people living at home compared to 100,000 acute hospital beds;
- Community care practitioners have a responsibility for a population as well as individuals and need to work with other statutory, voluntary and independent service providers to ensure that they search out frail and vulnerable people, 60% of whom are not known to district nursing services;
- Care management needs to be proactive and preventive to help people remain in their own homes;
- The community is the health care workforce. Active older people have skills, knowledge and experience that they can contribute to the health of the whole community.

“Although my story suggests that an awful lot of work does still need to be done, I have since felt genuinely listened to and involved. My ‘patient journey’ has been made into a training video for staff, our modern matron and PALS officers are championing a whole range of issues linked to dignity on the ward....Changes are taking place in the NHS and perhaps the onus is on us as older people to start shouting louder when it comes to telling our stories.”
Ina Acres, service user

Integrated care network

We have been one of the main sponsors of the integrated care network since it was set up in 2002 to promote and deliver integrated working through support to frontline organisations. It has done this to date through providing:

- Interactive website;
- National network meetings;
- Learning networks;
- Discussion and briefing papers; and
- Support to organisational development programmes.

The integrated care network will continue to work with CAT and other service improvement programmes to encourage and support the highest level of integration suitable to particular local circumstances. Key tasks in the year ahead are to pull together the practical learning from these initiatives for wider use in systems where integration is less advanced and to provide specific advice on the more complex aspects of integration such as workforce issues and finance.

Where to find out more

There is further information on the integrated care network's own website at www.integratedcarenetwork.gov.uk, including *Integrated Working: a guide* by Peter Thistlethwaite.

This guide contains practical guidance, case histories and details of related policies and research, and addresses a wide range of issues, including the definition of integration and how to build a common language, patterns of collaboration, how evidence-based findings can help integration, project planning, governance, tools and protocols. It can be downloaded from

www.integratedcarenetwork.gov.uk/resources.php?id=856



And finally...

Concluding comments by the Parliamentary Under-Secretary of State for Community, Stephen Ladyman MP



It is rare for a Minister's comments to appear at the end of an official report rather than the beginning – on this occasion for the excellent reason that this report begins with the story of someone who has experienced health and social care services as a result of being in hospital.

Mrs Parker's story, as described by her son, is a good illustration of what has been achieved in improving services for older people. That she received timely care in the right place is part of the reason for the big fall in the number of delays in hospital as a result of the 'Cash for Change' programme introduced by the Government in 2001. The combination of extra targeted resources, local partnerships between councils and NHS trusts, and the support offered by the Change Agent Team has transformed the position – from over 7,000 delays in 2001 down to less than 3,000 by the end of March this year. In effect this has freed up 4,000 extra beds – the equivalent of adding eight typical acute hospitals to the NHS.

As John Reid commented recently, this success has been driven by the work of the team, and I am grateful to change agents, associates and members of the wider expert group for the energy and commitment that they have brought to this.

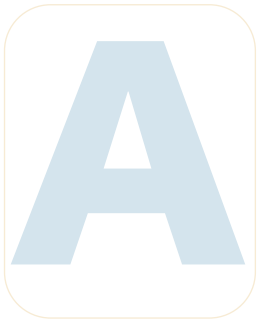
Solid though these achievements are, better services for older people are not just about hospital beds. We need a stronger focus on making sure that older people are admitted to hospital because it is the right option, not because it is the only option. I am very pleased that the Change Agent Team has increased its attention to alternatives to hospital and helping local systems develop a balanced spectrum of services in which more needs can be met in people's own homes or in local community settings such as extra care housing, making greater use of direct payments and slicker ways of delivering services,

for example through telecare and assistive technology. This is the way forward.

I want to see many more people have the kind of experience described by David Parker. There is much more to do. This is why CAT's remit has now been widened to support wider improvements in services for older people and I look forward to further achievements in 2004/5.

A handwritten signature in black ink, appearing to read 'Stephen Ladyman', with a horizontal line underneath it.

Stephen Ladyman
Parliamentary Under-Secretary of State for Community



Appendix A:

All Change Please – An independent evaluation of the Change Agent Team (executive summary)

Melanie Henwood

The Department of Health announced the establishment of the Health and Social Care Change Agent Team in October 2001, and it became operational in March 2002. The team was developed to support local change and implement contingency arrangements where there were particular problems in tackling delayed discharges of older people from acute hospitals.

This independent evaluation was commissioned by the Department of Health to examine the work of the team, its success in meeting its objectives, and to identify the implications of using a similar model on future occasions.

The problem of delayed discharges is of long-standing. However, the need to tackle the issues was signalled clearly in the NHS Plan, and has since been consistently reinforced in reduction targets and performance management. The Building Care Capacity grant introduced in 2002/02 had the explicit objective of enabling local authority and NHS partners to develop “sustainable long-term solutions aimed at eliminating delayed transfers of care.”

The work of the Change Agent Team

The model of the Change Agent Team was an unusual one for the Department of Health, with little precedent in other activity. There were some parallels both with the earlier Community Care Support Force (CCSF) established to assist with the implementation of the community care changes in 1993, and also with the more recent Adoption Task Force. However, while the similarities are evident in terms of working with a team of experts to support work in particular authorities, and in the development of good practice materials, there are also significant differences. The terms of reference for the Change Agent Team appear relatively straightforward at first sight. Thus the team was established in order to:

- offer targeted interventions to help eliminate delayed discharges.
- support implementation of key aspects of the National Service Framework for older people that impact on delayed transfers of

- care, and
- assist with the development of a more integrated approach to the commissioning and provision of services, particularly in relation to intermediate care and housing.

However, this apparent clarity belies the scale and complexity of the task in practice.

Initially established for just 12 months, the team has twice been extended, and the final year of activity is now expected to end in March 2005. In this third year there is to be a shift in focus, aimed at a broader engagement with aspects of NSF implementation than to-date. In ensuring that the team operates to maximum effect in its final months this evaluation is especially timely. There is an opportunity to incorporate many of the lessons from earlier activity and to take steps to redress any areas of weakness.

The CAT has undertaken a substantial volume of activity, both through intensive work with individual sites, and through a range of other programmes that have reached out to a far larger group of localities. When the team was first established, the Department of Health had already identified a group of 55 councils that were judged to be experiencing the most severe problems with delayed transfers (and that had been targeted for extra funding to tackle these issues). Despite the expectation that the team would concentrate particularly on areas in which discharge problems were especially intractable, a strategic decision was made to focus not only on these 55, but to deliberately seek engagement with all local authorities, PCTs, and acute trusts that wished to secure support from the team. This provided a valuable opportunity not only to address particular difficulties, but also to engage with localities in which good practice and innovative developments could be identified and shared more widely.

The team's approach to all localities was also important in seeking a mandate. The Change Agent Team visited authorities following an

invitation to do so. The voluntary nature of the relationship with the team was important in countering what could otherwise have been an unhelpful image of a 'hit squad' sent in by the Department of Health. If the team was to succeed in resolving problems with delayed transfers, and to ensure that solutions were sustainable in the longer term (rather than merely quick fixes), it would only be through establishing local ownership and responsibility for the changes put in place. In a few instances authorities that were experiencing particular difficulties did not initially approach the team for assistance. Steps were taken in such circumstances to seek an invitation, and very little resistance or hostility was encountered. Such as there was, appeared to be a reflection of a misunderstanding of the team's role and remit, and this was successfully overcome through engagement with the team.

The underpinning rationale and principles for the team's approach were grounded explicitly in a whole systems understanding that focused on engaging all local stakeholders in seeking solutions, and avoiding apportioning blame to particular sectors. Intensive site work began with an initial diagnostic of the reasons for delayed transfers in terms of funding, process, structure, and systems. This provided the basis for the subsequent Action Plan for addressing and resolving the issues.

By March 2003 the team was providing intensive support to 25 health and social care communities. However, this involved a total of more than 160 stakeholder groups in the form of: 30 councils, 72 primary care trusts, 43 NHS hospital trusts, and 18 other NHS trusts. The evaluation made contact with 60 key site respondents (identified by the team as their main point of contact). Confidential password-accessed on-line questionnaires were developed, and completed returns were received from just under half this total group.

Virtually all of these respondents indicated that they had greeted the arrival of the Change Agent Team positively and optimistically, hopeful of what might be achieved. Almost 90% judged that the team was either extremely (40%) or reasonably (48%) helpful, and in more than half the sites (52%), the help turned out to be better than had been expected. The team was also felt by around the same proportion to be different from most people's usual experience of

consultants or inspectors (more constructive and less judgemental). A particular contrast was identified in the continuing commitment and support provided by the team. Rather than simply 'arriving, delivering a report and moving on', the team continued to work with the sites and to help them in delivering against their agreed local Action Plan.

Translating an Action Plan into delivery necessitated active sign-up from senior managers and their staff to take responsibility for implementing the required changes. Ensuring that this happens in practice has important implications for performance management by Strategic Health Authorities and social services inspectors, particularly after the departure of the team from intensive site work.

A key objective of the CAT's intervention has been to ensure that changes are sustainable. More than 80% of site respondents declared that they were extremely (15%) or fairly confident (67%) that change would be enduring, and that underlying problems had been resolved. In support of this optimism respondents pointed to the demonstrable local achievements in terms of successful reductions of delayed discharges that were remaining stable, and in enhanced working together and whole system sign-up to change. This perception is consistent with the team's own judgement that over the 12 months from May 2002 sites in which the team was involved had achieved a 24% reduction in the numbers of people delayed in hospital.

Not all respondents were as optimistic, nor as satisfied with their experiences of the team. However, those that expressed dissatisfaction represented a tiny minority. It would be surprising if site responses had been universally positive. The Team entered sites with a clear remit to bring about change. Such processes can be uncomfortable and difficult to manage, and inevitably challenge people's established ways of working.

Different members of the team were involved in work with different sites, and judgements about the success of the team's approach were often a reflection of the relative strengths and weaknesses of individual members. There was considerable praise for the skills and attributes of many members. Occasional criticisms were also made of

others, typically in terms of personal style or manner.

The intensive work with sites was by no means the totality of the work of the CAT. Other programmes of work took place in parallel including: one-off support; allocation of innovation funding; a London and South East Development Programme; three Learning and Improvement Networks; a related Integrated Care Network; a programme of implementation support around the introduction of delayed discharge reimbursement, and a wide range of workbooks, practice checklists, and other good practice material. The volume of activity is impressive. However, not all elements have proved to be equally successful, and at times there has been a lack of coherence across the components largely because of the inability of team members to have access to the 'big picture' or to be aware of the totality of activity.

Three Learning and Improvement Networks (LINs) were established (addressing intermediate care; discharge pathways; and housing and extra care). The housing LIN will continue to operate in the final year of the CAT programme. The objectives of all three LINs were concerned with:

- Identifying and sharing what works.
- Facilitating development work, including the adaptation of good practice to local settings.
- Promoting the development of a whole systems and joined-up approach to services for older people.
- Supporting a local action plan, including implementation and follow-up to achieve improvements.

Participants in the LINs rated access to good practice as the most valuable aspect of LIN activity. Information provision, and establishing contact with others were also highly valued. The housing LIN has been judged to be especially successful in meeting a need for support in an area that was not being address by other forums. It has adopted a model that is closer to community development and has focused on "trying to change people's thinking". A more strategic approach is envisaged for the final year that will build on this foundation and seek to develop a network that is self-sustaining.

The Integrated Care Network has been financially supported in part

by the CAT (but also through the Department of Health and NatPaCT). The objectives of the ICN are highly congruent with those of the CAT, particularly in a central focus on partnership working. If the CAT had not invested in the ICN it would have needed to find other ways to support integrated working, and there would have been no point in needlessly duplicating effort. Opportunities for closer integration of the two agencies should arise in 2004/05.

The London and South East development programme was established as a complement to site work, and was an attempt to address the particular difficulties that arise around socio-economic, workforce and market management variables. In retrospect it can be seen that the programme suffered from vague objectives and a lack of clarity of relationship with other related areas of activity. In many ways the task that it was established to address was an impossible one given the uncertainty of its parameters. Despite some reservations about the overall impact or coherence of the London & South East programme, it was clear that a number of important associated products arose from this work, notably the commissioning workbook, A Catalyst for Change.

The Team undertook a range of activity, and developed a number of products, around hospital discharge and reimbursement. The revised Hospital Discharge Workbook, Discharge from Hospital: Pathway, process and practice, brought together research evidence, best practice and current thinking around discharge practice within the context of whole systems working.

Other discharge-related activity of the Team was developed in response to the changing policy environment and new legislation to introduce financial reimbursement mechanisms for the NHS for delayed discharges that are agreed to be the responsibility of social services authorities. The Community Care (Delayed Discharges Etc) Act, 2003 was met with considerable hostility and confusion in the field. The CAT reimbursement group was established to address the significant implementation task associated with the introduction of the legislation in shadow form from October 2003, and becoming fully operational in January 2004. Working in close liaison both with Department of Health partners, and with key stakeholders on the

ground, the group developed a range of practically-oriented support products which refined the stages of the new discharge notification process and made clear the new duties for local authorities, but also for the NHS.

The reimbursement work was highly successful, not least in contributing to a shift in perception on the ground and an improved understanding of the objectives of the legislation to improve the quality of hospital discharges and ensure people do not remain in hospital beds needlessly. Feedback on the value of the products has been positive, and an indicator of the enthusiasm with which the material was received was provided by the data on the high volume of visitors to the reimbursement website during June-September 2003 when pressure was rising for local agencies to ensure their adequate preparations for the introduction of reimbursement arrangements.

The successful operation of the group reflected, in particular, a highly constructive relationship between the change agent leading the work and their Department of Health policy counterparts. In a policy area that had enormous potential to go badly wrong, the value of this relationship was paramount.

Team organisation and operation

The composition and nature of the Change Agent Team were important variables that shaped the way in which the team operated and the skill mix that it had available. The team operated from a small core of members (the change agents) alongside a much larger Expert Group. In addition, various people have been engaged as 'associates' for specific pieces of work.

The change agents brought a wealth of experience, with around half the team coming from social care backgrounds, and the others mainly drawn from primary and community health service experience. Members expressed a firm commitment to wanting to make a contribution to an important area of development, and viewed the team as an exciting and innovative opportunity. For seventy five per cent of the team, the experience with the CAT more than lived up to their hopes and expectations.

Members were recruited to the team on the strength of their experience and track records in service improvement and change management through whole systems and partnership working. However, it was apparent that the transition involved in working for the team was a highly demanding one that required members to rapidly develop new skills and confidence. Nonetheless, it was precisely for their capacity to respond to such demands that these change agents had been appointed.

New ways of working (particularly with a 'virtual' or dispersed team such as this) present new challenges to business support and infrastructure, and it was clear that the CAT had struggled, particularly in the early days, to develop appropriate and responsive systems. The Department of Health was not used to working with staff in a structure such as this, and basic administrative and technical requirements all had to be resolved. This created difficulties and frustrations for change agents and support staff alike. While new ways of working necessitate greater flexibility from the Department of Health, there is also a need for a shift in expectations and the development of new IT skills from all those involved.

Almost universally the change agents were convinced that their experiences with the team had been of value to them. Tangible benefits were identified in particular in respect of:

- Gains in confidence.
- Development of new skills and knowledge.
- Personal and professional development opportunities.
- Beneficial networking opportunities and ease of access to the Department of Health.

The high level of satisfaction in being part of the CAT has also been underlined by the continuity that has been achieved in membership, and the re-appointment of most team members for the final year. Others who have now left the team have done so because of promotion and career progression opportunities.

Alongside the main team, the Expert Group was considerably more numerous (52 members at the time of the evaluation) and diverse. The professional backgrounds of members were more varied, with a larger proportion engaged in independent consultancy. Members of

the group had deliberately been recruited in order to bring in a wider range of skills than was represented in the core team, particularly around clinical experience and housing backgrounds.

Unlike the main change agents who were almost all appointed to the team on a full time basis, the pattern of involvement of expert members was considerably more varied. A small core of members have been heavily involved with the team's work, while most have had occasional engagement and have operated more on the periphery. More than two thirds of expert group respondents were satisfied with their experiences on the team. Those who expressed disappointment typically wanted to be more involved than they had been to-date.

The pattern of involvement of members was viewed by many as haphazard, and it was unclear why some members became more heavily involved than others. The single most important factor appeared to be the extent to which members deliberately sought engagement; those who did so were generally those who were more likely to be used for other pieces of work while those who waited to be asked often continued to wait. Such an approach was likely to ensure that the most motivated and confident individuals would be those working regularly with the CAT; arguably these were precisely the skills that would be of most value to the team.

The expert group had important functions in addition to providing a wider pool of members to contribute to field work or other development work. In particular, it provided a valuable sounding board and external reference group for the overall direction of the CAT. Such a role was deliberately encouraged, not least in the regular meetings of the expert members and key change agents.

The view from the Department of Health

The perspective of the Department of Health was an important one to include in the evaluation of the work of the Change Agent Team. Reflections were sought both on the specific work undertaken by the CAT, but also on the model of working that had been developed in the team's creation.

There was considerable support for the CAT within the Department, both as a general principle, and in terms of particular areas of work and impact. Some customers indicated that they had been sceptical at the outset but had changed their view in the light of experience and had become much more positive.

It was widely recognised that the major changes that have taken place in health and social care policy in recent times, particularly in the shift towards greater devolution of power to local level, create new opportunities but also considerable challenges. For the Department of Health, there is a reduced capacity to directly influence local developments. The loss of the familiar 'command and control' style has necessitated the creation of new ways of working with the field. The Change Agent Team needs to be seen within this context; it provided a practical way of filling a gap in the implementation process that would otherwise have been very difficult to address.

The strengths of the team were widely recognised by Department of Health respondents, particularly in the capacity of change agents to get engaged in local systems and find ways through intractable difficulties. At the same time, it was recognised that there could be tensions between this intensive targeted work, and the need to influence more widely. Clearly, getting this balance right has been an ongoing challenge for the work of the CAT.

The new model of working that the CAT represented was also one that could be difficult for some policy customers to engage with. Some respondents were concerned that they had been insufficiently involved in the work of the team, or did not know enough about their activity. A minority acknowledged the discomfort that could accompany the team's involvement in policy areas that officials had often been closely involved with for some time and towards which they felt some ownership.

Some respondents were also concerned at the apparent lack of understanding of some CAT members of the policy process, and the respective responsibilities of officials and Ministers. This could have created difficulties, particularly in terms of confusion of important

policy messages. The fact that this potential was recognised enabled it to be resolved

The need for mutual trust between the team and policy customers was of the utmost importance. While this can only develop on the basis of experience over time, it is likely that it might have been easier if there had been greater attention early on to developing the relationship through regular information exchange and contact between the two groups.

Despite some reservations, the general response of policy customers towards the CAT was overwhelmingly positive and optimistic. At the very least, the team is judged to have been successful in getting people in the field to talk to each other and to move away from a history of poor partnership working. The team is believed to have made a real contribution to the achievements in reducing delayed discharges, and there is considerably more confidence that the changes will be sustainable than would have been the case in the team's absence. There are high expectations for continued delivery in the final year of operation, and an optimism that there is a real opportunity to energise the NSF for older people.

Conclusions and recommendations

This evaluation of the Change Agent Team analysed the way in which the team operated and the success of its strategies. The findings are of relevance not just for what they reveal about this particular initiative, but for what they also indicate about new models of working and support for policy implementation within the Department of Health (and potentially other government departments).

The evaluation has found many strengths in the Change Agent Team, and some weaknesses. Despite some minor reservations, the team is generally well regarded and credible. It has been extremely productive and has engaged with a large number of localities, and generated considerable material and implementation products. The greatest strengths of the CAT lie in its capacity to work with local sites and to tackle practical issues, as well as the ability to address key implementation needs of the field and to develop appropriate tools

to assist them (notably around reimbursement, discharge practice and commissioning). The diversity of the work programme has been a further strength, but has also posed the greatest challenge in ensuring that overall coherence is maximised.

Many of the issues that have been highlighted by the evaluation have been recognised and are being addressed in the team's reorganisation and the development of a revised programme for the final year of operation. The core recommendations from the evaluation have implications both for the Department of Health and for the team itself, and these include the following:

- In setting up any future agency to support the implementation of policy, the Department of Health should pay particular attention to the administrative and support needs of the members (including their needs to develop new IT skills), which are likely to be considerably different from those of largely office-based civil servants. At the same time, attention should be paid to addressing the support expectations of members, and ensuring that there is greater mutual understanding between the team and its support staff over what needs to be provided, and in what respects it is reasonable to expect members will be largely self-supporting.
- In 2004/05 the CAT should ensure that greater attention and resources are committed to actively building linkages between the programme components, and ensuring that there is systematic cross-fertilisation of knowledge and experience in order to secure added value from the programme overall.
- The Department of Health should consider what further leverage and performance management is needed to prioritise the implementation of the NSF. The timing of the NSF review could militate against such action since the temptation could be to await the findings of the review before deciding on what, if any, reinforcement is necessary. However, without such action before the end of 2005 there is also a risk of inertia and of insufficient priority being attached to meeting the NSF targets, and it is recommended that the central importance of health and social care communities implementing the NSF is addressed by the Department of Health as a matter of urgency.
- The Department of Health and the Change Agent Team should

both address how best they might support interaction between their two agencies, and maximise opportunities for shared learning and development.

- The Department of Health should explore how best it might support people engaged in successful careers in different aspects of health and social care practice, management or consultancy, to contribute their skills – as part of their personal and professional development – to new models of working in support of policy implementation. At the same time, their host organisations may need further help in recognising the mutual benefits of such secondments. It is probable that the use of external bodies such as the Change Agent Team will become of increasing importance (not least because of the down-sizing of the Department of Health and its reduced capacity to address the detail of the policy implementation and support requirements of the field). At the same time, attention should be paid to identifying the training requirements of these change agents, and to ensuring that they are as well equipped as they can be for such demanding activity.

The conclusions and recommendations that have been offered above reflect the major themes that have emerged from the various strands of the evaluation of the Change Agent Team. They are offered as a constructive commentary on the work of the team, and in the hope of informing the refinement of aims and objectives for 2004/05, and ensuring that maximum use is made of the invaluable experience of the team and this innovative model of working. Change is an ever-present feature of the health and social care landscape; ensuring that such change is well managed, minimises disruption, and delivers on key objectives, is a continuing challenge. The approach and achievements of the Change Agent Team provide a powerful endorsement of what can be achieved through a managed, properly resourced and skilled support team. The experience also contributes to the development of a consistent model for managing change that has wide potential for further application in addressing the interface between central policy and local delivery.

For further information

The full report of the *evaluation of the Change Agent Team* is available from change_agent_team@dh.gsi.gov.uk

B

Appendix B: Membership of the Change Agent Team and Expert Group 2003/04

The Change Agent Team during 2003/04

Richard Humphries	Director
Fran McCabe	Deputy Director
Amy Nicholas	Co-ordinator
Anne Ashby	Change Agent (until September 2003)
Angela Glew	Change Agent
Fiona McLeod	Change Agent
Janet Crampton	Change Agent
Jill Tiernan	Change Agent
Judith Whittam	Change Agent (from September 2003)
Moira McGrath	Change Agent
Maureen Allan	Change Agent
Liz Foley	Change Agent
Liz Sargeant	Change Agent (until June 2003)
Nye Harries	Change Agent
Ruth Eley	Change Agent
Roy Harry	Information Manager & Analyst
Judy McCallum	Programmes & Office Manager
Claire O'Connor	Programme Support Officer
Rose Agyemang	LSE Programme Support Officer
Lucia Cornacchione	Temporary Clerical Support Officer

The Change Agent Team Associates during 2003/04

Jan Stevenson	Change Agent Team Intermediate Care Network Lead,
Jane Gilliard	Change Agent Team Lead for Mental Health services for Older People
Jeremy Porteus	Change Agent Team Housing Network Lead
Robin Lorimer	Change Agent Team Discharge Planning and Care Pathways Network Lead

Expert Group during 2003/04

Alan Clark	Project Director, London Commissioning of Older People's Services Project, ALG and GLADSS
Angela Nicholls	Independent Consultant and Researcher
Ann James	Independent Consultant in Health and Social Care
Anne Bailey	Manager, Older People's Strategy Team; Wolverhampton City Council
Annie Stevenson	Senior Policy Advisor (Health and Social Care); Help the Aged
Barbara Laing	Director of Anchor Homes, and Extra Care Housing Schemes
Beverley Castleton	Consultant Physician in the Care of the Elderly and IT Clinical Advisor to the Department of Health and NHSIA
Brian Parrott	Chair of Central Suffolk NHS Primary Care Trust and Independent Consultant
Bruce Herriot (Dr)	General Practitioner, Senior Partner and Trainer; Malvern
Cathy Smith	Independent Healthcare Consultant
Charlie Barker	Social Services Director; Sefton Metropolitan Borough Council
Chris Dunstan	General Practitioner (Partner); Parishes Bridge Medical Practice
Chris (Dr) Foote	Independent Clinical Systems Consultant and member of Balance of Care Team
Claire Old	Director of Quality and Nursing; Dudley Primary Care Trust
Eileen Kibbler	Director of Clinical Services; Oldbury and Smethwick Primary Care Trust
Eileen Means	Director of Social Services and Housing; Reading Borough Council
Frank Brown	Interim Head of Community Care; London Borough of Barnet
Helen Parker	External Consultant, Director of Healthskills
Hester Ormiston	Social and Health Care Consultant
Ian Knighton	Independent Consultant
Jan Allwood	Health and Social Care Consultant
Jane Minter	Head of External Affairs; Housing 21
Jean Tottie	Independent Consultant in Health and Social Care
Jenni Mogridge	Independent Consultant
Jill Lees	Health and Social Care Consultant
Laura Middleton	Professor and Social Work Consultant; CSCI
Lesley Sinnock	Independent Consultant in Health and Social Care
Linda Tully	Assistant Director, Older Peoples Services; North Sheffield
Liz Haggard	Freelance Consultant, Health and Social Care

Lorna Ainsworth	Consultant in Management and Health Care; Care Centre Manager
Lucianne Sawyer Maeve Groom	Lead Consultant, Community Care Research and Consultancy Independent Consultant Advising on Health and Social Care; Derbyshire.
Marian Harrington	Assistant Director Older People Disability and Health; Westminster City Council
Mary Crawford	Occupational Therapist and Independent Practitioner in Health and Social Care
Mike Padgham	Managing provider services for Older People with Dementia, Independent Consultant
Olwen Pollinger	Intermediate Care Co-ordinator, South Tyneside Primary Care Trust
Paul Hodgkin (Dr)	General Practitioner, PEC member and Cancer Lead for SE Sheffield Primary Care Trust and South Yorkshire Strategic Health Authority Clinical Lead for Choose and Book programme.
Pauline Spencer	Yorkshire Strategic Health Authority
Rob Johnson	Independent Sector Home Owner
Rosemary Hurtley Ruth Gordon	Independent Consultant and Occupational Therapist Assistant Director of Corporate Development; Bradford City Primary Care Trust
Stephen Thorpe	Associate Director – Partnerships, Avon, Gloucestershire and Wiltshire Strategic Health Authority
Trevor Purt	Independent Business Consultant



Appendix C:

Activity Matrix – What we have done and where in 2003/04

LOCAL AUTHORITY	Site Work	LIN DP & Int. Care	LIN Housing	Innovation Funding	Int. Care Capital	One-off Support	London & SE Capital Dvlpmnt Prog				London Jt Comm. Proj	W'chair Collab	Comm. Eqpmnt
							1	2	3	4			
London Boroughs													
Barking & Dagenham	2				•	•				•	•		
Barnet													
Bexley					•				•	•			
Brent										•			
Bromley				•					•			•	
Camden									•			•	
City of London				•					•	•			
Croydon										•			
Ealing		•	•						•		•		
Enfield		•		•	•							•	
Greenwich							•			•			
Hackney									•	•			
Hammersmith & Fulham			•	•			•		•				
Haringey					•								
Harrow			•		•	•			•	•			
Havering										•		•	
Hillingdon	2b	•		•	•				•	•			
Hounslow				•	•					•			
Islington													
Kensington & Chelsea					•					•			
Kingston upon Thames									•	•			
Lambeth		•	•						•				
Lewisham		•	•		•					•			
Merton									•	•			
Newham			•						•	•			
Redbridge									•				
Richmond upon Thames				•					•	•			
Southwark		•					•			•	•		
Sutton	1	•	•						•	•			
Tower Hamlets			•		•				•	•			
Waltham Forest		•	•		•	•			•	•			

LOCAL AUTHORITY	Site Work	LIN DP & Int. Care	LIN Housing	Innovation Funding	Int. Care Capital	One-off Support	London & SE Capital Dvlpmnt Prog				London Jt Comm. Proj	W'chair Collab	Comm. Eqpmt
							1	2	3	4			
Wandsworth					•					•			
Westminster								•	•				
Eastern Area											•		
Bedfordshire					•								
Cambridgeshire	1			•	•								
Essex	3			•	•						•		
Hertfordshire	2b			•									
Norfolk													
Peterborough	2			•*									
Southend	3												
Suffolk	3	•	•	•							•		
Thurrock	3		•										
Midlands													
Birmingham	1			•	•						•		
Bolsover			•										
Chesterfield			•										
Coventry	2			•	•								
Derbyshire			•								•		
Dudley			•	•									
Herefordshire	3	•											
Leicester City											•		
Lincolnshire			•										
Northamptonshire	3	•	•	•					•				
Nottinghamshire		•	•										
Sandwell		•		•						•			
Shropshire		•											
Solihull				•									
Staffordshire	3										•		
Stoke	3		•										
Walsall				•		•					•		
Warwickshire	3										•		
Wolverhampton			•	•									
Worcestershire	1										•		
South East Area													
Bracknell Forest									•				
Brighton	1			•			•	•	•				
Buckinghamshire				•		•		•	•				

LOCAL AUTHORITY	Site Work	LIN DP & Int. Care	LIN Housing	Innovation Funding	Int. Care Capital	One-off Support	London & SE Capital Dvlpmnt Prog				London Jt Comm. Proj	W'chair Collab	Comm. Eqpmt
							1	2	3	4			
East Sussex	2			•	•		•		•	•			
Eastbourne			•										
Hampshire	2b	•							•	•			
Isle of Wight									•	•			
Kent	1		•				•	•		•		•	
Medway	1		•				•			•			
Milton Keynes						•				•			
Oxfordshire	1								•			•	
Portsmouth	3							•					
Reading									•				
Slough		•		•									
Southampton	2		•				•						
Surrey	2		•	•	•		•			•			
West Berkshire		•	•		•								
West Sussex	2b				•		•	•	•	•			
Windsor & Maidenhead		•	•	•					•				
Wokingham			•										
South West Area													
Bath & NE Somerset				•									
Bournemouth	3		•										
Bristol	1	•	•	•	•							•	
Cornwall	3			•									
Devon (South only)	2		•	•				•					
Dorset	3											•	
Gloucestershire				•	•			•					
North Somerset				•									
Poole	3												
Somerset				•				•					
South Gloucestershire	1		•	•	•								
Swindon				•		•				•			
Torbay	2			•									
Wiltshire	2b			•	•								
North West													
Bury				•									
Cheshire			•		•								
Cumbria												•	
Knowsley	1	•			•								

LOCAL AUTHORITY	Site Work	LIN DP & Int. Care	LIN Housing	Innovation Funding	Int. Care Capital	One-off Support	London & SE Capital Dvlpmnt Prog				W'chair Collab	Comm. Eqpmt
							1	2	3	4		
Lancashire			•									
Liverpool		•	•								•	
Manchester	3			•						•		
Salford			•	•								
Sefton		•			•					•		
St Helens	1	•		•	•							
Stockport				•								
Tameside				•								
Trafford			•	•								
Wirral	2			•	•						•	
North East												
Darlington		•	•									
Durham		•	•	•		•						
Gateshead										•		
Hartlepool			•								•	
Middlesbrough		•										
Newcastle			•	•								
Redcar & Cleveland			•									
South Tyneside				•							•	
Yorkshire & Humber												
Doncaster											•	
Kingston upon Hull		•										
Leeds	2			•								
North East Lincolnshire		•	•	•		•						
North Yorkshire	1		•	•							•	
Rotherham			•		•							
Sheffield	1											
Wakefield						•						
York City	1				•							

N.B. Support activities are listed by local authorities in DHSC areas. In some places CAT support may not have been directly to the local authority but to a health/PCT or other partner within the local authority boundary.

LIN – Learning and Improvement Networks for Discharge Planning & Intermediate Care

London & South East Capacity Development Programme Activities:

1 = South East Commissioning Project

2 = Commissioning Workbook

3 = Independent Sector Intelligence Gathering

4 = Regular Attendance at Commissioning Seminars

London Commissioning Older People's Services Project

* = Funded but not directly provided by the CAT



Appendix D: CAT publications

1. *An engaging process*, 2003
2. *Directory of housing advice and information services for older people*, 2003
3. *Implementing building care capacity and partnership in care*, 2003
4. *Developing and implementing local extra care Housing strategies*, 2004
5. *Extra care housing for older people – An introduction for commissioners*, 2004
6. *Delivering person-centred care for people with dementia: Lessons for housing and care providers*, 2004
7. *Changing places: Report on the work of the Health and Social Care Change Agent Team 2002/03*, 2003
8. *Assistive technology and telecare: Forging solutions for independent living*, 2003
9. *Extra care housing directory*, 2003
10. *Discharge from hospital: Pathway, process and practice*, 2003
11. *A catalyst for change: Driving change in the strategic commissioning of non-acute services for older people*, 2003
12. *Discharge from hospital – A good practice checklist*, 2002
13. *Discharge from hospital – Implementing reimbursement*, 2002
Supplementary checklist to prepare for the Community Care (Delayed Discharges) Bill
14. *Defining a whole systems approach*, 2003
15. *Commissioning and the independent sector – A good practice checklist*, 2003
16. *Discharge from hospital – Getting it right for people with dementia*, 2003
17. *Discharge from hospital – A matter of 'choice'*, 2003
18. *Moves in hospital – Getting it right for people with dementia*, 2003
19. *Avoiding and diverting admissions to hospital – A good practice guide*, 2004

E

Appendix E: Patient and carer stories in full

A patient and two carers kindly wrote accounts of their experiences of the NHS and social care to help illustrate this report. David Parker's account of his mother's experience is a foreword to the report. Here the other two accounts, quoted throughout the report, are given in full.

A patient's account

"I am pleased to have been asked to tell my story as part of the Change Agent Team annual report for 2004. As chairperson of our local older person's forum, I am involved in a number of projects linked to the Modernisation Agency and the National Service Framework for Older People. Only days before my accident, I didn't hesitate to share with our local falls group my views that I personally wouldn't be seen dead in hip protectors. Lying on the floor of my basement with a broken hip, I wished I had taken a somewhat closer look at the issue of falls prevention. But of course, that sort of thing never really applies to you – does it?

My experience of the emergency services was very good. The ambulance arrived quickly and I was given pain relief immediately. I was seen very quickly in A&E and constituted a 'trolley wait' for only an hour or so while a porter could be found to take me to the ward. I had my operation the next day and even watched it on TV.

Staying in hospital is frightening and at times humiliating. There remains a great deal of variation between staff and their working practices. There are those who are genuinely kind and caring and those who are ignorant and abusive. All are 'too busy'. I was one of the lucky ones. Slightly younger and more articulate, I was able to look after myself. Others were less fortunate. Meals were left in front of people who were clearly unable to sit up and eat and people were shouted at to 'drink more' but never helped to do so. To be offered a bowl of water and an opportunity to clean your teeth before settling down for the night would have been nice. I eventually asked for one and it was willingly provided, but it took some courage to ask.

Being in hospital can also be lonely and depressing. Ward staff tended to shout because we were assumed to be deaf. Changes to visiting hours were poorly explained and there was no information given to patients and relatives about day-to-day routine. I was shocked to discover that fresh flowers were not allowed on the ward for reasons of hygiene. The toilets were filthy and when staff were busy, I was left sitting on a bedpan and unable to wash my hands. This irony fell on deaf ears.

In hospital I received very good care from my orthopaedic surgeon who worked very closely with my consultant rheumatologist about a pre-existing condition. I was later visited by the entire rheumatology team and was treated as a sane, articulate person. I was also visited by a specialist nurse who has provided a tremendous amount of support since I was diagnosed with Parkinson's disease.

I was visited by two physiotherapists on the ward. One spent ten minutes showing me how to walk using a frame and the other, from the rheumatology department, gave me some general advice about hip protection and managing my arthritis.

My discharge home was frenetic and unplanned. The consultant decided I was fit in the morning and I was home later that same day. Within minutes of being discharged, the physiotherapist visited me again to show me how to use sticks on the stairs and how to get into the car. Unfortunately, the lesson did not extend to showing me how to get out. I was given a scruffy bit of paper about using the stairs which was passed off as an information sheet. Shaky but home!

Five days later I was contacted by an occupational therapy assistant who enquired if I was managing OK. I explained about my difficulties and she arranged for me to have a trolley with wheels. The equipment arrived very quickly and a visit was arranged to show me how to use it. She apparently knew all about my home circumstances, but how she came upon this information I do not know as neither myself nor my husband were party to any such discussions.

Making the transition from the person that helps write the falls

prevention strategy to the person who needs to wear hip protectors (if only they made them in my size) comes as a real shock to the system. It is also a real eye-opener. There was no discharge planning, no single assessment, no carer's assessment, no intermediate care and no community care. In fact, I did start to wonder if the NSF had been a figment of my imagination.

Ironically, one of the things that helped me through was keeping a diary about my experiences. Although my story suggests that an awful lot of work does still need to be done, I can say with hand on heart that I have since felt genuinely listened to and involved. My 'patient journey' has been made into a training video for staff, our modern matron and PALS officers are championing a whole range of issues linked to dignity on the ward and the flowers I so desperately missed have been reinstated. Changes are taking place in the NHS and perhaps the onus is on us as older people to start shouting louder when it comes to telling our stories. Thanks to the Modernisation Agency and the local implementation teams for listening.

Mrs Ina Acres

Service user

A daughter's account

"In the early stages, when my dad was suffering from senile dementia, he was still being cared for in his own home. Care workers were employed to attend to him three times a day.

Unfortunately, he had a turn for the worst and he had to be admitted to a 'general' hospital. The medical staff suspected that he had yet another mini-stroke. The hospital did not cater for people suffering from senile dementia. My dad used to wander up and down the ward and on a few occasions he wandered off the ward.

On one occasion, he left the hospital in his night clothes and slippers and walked up to my sister's house, half a mile from the hospital. Fortunately, on that particular day, my brother-in-law had a day off work and was still at home to open the door for my dad. Luckily, he did not suffer any injuries, but needless to say we were horrified to

realise that my dad was able to walk all this way without the hospital staff realising that he was missing. Furthermore, the hospital staff failed to contact the family to notify us that my dad had gone missing. This experience would have been emotionally stressful for Dad, as he showed physical signs of his reluctance to return to the hospital.

The family decided that my dad could no longer live in his own home. Subsequently, we arranged for him to be admitted to a nursing home. As he was awaiting accommodation at a private nursing home, he fell out of bed, hit his side on his bedside cabinet and broke his hip. He had to undergo the trauma of a hip replacement, which left him virtually immobile. He was in a much more vulnerable position than he was before. As he had senile dementia, he could not understand why he could not get up and walk as he had done before.

While the staff in the hospital were very kind to my dad, the care they could give him could not match that of a specialist hospital caring for older people with mental health problems. They did their best to attend to his needs, but could not give him the full attention he required, including stimulating activities that would promote cognitive activities. Sometimes Dad would be taken to the toilet and the staff would forget that he was there, as they were so busy. While still in the hospital, my dad was always in an agitated state, and wanted to be on the move all the time.

Even when he was finally transferred to the nursing home, his needs were not fully met. When the staff did not have time to attend to him, they would sit him in a special chair to make it impossible for him to get up. The staff were also very kind, but they seemed to be short-staffed. On one occasion, my dad fell out of bed and the staff found him crawling on the floor.

Dad died two years ago."

Judith McMillan