Care Services Improvement Partnership CSIP

High Impact Changes for health and social care

An inspirational collection of organisational initiatives, which are changing health and social care services and the lives of people who use them

March 2008

DH INFORMATION READER BOX

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Foreword

The White Paper, Our health, our care, our say and statements in the 2007 budget report and comprehensive spending review announcement outlined the key elements of a reformed adult social care system in England. This will be a system able to respond to the demographic challenges presented by an ageing society and the rising expectations of those who depend on social care for their quality of life and capacity to experience full and purposeful lives.

The approach was confirmed in the landmark 'Putting people first', a concordat between six government departments, the Local Government Association, the Association of Directors of Adult Social Services, the NHS, representatives of independent sector providers, the Commission for Social Care Inspection and other partners, published in December 2007.

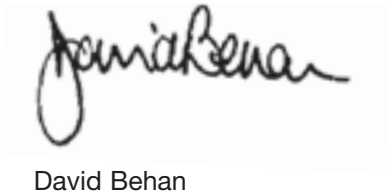
Putting people first outlined a shared vision and commitment to the transformation of adult social care. This landmark protocol seeks to set out and support the Government's commitment to independent living for all adults. It also outlines the shared aims and values which will guide the transformation of adult social care.

The report is unique in establishing a collaborative approach between central and local government, the sectors of professional leadership, providers and the regulator.

To achieve the transformation required to deliver this agenda will mean working across the boundaries of organisations such as adult social services and health, housing, benefits, leisure and transport. It will also mean working across the sector with partners from independent, voluntary and community organisations

These High Impact Changes provide an evidence base for organisations delivering this agenda. This guide includes examples of effective partnerships between staff, service users and carers and how we can change practice in ways that will make a genuine difference to people's lives and experience and to the working lives of staff.

Offering real choice and putting people in control of their services requires significant cultural change, organisational support and leadership. Some of the changes are small, some very large but all have the impact of improving people's lives.



David Behan
Director General for Social Care

March 2008

Introduction

The Government focused on seven positive outcomes for people using health and social care services in its Green Paper Independence wellbeing and choice and the White Paper Our health our care our say.

Putting people first, published in December 2007, built on these and was closely followed in 2008 by the Local Government Circular Transforming Social Care.

The seven outcomes are:

- improved health and emotional wellbeing
- improved quality of life
- making a positive contribution
- choice and control
- freedom from discrimination
- economic wellbeing, and
- personal dignity.

These outcomes were identified following a major consultation exercise and are informed by the expressed views of service users and carers across the country.

Now the Care Services Improvement Partnership (CSIP) has identified an inspirational collection of organisational initiatives to achieve the seven outcomes which are changing health and social care services and the lives of people who use them.

The changes support the Department of Health's objectives to:

- develop a future strategy to deliver modernised services, to an ageing population.
- give people greater control, choice and services that are built around the individual.
- drive continuous improvement in the quality of services whilst ensuring value for money through the fair and effective use of resources, and
- promote the commissioning, development and provision of services, which allow people to live independently in the community where they choose to do so.

They will also support the priorities identified for social care by the Department of Health which are:

- commissioning for outcomes
- delivering the dementia strategy
- personalisation of services
- early intervention, and
- dignity.

Background

In 2004 the NHS Modernisation Agency developed the '10 High Impact Changes for Service Improvement and Delivery: A Guide for NHS Leaders' (2004).

This guide is still being actively being used by local health services and systems. It highlights areas of service improvement that have the biggest impact on clinical outcomes, service delivery, staff and their organisations and so make a difference to service users and carers.

CSIP then developed 10 High Impact Changes for Mental Health Services' in June 2006, which were well received by practitioners, service users and carers alike. CSIP has now developed these high impact changes for health and social care so this successful model can support health and social care services to benefit from this approach to improvement.

The changes set out here will provide a framework for service improvement. They are not all new, but they do make a difference and have been selected to illustrate the way in which applying the principles of the White Paper can improve service outcomes.

These changes include examples of effective partnerships between staff, people who use services and carers; ways to change practice that make a difference to the lives and experience of people who use services.

The evidence

We have developed these ten changes from a wide evidence base. Evidence based academic research was commissioned from the Centre for Social Care Research at Swansea University and led by Dr Sherrill Evans and professor Peter Huxley.

The university reviewed existing literature and also ran web-based searches to identify and classify evidence about the impact of service changes.

Researchers then held focus groups with service users, carers, social care practitioners and managers to discuss the evidence and prioritise the service changes. The work included identifying other service changes not previously captured or written up as evidence.

The Social Care Institute for Excellence (SCIE) led a review on evidence conducted by Pete Fleischmann and Ossie Stuart called: What service users want from adult social care services and what makes a difference. (SCIE internal document, Sept 2007.)

CSIP requested evidence from the field by asking providers and commissioners to highlight service implementation that has a positive impact for service users in at least one of the seven outcome areas.

Some CSIP regional development centres also held focus groups for users and carers or distributed questionnaires to ask them about their experiences of effective services and what has made a difference for them.

Weighing up the evidence

The nature of evidence about what works is less clear in social than in health care, and hence the approaches to evidence based policy and practice differ. In social care, outcome-focused research is relatively scarce so it is important that reviews of 'what works' consider all the sources of evidence available.

We have been thorough in searching for and collating evidence and our findings are informative and instructive. But it is clear that the evidence base in social care needs strengthening. The following quotation is from the literature review conducted by Swansea University:

"If there is a general, overall result that can be gleaned from the research and the groups it is of the extreme variability of implementation of most of the changes across the nation. This has the consequence of making it hard to find one or more single change that has had a consistent national impact…This variability… suggests that more research of a larger scale…needs to be commissioned in order to get a more comprehensive picture of real impact"

This review has inevitably drawn on a great deal of 'soft' or qualitative evidence that is largely narrative and anecdotal in nature. As such it contains clear accounts from people who use services about what they find beneficial. Providers and commissioners need to make sure that additional measures of quality improvement are put in place to strengthen the evidence base.

The balanced scorecard

We have adopted a 'balanced scorecard' approach which shows the benefits from each change or service redesign. For every benefit identified in the service improvement or change process the questions we asked were:

- how will we know that we have achieved the benefit we identified? And,
- how can the benefit be measured and demonstrated?

Achieving benefits and demonstrating High Impact Change requires robust baseline assessment and ongoing measurement of the service improvement.

We have used this approach to assess the evidence. The scorecard shows the impact on people, partnerships, organisations and systems/processes. Not all changes will have a benefit under each heading but will have a degree of balance which will indicate that it is robust and that the impact has been considered on behalf of stakeholders involved and the whole system.

The format for the scorecard we used is:

Benefits for people

Benefits for partnerships

Benefits for organisation

Benefits for systems

Key principles of this approach are outlined below:

- a benefit can be defined as an advantage to a person or a group of people i.e. a stakeholder or group of stakeholders
- a benefit is only a benefit when the recipient says it is,
- the benefits are often retrospective i.e. they come to light afterwards rather than having been planned for
- we often rely on perceived benefits rather than articulating what benefits we expect to see before the change and identifying measures to show us that they have been realised
- benefits must at the very least be observable and should be measured, and
- realising benefits usually means: doing something new, doing things better or ceasing to do something.

The changes

The High Impact Changes are relevant across the range of social care, health and non-statutory organisations.

The principles and application of service improvement are often transferable and so we can share useful learning across different areas of health and social care.

We have identified changes which are illustrated with case examples to demonstrate each particular change.

Recurring themes

When analysing all the information we found that there were recurring themes upon which to base the changes which we list below. We have taken these recurring themes as our headings for this text and followed each heading with a section describing the change and a case study that shows the difference it makes in real terms.

1) involvement
2) dignity and respect
3) meeting fundamental needs
4) accessible information and support
5) partnership working
6) personalised services
7) effective commissioning
8) flexibility/challenge/creativity
9) inclusion, and
10) carers as partners in care

With each of these changes we have indicated which of the outcomes identified by Our health our care our say have been achieved with this change.

Details of the services and organisations that have provided case studies are listed at the end of this document.

Involvement

Change: involve service users and carers as the norm in every aspect of service planning, redesign and improvement and in recruiting and training of staff.

Description: training service users in recruitment and selection of staff and engaging them in service design helps them to exercise their rights as citizens, be included in daily life and develop skills relevant to empowerment and employment which give them chances to be independent.

Staff need to work in partnership with people who use services and carers, treating them with respect and dignity. Involving people who use services at all levels creates cultural change and is the key to improvement in all aspects of service provision.

Comment: organisations need to create opportunities for people who use services to participate in all stages of decision making i.e. planning, purchasing, delivery, inspection and monitoring and evaluating services.

Outcome: personal dignity; making a positive contribution.

Benefits for people

Greater self confidence
Have more control over their lives
Development of new skills
Have a clear and positive role
Improved quality of life

Benefits for partnerships

Increased understanding of each other
Organisational benefits shared
Common aims identified
Greater efficiency
Sharing of good practice

Benefits for organisation

Services appropriately targeted
Commitment to partnership with service users
Improved recruitment outcomes
Shared resource with other organisations
Cultural change

Benefits for systems

Improved information systems
Streamlined processes
Better strategic thinking

Choosing Staff: service user involvement in recruitment and selection throughout the Westminster Learning Disability Partnership

Partner organisations: *Westminster Employment, Westminster Society, Westminster Learning Disability Partnership, East London University, Southbank University, City University London, Westminster Primary Care Trust, Central and North West London NHS Foundation Trust and Our Choice Advocacy Project.*

People with learning disabilities living in Westminster had no opportunity to put their life experiences to use, to select the staff providing them with daily support, or to identify what skills and qualities they felt were important for these staff to have.

As part of modernising day services in Westminster, a Choosing Staff pilot was set up in one unit of the Westminster day services for people with learning disabilities in 2000. The unit aimed to train people with learning disabilities as consultants in recruitment and selection and involve them in choosing their day service support staff. It also aimed to improve the quality of support workers recruited to the day services and make them more accountable to the people they support.

Six consultants were originally trained to recruit support workers in the day service in 2000, and by 2003 the scheme had expanded to include recruitment of all staff working in the day services.

There are now 23 trained consultants who provide panels for recruitment to all posts directly managed by the Westminster Learning Disability Partnership. Consultants are paid for their work.

"I like doing it. I like being paid. Staff no longer treat me as a baby. I suppose I am the boss." A consultant.

For more information contact:
pnielsen@westminster.gov.uk

Visioning days – a service user's paradise: Rotherham Metropolitan Borough Council – Community Housing Services (improvements in the adaptations services).

Partner organisations: *Service users, Rotherham PCT, Rotherfed, TARA (Tenants and Residents Association), Carers Organisations, RAIN (Rotherham Information and Advice Network).*

Rotherham Metropolitan Borough Council (RMBC) originally aimed to engage disabled service users and carers to find out what they thought of services. It held three 'visioning days' where people could talk to council officers about a wide variety of issues.

Two of these days specifically targeted grants and adaptations. At 540 days, the average waiting time for adaptations was unacceptable. Following the consultation the service was revised and as a result:

- average waiting time for an adaptation has reduced from 540 days to 55 days
- average price paid for some adaptations reduced by 40%, and
- adaptations service nominated for a number of customer service awards.

Service users are now actively engaged in much of the work undertaken within the council. It is now inconceivable to think of undertaking a process without service user engagement. One quote from a service user sums up this new philosophy:

"I have had a lifetime of people pretending they are listening to me. I judge people by actions and not by words and this Council is actively seeking my opinion on a regular basis. They actually make you feel as if you have something to say."

For more information contact:
tom.sweetman@rotherham.gov.uk

Dignity & respect

Change: improve the skills, confidence and capability of staff to develop personalised plans with people who use services and their carers.

Description: training for frontline staff addresses personal feelings, develops non-judgmental listening skills and provides staff with the skills to provide information. People experience being treated with dignity and respect and staff can feel empowered, competent and helpful.

Comment: the face-to-face relationship with the service provider and service user is vital in achieving positive outcomes. Workforce development, support and training are necessary to deliver this.

Outcome: personal dignity.

Benefits for people
Receive personalised care Treated with dignity and respect

Benefits for partnerships

People who use services, carers and staff work together and focus on the service user

Benefits for organisation

Skilled and competent staff
Offer an improved service of care and support
Improved satisfaction rates

Benefits for systems

Clear procedures to follow

End of Life Project: Anchor Trust

The Anchor Trust began a two-year project in 2005 in partnership with professor Malcolm Johnson from the International Institute of Health and Ageing. They developed and delivered a three-day training programme in palliative care.

It included:

- sharing information (e.g. about cultural responses to dying and death, spirituality, funerals and funeral options)
- reflection on each home's current approach to death and dying, and
- exploration of personal feelings and how to listen non-judgmentally, palliative care and practice.

The training sessions took place in 22 different localities, from Newcastle-upon-Tyne to Cornwall, with the day sessions on palliative care being delivered by hospice or community palliative care team. Four key members of staff from each of the Anchor residential and nursing homes (101 in total) were trained.

The project has transformed the way the Anchor Trust staff approach the subject of death in their care homes. Staff now develop a personalised plan with the client and their relatives, considering the close of their lives and how they would like their care, funerals and memorials to be. They are now much more confident in breaking the taboos around death, helping address residents' natural concerns.

Each home is also encouraged to take an individual approach to end of life care, which has led to various innovative practices being adopted.

These were some remarks from staff:

"It has given me confidence to cope with residents and families"

"I find it much easier to approach residents and their families."

"Both residents and staff talk more openly now about their end of life care."

For more information contact:
Louise.Bulcock@anchor.org.uk or
ann.hughes@anchor.org.uk

Meeting fundamental

Change: provide for people's fundamental needs and ensure that the foundations are in place for improved quality of life and health, social and economic wellbeing.

Description: providing for people's basic needs such as housing, employment, occupation and transport has a systemic impact. If these are in place, foundations for healthy living services are significantly more effective. When fundamental needs are met people's wellbeing is enhanced which reduces pressure on other statutory services. Services that meet these needs can evolve from traditional services or can be provided in partnership with other statutory services. Services, which are personalised will need to adopt creative and flexible approaches to meeting these needs.

Comment: it is important to recognise that health and social care services only form a small part of what it takes for most people to experience a reasonable quality of life. Independence can be gained by adequate housing, domestic help where required and employment or activity.

Outcome: improved quality of life; economic wellbeing.

Benefits for people

Maintains independence
Increased inclusion in the community
Increased economic wellbeing
Improved quality of life

Benefits for partnerships

Shared costs
Reduced duplication
Increased trust

Benefits for organisation

Reductions in pressure for services
Improved performance assessment

Benefits for systems

Streamlined systems
Improved efficiency

Pathways to Employment (P2E): West Berkshire Council

Partner organisations: *West Berkshire Mencap, Resource (Mental Health provider), West Berkshire Disability Alliance, Turning Point, Progress to Work, Newbury College and Next Step. There are 50+ partners involved.*

The pathways to employment (P2E) service was set up to provide local people (previously excluded because of a disability or other 'disadvantage), the opportunity to work and to bring together local employers, voluntary and private organisations.

The service has been operational since January 2005 and helps those who want to work to match their skills to the needs of employers and gain work opportunities through support and guidance.

Clients seeking work are generally referred by voluntary or private organisations. Employers engage either out of a sense of social responsibility or because they have vacancies that they can not fill locally.

As of July 07:

- 182 people have registered with P2E seeking work.
- 141 people had been placed in work placements or employment since January 2005 (63 had had a diagnosed mental illness, 30 a learning disability, and 27 a physical disability),
- 60% of people placed in work placements succeeded in finding paid employment, and
- 250 employers have volunteered to be on P2E database (50 of these are or have actively provided work opportunities).

Neil has been helped by P2E:

Neil has misused alcohol and drugs. He has kicked both habits but his past has affected his ability to get work. P2E initially helped him with a voluntary work placement at West Berkshire Council Countryside Services. He did well and was then sent on an eight week work placement as a green keeper at a local golf course where he now works full time.

For more information contact:
alove@westberks.gov.uk or visit www.p2e.org.uk

Open Door Project: Wakefield Metropolitan District Council.

Partner organisations: *Various.*

During 2005 the council produced a plan to find homes for half the number of people in temporary accommodation by 2010. It needed to identify housing need early and provide and help people retain and or find alternative accommodation before they become homeless. The council also aimed to improve the quality of temporary accommodation provided, reduce the time spent in temporary accommodation and provide support where necessary.

The action plan's specific objectives and some of the key outcomes they set to achieve were:

- prevent homelessness where possible
- make sure there is good service administration
- work with registered social landlords (RSLs) to access social rented housing
- increase access to private rented sector
- increase supply of affordable rented housing, and
- convert temporary accommodation into settled housing and improve the standard of remaining temporary accommodation.

There was a reduction of:

- 73% in homeless applications (2006/07 figures compared with 2004/05)
- 47% in temporary accommodation placements (2006/07 figures compared with 2004/05)
- 49% in homeless acceptances (2006/07 figures compared with 2004/05), and
- 89% in the number of cases under investigation awaiting a decision (2006/07 cases outstanding at year end compared to 2004/05).

For more information contact:
SPratheepan@wakefield.gov.uk

Meeting fundamental needs

Joint financial assessment and income team: Nottinghamshire County Council (Adult Social Care and Health Dept).

Partner organisations: *Department of Work and Pensions (DWP); seven district councils.*

In Nottinghamshire, a joint financial assessment and income team was set up to:

- collect the financial information to support both charging for adult care services and claims for Department of Work and Pensions administered benefits, housing benefit and council tax in a better way
- simplify claiming benefits for older people and vulnerable adults
- increase the uptake of benefits and the referrals to the Pensions Service
- remove duplication of effort for both the service user and the agencies involved, and
- ensure that all people visited are offered full advice and assistance on benefits and the services available to them.

Staff from the different partner organisations involved in administering welfare have formed one 'virtual team' and follow joint referral protocols, information sharing protocols and quality standards that were agreed in partnership, and which they were trained in.

The integrated Nottinghamshire-wide service now ensures that all older or vulnerable people who come into contact with social care, with the District Council or with the Pensions Service, will have their benefit entitlement checked and maximized. Service users only have to provide information once and are assured that contact with one agency will enable all relevant referrals are made to the other agencies in the partnership. In practice this means a single home visit rather than the person having to visit 3 different offices and the guarantee that verification of circumstances (like bank account details) only happens once. People are also offered referral to a wide range of preventative services.

Over a one year period, an additional £ 2,832,770 was generated in extra benefits for Nottinghamshire residents.

For more information contact:
john.hannam@nottscc.gov.uk

Accessible informatio

Change: provide relevant, accessible, targeted information to enable informed choice and good decision making, which leads to greater independence and self care.

Description: redesign information strategies with service users, carers and front line staff. Take a proactive approach, targeting information to those who need it, when they need it and in a format that suits them.

Comment: information is vital for people who use services and for carers to find out what services are available and how to access them. This is an issue that needs to be addressed through general policy and individual practice.

Outcome: improved quality of life.

Benefits for people

Increased awareness
Enabled to make informed decisions and choices
Greater independence
Greater involvement
Improved health

Benefits for partnerships

Information resources can be shared
Supports signposting between services
Partner organisations are supported in their work

Benefits for organisation

Develops efficiency (having information available, reduces demands on staff for information)

Benefits for systems

Promotes consistent care
Streamlined processes

Modernisation Initiative (funded by Guy's and St Thomas' charity).

Partner organisations: *Guys' and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, Lambeth PCT, Lambeth Social Care, Southwark Health and Social Care.*

The Modernisation Initiative Stroke Programme is a three-year service improvement project. One element focused on ensuring people living with stroke and carers had access to and relevant information about stroke, services and community resources.

They invited service users and people who care for them to attend events to share views and talk about their experiences. Service users and professionals then formed an information advisory group and utilised the health journey exercise to explore what information they wanted.

They evaluated existing stroke information and agreed what should be disseminated across the local health and social care economy. They then developed and circulated the ideal information pathway to services and worked with service users, staff and the voluntary sector to develop new resources for people living with stroke.

Now people who have transient ischemic attacks (TIAs or mini strokes) receive a handbook with information about TIA, risk factors and how to stay healthy with signposting to useful contacts and services.

An information prescription service is provided to people who have had a TIA via the Trust's Knowledge and Information Centre (KIC).

Stroke units have orientation leaflets/posters, accessible menus with photographs and picture pointer cards to assist patients with communication difficulties following stroke. Information about stroke and stroke services is on the ward/day room and a copy of Connect's Stroke and Aphasia handbook is by each bed

All stroke patients are given a handbook as part of their rehabilitation. It spans the care pathways and has sections for goal setting, appointment records and staying healthy, with signposting to useful contacts and services. Information can be tailored to individual need and level of comprehension

All stroke patients have access to a Stroke Peer Support Scheme.

A handbook and digital stories "Having a Stroke – Being a Parent" were developed with service users in partnership with Connect (the communication disability network).

A biannual newsletter is produced in partnership with service users, providing information about stroke, news, research and services.

A stroke information toolkit is available as a guide to assist health and social care staff in developing information within stroke services

For more information contact: *linda.briant@gstt.nhs.uk*
PDFs of resources are available to download *www.mystrokeservices.org.uk* (website closes December 2008)

The Carers' Resource: an independent charitable company (a social enterprise).

Partner organisations: *Health and social care services, education and housing as well as the local voluntary, community and independent sector.*

The Carers' Resource is the local, specialist carers' centre for the Harrogate, Craven and Airedale districts of Yorkshire. It provides:

- a direct point of contact for all carers and professionals seeking information, advice and guidance, representation and advocacy
- specialist emotional support for carers
- training for carers and health and social care professionals
- information for service providers and planners, and
- involvement in and consultation with carers, and research.

By June 2007, 6810 carers had received sustained one-to-one support since the Carers' Resource opened in November 1995. In the January to June 2007 period alone, its carer support officers had secured £536,328.52 in welfare benefits for carers and those for whom they care.

"During the period of my mum's illness, The Carers' Resource were the only people to pick up the phone and ask how I was … the information they gave me was invaluable." Carer

For more information contact:
director@carersresource.org

Partnership working

Change: work in partnership and provide the services people need and want in a streamlined and readily accessible manner.

Description: when organisations work closely together it has a positive impact on people's lives. When they develop shared protocols and co-ordinated interventions, people are able to access and use services more easily and effectively. It requires innovation and leadership and leads to reduced time, cost and duplication as well as simplified and accessible services, which improve wellbeing.

Comment: successful partnerships need will address the tensions between structures and cultures particularly in relation to national targets. They need to face the challenges associated with integrating services that are based on fundamentally different principles of governance and different types of central and local government accountability.

Outcome: improved quality of life and improved health and emotional wellbeing.

Benefits for people

Services designed to meet people's needs
Improved choice and control
Independence and inclusion
Targeted help

Benefits for partnerships

Sharing of knowledge and understanding
Pools resources
Reduced cost, time and duplication
Strong local ownership

Benefits for organisation

Increased capacity to deliver community services
Increased satisfaction with the service
Improved performance assessments

Benefits for systems

Services designed to meet people's needs
Streamlined processes and systems

Connected Care: Turning Point.

Partner organisations: *Hartlepool Pilot site – Hartlepool Adult Social Care Housing Hartlepool & PCT.*

Turning Point Centre of Excellence in Connected Care in close conjunction with Hartlepool Borough Council, Housing Hartlepool, the PCT and the local community have developed the connected care model, currently being piloted in Hartlepool and Bolton, which provides a co-ordinated range of services directly reflecting and responding to the needs of individuals and communities they serve.

The concept is based on engaging with what the community needs and then working with commissioners to redesign service provision to be more inclusive.

In Hartlepool, local people were recruited as community auditors and were supported by Turning Point and local agencies to undertake connected care audits to determine the needs and aspirations of the local residents, current service users and carers and their perceptions about patterns and structures of current services. Some 251 local residents participated in the audit.

The results of the audit included:

- better information provided at the right time and place, would help residents both to make better use of the options available, and take more responsibility for their health and social care.
- connected care should support and empower people to make choices for themselves
- difficulties in accessing services reflected gaps in provision as well as poor information Residents looked for a more integrated, high quality out-of-hours service closer to home and involving cross-agency working based on individual needs.
- continuity and co-ordination were frequently identified as problematic. Services were complex, complicated and sometimes alienating. A dedicated connected care workforce would focus on people's whole needs, support them to find their way through the care system and help them to obtain integrated and personalised care and support.

The connected care service in Hartlepool now comprises of the following elements:

- a complex care team integrating specialist health, social care and housing support
- a service co-ordinator to manage the service and promote change in the wider service system
- the development of a range of low-level support services that focus on maintaining independence, and
- navigators, working to improve access, early interventions, choice, ensure a holistic approach, and integrate with universal and long term support.

For more information contact:
Richard.Kramer@turning-point.co.uk

First Contact Signposting Scheme: Nottingham County Council, Adult Social care and Health Department and voluntary sector providers.

Partner organisations: *PCTs, seven district councils, voluntary sector, Fire and Rescue Service, Police Services.*

Nottinghamshire County Council and voluntary sector providers wanted to improve access to services for older people in Nottinghamshire .They introduced the First Contact Signposting Scheme (FC), a multi agency checklist which through partnership working, enables staff, volunteers and older people to access a range of preventative services through a single gateway. The simple checklist covers a wide range of needs including safety, benefits advice, repairs and adaptations.

The scheme provides a holistic service giving advice and information through one single contact. Needs are provided for at an early stage in an integrated and seamless manner. This has enabled early interventions reducing the need for more costly and intrusive services in the future.

The initiative began in the Rushcliffe district in November and by September 2007 was introduced in all seven districts, costing approx £29k per District (mainly for the cost of a co-ordinator).

Mr C, caring for his disabled wife now receives an additional pension of £10.32 per week and £134.00 arrears, new locks for his doors, adaptation and falls assessment for his wife and smoke alarms.

For more information contact:
Peter.mcgavin@nottscc.gov.uk

Personalised services

Change: put service users at the centre of service design and delivery to give people control over their eligible service resource. Provide the framework in which people can direct their own support.

Description: personalise services by designing a new system to enable people to gain information and control of their allocated resource and be able to plan how to use that resource to most effectively meet their needs. Build on existing direct payments schemes that have paved the way by shifting thinking and changing the culture within organisations.

Comment: services that have demonstrated significant improvements in the confidence, morale and physical functioning of service users have attributed these to maximising choice and control for people who use services.

Outcome: choice and control.

Benefits for people
Improved quality of life
Services users in control
Flexibility and choice
Focuses on outcomes

Benefits for partnerships

Good partnerships with service users
Generating a broader care market

Benefits for organisation

Transparent allocation of resources
Affordable

Benefits for systems

Efficient and clear systems
Payment cards will be easier to manage and reduce administrative costs

In Control: independent company and charity.

Partner organisations: *At least 20 partners.*

In Control has created a new system for people to gain information and control of their allocated resource and to then plan how to use that resource most effectively to meet their needs. The system is called self-directed support and is designed for local authorities to use.

There are seven steps to the self-directed support process:

1) people are allocated an Individual Budget on the basis of a validated self-assessment
2) people are able to develop their own support plan
3) the support plan is agreed with the local authority
4) people can then control their Individual Budget in the way that suits them best
5) people can choose to use traditional services or can use flexible and community supports
6) people can set their own outcomes and control how they meet them, and
7) the local authority continues to review the situation

In Control now has 106 local authorities (to date) who are in various stages of developing their local systems to make them available for people with all needs to use.

Evaluation findings from 2003-2005 demonstrated that:

- the number of people satisfied with their support increased from 42% before In Control to 97% after gaining control over their support
- those satisfied with their plans and the direction of their life increased from 61% of the group before involvement to 90% when they had control over their support
- 48% of people were satisfied with their support prior to their involvement with In Control. The changes made in support arrangements led to 100% satisfaction.

For more information contact:
Julie.stansfield@in-control.org.uk

Personalised services

Changing Lives Programme: Staffordshire County Council.

Partner organisations: *Rowan Organisation and ELITE.*

In March 2006 Staffordshire County Council's Social Care and Health Directorate had around 28,000 service users and by 31 March 2006, only 310 (or 1.1%) were in receipt of direct payments, placing it near the bottom of the 'league' table of comparable authorities.

As part of the Directorate's 'Changing Lives' Programme, reproviding their in-house services, they set up a dedicated project with the specific targets to:

- increase the take up of direct payments by nearly 100% to 600 recipients, and
- improve their position in the league table.

From March 2006 to March 2007, launching a new scheme in April 2007.

A planned work programme was undertaken that involved three stages:

- a detailed critique of Staffordshire's current scheme and potential for change
- research into best practice elsewhere, and
- identifying collective groups of work packages in Staffordshire to improve take up.

Both the targets set were achieved.

The directorate's new scheme was rolled out in April 2007. It is more streamlined, less bureaucratic and uses fewer forms. There are clearer roles/responsibilities for managers, practitioners and service users. There is a dedicated council direct payments team, wide range of user-friendly direct payments policies and practice guidance and improved communications.

For more information contact:
helen.trousdale@staffordshire.gov.uk

Effective commission

Change: commission services that are flexible and responsive to people's needs and wishes.

Description: commissioning services that offer highly individualised, flexible services in response to the assessed needs and wishes of people who use services, can achieve substantial benefits such as improved daily living skills, greater independence, and improved physical health. Small projects can also have a big impact on outcomes for the service user and reduce demand on statutory organisations.

Comment: responsive and flexible services can be promoted by commissioning specifically for this outcome.

Outcome: improved health and emotional wellbeing.

Benefits for people

Improved physical and emotional health
Dignity
Increased independence
Improved confidence
Support to carers

Benefits for partnerships

Supports work of each organisation
Shared resources

Benefits for organisation

Better strategic planning
Shared knowledge base
Increased efficiency

Benefits for systems

Shared information

Sole Mates Footcare Service: Age Concern Oxfordshire.

Partner organisations: *Oxfordshire NHS podiatry service, Oxfordshire Primary Care Trust (including 3 GP surgeries), Oxfordshire County Council, Cherwell District Council, Oxford City Council, Local voluntary sector agencies at 'The Corner', an Age Concern Oxfordshire drop-in lunch venue.*

This service has enabled people with limited mobility to maintain their independence.

The Solemates Footcare service is for older people who can not cut their own nails or afford to have them cut but who are not eligible for the NHS podiatry scheme.

Partly funded by Oxfordshire County Council, some local PCTs and a district council, it is staffed by a part-time paid manager, two paid co-ordinators and 70 trained volunteers.

Foot care can be accessed in older people's homes, GP surgeries, day centres, at special foot care sessions in community venues across the county and in two Health Buses.

Regular treatments are given every 6 to 8 weeks, dependent on individual need and to 1,000+ people annually.

Improved health and emotional wellbeing and quality of life results from people being enabled to stay mobile, walking more comfortably and being able to more easily get out of the house and socialise.

For more information contact:
marydaniel@ageconcernoxon.org.uk

Flexible Care Service: Age Concern Oxfordshire.

Partner organisations: *Oxfordshire County Council Social and Community Services; Oxfordshire and Buckinghamshire NHS Partnership Trust and Oxfordshire Primary Care Trust.*

The flexible care service responds to the needs of older people with dementia, depression, anxiety, personality disorder or enduring mental health problems that are unable to access day or home care. The service offers an active home-based therapeutic support programme of interventions that are planned in direct response to clients' specific needs and wishes.

Activities with the flexible carer vary from letter writing, cooking, and gardening to sharing a pot of tea and a chat.

An independent evaluation carried out by the Oxford Dementia Centre in 2001 found that users of the service experienced:

- increase in social contact outside the home (84%)
- improvement in communication (70%)
- improvement in daily living skills (70%)
- Improvement in mental health (58%), and
- reduction in stress and anxiety (56%).

Carers experienced:

- gains from respite (70%), and
- less stress and burden (66%).

Mrs G lived alone in a rented Housing Association flat. She suffered high levels of anxiety and depression, compounded by severe fibromyalgia and a visual impairment. Mrs G was receiving support from her GP and counselling. Her neighbours were very noisy, and she perceived them to be hostile which made her anxious. Mrs G was referred to the Flexible Care Service by her GP with a view to the flexible carer being able to suggest and reinforce coping strategies for her to deal with day-to-day living.

The Flexible carer supported Mrs G to apply for better housing and she has since moved to a bungalow, which she calls 'Peacehaven'.

For more information contact:
adriansell@ageconcernoxon.org.uk

Flexibility/challenge/

Change: implement meaningful and effective processes, adopt creative solutions and provide flexible services to prevent people becoming more dependent and to achieve greater efficiency and reduce unnecessary pressure on services.

Description: services which challenge the exclusive focus on eligibility criteria by developing creative and flexible alternatives can reduce dependency. By establishing services which can respond to low level needs and focus on a supportive and empowering approach the demand for high level, more expensive services can be reduced. People express high levels of satisfaction and wellbeing and quality of life is improved.

Comment: innovative approaches need commitment from senior management.

Outcome: improved health and emotional wellbeing.

Benefits for people

Improved quality of life
Independence and dignity
Choice and control
Increased income

Benefits for partnerships

Improved relationships leading to better outcomes

Benefits for organisation

Improved access to services
Ability to deliver department of health priority of early intervention
Reduced pressure
More efficient use of resources

Benefits for systems

Services work intelligently to complement each other
Improved co-ordination

The PHILLIS (Promoting Health and Independence through Low Level Integrated Support) Service: Warwickshire County Council

The PHILLIS service finds and accesses services that help older people stay at home. It was developed to respond to people with low level needs unlikely to be known to statutory services and/or part of a hard to reach community. The service offers a 'safety net' to people identified as having specific needs but who do not meet the eligibilty criteria, which is set at having a 'critical' or 'substantial' need.

The success of the service has identified that this model of community outreach would also be suitable for those with disabilities, and the service is currently being developed to respond to the needs of such individuals.

For more information contact:
joycewoodings@warwickshire.gov.uk

'Help @ Home' Scheme (focus on preventative services): Shropshire County Council

Partner organisations: *Age Concern.*

Shropshire County Council wanted to provide more practical assistance to support and enable more older people to stay at home. A contract was agreed with Age Concern for enhanced preventative services.

New, at-home services are now provided (partly by newly recruited and trained volunteers), including housework, dog walking or just having a chat.

Service users contribute a flat rate of £7.00 per week (regardless of hours provided). In the current year there are more than 1000 users of the Help@Home services.

Service users recently surveyed say that the service:

- was useful or very useful in helping to stay at home (97%)
- enabled them to maintain their independence (78% with major effect and 21% with some effect), and
- resulted in improved wellbeing/peace of mind (58%)

Admissions to residential care in the area have been reduced.

The preventative service is now in its seventh year and Shropshire County Council has renewed its commitment by awarding the contract again for a further period of up to five years.

For more information contact:
Ruth.Houghton@shropshire-cc.gov.uk

Inclusion

Change: identify people who are excluded from health and social care benefits and from social participation, consider their needs and design services to meet those needs.

Description: projects which target particular groups are successful in engaging with them and the relevant partner agencies to achieve higher levels of inclusion. These projects can reduce prejudice by providing information, enabling people to access services by informing and supporting them, developing their self help skills and developing meaningful services. This improves health and wellbeing, reduces discrimination and increases inclusion in mainstream services.

Comment: to effectively include people from excluded communities they should be consulted by properly trained workers who understand the requirements of the communities and families involved. Equal, transparent and non-discriminatory decision-making will support inclusion. Carrying out equality impact assessments on service commissioning strategies and plans will support this process.

Outcome: freedom from discrimination.

Benefits for people

Improved access to information
Peer support from groups
New skills and confidence

Benefits for partnerships

Improved knowledge base for partner organisations
Training for staff in partner organisations

Benefits for organisation

Improved knowledge and information base from which to commission relevant services
Cultural awareness
Additional income

Benefits for systems

Development of methodology for partnership working
Improved systems which do not discriminate

Norfolk and Waveney Mental Health NHS Foundation Trust

Partner organisations: *Various including Great Yarmouth Refugee Outreach Service (GYROS).*

Norfolk and Waveney Mental Health NHS Foundation Trust wanted to improve access to and appropriateness of mental health services for their local communities, targeting refugees, asylum seekers and migrant workers.

They set up a two-year project:

- part 1: liaising with community organisations and members and conducting research to explore local knowledge and understanding about mental health needs, and
- part 2: taking action in collaboration with the local communities to implement research recommendations, including innovative ways of promoting mental health.

Barriers to accessing services included stigma and reluctance to talk about mental health; different understandings of mental health problems; mental health not being prioritised; lack of awareness of services; and lack of translation services to identify mental health problems. People also needed more information about mental health.

As a result:

- seven self-help/information leaflets have been translated into Portuguese and two into Lithuanian and websites have been identified with information about mental health in a range of languages (addressing the information need)
- several community groups have been developed
- information about mental health and mental health services have been made available in a number of community settings and events, and
- one group worked with CME (Community Music East) to develop an 8 week arts based anti-stigma campaign, producing a film that has been shown at a number of local events and is available on the internet.

For more information contact:
Gillian.Bowden@nwmhp.nhs.uk

Speaking Up Training and Consultancy Service: Cambridge.

Speaking Up wanted to address the discrimination and inequality faced by people with learning disabilities in Cambridge. There was little opportunity for people with learning disabilities to play an active role in their community, gain jobs or contribute in other ways.

In 2001, Speaking Up began to offer used-led consultancy and training services to organisations in order to address any discrimination against people with learning disabilities. The consultancy and training services were delivered by people with learning disabilities, which helped them develop their skills and increase awareness of disability issues. They were a success and have continued to expand, in reach and content.

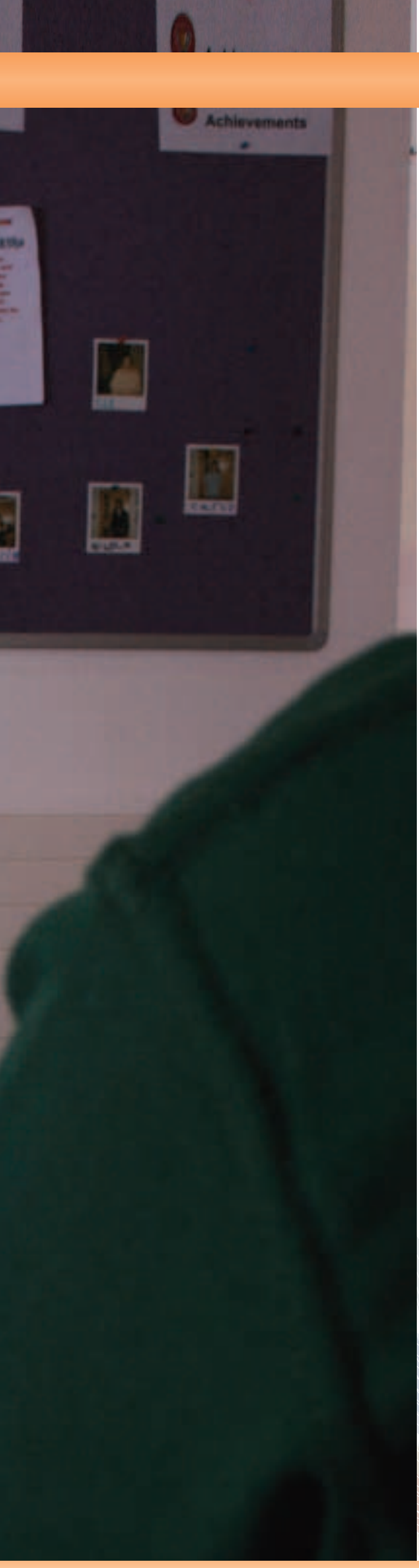
Speaking Up now has a manager who is responsible for the long-term strategic development of the initiative and has a dedicated team of learning disabled trainers (2 employed full time, 4 employed part-time).

It has provided training and/or consultancy to major national organisations including the Police, the NHS, the National Patient Safety Agency, the Disability Rights Commission, Valuing People and the Commission for Social Care. 90% of customer feedback on the consultancy and training services has shown complete customer satisfaction at 10 out of 10.

All of the training team has been trained through their own user-led “Training 4 Trainers” programme, which gives people with learning disabilities the opportunity to develop confidence and skills as well as offering the opportunity for employment and volunteering.

For more information contact:
Vicky.Barker@speakingup.org

Inclusion



Self Care for People Initiative: The Working in Partnership Programme.

Partner organisations: *Oldham PCT, South Tyneside PCT, Bradford and Airedale Teaching PCT*

The Self Care for People Initiative (SC4P) piloted a new self care skills training course, Self Care for You, throughout 2005 and 2006 in three Spearhead PCT areas: Oldham, South Tyneside and North Bradford and Airedale, alongside the development of the role of a self care support co-ordinator and local directory of self care resources.

Minority ethnic groups in the communities were targeted for the course as public health information highlighted issues of poor access to health services by these hard to reach groups. Local community workers and lay trainers were trained to deliver the course where people naturally congregated such as the workplace, the local social club, local schools and local mosques.

The content of this flexible, modular course includes: understanding the relationship between health and behaviour, learning how to change unhealthy behaviours, building confidence and self esteem, managing stress and anxiety, recognising the importance of healthy eating and exercise, and managing minor ailments.

Evidence from interviews with study participants six months later has shown raised awareness and increased motivation for self care and more positive behaviour changes – in diet, physical activity and dealing with stress.

“We’ve changed quite a few things at home, they’re eating a lot healthier and it makes you feel better in yourself” (female, workplace)

“I did not need to seek medical attention because working off what [the Self Care Support Co-ordinator] said about the types of cough you can have I didn’t need to” (male, workplace)

For more information contact:
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anna.lynall@wipp.nhs.uk

Carers as partners in

Change: treat carers as true partners by making them integral to the design, planning and delivery of services. Raise awareness of the central role of carers and change provider's perceptions of them. Support carers to continue to provide care.

Description: working directly with carers to design and deliver services and providing direct payments for carers can lead to increased numbers of carer assessments, improved staff morale, and improved health and wellbeing for the carer with associated benefits for the cared for.

Comment: there is a close relationship between the health and wellbeing of the carer and the person cared for. There is a cumulative effect whereby the benefits of services for the carer and the cared for are mutually reinforcing.

Outcome: improved health and emotional wellbeing.

Benefits for people

Recognition of carers as an individual
Improved wellbeing
Opportunity for carers to take a break

Benefits for partnerships

Sharing of knowledge and expertise

Benefits for organisation

Cost effective
Improved staff morale

Benefits for systems

Improved performance

Carers Direct: Dudley Metropolitan Borough Council.

Carers Direct aimed to increase the number of breaks provided to carers of adults, the perceptions of workers in respect of options to support carers and number of carer's assessments completed.

They allocated part of the carers grant to provide one-off payments of up to £300 to carers to enable them to take a break, pursue a leisure activity or to fund other carer specific services that the carers themselves identified.

Now over 200 carers per year are funded to do something that helps them to carry on caring, which helps both their health and wellbeing.

"The money has allowed me to take a more independent step to escape from stressful routine (and) allows me to meet new people and keep myself calm and stress free." (Gym membership)

"I think the support I have had has been magic. You feel much better when someone understands how you feel, and sometimes that's very low. It has given me a boost to know that someone cares…" (Weekend break)

For more information contact:
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Conclusions

There is strength in the examples we have collected and in the belief of people who use services that these changes will make a difference.

But the evidence base must be strengthened and practice driven by this evidence if the social care profession is to gain public confidence and the full respect of other professions.

It is vital to listen to and involve service users and carers who are the 'experts by experience'. They can very often identify small changes or service improvements, which make a big impact.

Organisations must deliver the seven outcomes the government identified in its consultation processes. Implementing the changes described here will contribute to achieving this aim and will build on the aspirations of Putting people first.

Effective and sustainable change is not easy to achieve. There are many reasons why people and systems are resistant to change. This resistance will need to be overcome if benefits for people who use services are to be delivered. It is important that we understand the complex nature of change and what helps to bring about change.

Small barriers can prove a major block. One of the most significant is the inability to listen to or involve service users and their carers. Then there is the critical nature of the face-to-face relationship between staff and people who use services. Investing in a skilled and confident workforce must be taken seriously.

The initiatives described here have in some cases meant discarding existing thinking and practice, and finding resources from stretched budgets. This requires courage and leadership.

When organisations rise to the challenge they will deliver better outcomes that make a real difference to people.

Acknowledgements

We would like to acknowledge all the services and organisations for sending in their case studies to inform the High Impact Changes for Health and Social Care project.

Initiative	Provider Organisation
Support brokerage service for older people	*Age Concern Cheshire*
Housing options service (HOPS)	*Age Concern Derby and Derbyshire*
Transport Access People Project	*Age Concern in Cornwall & the Isles of Scilly*
Hospital Re-admission Avoidance Service: "A Little Help"	*Age Concern Northamptonshire*
Sole Mates Footcare Service	*Age Concern Oxfordshire*
Flexible Care Service	*Age Concern Oxfordshire*
A&E Diversion and Discharge Support Service	*Age Concern South Staffordshire*
Case Finding Service	*Age Concern Waltham Forest*
End of life project	*Anchor Trust*
Dementia Care	*Anchor Trust*
Person-centred approach to assessment and care planning	*Anchor Trust*
Experts by Experience project	*Bracknell Forest Borough Council*
BME Reference Group Bristol The Two Way Street (TTWS)	*Bristol Local Implementation Team*
Asian Women's Involvement Group (AWIG)	*Calderdale Health and Social Care*
Calderdale MBC, Health and Social Care Learning Disability Service	*Calderdale MBC, Health and Social Care Learning Disability Service*
Open Studios	*Cambridge Mental Health Resource Centre, Cambridgeshire and Peterborough Mental Health NHS Trust*
Back into Training Education & Employment (BITE programme)	*Cambridge Mental Health Resource Centre, Cambridgeshire and Peterborough Mental Health NHS Trust*
Cambridge Mental Health Resource Centre Café	*Cambridgeshire and Peterborough Mental Health NHS Trust*
Saturday Circles	*Cambridgeshire County Council*
Equal Partners Equal Wellbeing	*Cambridgeshire County Council Learning Disability Partnership (Adult Disability Service)*
Day services for people with mental health needs	*A consortium comprising MIND in Camden, the Holy Cross Trust and the Volunteer Centre Camden*
A whole system approach for reviewing service users placed out of their local area and relocating them back into Camden & Islington	*Camden & Islington Mental Health & Social Care Trust*
Camden REACH	*Camden PCT*
Generic Advocacy Service for Adults.	*Cloverleaf Advocacy*
Move On Work	*Colebrook Housing Society*
Improving service performance and outcomes for service users through outcomes-focused commissioning	*Community Care Services, Wokingham Borough Council*
Learning Disabilities Joint Commissioning Plan	*Community Services, Coventry*
Experts Through Dialogue – Self help support group for people diagnosed with a personality disorder in Cornwall	*Cornwall*
Community Services Directorate	*Coventry City Council*
Modernising day opportunities in learning disabilities services	*Coventry City Council*
Extra Care Housing: Increasing Choice for Older People	*Coventry City Council*
Occupational Therapy Service Provision	*Coventry*
Supporting the health of carers	*Crossroads Birmingham*
Supporting Carers of a person with dementia	*Crossroads Caring for Carers*
Supporting Carers to remain in or return to employment, training, education or leisure activities (ETELAs)	*Crossroads Caring for Carers*
Older People and Physical Disabilities Division (DMBC)	*Directorate of Adult, Community and Housing Services; Dudley Metropolitan Borough Council*

	Derbyshire County Council
EmPower – 50+ Personal Safety Peer Training Initiative	*Doncaster Alcohol Services*
Fulwood/Floating Support Projects	*Dorset County Council and PCT*
Dorset Partnership for Older People Project	*Dudley Carers In Partnership for Mental Health (DciP)*
Dudley Carers In Partnership for Mental Health (DciP)	*Dudley Metropolitan Borough Council*
Carers Direct	*Dudley Metropolitan Borough Council*
Increasing efficiency	*Dudley Metropolitan Borough Council, Directorate of Adults, Community and Housing Services*
Reduction of waiting list for an assessment by the OT Section	*Gateshead Council*
Improve preventative activities for older people in promoting Independence Centres	*Gateshead Council*
Domiciliary Care Service	*Gateshead Council*
Development of a Peer Mentoring Service (Families Matter)	*Gateshead Council*
Develop One4All Social Enterprise	*Gateshead Council*
Promoting Independence Teams	*Gateshead Council*
Link Up in Gateshead initiative	*Guy's and St Thomas' NHS Foundation Trust*
Modernisation Initiative	*Hammersmith & Fulham Primary Care Trust*
Supporting women of child bearing age group to stop smoking	*Hampshire Partnership NHS Trust*
Consumer Advisor Role	*Hampshire Partnership NHS Trust*
CMHTs Caseload Management	*Havering PCT*
Joint loan store (ICES)	*Hertfordshire County Council's Adult Care Services, the Hertfordshire Partnership NHS Trust, Hertfordshire Supporting People and Welwyn Garden City Housing Association*
Swanfield Court Extra Care Housing Scheme for people with dementia	*Herts Mind Network*
Herts Mind Network	*In Control*
In Control	*In2work*
In2work	

Neighbourhood Renewal Building Neighbourhood Capacity for Adult Social Care	*Kirklees Council*
Health and Social Care Worker	*Knowsley Primary Care Trust, Integrated Health & Social Care Provision*
Integrated Palliative Care at Home (Henrietta)	*Knowsley Primary Care Trust, Integrated Health & Social Care Provision*
NeAT (Newham Advanced Telecare)	*LB Newham Adults Services*
Learning from Customers – a consolidated approach	*Learning from Customers Forum, Customer Inspection Service and Working Together Group*
H.A.R.T. (Homecare Assessment and Reablement Team)	*Leicestershire County Council In-House Home Care Service.*
Enhanced call screening and management in Careline	*Liverpool City Councils Social Care Contact service*
Service Redesign	*London Borough Barking & Dagenham and North East London Mental Health*
Strategic Indicators Outcome Monitoring Tool (SIOMT)	*London Borough Barking and Dagenham*
PCP Transition Reviews for Young adults in Yr 9 (age 13/14)	*London Borough of Barking & Dagenham*
Individual Budgets Pilot programme	*London Borough of Barking and Dagenham*
Domestic Violence Intervention Project East (Non-Court ordered perpetrator scheme)	*London Borough of Barking and Dagenham*
Social Regeneration Unit	*London Borough of Newham*
Rehab at Home Service	*Medway Council*
Understanding how mental health needs are perceived by refugees, asylum seekers and migrant worker communities.	*Norfolk and Waveney Mental Health NHS Foundation Trust*
Joint Financial Assessment and Income Team	*Nottinghamshire County Council (Adult Social Care and Health Dept)*
Books on prescription	*Nottinghamshire County Teaching PCT*
First Contact Signposting Scheme	*Notts County Council, Adult Social Care and Health Department and Voluntary Sector Providers*
Older Peoples' Partnership	*Older Peoples' Partnership (Wokingham)*

Support in to Employment	*Papworth Work 4 You, Phoenix Employ and Social Enterprise partners*
Healthy Ageing in Southwark (Hospital Discharge Pathway).	*Partnerships for Older People Projects POPP*
Plain Speaking	*Policy, Planning & Research Team - Rotherham Metropolitan Borough Council*
Specialist Dementia Support Service	*Portsmouth City Council, Adult Social Care*
Nottingham Dermatology Community Pilot	*QMC Dermatology Directorate*
Staying Home Scheme	*Reablement teams in Newcastle, Staffordshire Moorlands, Lichfield, Tamworth and East Staffordshire*
Cross Cultural Support Service	*Reading Borough Council Community Care*
Rural Community Link Project	*Restormel Mind Association for Mental Health*
Visibly Better	*RNIB Royal National Institute of Blind People*
Creating opportunities for mental health users to receive an individual budget	*Rotherham Metropolitan Borough Council*
Visioning days - a service users' paradise	*Rotherham Metropolitan Borough Council Community Housing Services*
'Sharing Rotherham's experience and expertise in improving the take up of direct payments for people with mental health problems'	*Rotherham Metropolitan Borough Council*
Joint Health and Social Care Policy Unit	*Sandwell Metropolitan Borough Council and Sandwell PCT*
Extra Care Housing: Increasing Choice for Older People	*Sandwell Metropolitan Borough Council*
Modernisation of Home Care Services	*Sandwell Metropolitan Borough Council*
Telecare	*Sandwell Metropolitan Borough Council*
Out of hours palliative care drugs service	*Service from community pharmacy, Middlesex Pharmaceutical Group (of Local Pharmaceutical Committees)*

'Help @ Home' Scheme	*Shropshire County Council*
Joint Training Initiative for Multi-Agency Adult Protection Policy	*Shropshire County Council and Shropshire Partners in Care*
Delivering efficiencies in access to benefit advice.	*Shropshire County Council Community Services Division*
Developing the capacity of the independent care sector in Shropshire	*Shropshire County Council*
Somerset County Council. Community Directorate – Adult Social Care	*Somerset County Council. Community Directorate – Adult Social Care*
Sun Project	*South West London and St Georges Mental Health NHS Trust*
Culture Change: Increase independence and choice through Direct Payments	*Southend Borough Council*
Culture Change: Involvement of older people in the development of Southend's first Older People Strategy	*Southend Borough Council*
Young People Speaking Up	*Speaking Up*
Advocacy Services	*Speaking Up*
The Cambridgeshire Parliament	*Speaking Up*
Next Steps	*Speaking Up*
Training and Consultancy Service	*Speaking Up*
Changing Lives Programme	*Staffordshire County Council*
Active Carers Forum	*Stoke-on-Trent City Council*
Approach, Alzheimers Café	*Stoke-on-Trent City Council*
Rehabilitation	*Stoke-on-Trent City Council*
SW Seniors' Network	*SW Seniors' Network*
Beginners Arts & Crafts & Improvers Arts & Crafts	*Swindon Mind*
Oak Lodge (Crisis House)	*Swindon Mind*
'Live Independently in Telford & Wrekin'	*Telford & Wrekin Council (Housing & Social Care)*
Chronic Obstructive Pulmonary Disease (COPD) supported discharge pathway	*Telford & Wrekin Intermediate Care Team*
Telford Rapid Assessment Service for the Elderly	*Telford & Wrekin PCT*

The Carers' Resource	*The Carers' Resource*
Self Care for You programme	*The Working in Partnership Programme*
Health Action Plans	*Thurrock Borough Council and South Essex Partnership Trust*
Community wellbeing	*Thurrock Council*
Connected Care	*Turning Point*
Building quality and sustainable capacity within the local independent sector home care market	*Wakefield Metropolitan District Council*
Wakefield Metropolitan District Council Family Service	*Wakefield Metropolitan District Council*
Open Door Project	*Wakefield Metropolitan District Council*
Modernisation of Day Services for People with Learning Disabilities	*Wakefield Metropolitan District Council, Family Services*
The PHILLIS Service	*Warwickshire County Council*
Reducing delayed transfers of care	*Warwickshire County Council*
Home Care Electronic Systems	*Warwickshire*
Pathways to Employment (P2E)	*West Berkshire Council*
Choosing Staff - Service User Involvement in Recruitment and Selection	*Westminster Learning Disability Partnership*
Local Enhanced Scheme for people with learning disabilities	*Westminster PCT*
Transforming intermediate care	*Westminster PCT and St Marys NHS Trust*
Rapid Response Nursing Team	*Westminster Provider Services*
Community Development Team	*Wiltshire County Council*
Increasing the take-up of telecare and community alarms	*Wolverhampton City Council*
Tele-health project	*Wolverhampton City Council, Wolverhampton PCT and Wolverhampton Acute Trust*

The High Impact Change for Health and Social Care project group

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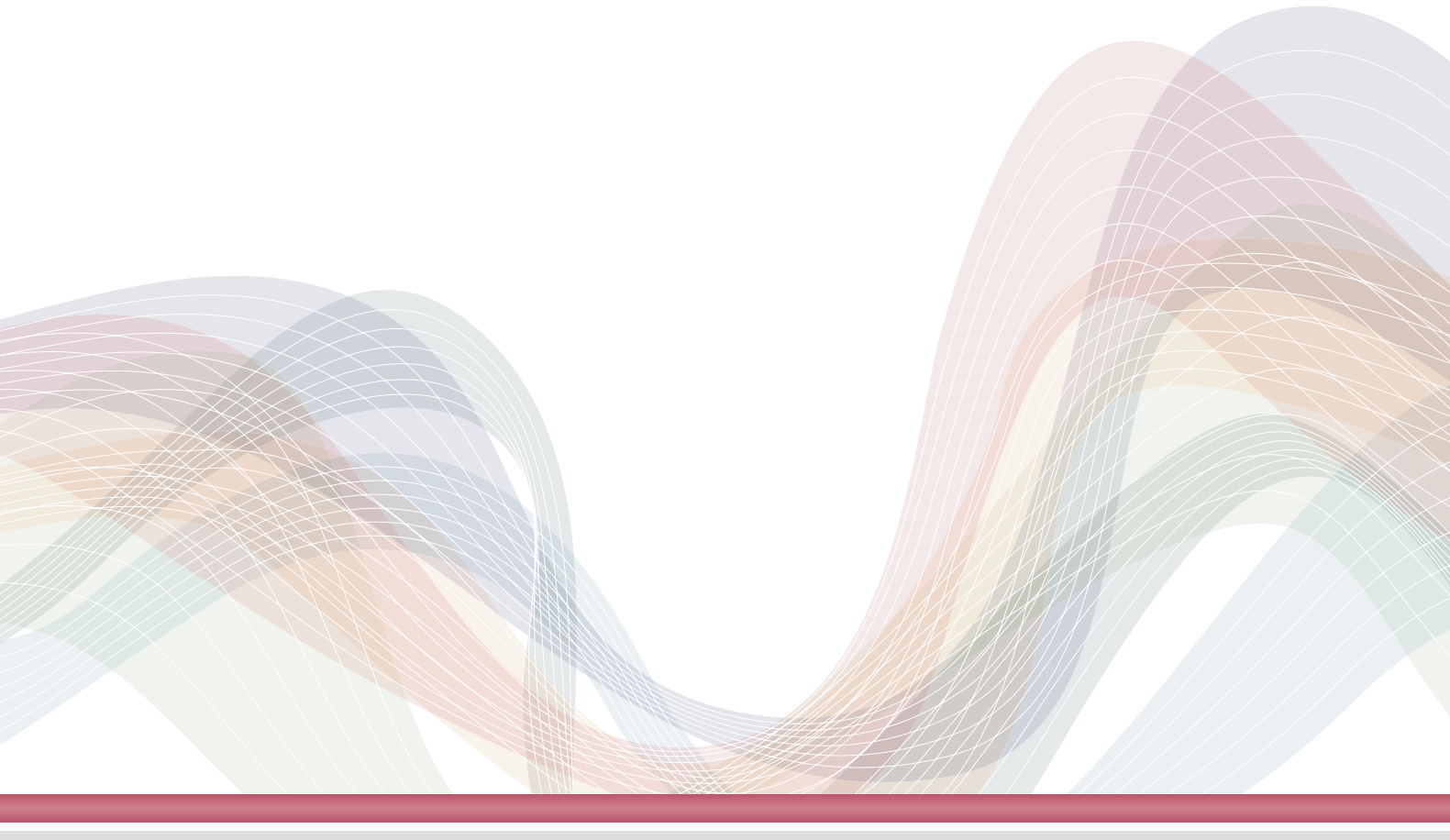

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