CHANGE AGENT TEAM
RECORD OF PRACTICE IDEAS AND INNOVATIONS

*Please record any new ideas in service provision, (service re-design, successful partnerships etc) or big or **small** innovative practices/processes that appear to have a significant impact on service delivery (e.g. flagging specific patient notes to identify a risk factor). Please check that the 'contact' is happy to be contacted to explain their practice*

These are practices and ideas heard about or seen on visits by the changes agents. We think they could be applied in other situations and should be shared more widely. They have not necessarily been evaluated, nor are they endorsed by the Change Agent Team.

Name of Organisation: Somerset Coast Primary Care Trust	
Service*: (e.g. physiotherapy, care management)* *Rehabilitation Services- integration of existing services and development of closer working practices with Social Services and Housing Departments*	
Contact: Ann Anderson **email address: aanderson@somcoastpct.nhs.uk**	**Tel No:** 01278 410067
Key Words *(3-4 words which sum up the service, for cataloguing purposes)* *Integration of community- based rehabilitation services*	
Brief description of the 'new practice/bright idea Current rehabilitation services offered from separate teams using different processes. (Occupational Therapy inpatient/outpatient/community outreach, Physiotherapy inpatient/outpatient/community outreach, and Community rehabilitation teams offering community based services/intermediate care/longer term rehabilitation). This has resulted in considerable fragmentation of service, with overlap and duplication, confusion for referrers, and a disjointed service for patients. The new integrated teams will be established by January 2003, with one integrated rehab service based at each of our four community hospital locations. Team will inreach into hospital as well as covering long-term and intermediate care needs in the community. Single point of referral, triage system for referrals, multidisciplinary documentation, consistent outcome measures, increased use of generic workers etc. Aim to develop improved partnership working with Social Services, Housing and Voluntary organisations in order to maintain older people for longer in their own home.	
Impact of the introduction of the change/development • Streamlined patient centred service • More effective use of existing rehabilitation service staff • Plans to build additional services onto these teams as resources become available. Already in discussion with Social Services about introduction of augmented home care, and are exploring the integration of Social services Occupational therapists with the team. • Increased use of core skills and use of generic skills across both hospital and community. • Clear referral pathway • Improved communication and multidisciplinary working	
Why did this change/development 'work'? Could it be replicated? • The changes are not yet fully implemented. • Full consultation and staff involvement in change process • Full support from PCT management team / Executive Committee. • Key champions who are willing to assist with change process.	
Has the practice been formally evaluated? Please describe briefly. • Plans in place to evaluate service	
Submitted by: Ann Anderson	Date: 13.11.2002

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