NHS SOMERSET AND SOMERSET COUNTY COUNCIL

'DESIGN TO UNDERSTAND' IN HEALTH AND SOCIAL CARE

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This case study illustrates the following:
- Building relationships and understanding what 'a good life' is from the perspective of the individual, rather than 'pushing' standard services, products, processes and commodities, is key to helping them solve their real problems.
- The more we standardise and functionalise services the less we understand what matters to people and the less able we are to help them.
- The counter intuitive act of putting more resources and expertise at the beginning of the process delivers better outcomes and savings over time.
- People shaped solutions are often simpler, more effective and cost less than service shaped solutions.

Background

This chapter is about transforming health and social care in Somerset to reable people to maintain their independence and do the things that matter to them.

The term 'Reablement' has a variety of meanings referring to a wide range of services, interventions and treatment goals. However, the main purpose of reablement is:

- To enable patients or their carers to be experts in their own care and avoid care solutions which foster dependence.

- To support people to stay in their own homes for as long as possible and prevent inappropriate admissions to hospital and long term care.

- To ensure people are able to access effective and holistic reablement in a timely way and remain independent for longer in the community reducing inappropriate admissions to hospital and care home placements.

- To focus on supporting people to regain life skills and control, enabling them or their carers to be experts in their own care and avoid behaviours and care solutions which foster dependence.

Reablement in Somerset has developed historically over many years and is provided in a range of settings and by a variety of providers. This has led to a lack of clarity in roles and relationships between services. Overlaps and gaps have been identified.

Reablement was identified as a key priority for both NHS Somerset and Somerset County Council within the 'Delivering Independence' and 'Quality, Innovation, Partnership and Prevention' (QIPP) Programmes. Both organisations have recognised the potential for significant gains in terms of service quality, patient (the term patient is used to represent

both patients and service users) outcomes and productivity and for increased partnership working with both private sector and voluntary and community sector organisations.

This joint priority provided an exciting opportunity to explore ways of improving outcomes for people with reablement needs, achieving a more integrated whole system approach, and using resources more effectively.

A key challenge for this project has been the defining of the scope and boundaries of the work within the existing complex rehabilitation provider landscape across Health and Social Care.

Why we had to change

When people think of health and health care, it is often hospitals that spring to mind. However, the great majority of people do not need hospital care in any given year. Over 90% of all contact with the NHS takes place outside hospital in people's homes and in other community settings.

Effective and efficient community rehabilitation services aim to support people to stay healthy and ensure people can live as independently as possible and for as long as possible within their own homes, and to have the best possible outcomes in terms of quality of life.

However, primary and community care must evolve to meet changing circumstances. Advances in treatment are allowing more care to be provided in local communities, people in Somerset are living longer and we are facing greater public health challenges from obesity and other 'lifestyle diseases'.

Historical approaches to reablement are scattered across the NHS and social care organisations where staff all work hard in their functional islands. They 'assess' patients, 'treat' them and if necessary refer them onto other appropriate services, often not knowing whether other interventions are successful.

Many of these people continue to present at GP surgeries, A&E, outpatients and social care services despite numerous interventions by health and social care staff; each intervention has its associated costs in time and money.

The Vanguard Method was chosen to support the change to a more localised, integrated approach to reablement.

Check

We started by studying our system. We undertook a range of Check activities to understand current demand and to find out what was really going on. This ranged from mapping current services across health and social care, understanding where and when demand entered the system; what people were asking for and what mattered to them.

Professionals from across the health and social care system engaged enthusiastically in building up an understanding together of how each part of their respective system currently worked, identifying many overlaps, gaps, duplication and frustration.   For many, this was the first opportunity to put a face to the name of a colleague to whom they had referred patients for years.

Throughout this process we validated what we were learning with a group of wider stakeholders.

Detailed analysis of patient journeys through the system proved particularly helpful in understanding what was happening to people over time, how the system was intervening in their lives and their experiences and outcomes. Five patients were followed in the detailed analysis over a two year period. Over this time, there were a total of 71 GP contacts, and 20 hospital admissions of which 70% were for non medical reasons. These five patients used a total of 415 bed days over this period and despite the fact that all of them wanted to remain in their own homes, the outcomes were as follows:

- Three of these service users are currently in residential care.
- One service user has 24/7 care at home.
- One service user has died.

New thinking

The new thinking involved first looking at how the parts of a service come together to produce the whole that the service user experiences. Often taking such a perspective reveals a large opportunity for improvement, as conventional management thinking encourages us to concentrate on improving the parts rather than the whole. The approach requires a real understanding of why are we doing something, before considering how we do it more effectively.

Once the new perspective has been taken, the second stage is the intervention theory - how to make a change. This approach highlights that there are two orders of change:

- **First order:** doing more or less of the same sort of thing (i.e. doing the wrong thing righter)
- **Second Order***:* doing a different sort of thing. This requires us to stand back, reframe and challenge the (often implicit) assumptions and operating principles of the current system

A new purpose

Our complex health and social care rehabilitation and reablement systems have grown historically over many years and are largely driven by political policies and targets. There was a real danger that the functional targets and objectives had become the de-facto purpose. One of the key objectives of the Rehabilitation/Reablement Programme is to ensure that the real purpose, the patient's purpose, is clearly articulated and becomes the driver for recommendations regarding future service models.

The following common purpose was agreed for the new service and takes into account the feedback received from the service user consultation:

"I want to maintain my independence: help me to find the solutions to do the things that matter to me. The things that matter to me are:

- *that you listen to me*
- *that you understand me and my needs*
- *that I do not have to repeat myself*

- *that you respond in a timely manner*
- *that it is easy for me to access the services I need*
- *that I am in control*
- *that you do not pass me from pillar to post*
- *that you respect me"*

The test phase

We decided to test a new reablement model, based on the principles above, investing more time and money upfront when responding to referrals for reablement. This emerging model tested the hypothesis that investing resources and time at the beginning to understand the real problem that needs to be solved saves time and money later.

A new team, called the 'Integrated Support Service' (ISS) team was set up. This involved:

- One GP surgery, including the District Nurse, Pharmacist and Community Matron.
- A single telephone number for referrals.
- An Integrated Support Service team with five team members (Health Occupational Therapist, Health Physiotherapist, Adult Social Care Occupational Therapist, Social Worker, Care Worker Supervisor).
- One key worker per patient.
- Simple paperwork and minimum criteria.

This Integrated Support Service team was given 'permission' to test different ways of working, and were not constrained by organisational barriers and systems. Wherever possible the team did the work, ensuring a minimum of hand offs and established good direct relationships and communication with the GP practice.
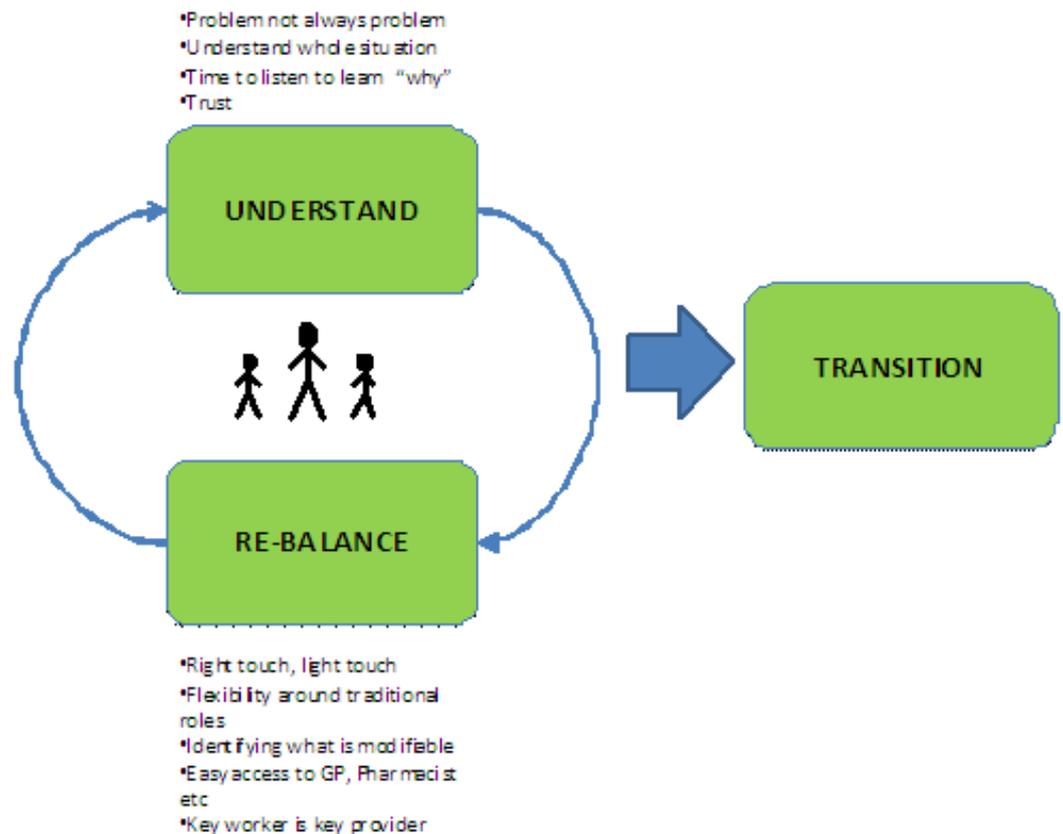
The old model

Old practice involved health and social care practitioners assessing, treating and in most instances referring people on to other services.

We know from the evidence that this method is far from effective in maintaining independence. It often results in costly and ineffective solutions and further admissions to hospital and long term care, mainly because the underlying problems are not fully understood.

The new reablement model

The model that the Integrated Support Service team now use is based on the new purpose and principles.

- Problem not always problem
- Understand whole situation
- Time to listen to learn "why"
- Trust

UNDERSTAND

RE-BALANCE

TRANSITION

- Right touch, light touch
- Flexibility around traditional roles
- Identifying what is modifiable
- Easy access to GP, Pharmacist etc
- Key worker is key provider

Transition in this context means setting people on track to move forward confidently with their own life.

The test phase ran for 5 months. Qualitative and quantitative data showed that there were encouraging signs of successful outcomes. This needed to be tested on a larger scale so over the next 6 months a further 15 GP surgeries in Taunton Deane were 'rolled in' to the new way of working. This resulted in the creation of a further five ISS Teams.

New service criteria

The new service criteria are minimal. Specifically, we do not apply the Fair Access to Care (FACS) criteria. To qualify for a service, users simply have to be over 18 and registered with a Taunton Federation GP. The intention is to develop and provide a service that fits the needs of the population: historical working practices show that the development of eligibility criteria leads to individuals falling between services, and their needs often then escalate into a crisis situation.

The old eligibility criteria were designed to meet the service needs not the individual's needs. Re-design has tested our new thinking that considering all referrals with minimum criteria will lead to more efficient use of resources in rebalancing the individual at an earlier time point, and so deliver better outcomes and savings over time. There were early concerns and anxieties about the potential for new demand to emerge from fewer criteria; however, the delivery of the service within the resources has on the most part been achieved.

Where it has become clear that some cases are not wholly suitable for the Integrated Support Service, these are managed on a case by case basis by the team in deciding through discussion, the appropriate agency for their needs to be met.

A new referral process

The new referral process is by telephone conversation direct to a team member. Each team organises their diaries to make a registered staff member available on a daily basis to receive referrals by telephone from the GP's and surgery staff, the Acute Hospital wards, and Community Hospitals, as well as traditional referrals forwarded from Adult Social Care and the Adult Rehabilitation Service.

We have identified that referral forms and templates are not effective in the transfer of knowledge and information about an individual in the same way as a real conversation. The referrer is encouraged to have a conversation with the team about concerns and gauge urgency.

The teams aim to see all referrals within the timescale recommended by the referrer, commonly two to three days. However, teams are able to prioritise urgent individuals in order to prevent a crisis and would aim to be available within one hour if required.

Two members of the team undertake the first visit to the individual and spend time listening to the service user and their family, understanding the problem and identifying what matters to them. This process is based on each team making use of the diversity of skills within the team, enabling a more effective understanding of needs, problems and innovative solutions. Regular interdisciplinary team discussions are essential in ensuring that the skills and experience of the whole team are incorporated in the development and evaluation of the individual's support plan.

New documentation

Each team now complete a single shared document called '***understanding you***' in replacement of single assessments from each profession. This builds a clear picture of not only what the person is able to do or has problems with, but also who they are, what is important to them, how they choose to live, and what their good life looks like. This document forms the basis of the support plan that is left in the person's home, and will be updated as more is understood about the person and their goals, and barriers.

The support plan is agreed with the individual and the team with the intention of attaining the goals over a six to eight week period. The support plan identifies their specific goals, who and how they will be achieved and what the person themselves are responsible for doing. It also has the contact details for their key worker and team details. If additional expertise is required that sits outside of the team, this expertise is pulled into the team and incorporated into the support plan rather than triggering a referral to another service and returning to the former systems of separate islands of help.

The role of the key worker

Each individual accessing the service now has a key worker from the team. This is usually the team member who has the majority of the contacts in delivering the support plan and has a strong and effective relationship with the individual. The key worker is responsible for

coordinating the elements of the support plan and is accountable for the individual and their plan. The key worker is the main point of contact for that individual.

The role of the domiciliary care workers

Three preferred provider care agencies in Taunton provided staffing for two of the teams and these paid care workers are important members of the teams, enabling care support to be accessed immediately and flexibly. Being an integral part of the team gives care workers an additional awareness and understanding of service users changing needs, whereas previously care workers were isolated from decision making and planning.

A new approach to hospital discharges

The teams now have closer involvement in hospital discharges. The referral consists of a conversation with the ward based staff about the barriers and problems experienced by the individual, and a discussion about the possible ways of supporting the person to be at home. It has taken time to engender a trust relationship in the service as the new model is able to provide services in a different way to that traditionally deployed.

The teams encourage positive risk taking to facilitate discharges as soon as is practical, with rapid review at home and quickly amend plans as required. It is acknowledged that people often function differently once in their home context, and so the understanding process is usually most effective when started once people have gone home, to prevent duplication and false assessments.

The transition from hospital to self management

As part of the support plan, the team identify what support systems will be required by the individual to enable them to self manage their needs in the longer term. Work towards this transition phase is integrated into the reablement process. Some individuals may require extensive intervention to develop their self management techniques and this would be considered as part of their reablement goals.

The teams have developed a model of intervention based on personalisation and professional reasoning. If the team identify a task that will require ongoing input from another agency or worker, the key worker will draw that new worker into the team and undertake a careful transition of responsibility to the new worker, ensuring all the understanding of the person is not lost at a handover point.

A new approach to communication

All communication to key staff, such as the individual's GP, follows the principles of reducing processes that do not add value. Conversations by phone are encouraged as are short secure e-mails to transfer information. This enables the key information, specific to that individual, to be transferred efficiently and effectively rather than providing additional information through letters, forms or templates.

The focus around GP practice is maintained though providing the GP with a short summary of work by email or phone at the end of intervention.

A new management structure

Early implementation of the team's day to day support is provided by project leads to support the new model and operating principles so they become embedded into everyday practice. As teams developed in number, a new role was required to support the teams operationally with day to day management tasks.

A preferred management structure was developed with the intention of testing this in the Taunton Deane area and supporting inter-organisational working. Two managers, one from Adult Social Care and one from Somerset Partnership NHS Foundation Trust job share the management of the six teams, each taking lead responsibility for three teams. A Partnership Agreement was developed to provide a governance structure to support this working arrangement, which details the lines of responsibility and accountability for managers and teams and organisations

A new approach to administrative support

The intention is that rather than making assumptions based on previous practice about what is needed, the administrative systems will evolve in response to demand, and be designed against actual need.

Capacity versus demand

The planned resource for each team was based on the level of referrals from practice populations previously received by Adult Social Care and Community Rehabilitation Teams.

Each team, as it has taken on its full population cohort, has experienced a period of more demand than they can cope with. Traditionally, services introduce tighter criteria or have waiting lists to manage such demand. However, this does not enable the service to meet its purpose, and so during this test period some additional resource has been added to teams to meet this demand.

We have learnt from the experience of the earlier teams that although there is a surge in additional workload in the first months, the referral rate eventually stabilises as the individuals with complex conditions have become known and understood by the team and future contacts with these individuals are reduced. Our experience is that a balance between demand and capacity can be achieved without recourse to traditional demand management approaches such as eligibility criteria or waiting lists.

Flexible working across teams in times of high demand has been encouraged. Fundamental to the way the teams work is the concept of sharing skills and looking across the team to see what skills are most appropriate in any given situation and not being confined to traditional roles.

Culture

Bringing together staff from three organisations has been challenging in part due to the difference in cultures that exist between the organisations. This can be seen at many levels and it is important that teams identify common ground and work in a joined up way to complete an 'understanding you' with each individual.

Health care staff are naturally preoccupied with the human body and the functional consequences of ill health. Social care staff are focused on the functional skills and the impact of the environment, family and community that support them.

It has taken time for staff to appreciate the value of different skills and areas of expertise and to develop strategies for incorporating all of these skills in the care planning for an individual.

The most challenging change in culture and practice is encouraging the teams to be self managing and return to professional reasoning and personalised care planning. As services have evolved it appears that an over-dependency on processes has developed, together with a need to get authorisation to deliver services. This culture over time has created a dependency in the staff on process. It has also affected the ability of some staff to use reasoning and consider the best or most appropriate opportunities for the individual.

Across the staff groups it has taken time to adjust to the *team* holding a caseload rather than *individuals* holding a caseload which means sharing the responsibility for the support plan and interventions.

Information Sharing

It has been essential to develop a collective vision for information sharing and governance across the partner organisations. Early barriers to effective working were based on not having easy access to computers for processing data in the existing organisations IT systems, not having a team single record for interventions, and double entering of information across organisations. This was further complicated by no one unique identifying number being readily accessible for the individuals; Health care staff used NHS numbers and Social Care staff used a different number generated by their IT system.

Challenges for Adult Social Care managers

Adult Social Care has traditionally always worked very closely with health services in Somerset. However the challenge for managers was that the integrated model raised many more cultural issues than we would have expected and the blurring of organisational boundaries proved challenging for staff and managers alike. We recognised there was a difference between working in a multidisciplinary way (old world) to a new interdisciplinary model.

Although social care staff liked the new model, described by some as 'old fashioned social work', they have been frustrated at the speed with which the organisations have been able to reduce the constraints that block working in this new way.

Social care staff are also now able to do preventative work whereas previously the 'Fair Access to Care' criteria meant they were only working with people with critical and substantial needs.

Adult Social Care in Somerset, like many other local authorities, has over the years introduced processes and policies designed to reduce spending and in doing so, has disempowered workers and undermined their ability to rely on their professional judgment. Working to this new model has liberated workers to become more creative and to do what they want to do which is understand the problem and achieve success by using their skills

and knowledge. However, some workers have found this new model difficult because they are out of their comfort zone. As managers we have had to support workers to embrace change.

The impact on Adult Social Care services outside of ISS has been significant and it has meant we have had to review all the systems and processes with which we have worked for years. This project has not been an isolated piece of work - its tentacles have reached to the furthest corners of Adult social care.

Challenges for health managers

Health services have, in most cases, been developed by provider organisations, adapted and added to over many years to meet changing demand and top down standards and targets. For health commissioners, when working with provider organisations to redesign services, the complexities of the systems already in place often present a considerable challenge to the goal of achieving better outcomes for service users. However it is clear from our stakeholder feedback that health staff working within these complex systems are aware of the constraints these systems put on their ability to do their jobs well.

The most important element of the initial work on this programme was identifying the 'purpose' of reablement services, and doing this from the service user's perspective. This was harder to do than anticipated because the language used in health frames services from the perspective of the service provider. However, once achieved this seemed very simple and straight forward, and enabled us to design against the real demand rather than perceived demand. Health staff within the teams have welcomed the new way of working and the opportunity to spend more time understanding the service user and therefore more effectively supporting them to achieve what matters to them. However health staff are equally frustrated that it takes longer that they would like to deal with the organisational constraints that have emerged and which are so ingrained within our current systems.

Delivery of safe and high quality services is critical to all health service commissioners and providers and there a number of mechanisms and frameworks in place across organisations to provide assurance in these areas. The key challenge for health managers when supporting the reablement pilot was to ensure an adequate clinical governance framework was in place, whilst retaining the flexibility to learn and adapt the model throughout the development phase. This continues to be an area of learning and has required the strong support of provider organisations.

The other key challenge for both health commissioners and providers is to understand the impact of this service redesign on other areas of health service provision, and to gain a clearer view of how this programme links with other initiatives being delivered across acute and community settings, and how this methodology can be utlised effectively in other areas.

New thinking about cost

In service organisations, the majority of cost is in the time of professionals. The plausible logic is that if we can control that amount of time then we will save money.

This manifests itself in the system in a focus on productivity and the length of transactions, for example, eight minute GP appointments in the surgery, 12 minute average handling time

targets over the phone at the call centre, kitchen assessments in the hospital kitchen rather than in service users' homes.

The consequence for performance is that the service user has to repeat him or herself , feels passed around and will often re-present repeatedly in the system because their real problem still hasn't been understood or solved.

Alternative Principle – Design to Understand

For those service users with non-straightforward issues, this might mean taking more time and going to their own environment. When this is done we learn that the presenting problem is quite often not the actual problem. Frontline workers can then build solutions to address the cause of the problem, rather than transact with the symptoms.

The consequence on performance is that the service user receives help for their actual problem, decline is avoided and the system saves on expensive support.

The problem with functional design

The logic here is that if everyone is given a smaller part of the process then they will become very good at doing that bit and the overall speed and quality will improve. However, this flawed logic leads to functional islands of help with many hand-offs, over-specification, duplication and re-work.

The consequence for the service user is frustration and for staff it can mean being denied seeing the end result of their labours, and extra cost for the organisation.

Alternative Principle – Retain Ownership and Pull Support

A key-worker is selected and they then have responsibility for that service user and will pull for help if the problem is not one they can solve on their own, rather than referring on to another professional to begin the process of understanding afresh.

The service user establishes a relationship and trust, and the system can design a service user-shaped solution which can develop as they do. Staff get to know the people they are helping and can see their progress. Although the professional might spend more time with the service user, the system spend less time and money overall.

The following examples show what would have happened to service users in the 'old world' and what happens now.

Example 1 - Prevention of admission

Mrs L

GP referred this lady for frailty, sickness, constipation, diarrhoea, not eating or drinking. GP saying he would have to admit if team could not act. Mrs L reluctant to have help but with encouragement the care worker from team visited several times daily as appropriate to encourage Mrs L with food and drinks. She started to stabilise and get better and after 2 weeks her family took over and she is now better with no care.

During this time the social worker organised a follow up GP visit as some suspicion that she may have other things wrong with her and she also received some suitable aids to living equipment. The rehab worker noticed she was using her husband's walking stick which was too long and causing her to have poor mobility. He cut it down to fit.

Old world:
Hospital admission.

New world:
Care worker has freedom to organise visits appropriate to problem and enables Mrs L with encouragement to eat and drink. GP visit arranged in a timely manner. Equipment given and adapted to suit individual.

Example 2 - Hospital Discharge

Mrs G
Has mild learning difficulties and hydrocephalus. She was admitted to hospital with vomiting and diarrhoea and referred to team with incontinence and help needed with transfers. The hospital initially was looking at a nursing home placement. A large package of care was put in, 2 carers twice a day and night care as she was very incontinent. The Occupational Therapist had been working with her so that she can now do her own breakfast. The Physiotherapist had been looking at transfers and 3 visits a day are now with one carer using equipment and once the District Nurses have sorted out her incontinence it is planned to remove the night support. Mrs G is improving on transfers and will remain at home.

Old world:
Probable placement in a care home due to needs that were over and above what would normally be met at home.

New world:
Occupational Therapist and Physiotherapist have worked with Mrs G and care workers to put in a reabling package. This is now showing results.

Learning

Our key learning can be summarised as follows:

- Minimal criteria will lead to more efficient use of resources in rebalancing the individual at an earlier time point, and so deliver better outcomes and savings over time.
- Eligibility criteria and waiting lists lead to people falling between services, their needs often ignored and their situation later escalating into a crisis.
- When removing eligibility criteria, there is an initial increase in workload. This stabilises when people with complex needs are understood and further contacts with the same person reduced.
- Not understanding underlying problems in a health and social care setting can result in costly and ineffective solutions and preventable admissions to hospital and long term care.
- The presenting problem in a health and social care setting might not actually be the real problem. Taking time to understand people in their own home and context

allows workers to build solutions to the real problem instead of providing transactions to deal with the symptoms.

- Real conversations between professionals about service users are more effective than referral forms and templates, especially when trying to judge the urgency of a situation.
- Administrative support should evolve in response to an understanding of demand and not be provided on the basis of previous practice.
- The consequence of a functional design for the service user is the feeling that they are being 'passed from pillar to post'.
- When people from different organisations come together to agree a single common purpose from the point of view of the service user, working together becomes more straight forward and productive
- The allocation of resources should not based on historical configurations and complex systems. They should be configured around the needs of the service user.
- Front line staff are usually well aware of and frustrated by the system conditions that are preventing them from doing their job.
- Giving individuals a key-worker who has responsibility for either solving the problem or pulling for help if the problem is not one they can solve on their own, avoids the cost and frustration of multiple assessments

Results

The qualitative evaluation of the pilot has shown very positive results from service users, staff and clinicians. The responsiveness of the service and the focus on individual need is very much welcomed and is considered to have resulted in an improved quality of service provided to individuals and overall, an increase in staff motivation and satisfaction.

A study of the first 120 people to be supported by the ISS show the following results. 38% were referrals to support hospital discharge and 62% were referrals from the community.

Reduced length of stay in hospital	**26**
Prevented admission to hospital	**12**
Reduced package of care	**18**
Prevented package of care	**27**
Prevented admission to care home	**7**
Reduced carer strain / prevented breakdown	**10**
Prevented provision of equipment	**16**

A wider cohort study indicates that the reablement group had significantly better outcomes for 30-day re-admissions and social care costs when comparing the change between those at one year prior to intervention and three months post intervention.

Further work will be conducted to consider the financial cost of the intervention in terms of staffing and care costs against any savings made through a reduction in future service use. Initial calculations from this cohort indicate that the additional cost of social care during the reablement period can be offset by reduced need following reablement.

Conclusion

We know that we are only just beginning on our journey to transform reablement in Somerset. However, what we have learnt and the outcomes we are achieving give us the

confidence to continue to embed this new way of working across the County and importantly to work on resolving the constraints and system conditions that get in the way of achieving purpose.

To conclude, a Taunton GP / LMC Medical Secretary said the following after recent successful involvement of the ISS team with one of his patients:

"The ISS approach is more than a breath of fresh air; it is potentially a storm to blow away established unhelpful working practices…

The best way to make the new NHS work is to continue to build organic cross-disciplinary teams who are given autonomy to share professional skills to find the quickest answer to each patient's problems. This is a new way of thinking that could really make a difference."

About the authors

Ann Anderson

Ann worked as an Occupational Therapist within the NHS for many years, practicing in both acute and community settings, before moving to a senior NHS management role 12 years ago. She is currently working as Deputy Director of Strategic Development with NHS Somerset, leading a number of strategic programmes in Somerset including Long Term Conditions. Her work includes some exciting initiatives to support improved quality and outcomes for service users and their families with a focus on achieving efficiencies in the system and preventing unnecessary admissions to hospital. . Ann has lead a range of service redesign programmes within both children and adult services, working across organisational boundaries, envisioning individuals and teams to embrace innovation and new models of care.

Fred Parkyn, Service Re-Design Manager, Adult Social Care, Somerset County Council.

Fred qualified as a social worker and became a senior manager in Somerset County Council Adult social care with special responsibilites for liason with the NHS. For the last 18 months, she has been working solely as the community services design manager and the project lead for adult social care on this project. She retires shortly.