Ffordd Gwynedd Health and Care

Leaders have been talking about delivering client centred services for a long time and this is what workers are trying to do every day. But the work systems that were developed seem to have been hindering rather than supporting this.

A key Vanguard concept is that of 'Failure Demand'. This is demand that re-occurs because the system has failed to meet it at the first opportunity. So it shows up again in the form of re referrals and re assessments.

Armed with this, a Team of Social Services and Health Staff (Managers and Practitioners) spent six days with Vanguard to:

- Find out what matters to users
- Find out how our system works

This was done by:

- Interviewing users
- Case file reviews
- Work flow analysis

Following this we used the system / performance and user knowledge to work backwards to the 'thinking' which underpins our current system and our current purpose. We found that it included the following features:

- We tend to see Social Services solutions as the only options; fitting the individual to the service rather than seeing what matter's to them.
- We tend to solve single issues / problems; not necessarily addressing root causes; some examples of poor multi-agency working.
- Too many assessments and re assessments; not sure about effectiveness of reviews.
- Standardisation is seen as good; if you fill in the form you have done a good job; pushing people through a production line.
- We do things because we have to measure it that way; individuals must hit 'triggers' to be "bad enough" to move to the next stage.

This encouraged us to visualise what 'perfect' would look like by giving us a new **purpose** and a new set of **operational principle and Value steps** as follows:

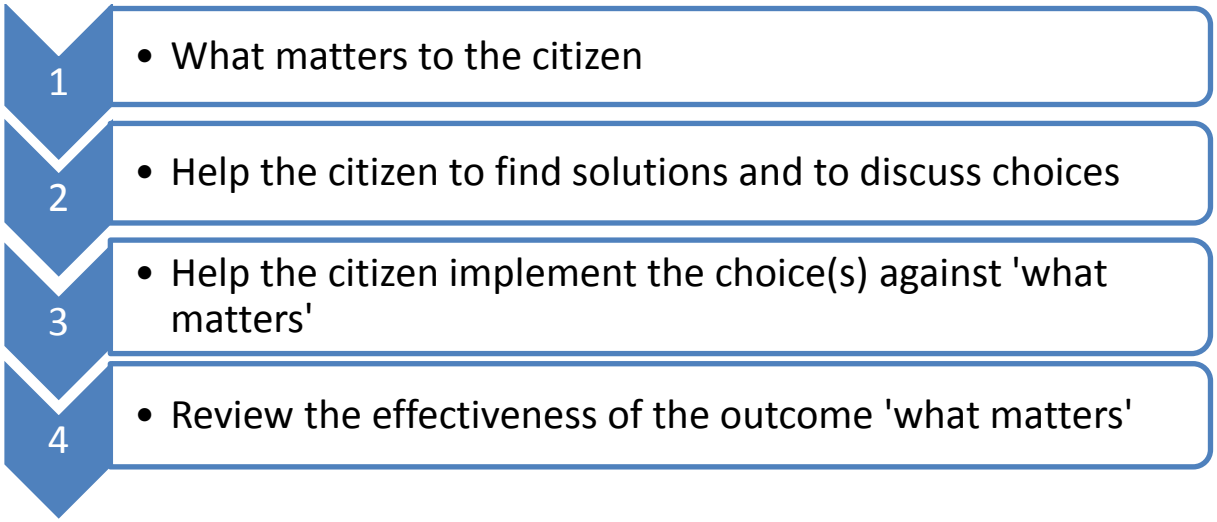
New purpose: "Help me to live my life as I want to live it"

New operational principles:

1. What matters to the individual is at the centre of all we do.
2. We have a conversation with the individual about their story and the strengths they wish to build upon; supporting the individual to make informed choice.
3. We make decisions with the individual at the right time in the right place.
4. Interventions are based on what matters to the individual by working in partnership with their personal networks.

5. We retain ownership and pull in expert support as required.
6. Information focuses on what matters to the individual and is readily accessible to all who needs it.
7. Our measures drive our learning and whole system way of working.
8. We all work as one team.
9. Leaders act to remove barriers to enable effective service delivery.

Value steps:



After the initial 6 days an integrated team of health and care professionals were put together to test these principles in an operational context. This pilot ran for a period of 12 weeks (January 2015) which included the following professions:

- 2 x social worker
- 1 x Occupational Therapist (GC)
- 1 x Occupational Therapist (BCU) (no longer within the core team since June)
- 1 x District nurse
- 1 x Enablement Officer

(This team remains as the core team who mentors and continually tests out new ways of working and challenges forms and identify blockages to remove to ensure that the team are able to adhere to the new purpose and principles. The core team do not take on cases.)

Following the pilot a subsequent roll in of multidisciplinary staff members took place in April and July 2015, and will continually grow until the whole area (Eifionydd) has been rolled in to the new way of working. This way of working will subsequently be introduced to other areas of Gwynedd following the team in Eifionydd being fully functional with relevant health staff joining the team and them all being fully confident in the new way of working.

What have we changed?

- Front line workers are leading the change on the basis of learning from real cases

- One team of health and social care workers working from a community hospital
- A design which will strive to ultimately result in less paperwork and more time spent with the citizen. (80% Care/20% paperwork)
- The same person holding the citizen's story end to end able to pull the right expertise at the right time
- Measures that help us learn understand and improve
- Skills that help us to help the citizen help themselves thus reducing the dependency on public services
- Improved citizen journeys.
- Team challenging what doesn't add any value to what they do.
- Identifying blockages in the system and eliminating them
- Leaders working on and getting rid of blockages.

Current Situation:

The operational team in Eifionydd include:

- 2.6 x Social Workers
- 1 x Occupational Therapist
- 1 x Enablement Officer (Currently on long term sick leave)
- 1 x Field Officer (3rd Sector, on a trial basis which will be reviewed regularly)

The team currently does not include any health members due to the member recently retiring and awaiting to move office for the district nurse team to join the team.

What Happens next?

1. District Nursing team to join the operational team in the next few weeks
2. Moving to a permanent office space (downstairs in Alltwen)
3. Rolling in the ward staff in Alltwen to the new way of working.
4. Workshops have been arranged for Regional Adult Teams within social care (dates on last page)
5. Sessions have been arranged for leaders of health and social care early in December.
6. Planning for other areas i.e identifying locations and timescales.
7. Introducing the new way of working to other local multidisciplinary teams ideally working in a community hospital or surgery setting.
8. Continue to identify blockages and getting rid of them to ensure a timely and effective service for the citizen.
9. Building on individuals and communities strengths
10. Trialling taking all calls for Eifionydd directly i.e. all calls coming through advice and assessment being passed on straight to the team before taking any details on the case.

Ffordd Gwynedd Health and Care's achievements:

- Agreement with audiology department that they will accept a referral via e mail and what matters form, instead of referring through GP. A mail box will be organized.
- Citizens in Eifionydd who have a current hearing aid and have concerns, are now able to self-refer to the audiology department at Ysbyty Gwynedd.
- Team able to borrow hearing aids for assessments
- District nurses are now able to contact out of hours through a direct number, instead of having to go through the triage system.
- A CHC applications mailbox has been arranged following a request by the team.
- An agreement is in place for any request for rubbish and recycling collection to be completed via e-mail. This provision is in place for social service and health workers. No longer a requirement to complete a form.
- Joint local stores
- Prescribers' rights- for all workers in the Eifionydd area for equipment such as profiling beds. The case will be discussed in a controlled environment prior- this is to ensure that every avenue has been achieved prior to ordering the bed.
- Welfare Rights Department- Willing to accept direct referrals via e-mail, instead of completing a form.
- Can refer direct to Orthotics instead of having to go through GP
- Access to ambulance Transport for intermediate care admissions in nursing care homes – direct number to the department.
- (DFG) disability grant – Health occupational therapist can refer directly and take responsibility (following multi-disciplinary discussion (Fish bowl))
- CCG adaptations – discuss case with CCG officer, therefore the case does not need to go to panel

Current Blockages that are being addressed

- CHC – form over 100 pages – long process
    - Process is being mapped to understand why all the documentation needs to be filled
- Telecare – Telecare process has been mapped to try and look at simpler and effective ways of providing the service without the need of filling forms and trying to reduce the time from point of contact to the point of receiving the equipment.
- Direct payments – work ongoing in adapting the guidelines
- Inconsistencies in short term care units – some units insist on going out to assess individuals for admission to short term care units even though an assessment by a professional member of Health or social care has already made an assessment. This is causing duplication and a delay in admission.
- Mapping work being carried out on the Welfare rights team

- Work being done on challenging national/corporate measures
- Best interest assessment /MCA being looked at – two forms different from Health and social care – looking at having one that cover both needs.
- Delays in house adaptations – housing associations – looking at how this service can be more effective
- CCSIW – age variation – having problems placing adults under 55 years of age in short term care units without having to make an 'age variation to the registration' of the home, which can take at least 5 weeks to be put in place. This does not take the individual's need into consideration.

Questions and answers

Questions that were raised from Focus groups held for Adult, Health and Wellbeing staff:

- What is the nature of cases the team are dealing with?
    - The team deals with all cases that come in directly and through advice and assessment, the ward, GP's etc. the team does not split long term or short term cases. They do not deal with any mental health or learning disability cases (OT might be pulled into these as they do not have an OT within LD team at present).
- How does the team receive referrals?
    - Directly on the phone, e-mail, fax
    - Through the advice and assessment team
    - The way of receiving referrals has not changed at present.
- What is the paper work used?
    - The only form that they have to fill is the 'what matter's' a copy can be seen below, this combines the old assessment and care plan. The 'what matter's form is also used for any reviews that need to carried out as well.
    - The team are looking to eliminate unnecessary forms for referrals to other services to avoid duplication, therefore the team are trying to use the 'what matters' as a form of information for any referral for example to refer to residential homes, as a care plan when referring for home care package, as the 'what matter's' document notes all relevant information to inform relevant agencies of what is important to the individual to enable them to live their life how they want to live it.
- What are the blockages and how have the team overcome these?
    - See page 4.

- Simply, what is the new way of working?

    - Ownership of cases from start to end of citizen's journey, no passing cases on to other workers, instead pulling them in when necessary.
    - Integrated working with health and social care –eliminating 'barriers'
    - Health and social care co-located
    - Less paper work – ideally 80% with the citizen 20% paperwork
    - Focus more on what is important to citizen, tries to move from notion that the solution is always statutory services.
    - Working closer with the citizen on the cusp/during enablement period.
    - Multidisciplinary meetings discussing cases which avoids having to take the case to panel for any service to commission care or order any equipment.

If you would like more information about the new way of working, workshops have been arranged for Adult regional teams:

Dwyfor Area Team: 09:30am, 21/10/15, Frondeg, Pwllheli

Meirionydd Area Team: 13:00pm, 18/11/15, Rm 2 Penralag, Dolgellau

Arfon Area Team: 09:30am, 4/11/15, venue to be confirmed, Caernarfon

For those not involved in the above teams workshops there are also open sessions for health and social care staff being held by the Ffordd Gwynedd health and social care team (contact the team to know when they are being held) if you would like the members of the team to come and present to your team separately please contact the team on 01766 510072 or contact Teleri Toohill ar Telerisamueltoohill@Gwynedd.gov.uk to arrange.

Appendix 1 –'what matters' form

"BETH SY'N BWYSIG I MI…"
"WHAT'S IMPORTANT TO ME…"

Dyddiad Cychwyn Y Ddogfen/ *Document Start Date :-*	

Enw a Swydd Cyd-lynyddd Gofal / Name and Designation of Care Co-ordinator	

Enw(au) Cyntaf y Dinesydd: *Citizen's First Name(s):*		**Cyfenw'r Dinesydd: *Citizen's Surname:***	
Rhif *NHS No*			
Rhif RAISE *No*		**Rhif D *No***	
Rhif Ffôn Cartref / *Home Tel No:*		**Rhif Ffôn Symudol/ *Mobile No:***	
Cyfeiriad Cartref: *Home Address:*			
Perchnogaeth / *Tenure*			
Dyddiad Geni: *Date of Birth:*			

Person Arwyddocaol / Perthynas Agosaf – *Next of Kin*

Pŵer atwrnai/Power of Attorney	

Gwybodaeth Meddyg Teulu / *GP Details*

Enw'r Meddyg Teulu: / *GP Name:*	
Cyfeiriad y Meddyg Teulu: *GP Address:*	
Rhif ffôn y meddyg: *GP Tel No:*	

Caniatad / Capasiti / Rhannu Gwybodaeth – Consent / Capacity / Share Information

Dewis Iaith. Llafar ac Ysgrifennedig – Language of choice verbal and written

Risgiau / Risks
BETH SYDD YN BWYSIG I CHWI . SUT MAE BYWYD DA YN EDRYCH FEL I CHWI? WHAT MATTERS TO YOU / WHAT DOES A GOOD LIFE LOOK LIKE TO YOU ?
1. CEFNDIR/HANES – BACKGROUND/HISTORY
2. IECHYD CORFFOROL/MEDDYLIOL PERTHNASOL – *RELEVANT PHYSICAL /MENTAL HEALTH*
3. BETH MAE TEULU, FFRINDIAU / Y GYMUNED YN GALLU EI WNEUD? – *WHAT CAN FAMILY, FRIENDS/THE COMMUNITY DO?* CYSYLLTIADAU CYMDEITHASOL - *SOCIAL CONTACTS*
4. SGILIAU A CHRYFDERAU (BETH YDYCH WEDI GWNEUD/YN GALLU EI WNEUD I HELPU EICH HUN I GYFLAWNI YR HYN SYDD YN BWYSIG I CHWI?) – *SKILLS AND STRENGTHS (WHAT HAVE YOU DONE OR CAN DO TO HELP YOURSELF ACHIEVE WHAT MATTERS TO YOU?)*

5. OFNAU A PHRYDERON/*FEARS AND CONCERNS:*

6. SYLWADAU CYFFREDINOL / *GENERAL COMMENTS*

ALLBYNNAU BERSONNOL A GANFYDDWYD (BETH SY'N BWYSIG) A'R WEITHRED A GYTUNWYD: ***PERSONAL OUTCOMES IDENTIFIED (WHAT MATTERS) AND AGREED ACTIONS***		
Beth yw'r amcan benodol. What is the individual Outcome ?	Gweithred a'r Camau a gytunwyd i gwrdd a'r Amcan benodol / Agreed actions for meeting The individual outcome	Pwy sy'n gyfrifol, sut a phryd? Unrhyw rwystrau i gyflawni yr allbynnau a'r risg sy'n gysylltiedig / Who will be responsible, how and when? Any barriers to achieving these outcomes and related risks.

Dyddiad Adolygiad : / Date of Review:	
AWDUR / AUTHOR	
DYDDIAD / DATE	

GWYBODAETH DIWEDDARAF SY'N BERTHNASOL I BETH SY'N BWYSIG / LATEST UPDATE THAT IS RELEVANT TO WHAT MATTERS		
Rhowch dic yn y blwch os mai adolygiad yw hwn/ *Please tick if this is a Review*		
AWDUR / AUTHOR (Yr Adolygiad/Review)		
DYDDIAD / DATE (Yr Adolygiad/Review)		
DYDDIAD CAU'R DDOGFEN / DOCUMENT END DATE		