Ffordd Gwynedd Health and Care (Ysbyty Alltwen Site, Eifionydd)

1. Aims and purpose of the Project

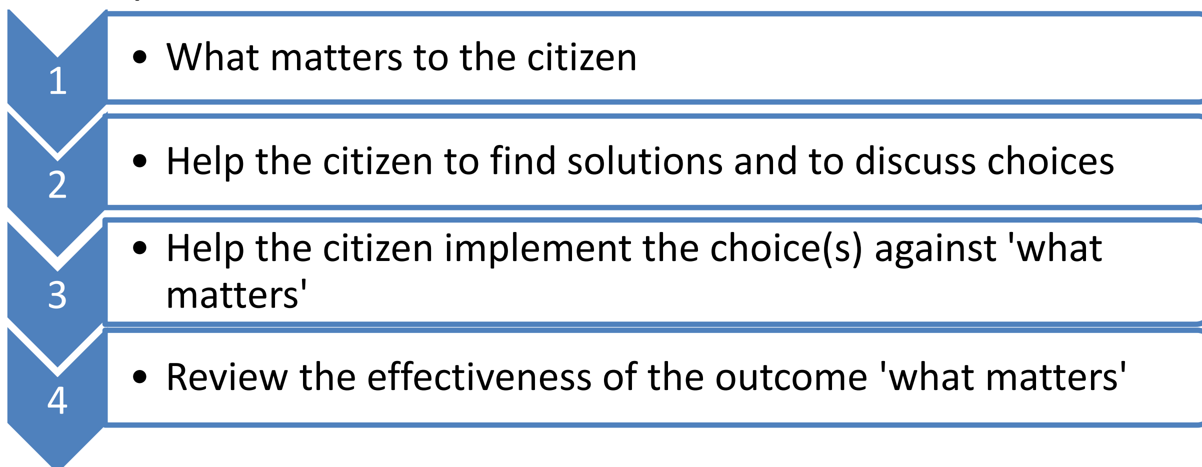
'Ffordd Gwynedd''s principles ensure that Gwynedd's people are at the Centre of all that we do. This is what staff are trying to do every day. But the system or processes in place are hindering instead of supporting this. **Ffordd Gwynedd Health and Care's aim is to simplify these work processes and avoid blockages that will lead to a better Service for the individual.**

P**urpose:** **"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:



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2. Operational Team Set-up

This team will continually grow until the whole area (Eifionydd) has been rolled in to the new way of working. At present, the team in Eifionydd includes:

- 3.4 x Social Workers
- 1 x Occupational Therapist
- 1 x Enablement Officer
- 1 x Field Officer (3rd Sector, on a trial basis which will be reviewed regularly)

3. Questions and answers

- **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 form, this combines the old assessment and care plan. The 'what matter's form is also used for any reviews that need to be 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.

- **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 avoid having to take the case to panel for any service to commission care or order any equipment.