

With YOU For YOU

Our Shetland - Working Together



Guidance

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With Y😊U, For Y😊U

Foreword

We are delighted to have this opportunity to introduce the **With Y😊U, For Y😊U** Guidance.

This heralds a new way of working together with people in the community who require support and working in partnership across agencies to ensure we have a way of meeting needs that is sustainable in the long term.

In our introduction to the Community Health and Care Partnership (CHCP) Agreement 2009 – 2012, we spoke of the need for our plans for the future to be ambitious if we are to maintain the quality and levels of service that Shetland has enjoyed in recent years.

We spoke of the commitment and courage across our services that would help us to work through the challenging times ahead. Nowhere has this commitment and courage been more in evidence than in the work on the redesign of our Single Shared Assessment Processes culminating in the **With Y😊U, For Y😊U** initiative.

The LEAN project team who have worked on the redesign have worked tirelessly gathering information, seeking the views of service users, carers and colleagues across partner agencies; presenting ideas; collating feedback and designing the new process.

We are grateful to everyone who has helped in any way to develop the **With Y😊U, For Y😊U** philosophy and process: Our special thanks to:

LEAN Team leaders – Rosemary Blain and Sue Peaker

The LEAN Team –

- Eleanor Sales
- Mylene Watt
- Keri Ratter
- Janice Irvine
- Ruby Jamieson
- Andrea Holmes
- Jane Cluness
- Rod Key
- Elaine Thomson
- Isobel Wishart
- Steve Meades
- Teresa Slater
- Laura Saunders

- Project Sponsors – Christine Ferguson, Ann Williamson and Edna Mary Watson

Also to Liz Freeman of **Alexander** who introduced the Team to LEAN methodology and facilitated the Kaizen Blitz week.

We are confident that this radical new approach to identifying needs and providing support **With Y😊U, For Y😊U** will lead to improved outcomes for the people of Shetland and ensure we make the very best use of our resources.

We look forward to seeing the process fully implemented across Shetland and making a real difference in our community.

Sandra Laurenson
Chief Executive
Shetland NHS Board

Hazel Sutherland
Executive Director
Education & Social Care
Shetland Islands Council

The Lean Team would like to add special thanks to the following:

- Dougie Shearer for his help in gathering and providing initial data,
- The CHCP committee, NHS senior management team and the community care management team for their continued support,
- Mark Henry, Gail Bray and Andy Glen for staff training support;
- The members of the public who gave their time to engage in the initial consultation and feedback process,
- To all staff who gave up their time to engage in the initial consultation and feedback process,
- Tay-Cad for developing and publishing all publicity materials
- Mike Stevenson of Thinktastic for help with our logo;
- Kay Eastwood of the Joint improvement Team for support with training;
- Shetland Islands Council's Capital Programme Service and Shetland Primary Care Team for the use of accommodation.

And finally a big thank you to all who took the time to come to our open sessions and assisted in giving comments and feedback on **With Y😊U, For Y😊U** documentation and process.

It has all been greatly appreciated.

SECTION 1 - BACKGROUND INFORMATION



NATIONAL POLICY AND LEGISLATIVE FRAMEWORK

There are various pieces of national legislation and guidance that shape the way in which we work. The main ones are:

The **Social Work (Scotland) Act 1968** places general duties on the Local Authority to promote social welfare and to provide or arrange the provision of residential care and other services.

The **NHS and Community Care Act 1990** established the concept of Community Care by amending the Social Work (Scotland) Act 1968 and placing a duty on the local authority to assess the needs of an individual for whom they may have a duty or power to provide community care services.

The **Community Care and Health (Scotland) Act 2002** further strengthened joint working and integration by establishing the delegation of functions, the transfer of resources and the pooling of budgets between local authorities and NHS Boards.

It also introduced additional duties by strengthening carers' rights and introduced the concept of eligibility for assessment if carers were or were intending to provide a substantial amount of care on a regular basis.

Local authorities, therefore, have the lead responsibility for coordinating the assessment of all community care needs and this must be done in partnership with colleagues from partner agencies, service users and unpaid/family carers.

The **Adults With Incapacity (Scotland) Act 2000** provides a framework for safeguarding the welfare and/or managing the finances of adults who lack capacity due to mental disorder or inability to communicate because of physical disability/illness. Incapacity due to an inability to communicate only applies where this cannot be overcome by human or mechanical aids.

The Act is underpinned by a set of principles and any decision taken will only be lawful if it can be demonstrated that the principles have been applied.

Under the Act four public bodies are involved in the regulation and supervision of those authorised to make decisions on behalf of a person with incapacity. These are: the Office of the Public Guardian (Scotland), the Mental Welfare Commission for Scotland, the courts and the relevant local authority.

The **Mental Health Care and Treatment Act 2003** reformed and modernised the legal framework for compulsory detention and treatment. It identified clear criteria which must be met before compulsion can be authorised.

It strengthened the role of the Mental Health Officer and extended the duties and powers of local authorities to provide services for individuals with mental disorder.

These include care and support services; services to promote well being and social development and assistance with travel in connection to these.

The **Adult Support and Protection (Scotland) Act 2007** introduced new measures to support and protect adults who are seen to be at risk of harm, whether this is physical or psychological harm, neglect, sexual abuse or financial exploitation.

It defines 'Adults at Risk' and the concept of 'Harm' and 'Risk of Harm' and places a new duty on local authorities to inquire and investigate when it appears that an adult is at risk of being harmed. The Act also places a duty on other public bodies, such as Police and NHS, to cooperate with the local authority's investigations.

The Act is supported by a set of principles and any intervention must:

- a) provide benefit to the adult which could not reasonably be provided without intervening in the adults affairs, and;
- b) be the least restrictive option available to achieve the desired outcome for the individual.

In considering a decision or course of action, one must have due regard to the following:

- The wishes of the adult (past and present)
- The views of others
- The importance of the adult participating as fully as possible
- The importance of the adult not being treated less favourably
- The adult's abilities, background and characteristics

For a comparison of the Adult Support and Protection (Scotland) Act 2007 (ASP) with the Adults with Incapacity (Scotland) Act 2000 (AWI) and the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHCT) go to the following link;

<http://www.scotland.gov.uk/Publications/2009/02/25110701/1>

In addition when developing **With YOU, For YOU** the team has taken account of:

National Guidance

- Fair For All, 2002
- Better Health, Better Care, 2007
- Scotland's Health White Paper "Partnership for Care" 2003
- Delivering for Health 2005
- Getting it Right for Scotland's Children 2005
- Changing Lives: 21st Century Social Work Review
- Delivering for Mental Health, 2006
- National Minimum Information Standards, 2008
- Community Care and Health (Scotland) Act 2002 – Guidance on Sections 8 -12, November 2003

Legislation

- Carers (Recognition and Services) Act 1995
- Children (Scotland) Act 1995
- Antisocial Behaviour (Scotland) Act 2004
- Housing (Scotland) Act 2001
- Homelessness (Scotland) Act 2003
- Data Protection Act 1998

Including, Equality Acts

- Equal Pay Act 1970
- Sex Discrimination Act 1975, (Amended) regulations 2003
- Race Relations Act 1976 as amended by the Race Relations (Amendment) Act 2000
- Disability Discrimination Act 1995 (2005)
- Equality Act (Sexual Orientation) Regulations 2007
- Employment Equality Regulations 2003
- Human Rights Act 1998
- Convention Rights (Compliance) (Scotland) Act 2001
- Scotland Act 1998
- Work and Families Act 2006

COMMUNITY HEALTH AND CARE PARTNERSHIP

Shetlands Community Health and Care Partnership (CHCP) is a joint partnership between NHS Shetland and Shetland Islands Council. The CHCP is responsible for managing a wide range of community based health care services. These include:

1. Community Mental Health
2. Occupational Therapy
3. Community Nursing, Health Visiting and Specialist Nursing,
4. Social Care
5. Community Care Social Work
6. Podiatry/Chiropody
7. Community Pharmacies

The main challenge for the foreseeable future comes from population projections, which show an ageing population, with increasing levels of dementia and disability, alongside increasing levels of disability amongst children and younger adults, in part due to improved survival rates in neo-natal units.

To meet the needs of the population now and into the future, the partnership must be more efficient, more flexible with solutions and more responsive to the needs of customers.

In light of this, the LEAN Team was put together to redesign the Single Shared Assessment and accompanying process to make it more customer orientated.

The outcome was **With Y😊U, For Y😊U**.

The original LEAN team has evolved into the **With Y😊U, For Y😊U** partnership with a responsibility to report on the project's progress to the CHCP Management Team.

The reporting mechanism for the CHCP Management Team is to the CHP Committee, which meets quarterly and has management representation from each service area across the partnership.

SECTION 2 - INFORMATION FOR CUSTOMERS



WITH Y😊U, FOR Y😊U - THE PHILOSOPHY

The 'customer' will always be at the heart of the **With Y😊U, For Y😊U** process, with the main aim being to **'get it right first time for every customer'**.

A customer can be a person in receipt of services, their carer/s or guardians.

With Y😊U, For Y😊U is an approach that focuses on the customer's goals and involves everyone working together to achieve the best possible outcome for the individual. This means understanding customers in the context of their whole lives, and working with them to identify their life goals.

The philosophy behind this approach emphasises the strengths, capacity and resilience of people and builds upon natural support systems, such as family and the local community.

The starting point is to get a clear understanding of the goals, and the needs that have to be met to support the goals that matter to people. This understanding is then used to inform key decision making processes, namely support planning, monitoring and review.

Involving customers in identifying and working towards their goals is critical to the **With Y😊U, For Y😊U** approach and will support their independence and wellbeing.

WHAT WITH Y😊U, FOR Y😊U MEANS FOR YOU

Our commitment to you

Shetland's health and social care organisations are signed up to the **With Y😊U, For Y😊U** process and make this commitment to customers requiring our support:

"To listen to you in order to identify your goals and to begin to provide flexible solutions and support to achieve these within 21 days of you (or your referrer) contacting WYFY partners for assistance."

What is meant by 'Customer'? (If you or someone you care for requires support with daily living and/or home management of a health related condition you are a **Customer** of local community health and/or care services. You may also be a customer if you need support in your own right to carry on caring for someone.

We want to work with you, in a joined up way, to assist you to find solutions to your difficulties and to enhance the quality of your life.

The process Shetland's social care and healthcare organisations use to coordinate support is called **With Y😊U, For Y😊U**.

What does **With Y😊U, For Y😊U** involve?

With Y😊U, For Y😊U wants to understand **your** story. It aims to find out what **you** want, what **you** need and who can support **you** best to achieve **your** life goals.

We will share the information you want shared, with the people who need to know, **so you won't have to tell your story over and over again**. This is achieved by compiling one shared information document and support plan, known as an Understanding You form.

You will work together with your Coordinator For You to complete the Understanding You form, involving other relevant people if and when required.

Once the form is completed to your satisfaction it is used as a basis for planning the support you require. You will be asked to sign the form and support plan to show that you have agreed the information recorded. When the support plan is implemented it will be regularly monitored and reviewed.

The aim is to get it right first time every time and we need you to tell us what works and what doesn't so that we can continue to improve our service provision.

If you agree we'll call you 22 days after your first contact to ensure we've done what we said we'd do.

Who will be my With Y😊U, For Y😊U Coordinator?

The Coordinator **For Y😊U** will be the most appropriate person to take forward the gathering of information, creating your agreed support plan and following through the implementation of that plan. This person may be a social care or healthcare professional who is already working with you or it will be someone from a service you are interested in receiving. For instance, it could be a senior social care worker, a district nurse, an occupational therapist or a social worker.

The identified person may change if it turns out that someone else would be more appropriate in the role.

The Coordinator **For Y😊U** is responsible for liaising with you to produce an Understanding You form and associated support plan and for coordinating its implementation, monitoring and review.

What if I am unhappy with the process?

Please discuss any problems with the Coordinator **For Y😊U** or, if the Coordinator is the problem you can follow their agencies complaints procedure.

If you are not happy with their response you can make a formal complaint using the complaints process for the relevant organisation. If you are not sure about which organisation to complain to please contact the independent Customer Resource Centre for advice. You can contact them on **01595 808080**

WITH Y😊U, FOR Y😊U – EASY READ VERSION

If you think you need support with everyday life:

- **Nurses, Social Workers, Care Staff, housing, members of voluntary organisations will work together to support you.**
- **They will find out what support you need using a process called With Y😊U, For Y😊U.**
- **One person will talk to you to fill in a form called Understanding You.**
- **This person will be the Coordinator For Y😊U.**
- **They may need to speak to other people if you agree.**
- **Together you will decide what support you need and make a plan.**
- **The plan will start within 3 weeks.**
- **If you agree, the Customer Relations Officer will check the plan has started.**
- **The Coordinator For Y😊U will make sure the plan works.**
- **If there are problems with the support you are getting, tell the Coordinator For Y😊U.**

SECTION 3 – INFORMATION FOR STAFF



WITH Y😊U, FOR Y😊U - THE PHILOSOPHY

The 'customer' will always be at the heart of the **With Y😊U, For Y😊U** process, with the main aim being to **'get it right first time for every customer'**.

A customer can be a person in receipt of services, their carer/s or guardians.

With Y😊U, For Y😊U is an approach that focuses on the customer's goals and involves everyone working together to achieve the best possible outcome for the individual. This means understanding customers in the context of their whole lives, and working with them to identify their life goals.

The philosophy behind this approach emphasises the strengths, capacity and resilience of people and builds upon natural support systems, such as family and the local community.

The starting point is to get a clear understanding of the goals, and the needs that have to be met to support the goals that matter to people. This understanding is then used to inform key decision making processes, namely support planning, monitoring and review.

Involving customers in identifying and working towards their goals is critical to the **With Y😊U, For Y😊U** approach and will support their independence and wellbeing.

WITH Y😊U, FOR Y😊U - THE VISION

The brief for the **With Y😊U, For Y😊U** LEAN team was to design and implement a new process in which:

- The first customer contact with a WYFY partner is the start of the assessment;
- 90% of customers will have their planned support begin to be provided within 21 days from the first point of contact;
- 100% of carers are offered an individual needs based assessment;
- The most appropriate person for the customer coordinates the process;
- Puts an end to inappropriate placements, through access to a range of flexible support, and
- Improves customer satisfaction.

What we will achieve **With Y😊U, For Y😊U:**

- The focus will be the customer.
- Partner agents will engage with the customer and continue to engage with the customer throughout the process.
- Partner agents will be accountable to the customer, to other partners and to their agency.
- Quality will be intrinsic throughout the process.
- The customer's experience will be right first time and every time.
- Positive behaviour will be the norm, promoting trust between the customer and partners.
- Partners will provide flexible, effective solutions to meet the customer's unique needs.

How **With Y😊U, For Y😊U will deliver:**

The 4 'U's

- Universal equal access for all adults to the WYFY process.
- Understanding the customer's situation, goals and the needs that have to be met to support the attainment of those goals.
- Unified partnership working, sharing the information and working together.

- Unique plan that is tailored to support each individual customer to meet their needs and achieve their goals.

Plus:

- Pro-active capture of customer experience including any process failure reported to the correct partner agency.
- Pro-active reporting of the experience.
- Pro-active approach of continuous improvement throughout the process and all support activities.

HOW WILL WITH Y😊U, FOR Y😊U WORK IN PRACTICE?

Someone needs a service

Anyone can contact partner agencies (such as the NHS or Shetland Islands Council's Community Care or Housing Services) direct regarding their or their relative or friend's support needs. As soon as they do this they become a customer.

It is important for the person who receives the information to make it clear early on in the conversation that it will probably be useful if the information is shared with other relevant individuals or partner agencies and to seek consent for this.

If the person is already in receipt of support, then the staff member who is contacted about the need for more or different services should liaise with the allocated Coordinator **For Y😊U** and alert them to the situation, working with them to resolve the matter if necessary.

If the person is not currently receiving support, the staff member should either initiate an Understanding You assessment themselves (or by an appropriate person within their team) or contact the partner agency which seems to be the most appropriate to take the **With Y😊U, For Y😊U** process forward. Contact details of partner agencies are published locally in the Shetland Directory and on SIC, NHS and voluntary sector websites.

The independent Customer Resource Centre is another starting point for people who do not know which agency to approach or what support may be needed. The contact phone number for the Centre is **01595 808080**

Recording information

New customers contacting the Customer Resource Centre or a service direct will be asked to give some basic information to allow the person receiving the contact to identify the most appropriate team or person to assist with the request.

Existing customers will have their details checked to ensure all information is up-to-date and their Coordinator **For Y😊U** will be notified of any changes.

With the customer's consent, **With Y😊U, For Y😊U** information can be shared with relevant partner agencies via the Social Care information system.

The WYFY Information Sharing Agreement can be found in Appendix C and the WYFY Information leaflet explaining information sharing can be found at Appendix D.

If the customer at this point is a friend or family member they cannot give formal consent on behalf of the customer, unless the customer does not have capacity under the Adults with Incapacity (Scotland) Act 2000.

More detailed information can be found in the **With Y😊U, For Y😊U** Data Sharing protocol.

Identifying the Co-ordinator **For Y😊U**

Whenever possible the customer will have a say in the appointment of their Coordinator.

The Coordinator **For Y😊U** should be the person best placed to gather the information about the customer, complete the Understanding You form, implement, monitor and review the support plan.

Whoever receives the initial contact is responsible for following the allocation process for a Coordinator **For Y😊U** within their team or for passing the responsibility on to a more appropriate partner agency or individual. The process must be managed in a way which provides clarity for the customer. If any difficulties are encountered when trying to find an appropriate Coordinator **For Y😊U** this should be reported up the line management structure and to the customer.

As the customer's needs will only become clear during the completion of the Understanding You form it may be necessary to transfer the role of Coordinator **For Y😊U** at an appropriate point in the process.

Completing the Understanding You form

This is normally carried out by the Coordinator **For Y😊U**, with the customer. Separate detailed guidance is available, explaining how to complete the form; the holistic prompt sheet and capacity issues.

The form records a holistic view of the customer's current situation and is completed following one or more meetings with the individual and, sometimes, others involved in supporting them. The Understanding You can also be used to record information regarding the Carer, their goals, linked needs and plan.

Understanding You involves taking a holistic view of an individual, identifying what is important to them, the difficulties they face, the strengths they have to draw on and how they manage around the clock.

Other practitioners involved in supporting the person may be asked to contribute to the Understanding You form or to provide a specialist assessment for inclusion.

Once the holistic view is gathered, the goals and needs identified, an associated support plan is drawn up.

The plan will reflect the individual's eligibility for services.

The document must be signed by the Coordinator **For Y😊U** and the Customer or their representative. When complete and with the Customer's consent to share the form and relevant information will be entered onto the shared information system which is used to support the **With Y😊U, For Y😊U** process in Shetland. This system is accessed by the partners to **With Y😊U, For Y😊U**.

Implementing the Plan

The Co-ordinator **For Y😊U** will implement the agreed support plan and/or liaise with another partner agency to ensure the support plan is put in place as quickly as possible.

Requests to partner agencies can be made and responded to using the **With Y😊U, For Y😊U** form.

The agreed support plan must be reviewed regularly, in line with the requirements of the support being delivered. The Reviews should include all agencies involved in the support plan, the aim being for the Customer to have one review meeting. This should be arranged by the Co-ordinator **For Y😊U**.

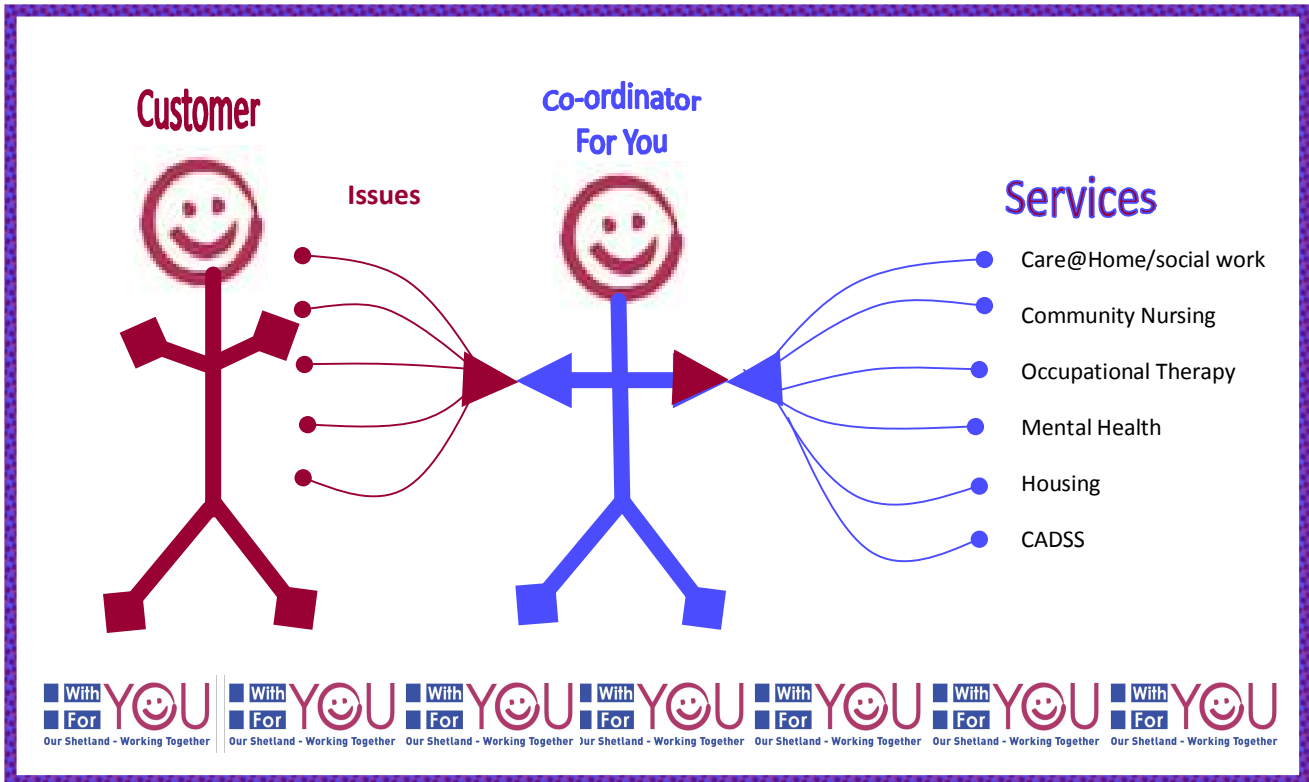
Feedback

The independent Customer Resource Centre will be carrying out customer feedback checks. 22 days after the initial contact with a WYFY partner agency the customer will be called to find out about their experience throughout the process. The Customer's views and outcomes will be fed into the **With Y😊U, For Y😊U** quality assurance process.

Within-team guidelines

No multi-agency guidance can take account of every team or service structure so each team should have its own guidelines detailing how the team will link with the **With YOU, For YOU** process internally.

The diagram below shows the scope of the **With YOU, For YOU** process:



GLOSSARY OF TERMS

New terms have been introduced to signify a break away from the old way of working.

Customer

For the purposes of **With YOU For YOU**, the term customer refers to a person in receipt of a service.

Coordinator For YOU –

This person is the most appropriate person to coordinate the **With YOU For YOU** process for the customer. The Coordinator could work in housing, social care, community nursing or any other relevant partner agency. This person will be the main contact in relation to the customers support plan.

It is their responsibility to work alongside the customer to:

- a. Gather relevant information
- b. Identify the customer's needs and goals
- c. Agree the support plan
- d. Facilitate the implementation of the plan
- e. Ensure the support plan is achieving agreed goals
- f. Understand when needs and goals change
- g. Review and manage the support plan to accommodate these changes, and
- h. Ensure only relevant information is recorded and shared with all relevant partner agents

Eligibility Criteria –

The Scottish Government has published national eligibility criteria for Community Care Services which identify the following levels of need:

- a. Critical
- b. Substantial
- c. Medium
- d. Low

Services are targeted at those most in need.

First point of contact For YOU –

This is the first person in a WYFY partner agency to be approached about a customer's need for support. Partner agencies have a responsibility for ensuring that first points of contact will:

- a. Listen to the customer's needs and requests
- b. Gather relevant information
- c. Direct the customer to the most appropriate partner agent or agency (if appropriate)
- d. Pass relevant information to the most appropriate partner agency (if consent is given).

Partner Agency –

The umbrella group or team that partner agents work within, e.g. your local health centre, community nursing team or the care centre which co-ordinates and delivers services. See Appendix E for a list of Shetland's WYFY Partner Agencies.

Partner Agent –

Skilled people working in various capacities in partner agencies.

Support Plan –

The support plan forms part of the Understanding You form and should reflect the goals and needs identified. It shows how the goals and needs can be met.

Understanding You –

This is the new form that will be used to allow those involved in delivering the support plan to identify the customer's needs and to achieve their agreed goals.

Appendices A, B, C, D & E are promulgated separately.