Case studies

Using SF To Create Whole System Change In Social Care

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Abstract

What are the limits of SF? How far can it be extended to create change beyond personal interactions? This case study examines ways in which SF can be extended to create whole systems change in social care. It describes how SF has been used to enable change in four areas: client interaction, tools for documentation, changes to public sector strategy and the development of a community approach to social care.

Introduction

This case study explores how change for social care clients in the community is being achieved in the county of North East Lincolnshire using SF.

In 2007 in the UK, the Prime Minister's Strategy Unit Report described a vision of a State that "should empower citizens to shape their own lives and the services they receive" (p. 32). The Government's vision covers all areas of life including for example housing and transport. This vision has become common language in the Health and Social Care worlds where the term "personalisation" has come to describe "the process by which services are tailored to the needs and preferences of citizens".

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The aim of the Government's vision is to:

1. maintain people independently in the community in a way which meets people's desires to be in control of their own lives, and
2. build capacity in the community to meet low level needs rather than using the public sector. The aim is that people in the community, including those with health and social care needs, will shape and where possible be involved in the delivery of services.

The Government's vision seemed ripe for an SF approach because of its desire to work from client control. Since 2008 these concepts have been slowly introduced into social care in North East Lincolnshire using SF as a guide. While SF is traditionally used to change interactions with clients, long lasting change towards citizens shaping their lives and the services that are developed needs major systemic change. Knowing that SF would provide an answer, the work has involved extending SF thinking to provide solutions for change throughout the hierarchy and into the community. For change to have a long-term impact, it needs to be seen, at least to some degree, in the following areas:

This case study exemplifies how SF was used to assist this thinking and these changes.

Section 1: Interactions with clients

The difficulty of creating strategic change in the public sector is knowing with whom and where to begin. A fruitful opportunity arose when a powerful change agent became a Director in the Trust (a Government name for a publicly funded health or social care organisation) who was driven by a moral imperative to make things better and was not afraid to act. It became clear that he would be a powerful customer for change. His decision to establish a Single Point of Access provided the perfect opening to create a real difference. One phone number was set up that any community member could call for crisis, rehabilitative or longer-term social care. The team that answered this telephone line were thrust centre stage, as the gate keepers for the community's access into care services. This provided a direct opportunity to change their interactions with callers and foster independence.

Until this point the culture of care in the Trust had been to create dependency. Staff were protective in their approach believing it was kindly to bring people into care. Now the remit was to give people independence, a perfect opportunity to introduce an SF approach, but a huge cultural shift in expectations for both the care staff and the community. New guidelines also meant that some services would no longer be provided, the goal being to build community capacity to deliver these.

Working with the Single Point of Access team would have a powerful effect. It would immediately stop people coming into care and start to change community expectations of care. However a fine balance was required. The trust had a desire and responsibility to provide care when required and without a new way of responding to calls to help callers manage for themselves when appropriate, staff were feeling pressed to just say "no we won't help you" rather than finding ways to foster independence.

A two-pronged approach was taken. One was for staff to familiarize themselves with all the alternatives that already existed in the community that callers could access. The second was using SF to change the conversations staff were having with callers to enhance client independence. Particular aspects of SF were critical. As staff were interacting with clients on the telephone, highlighting the importance of language was one. With staff steeped in a problem-focused medical model it was important to start changing their conversations. To explain the power of conversation, the following example amongst others was used.

Loftus (1975) experimented with the difference between two questions: "Do you get headaches frequently?" or "Do you get headaches occasionally?" She followed each question by asking "If so how often?" The answers were 2.2 headaches per week versus 0.7 respectively. On this basis staff began to realise that if they continued to ask people "Do you need help on a daily basis?", as they had been instructed to do, they would be falling into the same trap as asking "Do you get headaches frequently?" The caller could decide they needed help on a daily basis simply because staff verbalised this. So instead staff learnt to ask "do you need assistance?" Examples like these started to change their thinking about the power of language. Rather than saying "Can you tell me about the problem", they learnt to say "What would you like to talk about?" and "What would you like to happen?"

To effect such a deep change in practice, the consultant worked alongside staff so they could hear the language they were using and alter it. They would talk about how they would converse with callers and alternatives would then be discussed and suggested. Eventually staff took the leap to listen to recordings of their phone calls and to their surprise, could see quickly what needed changing and generate the changes themselves.

Whether giving advice about alternatives in the community or trying to problem solve, the emphasis was on keeping the balance of control in the hands of the caller. Staff started hearing their own assumptions. They learnt to ask questions

that enabled the caller to identify their own possibilities. They understood the power of active listening and reflected the information or question back to the caller so they could decide how or whether the Trust could be useful.

They started to realise that the individual may not fall all the time, or get stuck in the bathroom all the time or forget to lock the back door all the time and enquired about exceptions to the problem. Callers would then say "I can feel a dizzy spell coming on so I lie down till it passes and that way I don't fall". Staff would offer the reassurance about self-management that was often the reason for the call and the advice to visit the GP or call back should the situation change.

Ultimately they realised that their conversation was a critical intervention in and of itself; that it was not message taking for the "real work" done by social workers, nurses and occupational therapists. An emergent effect reported was that the self- esteem of the staff grew as they saw a renewed sense of purpose and serious responsibility in their role.

This year a similar intervention is being introduced in the social work practice with 28 staff working with adults with complex needs. This too will provide some creative challenges using SF.

Section 2: Tools

Changes in conversation are often let down by tools that reinforce old ways. So change needs to start reverberating through the system if it is to last.

The Single Point of Access team had a social care screening tool with a list of questions to ask. They had also been given lists of questions that the physiotherapists and occupational therapists wanted. Additionally, they had computer screens guide them through bureaucratic questions to track such things as ethnicity. All of which made the client a lower priority.

Each of these tools and lists was replete with traps for the professional and client. For example the social care screening tool asked for "name of referred" on the assumption that an individual could not have called themselves. Similarly it asked

"who cares for you?" assuming people were unable to care for themselves. When callers rang, staff could interrupt clients to fill in the bureaucratic questions on the screen first. This act instantly changed the balance of power and also presupposed that the client would need their services. At the beginning of the work together, staff legitimately had difficulty seeing outside their old world view to recognise the difficulties with these questions.

Together, we started to shift this approach. It was not easily possible to have screens rewritten, however staff could learn to focus on the conversation with the client first and fill in the screens later. They could also be taught to start with an assumption of client competence. Aside from compulsory fields, they could decide with the client which fields to fill in, rather than looking for deficits which weren't there.

There was a small blank area for the staff member to use. If one were creating a computer screen in an SF-inspired way it becomes apparent that a blank screen would be all that would be required and cheaper to design. Instead of a hierarchical cascade, we would simply record the client's world view and the outcomes of bringing two skilled heads together on the telephone. A set of icons could be attached to the blank screen to provide information as required (about bathing for example). So staff were encouraged to use their small blank area to bring the client into focus.

Staff were also encouraged to record what clients could do as well as what help they needed. This would represent the client more accurately. It would also bring the attitudinal shifts required into documentation that other health and social care staff would see. This was especially important as such information would remain on the books and form the views of professionals indefinitely. One staff member was scared to write down what the client could do feeling that unless she focused only on clients' deficits they would not get the needed help. Encouraged to experiment by writing down the individual's abilities, she was encouraged that the needed help was still provided.

Early on, the consultant redeveloped some documentation

as an example of what could be done. This was the "self-assessment" framework that staff used with people at home. It assessed their care needs in ten areas such as shopping, cooking etc. and determined financial provision. As the public sector is accountable for spending public monies, it is not always considered possible to take the blank screen approach, the alternative being to insert as much SF as possible into required frameworks. Taking the example of someone's care needs through the night, the original framework is provided on the left and the suggested changes on the right.

ORIGINAL FRAMEWORK	NEW FRAMEWORK
• I can manage on my own during the night • Sometimes I may need support if I am ill or in an emergency • I need support during the night – several (4–6) times a month • I need support during the night – several (3–5) times a week • I always need support during the night	• I am independent • I am generally fine during the night. – I only need assistance if I am ill or in an emergency. – I am fine about 25 out of 30 nights and only need assistance (4–6) times a month • I can sometimes manage during the night. I manage 2–4 nights and need assistance about 3–5 nights a week • I always need assistance during the night

As can be seen, the statements on the right lead to a very different conversation, focusing on how the individual is managing. This opens up new lines of inquiry for what could be done on nights when further support may be required in a manner that optimises how the client normally manages.

The experience of the consultant so far is that it has been easier for staff to change their conversations than to commit changes to formal documentation. However an opportunity for

piloting the self-assessment framework may appear working with the social work staff this year.

Section 3: Relationships with the community

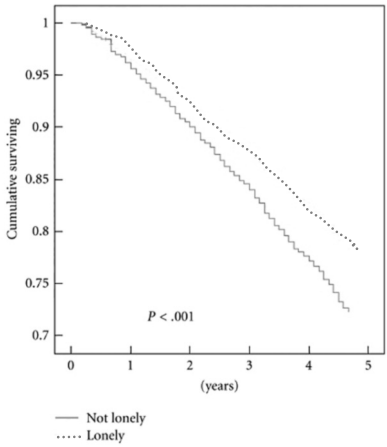
From an SF point of view, if one person, a small family or an organisation can know what they want and create it, there is no reason why 10 people living in a street can't know what they want and create it. This thought was the essence of how to jump from the traditional one-to-one work done by public sector staff to new ways of working with the community. It became the model for communal work. It is important to recognise that this is a significant behavioural and mental leap for staff that should not be underestimated.

When the consultant started working with the Community Development Leader using SF principles, it did two things. He could see that what applied to an individual could apply to a community. For him it unlocked a model of how to go about the change, and permission to do so by providing a sound theoretical basis. The model would guide the work and its theoretical basis gave permission to this Leader to argue the case when faced with a sceptical establishment.

For example, to assist staff with this significant shift, he arranged for social care staff to go to the local shops and ask for people's time to discuss what a quality service would mean to them. This type of activity is very different for staff and they found it quite challenging to have a free flowing conversation out in the community rather than a conversation controlled by a questionnaire in a traditional setting. Such small steps are important in changing the patterns of interaction towards community partnership.

In terms of community need, mountains of evidence exist regarding the work required to improve care in the community. For example the following diagram shows how suffering from loneliness indicates a significant mortality risk for older people. (Tilvis, R. S., Laitala, V., Routasalo, P. E., Pitkälä, K. H. 2011)

Resources are not available within the public sector to provide for lonely people, if that is considered a public sector



responsibility. An SF view might be that communities can look after themselves. The dependency model would see the lonely person as dependent on being "fixed" by the system, rather than as an asset to the community who might offer afternoon tea to reduce their loneliness and the loneliness of others. From a social constructionist point of view it is not surprising that the mortality risk increases for lonely individuals; it could be argued that their sense of being is depleted by social isolation. Early intervention is therefore important.

Similarly to SF with individuals or groups, communities should not however be forced into action. Luckily within North East Lincolnshire there is a great readiness to act. An elderly community member who had a stroke and found her mobility limited by her wheelchair, found others interested in knitting and established a knitting group in the local library. The Trust then approached her to teach knitting to textile students at the School of Technology, an offer she gladly accepted. On the other hand, some ideas don't fly. The Community Development Leader held several public meetings to gauge interest in setting up time banking within the community, especially as 32% of households have no access to their own vehicle and could find this approach useful. There was little interest in it. While this Leader said he would previ-

ously have felt compelled to set up the time bank or he would have failed as a public servant, SF let him off the hook to place his efforts where the community wanted them.

Naturally finding what already worked was not a problem. Good examples of community partnering existed that could be used to expand the SF approach. Some had achieved excellent health outcomes. For example, the Trust took to the community the need to decrease the number of elderly people falling in the street. Volunteers established that the number of people falling increased on pension day as people walked to collect their pension. As a result the Council repaired uneven pavements near pension collection points. The volunteers now run a group taking professional advice when they need to. They go to markets and change the rubber ends that have worn out on walking sticks so people slip less. One lady sends photos of cracks in the pavement to the Council for repair.

Many opportunities to work differently exist in partnership with the community. For example there may be an individual with a car who is interested in doing the shopping for isolated people in their own street for a small fee. These sorts of connections need to be facilitated and North East Lincolnshire has commenced working with a partner skilled in this area. Part of the consultancy involved developing a tender for this work with the Community Development Leader. This incorporated SF guidelines to set expectations for community interaction including that the partner:

- would respect that individuals and communities are experts in their own lives
- demonstrate that they are not imposing structures on clients but are working to the clients' agenda
- would not create dependency but notice and enhance what was working for the individual and the community
- recognise that change is continuous in communities and be adept at working to these changing needs.

Achieving this is no small feat, but the fact that the Trust accepted the SF points in the tender was an important stepping stone.

Section 4: Systems that change

If change is to be successful, it is elemental that the public sector also adapts, particularly as it holds considerable power and purse strings. The system needs to shift its balance further towards matching itself to the ever changing needs of individuals and communities in a timely, interactive fashion.

In the winter of 2011, there were severe snowfalls in the UK. To provide care to those who required it in North East Lincolnshire, rules were broken. For example, spouses of employed staff came along with their four wheel drives to get staff to individuals in their homes isolated by snow. This flexibility, used in emergencies, needs to be built into the system.

Some staff simply choose to act flexibly. One of the staff who worked with people with learning disabilities took it upon herself to speak to the management of the local swimming pool to arrange access for her clients. This role was clearly outside her job description. Another staff member who was assessing an aged client for personal care in his home realised that the issue was loneliness. She rang his friend to buy him swimming trunks and arranged for him to fulfil his dream of regularly going swimming again in the company of others. As a result he no longer felt he required the personal care. What these examples show is that for this change to succeed, job descriptions need to be loosened to allow staff to have the freedom to do what the client requires. This type of change takes a while. Early on in the consultancy when these changes to job descriptions were suggested, HR struggled to understand why they were needed. More recently an autonomous social work practice has been established with one aim being to give staff real flexibility in their roles. Staff need greater levels of autonomy to act in the community interest.

Timely responses are also required. A proposal for the Board regarding the change in structures required to facilitate the shift to low-level provision in the community was developed together with the Community Development Leader. As a result a flat structure has been established. A governance and a finance commissioner sit on a panel along with

community members to immediately approve new community-based provision, rather than using a long-winded hierarchy. A database is also being set up for the public to rate the quality of this provision, enabling the community to directly influence what is then funded.

The system is also being shifted through the engagement of 2000 community members who had expressed an interest in being involved in different areas of health and social care. The Community Development Lead had established this group. In terms of transferring further control to the community, a hope going forward amongst many other ideas is that this group will become a wholly citizens'-owned body that will help shape the priorities of the public sector.

Conclusion

When the consultant commenced this piece of work, it would not have been possible to predict the many ways in which SF would be welcomed and marry with the Trust's agenda. What has been particularly exciting has been working out how to stretch the uses of SF further into the culture of the organisation and the community to use it to assist change.

References

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