

# Facilitating a Person Centred Approach within the Unified and Children's Assessment Frameworks: A Practice Guide

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***The group would also like to acknowledge the extensive use of DoH guidance: Valuing People:***

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## Summary

### Section 1: Introduction

This introduction describes how people with learning disabilities should be able to have as much choice and control of their lives as possible and sets out how person centred approaches and tools can help achieve that aim.

**The Unified and Children's' assessment frameworks are the formal ways for linking individuals with public services and assessment, determining eligibility, care planning and review are part of those processes. When the person's care and support needs are being assessed or planned agencies should always take a person centred approach to that process.**

This guidance describes how person centred approaches can help people to think about what they want from life and how they can plan to reach their goals. It explains how person centred planning tools and approaches help communication and how this can link into assessment and care planning.

The guidance also gives some introductory information about person centred planning and some person centred planning tools. It explains who can facilitate the person centred approach to planning.

Person centred planning is about a person's whole life. It is not just about the things are arranged or provided by social services, education or health. The person centred plan should therefore inform the assessment and care planning process but it is not the same thing.

### Section 2: The key features of a Person Centred Planning Approach

This section explains that a person centred planning approach is about finding meaningful ways of helping someone find out what they want out of life and helping them plan how to get it.

It describes useful ways of really involving the person in the process and how they can develop a wider support network to help them work towards their ambitions and plans for the future.

It gives an introduction to some person centred planning tools and describes how these have been used to enable people to achieve their goals.

### **Section 3: Roles and responsibilities**

This section describes the part that various people, such as service users, families and carers, facilitators and staff should play to get the most out of person centred approaches and tools.

It shows that everyone involved has to take responsibility for making it work.

### **Section 4: Measuring Success**

This section explains that it is important that a person centred approach has to be accepted, not just by service users, families and care managers, but also by senior managers and the leaders of agencies.

The reason for taking person centred approaches and using person centred planning tools is to make lives better for people. So it is important to know if it is working or not.

We need to know what works well and what does not. The main questions to ask are

- How effective is the person centred planning?
- Is it changing peoples lives for the better?
- Are services changing as a result of person centred planning?

This section suggests some ways of collecting that information.

### **Section 5: Training and support**

This section explains who needs to be trained and to what level.

**Breadth training** raises awareness and understanding of person centred approaches and its benefits. It is helpful for many people including service users, their family and friends and staff or volunteers in organisations to have this training so that they know what it is about.

It is a good idea to build this training into induction programmes for new staff. Often people doing this training will become really interested to learn more about person centred planning approaches and tools and they may want to have more training and become facilitators.

**Depth training** gives people a deeper understanding of the approaches and the people who do in-depth training will begin to experience how to use some of the person centred planning tools.

None of this training can be achieved in a one-off session. It is important that people have the chance to build on their learning, develop skills gradually and share their experiences with others.

## **Section 6: Examples of benefits of Person Centred Planning Approaches**

This section gives short real life examples of ways that using person centred approaches have made things better for people with learning difficulties and for some organisations.



## SECTION 1: INTRODUCTION

The all-Wales strategy for people with learning disabilities says that people with learning disabilities should be able :

- to do the same sorts of things as anyone else
- to take part, with their families, in community life
- to make the best of their lives, with help if they need it, but also by managing their own lives.

Key values which underpin the strategy are that all people should be able to be fully included in society and have maximum possible control of their own lives. The social model of disability is referred to in this guidance – what we mean by this is that there are many social and environmental factors that impact on a person’s needs and situation. These factors may include a variety of elements such as:

- Physical barriers to participating in the mainstream of society
- The expectations and attitudes of parents, carers, professionals and others
- Culture of dependence
- Poverty
- Lack of opportunity
- Lack of communication facilities
- Poor housing
- Neighbourhood.

Unlike models which locate the needs within the person and seek to “fix” the problem, the social model emphasises unique solutions guided by the person’s sense of priorities and their approach to life.

### **A Person Centred Approach to Assessment.**

The Welsh Assembly Government has issued two assessment frameworks, the Unified and Fair System for Assessing and Managing Care (UACM) for adults and The Framework for Assessment of Children in Need and their Families. Both of these frameworks require a person centred or child focused approach to individual planning and service planning to be taken.

***These frameworks will remain the formal mechanisms for linking individuals with public services and will incorporate the core tasks of assessment, determining eligibility, care planning and review.***

Use of person centred or child focused ***approaches*** in these processes will help service users to get the best outcomes and live their lives the way they want. This practice guidance explains to service users<sup>1</sup>, families, social workers, managers and others how their work and service provision can become more person centred. ***In their assessment and care planning role it is expected that social workers and care managers will always be person-centred.***

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<sup>1</sup> Separate but related service user guidance will be issued

## **Who is this guidance for?**

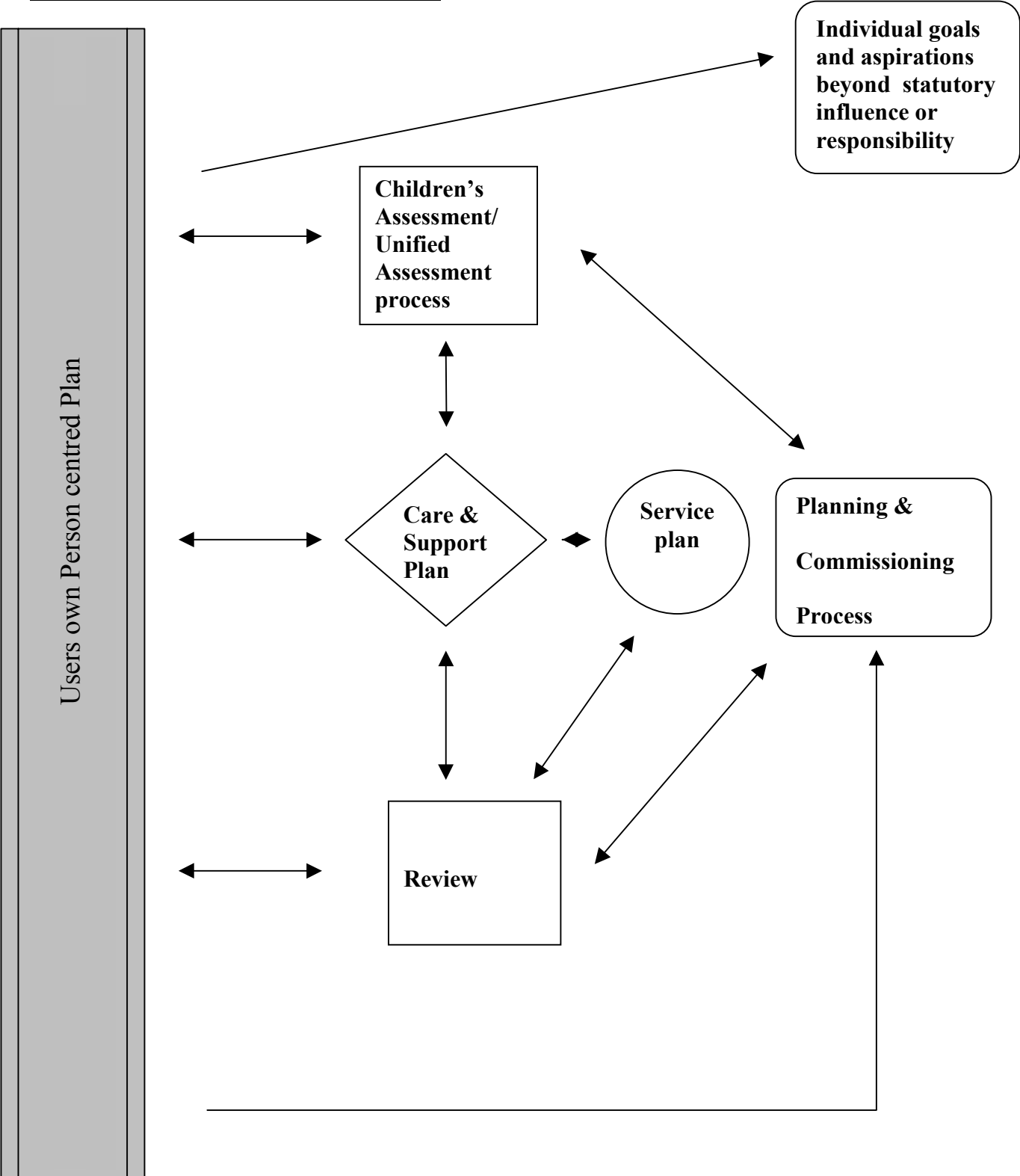
This guidance describes how person centred approaches can be used to enable people to think about and plan their lives. The guidance is mainly for use with people with learning disabilities but can usefully be used for other people too.

There are several approaches or tools that can be used and different ones will suit different people. When a person centred approach is well facilitated it can enable people with, for example, communication problems or multiple disabilities, to find a way of expressing their views on how they want to lead their lives.

## **The Person Centred Planning Tools.**

This guidance also explains some tools which enable a person centred **planning** process. This process often encompasses a wider spectrum of issues than those in which statutory agencies are directly engaged but the outcome of such a process can provide crucial insights and views which can help to inform the formal assessment and shape the way services are provided.

**Figure to demonstrate the relationship between  
 The Person's own Person Centred Plan and the Children's  
 and Unified Assessment Processes.**



## Who facilitates the person centred planning process?

It will only be on some occasions that social workers or care coordinators will take the primary role in facilitating the person centred planning process. This role will often be more appropriate for other people, such as relatives, foster parents or friends to take depending on the circumstances and the wishes of the person. It could also be facilitated by another person with learning disabilities with support. The type of training that facilitators will need is set out in section 5. The role of self-advocacy and any other forms of advocacy (including citizen, peer advocacy or circles of support ) is also central.

The occasions when it may be appropriate for social workers or care coordinators or other staff to be very closely involved with, or to facilitate the person centred planning process. May include for example, where the situation is particularly complex, or where a social network has not yet been established and there is no other suitable person.

In these circumstances, where the proposed facilitator has a work relationship with the service user, it is vital that the work relationship remains clear and unambiguous. It is not possible, because of accountability issues, for a social worker or care worker to become a “friend” – however good the relationship may be – whilst the work relationship exists. It is also essential that the staff member is clear and accepts the expectations that being a facilitator will bring and that they are able to determine limits e.g. to the expectation that they will change their working hours to accommodate meetings. It is also essential that employers give their agreement to a staff member becoming a facilitator as this has implications for the organisation, for example over accountability or when there may be a potential conflict of interest between the facilitator and care management roles.

It is acknowledged that many people who work for care agencies will be friends, neighbours, or relatives of people who are service users. In these circumstances, where there is no direct work relationship, they would be able to fulfil the role of facilitator in the same way as any other friend or relation.

This practice guidance explains HOW person centred tools and approaches can be used to help people with learning disabilities make choices and express their views about how they want to live their lives.

It also describes the links that need to be made so that commissioners and providers can use this information alongside other planning information to learn how their services and systems need to change so that they can respond effectively to the aspirations of people with learning disabilities and their families.

## Why do Person Centred Planning tools help?

Person Centred Planning tools help in talking to and more importantly **hearing** a person

- to help them develop plans for their support and future
- to help them develop a network of contacts and friendships
- to help agencies develop the sort of support and services that are really useful.
- including those who have communication difficulties, challenging behaviour or complex needs

## **A Person Centred Planning approach IS NOT.....**

- A new system to use once and tick the box
- Something which professionals “DO” for people with disabilities
- A wish list. But it is a way of determining what ambitions a person might have and in what ways they can practically take steps towards fulfilling these.
- the same as assessment and care planning but it can add to and inform this process nor a collection of new techniques to replace I.P.P.
- a substitute for a review of a person’s care needs or service provision but it can be used to make sure that the services are based on what matters to the person.
- The latest fad which will go away if we ignore it

## **How do Person Centred Planning approaches link with adult and children’s’ assessment frameworks?**

In Wales we have the Unified and Fair System for Assessing and Managing Care (UACM) for adults and The Framework for Assessment of Children in Need and their Families The UACM says

2.8 One of the key principles underpinning this Guidance is that assessment should always be person-centred. This means ensuring that the person’s views and wishes shape the assessment process. Using methods which help individuals prepare for their contribution to the assessment and having the right assessment support and advocacy arrangements available, will facilitate this.

The Children’s Assessment Framework echoes this,

1.34 The importance of undertaking direct work with children during assessment is emphasised, including developing multiple, age, gender and culturally appropriate methods for ascertaining their wishes and feelings, and understanding the meaning of their experiences to them.

Section 2 of this guidance will explain some of the approaches or tools which can be used to help professionals/facilitators involve the person in planning for their future and working out what they want out of life.

The Unified Assessment Process says that plans should focus on the long term as well as on what the person needs now.

2.36 An evaluation of assessed needs should take full account of the likely progress of people’s conditions and health status, their potential to become more independent, given the right help, or the likely outcomes if help were not to be provided or was provided in different ways. In thinking through how needs and risks might change over time, professionals should focus on the impact of needs on people’s independence both in the immediate and longer term.

For some people who may have significant mental health needs PCP approaches can inform the Care Programme Approach (CPA).

Similarly the Children's Assessment Framework says,

1.53 Assessment is an iterative process which for some children will continue throughout work with the child and the family or caregivers. In order to achieve the best outcomes, the framework should also be used at important decision – making times when reviewing the child's progress and future plans.

Person Centred Planning approaches can be used to help people work out what their longterm goals are. Often these goals will need to be broken down into a number of stages which can be reached a step at a time so that the person progresses towards their goal. Some of these steps will be part of the persons formal care plan. Others may be brought about through more informal support from friends or local networks.

Often the actions necessary to significantly improve people's quality of life take months of sustained and purposeful activity to be established in a person's day to day life. The development of a person centred planning approach is not an end in itself, it is the positive impact that it can make on the quality of an individual's life that counts.

The draft National Service Framework for children (disabled children module) indicates that the use of person centred approaches would greatly enhance the assessment process and PCP tools should be considered when assessing for transition planning.

## **SECTION 2: KEY FEATURES OF A PERSON CENTRED PLANNING APPROACH**

In simple terms person centred approaches are about finding creative ways to help someone work out what they want out of life and then helping them work out how to get it.

Over the last 20 years a whole set of specific methods\* (or 'tools') have been developed to help people to do this. It is very important to understand the various methods as a single approach may not work for all people. It is recommended that a menu of tools is available, from which the best one for the individual and the situation can be selected. These tools help us to:

- ❖ **Find ways to include the person**
- ❖ **Find out who the person really is**
- ❖ **Build a natural support group**
- ❖ **Discover major life ambitions**
- ❖ **Make an Action Plan**

### **FINDING WAYS TO INCLUDE THE PERSON**

The whole point of taking a person centred planning approach is to find out what the person wants, to give them ownership of their future and to work alongside them in making changes to their life. The person (or there could be a couple of people who share this role) who gets alongside the person to begin planning with them, must be:

- ❖ Someone who the person trusts and gets on with.
- ❖ Someone who is willing to work in a way which is comfortable for that person.
- ❖ Someone who is willing to be a listener and an enabler.
- ❖ Someone who has skills helping a group to problem solve and become independent.
- ❖ Someone who is willing to look at helping people to get involved in their community.
- ❖ Someone who has been trained in the use of more than one of the person centred planning tools.

\*The Person Centred Planning 'tools' will be introduced more fully after this section

There may be someone obvious like a relative, an advocate or a support person, or it may be a person who is willing to get to know the person and work on these terms. A good way to start is to maybe share your own person centred plan, creating a climate of equality as well as helping open up some 'discussion'.

*For example, Mark has his own mini – picture album (a ‘portfolio’) which he uses to introduce himself to the person he is working with, as well as an ‘Essential Lifestyle Plan’ which helps describe his ‘most important’ in more detail and a ‘PATH’, which colourfully shares his current ambitions in life and how he plans to get there.*

Right through the whole process of person centred planning this ‘facilitator’ must be prepared to make sure the person is involved and listened to. The environment, language and atmosphere of any get togethers must be enabled in a welcoming way, for the focus person themselves, but also for the people they invite to help them (see ‘building a natural support group’).

*When planned meetings or get togethers take place, it is again a good idea to help everybody to get to an equal level by introducing themselves in a person centred way – perhaps by talking about their own ambitions or interests. This again will naturally lead to possible developments for the person concerned, as mutual interests will be discovered.*

## **FINDING OUT WHO THIS PERSON REALLY IS**

One of the biggest things missing from many people’s individual plans or assessments is a real description or picture of who the person actually is. Most times we are told what their problems are – a focus on disability or difficulty. In taking a person centred planning approach we are trying to help the person to say – ‘here is the real me, the human being’ – a balanced picture of who I am and what I can offer to the world. Each of the approaches offers different ways of finding this out.

A ‘PERSONAL PORTFOLIO’\* is a very practical and personalised way of looking at this. It is a collection of work that shows a person’s abilities, achievements, experiences and ambitions and is put together in a way that will be meaningful for that person.

*For one man who liked to buy and carry around a Daily Paper it was suggested that he make his own Newspaper-based Portfolio. Over a period of time he made this document, which included ‘Top Ten’ lists, a TV and Fashion Guide, a Holiday feature, an article written by a person who knew him really well and a crossword. Because it was in a style he liked he was happy to use it to introduce himself to people.*

‘MAPS’\* has questions which help us to find out the person’s story and their strengths and qualities.

*For example, with one man who was labelled as having challenging behaviour it was revealed that when he was very young he had been physically abused by being tied to chairs and locked in cupboards – no wonder he had a problem trusting people, didn’t like sitting down and hated having to stay in unfamiliar confined spaces. At the same time it was agreed that one of his major qualities was his ‘wicked grin and sense of humour’. This helped the people around him to understand in a much more human way who he is as a person.*

*For another man, described as having emotional and behavioural difficulties – treated with medication, it was discovered that his Dad had suddenly left when he was very young and he had never had proper support to deal with this or any other losses or bereavements in his life. He needed emotional support and understanding, not drugs and tellings off. People also found out that he had a deep passion for animal welfare. Nobody had helped him to develop this interest before.*

'PATH'\* includes a section on what is life like now.

*A teenager with very complicated physical and health difficulties informed people that she was bored and frustrated at school, they didn't challenge her and treated her like a baby. Yet here was a young woman, who despite everything did have skills and abilities – she could draw and embroider using her mouth and loved singing and having fun.*

'ESSENTIAL LIFESTYLE PLANNING'\* has a focus on how the person communicates, their most important lifestyle issues and how they like to be supported.

*A Plan made with a young woman with profound and complex needs informs people that she likes routine and structure in her life. To help her to understand which day of the week it is, it is essential to say which day of the week it is, but also to burn a specific essential oil. She also definitely enjoys her own space and communicates this by turning her back on you, you should respond to this by giving her some time on her own.*

*A man with downs syndrome who is preparing to move onto independent living is most happy when he is organised and people understand what he is trying to tell them. In his plan it tells you that he must get his bag together the night before an activity, including the right wallet (he has a different one for each day). Also, his main support staff must be able to use makaton sign language.*

'PERSONAL FUTURES PLANNING'\* has a series of poster exercises, which help you to create a personal profile concentrating on the person's 'capacities'.

*A man who moved to the community after living for 35 years in an institution described himself as: A people person – I like to watch people and I'm observant. I love music, especially gospel and Irish folk music. I love animals, particularly small yappy dogs. I need people nearby to help me be active and understood by others. I am a gentle, loving and sensitive person.*

'INDIVIDUAL SERVICE DESIGN'\* looks at what has happened to the person in the past and what happens now.

*A young woman had spent her early years in a succession of foster homes, group homes, many different schools and 'respite' at hospital. Through re-visiting these experiences her support group came to the conclusion that: She has been rejected and needs love and acceptance. She has been hurt and needs to be safe. She has been frightened and needs to be re-assured.*

The other very important outcome of this part of the person centred planning approach is that it helps the person to build their self-esteem and confidence, because it values and promotes their experiences, their characteristics and their abilities and it highlights lots of possibilities for the future.

\* These are all Person Centred Planning tools.

## **BUILDING A NATURAL SUPPORT GROUP**

The most important person to help make the plan is obviously the person himself or herself, but it is also a good idea to help them to ask or invite others who they know and like, to help out. At the beginning of most of the approaches a question is asked or an exercise is used which helps the person to look closely at their present and previous relationships. The person is then supported to identify which people they might like to invite to a get together or talk to individually in helping them think about the future. If they cannot get to one get together, then perhaps a couple of sessions can be arranged. It is important that this is done in a relaxed, informal and involving way.

*One person who lived at home with his parents identified a group of people to invite to a get together. With the help of his family they rang around and followed this up with a short letter inviting people to an informal get together to help him to look at expanding his social life. All of the people asked, turned up - they included:*

*His keyworker of a few years ago.*

*An Instructor from a Workshop he used to attend.*

*One person currently working with him.*

*A person who used to provide family based respite care.*

*A friend of the family.*

*His parents.*

*His brother.*

*They were welcomed with food and drink and the person's brother talked a bit about the issues of isolation and the over reliance on their parents. They finished by talking about the person's achievements and abilities and agreed to meet again at the local Pub. This 'circle of support' has continued to meet over a 9-year period.*

*Another man whose life was dominated by paid staff due to his support needs invited people (because of his communication difficulties he relied very much on his staff team to identify the people he got on with) together for a Cheese & Wine evening. Quite a few from his local Church showed up and so his person centred planning circle was born (Note – the staff role was to help build this circle. They made great efforts to stay in the background after this).*

*A man living in a group home who was having a hard time of bullying in his local village invited a small group of people together to help him make some changes. Initially none of his family came to the get togethers, but over the years they've taken much more of an interest and now any one of his 7 sisters and brothers might turn up at a Meeting.*

*A young man with autism was helped to plan a get together at home. Representatives from 4 generations of his family came along, as well as his schoolfriend and her mum and his family aide worker. At a future get together he was lucky to get his teacher to come along and this time the meeting gathered around his outdoor trampoline – the place he was most comfortable at.*

*A man who didn't like to sit down for long invited people along to a few outdoor picnics – he much preferred this to the pressure of sitting in an indoor setting.*

As you can see informality (as far as possible) and being flexible about the environment the meeting is held in are very important. Over time, with the help of a skilled facilitator, this network of individuals can be nurtured into a natural support network.

## **DISCOVERING MAJOR LIFE AMBITIONS**

People must be asked what they want out of life – even though some dreams may not be fully realised. These big ambitions can give a real guide about what is important to individuals and they usually reveal a need to ‘be somebody’ – to make a contribution, to have choice, control and independence and also to have meaningful relationships.

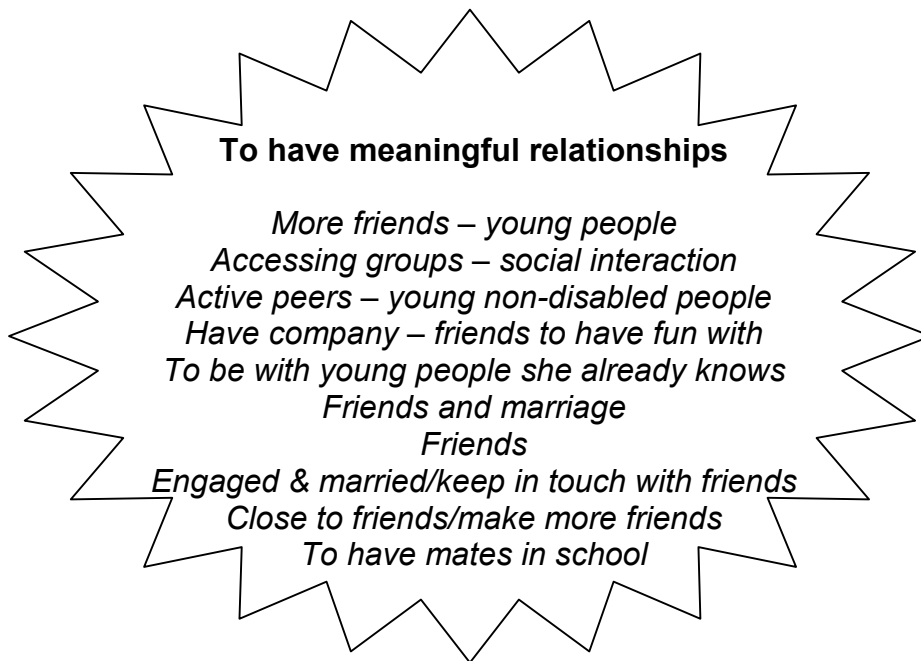
Here are some of the things that people (and those who know them best) have said when they’ve been asked to imagine an ideal future:

### **To be someone / To contribute**

*To help with (School) Assembly/To help other children  
To work in a themepark/on Computers/drawing cartoons  
To use his creative talents – making things  
To work with support – the Botanical Gardens?  
Dream jobs – acting (Casualty), dancing, singing (Pop Group)  
To work – video/photography, in a café, campaigning  
To be a paid worker – talk about circles/politics course  
To have a Workshop/Teach people to ski/DJ*

### **To have choice, control and independence**

*To communicate/be spontaneous/tell people he can  
Independent Holiday with Dad  
To be in his own bungalow/to get himself about  
Physical challenges/activity weekends (with others)  
To live in a house of my own (with helpers)  
Chances to be in control/develop his communication  
To become an adult, not to be ‘mothered’ all the time  
To go to College and try new things  
To be using a communication aid – to ‘talk’ to people  
Independence/parties/to be an intelligent person  
A new home - friends & family visiting  
My own home (& my girlfriend)/Travelling  
Countryside retreat/Cricket tour (West Indies)  
Learning to drive/Living on my own  
Getting back & fore from school alone  
Learning to use buses*



If the person has problems thinking of the things they'd love to do, or they have had very limited life experiences, then they may need to be helped to sample or try out a new range of activities. This will widen the possibilities, helping make choices more informed and would form part of the Action Plan.

## **MAKING AN ACTION PLAN**

Having found out about the person's ideal lifestyle the next step is to break things down, making goals which are positive and possible (PATH). This includes:

- ❖ What support people need.
- ❖ Who are the people who need to be involved.
- ❖ Who will volunteer to help.
- ❖ What we'd like to get done.
- ❖ By when.

An action plan should be produced, which is clear and accessible, including agreed dates to measure how things have moved on.

Importantly the person concerned must have ownership of the plan (It's not person centred if it's in the control of other people), but with the support of trusted others. Ideally this plan should then be used to influence and inform the various planning and commissioning processes that professionals use, in Education, Health and Social Services.

Here are some examples of plans in action:

*One young man with the support of his planning circle, used the MAPS process to make a plan and from this he was helped to make a PERSONAL PORTFOLIO to help him to talk about himself. Plans were made to set up a CIRCLE OF FRIENDS in school, he was helped to present his plan at his school review meeting and he managed to access Direct payments to have personalised weekend breaks.*

*A young woman with profound and complex needs used ESSENTIAL LIFESTYLE PLANNING and through this created a CIRCLE OF SUPPORT. A few years later she moved into a shared new bungalow with a disabled friend, employing a team of staff through direct payments. The Person Centred Plan acts as the guide for the team.*

*A man who was being bullied in his own community benefited from the MAPS approach and following on from this created a CIRCLE OF SUPPORT who provide telephone support in difficult times. They have also helped him to make stronger connections with his large family, creating more opportunities for him to do the things that he wants rather than hang around the local park at night. He also followed an Animal Welfare Course as a result of his Plan.*

*A man with Aspergers Syndrome had a PATH session and as a result formed a more appropriate Trust to help him to have more access over his own funding. The Plan also helped him find a quiet countryside retreat for weekend breaks, follow a Policymaking Course through which he wrote a thesis and become a paid Worker for a Voluntary Organisation. He also got engaged and moved out of a situation that wasn't working for him into one which gave him more independence.*

*A young woman with no speech used PATH and ESSENTIAL LIFESTYLE PLANNING to help her in her transition from school to adulthood. The Plan was used as the Agenda for her Social Services Transition Meeting and all of the people concerned worked hard to help make things happen. The biggest achievement was for her to attend her local College of Further Education, when previously she was told that they couldn't cater for her needs and she would have to go to the local Day Centre or Residential Specialist College (a long way from home and friends).*

In many of these situations Services had to respond in new ways. This showed a commitment to genuinely listening to people and a willingness to be creative with resources (not necessarily using more money, but putting a bit more effort into organising things).

## **THE PERSON CENTRED PLANNING TOOLS**

### **Personal Portfolios**

A Personal Portfolio is a collection of work that shows a person's abilities, achievements, experiences and ambitions. It can include anything that expresses something about the person and their life and it needs to be in a style or format that works for them. Some examples include a personalised newspaper, a read-a-long story book with a tape, a collage, scrapbook or photo album full of photo's, a video, bags and boxes full of objects and items, a filofax, a jigsaw puzzle, a wallet. Each example is unique to that person.

### **MAPS**

Using MAPS involves supporting the person to invite family and friends to a planning session. Using a series of questions and recording thoughts and ideas on a large sheet of paper using colourful graphics, it finishes with an action plan to move things forward. The questions asked are: What is the person's story? (or history), What are your

dreams? (big ambitions), What are your nightmares? (what must we avoid), Who is the person and What are their gifts? (strengths, talents), What do they need? (to move towards their dream future) and What is the Action Plan?

## **PATH**

PATH works well when an individual has a group of people around them who want to help them make life changes. It has a very clear structure and commits people to tasks and timescales. Using a very large sheet of paper with the PATH drawn on it, the group are guided through the process which asks: What are your Dreams?, What are the (positive and possible) Goals?, What does life look like now?, Who to enroll? (people to help), How to stay strong (for the journey ahead), Action (for the next few months) and First Steps (immediate action).

### **Essential Lifestyle Planning**

This is a very detailed planning tool which focuses on the individual's life now and how that can be improved and built upon. It is a way in which to learn about who and what is important to the person in their everyday lives and how to support them to have the lifestyle they want, while staying healthy and safe. The Plan is developed by using a series of workbooks, spending time with and listening to the person and having conversations with people who know and care about them.

### **Personal Futures Planning**

This form of planning concentrates on finding out and promoting the person's capacities (the positive things they have to offer to society). It then helps you to search for opportunities in the community or to create new service responses which match or develop these capacities. The process is colourfully recorded in words and pictures creating different 'maps' to show areas of a person's life. The maps look at: relationships, places, background, preferences, dreams, hopes and fears, as well as others if needed, such as health.

### **Individual Service Design**

Individual Service Design involves spending a day answering the following questions: Who is the person?, What do they need?, What would have to happen to meet these needs?. It emphasises the need for good understanding between family, staff and community members and is very much about trying to see what life is like through the focus person's eyes.

## **PERSON CENTRED APPROACHES**

Although not formally recognised as Person Centred Planning tools, there are other approaches which also help the person to say some very important things about themselves. These include:

## **Personal Communication Passports**

These booklets, sometimes headed 'All about me' are put together to help a person to tell others what is important to them. Speech and Language Therapists have been promoting these for some time.

## **Multi-media Profiles**

These profiles are a computer based catalogue of a person's daily activities and personal history. Each profile contains attractive and positive images conveyed through a range of media – stills, video, sound, graphics and text. Developed by 'Acting Up'.

### **Photovoice**

Photovoice helps people to represent their lives through easy to use cameras. Used together with the words and stories of those who took the pictures, a person centred perspective is given. Originally used as a community action tool.

## **I'll go first**

This is an interactive pack of materials designed to help a child or young person to have a discussion about their lives and their future. Designed by the PACT Children's Society project.

## **A circle of support or circle of friends**

Sometimes created as a result of person centred planning, this is a carefully constructed group of people who are invited together to help the person to plan for the future, as well as creating more opportunities for real friendship and support.

Basically, any approach which actively involves the person in a way that they are comfortable with, or in a style or format that is meaningful to them, could be described as a person centred approach.

## **SECTION 3: ROLES AND RESPONSIBILITIES**

It is important that all of those involved in a person centred planning process or in the care planning process have a clear understanding of their role in enabling the two processes to inform and influence each other. The following are examples of key aspects of the different peoples roles.

### **Role of People With Learning Disabilities**

- Access training and support to understand PCP approaches
- Access support and facilitation to develop views on all aspects of life as part of self-advocacy work
- Organize and convene a local support group/people first group meeting to discuss issues
- Take on and deliver disability awareness training locally with relevant support
- use support groups e.g. People First.
- seek support to develop a circle of support
- Be aware of their rights
- Seek support to develop some plans that provide examples
- Facilitate the development of their own plans or other people's plans if appropriate
- Feed into (if appropriate with help from an advocate) the unified or children's' assessment process the sort of support that you want.

### **Role of Parents / Carers**

- Access training and support to understand the Person Centred Planning approaches
- Enable to person with learning disabilities to take control of their own life (appropriate to their age – this is particularly critical for young people at the transitional phase)
- Contribute to the process as a significant person in the life of the person
- Respect the wishes of people with learning disabilities who wish to use an advocate
- Act as a resource (information / knowledge) to promote self-determination
- Facilitate plans only if asked by the person

## **Role of Facilitator**

- Access training to understand the Person Centred Planning approaches including knowledge of how to use PCP tools
- Build up a rapport with the person to enable effective communication
- Work alongside the person to help them consider and choose people who can help to develop a person centred plan
- Assist different members of the group to hear and understand each others different views and perspectives
- Assist the person to consider the views and perspectives, draw their own conclusions and communicate these so far as they are able.
- Assist the person to use their PCP to contribute to the unified or children's' assessment process.

## **Role of professional responsible for co-ordinating care**

- Access training to understand the Person Centred Planning approaches
- While they may not always take a primary role in facilitating Person Centred Planning, care coordinators/key workers/social workers can contribute to its success by supporting the process and listening to and acting on appropriate parts of the outcome.
- Take aspirations, strengths, ability, capability and risks into account in the assessment process.
- Support the person to be part of their community as much as it is possible
- Look for ways to develop and promote individual service responses which are matched to the person

## **Role of Professionals and staff who are not care coordinators or key workers.**

- Access training to understand the Person Centred Planning approaches
- Some staff who are more involved or have a good relationship with the person / family may be asked by the person to help facilitate or contribute to the plan
- Understand and pay particular heed to a social model of need / disability

## SECTION 4: MEASURING SUCCESS

Person Centred Planning tools and approaches need to become embedded at a number of levels.

It needs to be endorsed by **senior managers across all agencies and executive boards** so that an organisational culture develops which is designed to meet the needs of individuals rather than the service.

It also has to be accepted and promoted by statutory and independent **agencies which provide services**, for example, schools and colleges, supported living providers, employment agencies, health and social services departments. For some of these agencies person centred planning can be seen as a challenge to their professional or organisational practices or arrangements as it can be perceived as a criticism of the way professional decisions have been made and to the way services have been run. However it can also be seen as an opportunity to reconfigure, perhaps from a traditionally designed service to one which is more tailored to the needs of individuals. This will facilitate good practice in care planning and add value to that process.

It also has to be accepted and understood by **people with learning disabilities and their families**. Initial reactions and interest will vary. Some will want to grasp person centred planning immediately, others will be more susceptible or wary. Some parents may find it a challenge to their role and a questioning of their knowledge of their child whilst others may see it as a way of their child being able to shape their lives in an individual and positive way.

All of this means that implementing person centred planning is not a one-off task – it is more like an organic process which requires a combination of the right elements to get it started and then continual nurturing and to be sustained.

Measuring performance is a task that should be owned by the local joint planning group and they should be clear about who has responsibility for asking the questions which will feed into this process and who needs to be aware and use the information that is provided by the answers.

### So how do we measure success?

It is important to know, for example,

- ◇ how many facilitators have been trained ? and
- ◇ how many people have care plans that have been informed by the person centred planning process ?

but what is more important is to know

- ◇ how effective is the person centred planning ?
- ◇ is it changing people's lives for the better ?
- ◇ are services changing as a result of the person centred planning process?

## So how can we find the answer to these questions?

### ◇ How effective is the person centred planning process?

The most straight forward approach to this question is to determine whether the desired outcome has been achieved.

However where the outcome has not been achieved this may suggest that there have been deficiencies in the process. One approach would be to check out with those who have contributed to the plan, how it went. Consideration should be given to using a simple evaluation sheet, it is important not to over-complicate this process. Indicators which suggest a good quality process might be:

Indicators	Is this happening	How do we know
Has the person been central to the process ◇ Has the person been involved throughout the whole process ◇ Has the person chosen who else they want to be involved ◇ The person chosen where and when meetings take place		
Have friends and family members been partners in the process ◇ Friends ◇ Family members ◇ Has this changed overtime		
Has the process built on the persons strengths, interests and capacity rather than concentrated totally on their disability or needs ◇ it describes strengths, abilities etc ◇ it describes what matters to the person ◇ it includes what supports the person needs to stay safe and well		
Has the process enabled and supported the persons membership of a wider community as well as reflect service provision. ◇ Is there a balance between what is needed to keep the person safe and healthy and what is important to them ◇ Has the process included elements which will enable the person to develop in a direction which is important to them		

<p>Does the process enable future real communication, learning and change</p> <ul style="list-style-type: none"> <li>◇ Does it include a process for making sure that actions happen and will be reviewed</li> <li>◇ Does it allow for reflecting on what is/isn't working and what might need to be changed/improved</li> </ul>		
<p>Will it help the person get what they want out of life.</p> <ul style="list-style-type: none"> <li>◇ Does it allow for recording and sharing what everyone (including the service user) is continuing to learn about the person</li> <li>◇ Does it support the person to do new things</li> </ul>		

Making use of a regular supervision process or seeking views of stakeholders are additional methods of checking quality.

◇ **Is it changing people's lives for the better?**

**Outcomes** – rather than process - will provide the basis for evaluating this. Some outcomes will be factual and tangible whereas others will be more subjective. Service users, Circle/group members and service providers will need to contribute to and be informed about the answers to these questions.

For example:

<b>Tangible outcome</b>	<b>Achieved</b>	<b>Partially achieved</b>	<b>No progress</b>
	<i>State how</i>	<i>State how (much)</i>	<i>Comment</i>
Proposed actions in plan have actually happened			
Greater involvement in local community			
Living in home of choice with the support they want and need			
In paid work or doing chosen course or other meaningful daytime activity			
Have a wider network of friends and relationships.			

<b>Subjective outcomes</b>	<b>Persons own view</b>	<b>Family/friends view</b>	<b>Service providers view</b>
Is the person happier with their life			
Do people understand and communicate better with the person			
Does the person have more control over their life.			

Some of this information will necessarily be obtained at an individual level and it may be useful to “track” a number of individuals over - say 5 years - to see what changes are made. But at a “population” level it would be useful to know how many people are employed locally, how many people are being actively supported into the workplace, how many people are living in a home of their choice

Don't forget that sometimes it is apparently small steps in people's lives that provide a turning point towards greater control and independence !

◇ **Are services changing as a result of person centred planning?**

If person centred planning is being implemented well, then care plans should be more responsive and will be influencing commissioners to bring about changed models of service provision. Commissioners will need to know the answer to these questions. These changes should be evidenced by change of strategic direction or by change to organisational practice or procedures. E.g.

- What evidence is there that person centred planning has influenced wider strategies e.g. housing, employment?
- Have policies/procedures etc been adjusted to incorporate a person centred approach?
- Is there less rigidity in resource use i.e. do resources follow the person rather than linked to services.
- Do people have increased control of services e.g. use of Direct payments
- Have service providers changed or introduced new services in response to what people want?
- Has the range of service provision (e.g. day services) increased?

It is important always to remember that the key measure of success is what difference has person centred planning made to a persons life. Evaluating this draws upon many strands and needs to be approached from a number of levels and perspectives.

## **SECTION 5: TRAINING AND SUPPORT**

### **Who needs to be trained?**

The starting place has to be with service users. So that they can enjoy and benefit from a wide range of experiences it is important that they are helped to understand and see the opportunities that can become available to them. This can be approached through the person's PATH

The service users need to have an understanding of the process of person centred planning and of the part they can play in this process.

Families and carers will also need opportunities to explore and accept that a wider range of lifestyles, activities and managed risks can be tackled by their family member and this will inevitably bring with it the tensions that, for example, growing independence or leaving home often cause.

Training must also be made available to those who facilitate person centred planning but the approach also has to be understood by support workers, care staff, care managers, commissioners, senior managers and local politicians otherwise person centred planning will be happening in a vacuum and will not influence a shift in the way services are provided and delivered.

### **What level is training needed?**

#### **1 Raising Awareness – breadth training**

This level of training needs to be offered to people with learning disabilities, family members, health and social care staff who are not facilitators, supervisors etc.

To maximise the learning and gain most from the experience groups should be made up of a combination of family members, friends and multi-agency staff and the design and delivery of the training should be based on advice of all participants – this obviously gets better informed with experience!

This training needs to cover:

- Equality and values training
- What person centred planning is and how it can be useful
- How the person centred plan can inform the unified assessment process and what people can expect from services
- How service workers can improve their practice based on the information gained from and choices made as a result of person centred planning
- What information, materials and further training is available and how it can be accessed.

Breadth training will be most effective if it is followed up with further events or training. Much of it should form part of an induction training module. This training is a good way of to identify individuals with the potential, interest and talent to gain from more in-depth knowledge.

## **2. Depth training**

This provides facilitators with understanding, knowledge and practice in using one or more style of person centred planning. Careful consideration needs to be given to who should become a facilitator – personal qualities and skills are just as, if not more, important than formal qualifications or position. The development of the facilitators own person centred plan can often provide an important element of this depth training.

Effective methods of support include

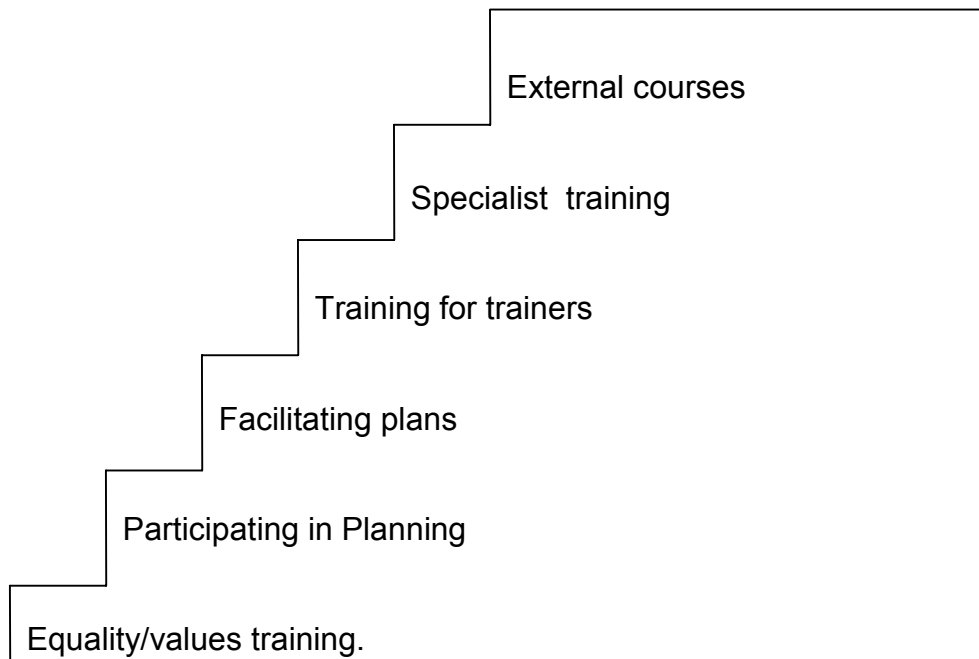
- Mentoring/coaching
- Exchanging good practice
- “buddy” systems
- networks

For example, Carmarthenshire have developed a “community of practice” where practitioners and facilitators can share their experiences, learn from each other and grow in confidence.

## Illustrative Example :Training in a Scottish authority

Below is a hierarchy of training that is currently being used in a Scottish Authority. This pattern and style of training is still evolving as experience grows, likely developments are training for senior staff who need to understand but not “do” person centred planning. The needs of corporate managers and politicians might also be considered.

### Training Hierarchy



The *Equality and values training* is a two-day multi-agency course which now forms part of general induction training. Some staff with particular skills and interests have been identified to play a key role in this training. The ultimate aim is to develop user led training for this module.

Initially the *facilitating planning* module took place in one block but it has been found more effective to run this as four two-day blocks over a four month period. This gives participants an opportunity to develop , build and apply their new skills to themselves and to others in a supportive environment and timescale. It also enables people to develop confidence in adapting and using methods which match both facilitator and service user. A Do it Yourself approach to finding a format or vehicle for production of a plan is encouraged – not everyone feels comfortable with trying to produce slick looking graphics but this type of training will become available as it is seen as a useful tool and skill for some, but not all.



## **SECTION 6: FURTHER READING**

A comprehensive resource guide and details of further reading is available in DoH guidance Valuing People. [www.doh.gov.uk](http://www.doh.gov.uk)



# Appendices

## Appendix 1

### **Illustrative Example: The Strategic Framework for developing and implementing a Person Centred Planning Approach used by Carmarthenshire**

This section describes the process which has been developed in Carmarthenshire based on learning from other areas.

Their experience is that the successful implementation of PCP requires the development of a framework which establishes the process or journey that people who are charged with the implementation responsibility need to take. They have found that there are no short cuts and that it is important to adhere to these steps, even if the order is changed.

#### **Step 1**

Identify and bring together a group of people in the authority who are interested in exploring PCP in relation to people with LD.

- The group must include people with learning disabilities and their supporters/carers.
- The group should include a mixture of key local operational and commissioning people (statutory + independent sectors) For instance the group could include representations from:-
  - ◇ Self-advocacy or local People First (or other similar group) +support
  - ◇ Social services
  - ◇ Health services (e.g. LHB)
  - ◇ Private providers
  - ◇ Voluntary sector
  - ◇ Parent and Carers Forum
  - ◇ Any other interested parties (e.g. Housing, Education, Leisure, Employment)
- The group should not be much bigger than this otherwise it becomes unmanageable but it may be appropriate to co-opt other members, e.g. training officers, from time to time.

#### **Step 2**

It may be necessary or helpful to commission someone with experience of PCP to explain the process to the group.

- Appoint an individual who can lead on PCP locally. This is someone who is enabled to freely promote the concept across all domains and make sure that PCP appears on the right agendas. This may be someone who has previous experience of PCP or who recognises its potential.

- Convene group meetings to interpret the guidance and clarify what people understand about PCP locally:
  - ◇ Rationale behind PCP
  - ◇ Where PCP comes from
  - ◇ A social model of need and disability
  - ◇ Person Centred Planning tools and approaches
  - ◇ Examples of Person Centred Plans – what do these look like
  - ◇ The importance of circles of support/friends
  - ◇ The need for values training
- Use of a facilitator could help these issues to be explored through discussion and/or by using pictures and/or words at regular meetings. This process will enable the group to become an established working team ready to act (through usual process of forming, storming, norming and through to performing).
- It is also important to gather useful materials and publications to share with group members.

### **Step 3**

- Develop a clear strategic vision and detailed step-by-step action plan to establish PCP using PATH.
- Present the Person Centred Planning strategy to the Joint Commissioning Team and seek approval from the Health and Social Care Partnership Boards through this process.

### **Step 4**

- Provide introductory (breadth) training to all people initially involved including people with learning disabilities, carers and supporters
- Provide detailed (in depth) training to a few key individuals including people with learning disabilities.
- For both sets of training it is important to engage experienced trainers from organisations with a track record in delivering training in PCP such as SCOVO ([www.scovo.org.uk](http://www.scovo.org.uk)) and Paradigm ([paradigmuk.org](http://paradigmuk.org)) or others.

### **Step 5**

- Facilitate the group to analyse what is working well and what is not in relation to Person Centred Planning. Look for examples

### **Step 6**

- Ensure that the strategy for PCP is incorporated into the local authority's current social services Strategic Plans for children and adults. More importantly it should feature in the emerging Health, Social Care and Well-Being Strategy.

- Ensure commitment of senior managers and Chief Executive Officers from all organisations and of Councillors.

### **Step 7**

- Support a few people who are skilled at using PCP tools and graphics to become local facilitators

### **Step 8**

- Develop an implementation (community of practice) group with a remit to:
  - ◇ Develop and deliver an Implementation Plan
  - ◇ Deliver ongoing introductory (breadth) training to all
  - ◇ Support skilled facilitators
  - ◇ Develop Person Centred Plans for people who want them
  - ◇ Learn from these plans and feed this information into the Strategic Commissioning Plans
- This must include people with learning disability and their supporters.
- Appoint a facilitator to support the group.
  - ◇ Identify existing and /or develop resources to help develop plans:
  - ◇ Graphics software
  - ◇ Computers
  - ◇ Digital cameras
  - ◇ Pictorial/symbol database such as CHANGE

### **Step 9**

- Develop a wider training strategy to continue to deliver the necessary depth and breadth training. With more people in the implementation group having received in depth training it should be possible to develop in-house depth and breadth training. It is important to ensure that this training is part of the County's training strategy.
- A programme of breadth (introductory) training should be set up and delivered regularly.
- In depth training for specific PCP tools should be delivered to small groups of staff who are working on a particular situation with a client rather than training the tools by rote. For instance 2 or 3 members of the implementation group train a group of staff in the use of Essential Life-style Planning to support a client being resettled from hospital.

### **Step 10**

- Develop a PCP Implementation Plan with clear priorities and support mechanisms
- The Chair of the PCP Strategy Group should attend the Joint Planning Team to give at least quarterly feedback on progress and lessons learnt.

## **Step 11**

- Encourage and support those people who want to have a plan to record their life stories for other people to read if they so wish.

## **Step 12**

- Share experiences of developing PCP through writing short articles, contributing to local conferences and in other ways using internet sites in order to maximise debate and ongoing learning.

## **A Person Centred Approach to Commissioning Services**

Strategic planning and commissioning of services needs to be informed by demographic data and research evidence. Collated information from individual assessments using the adult and children's assessment frameworks also needs to be taken into account. Person centred approaches should help to inform this process.

**The figures below show the model which Carmarthen has developed.**

These illustrate the links an authority needs to make between PCP and other responsibilities and services. Information arising from PCP must be fed into the Unified and Children's Assessment processes. The Unified and Children's assessment processes will in turn inform both operational policies of statutory services and strategic commissioning.

**Figure 1. Connections between PCP and other services: Carmartheshire**

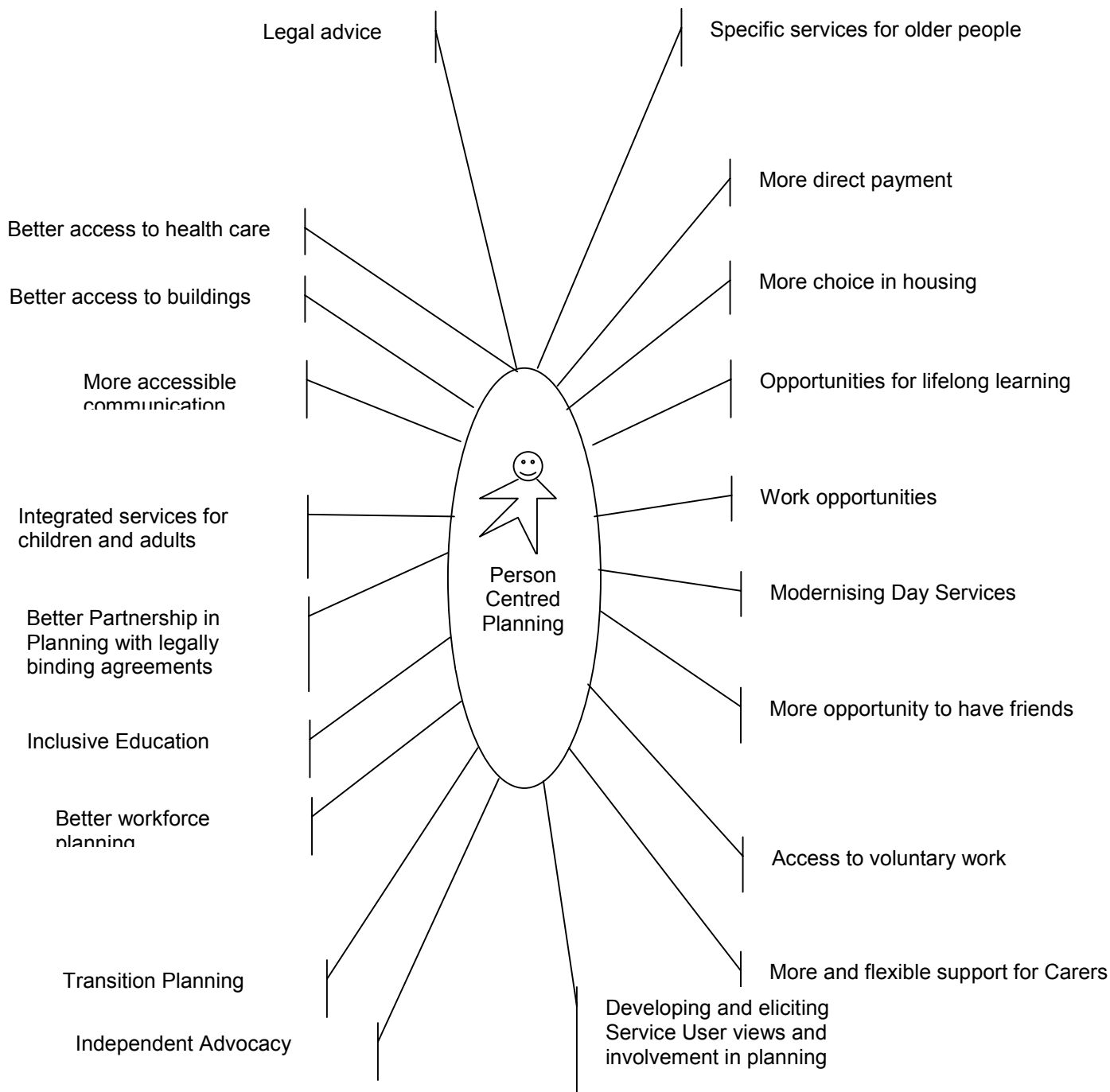
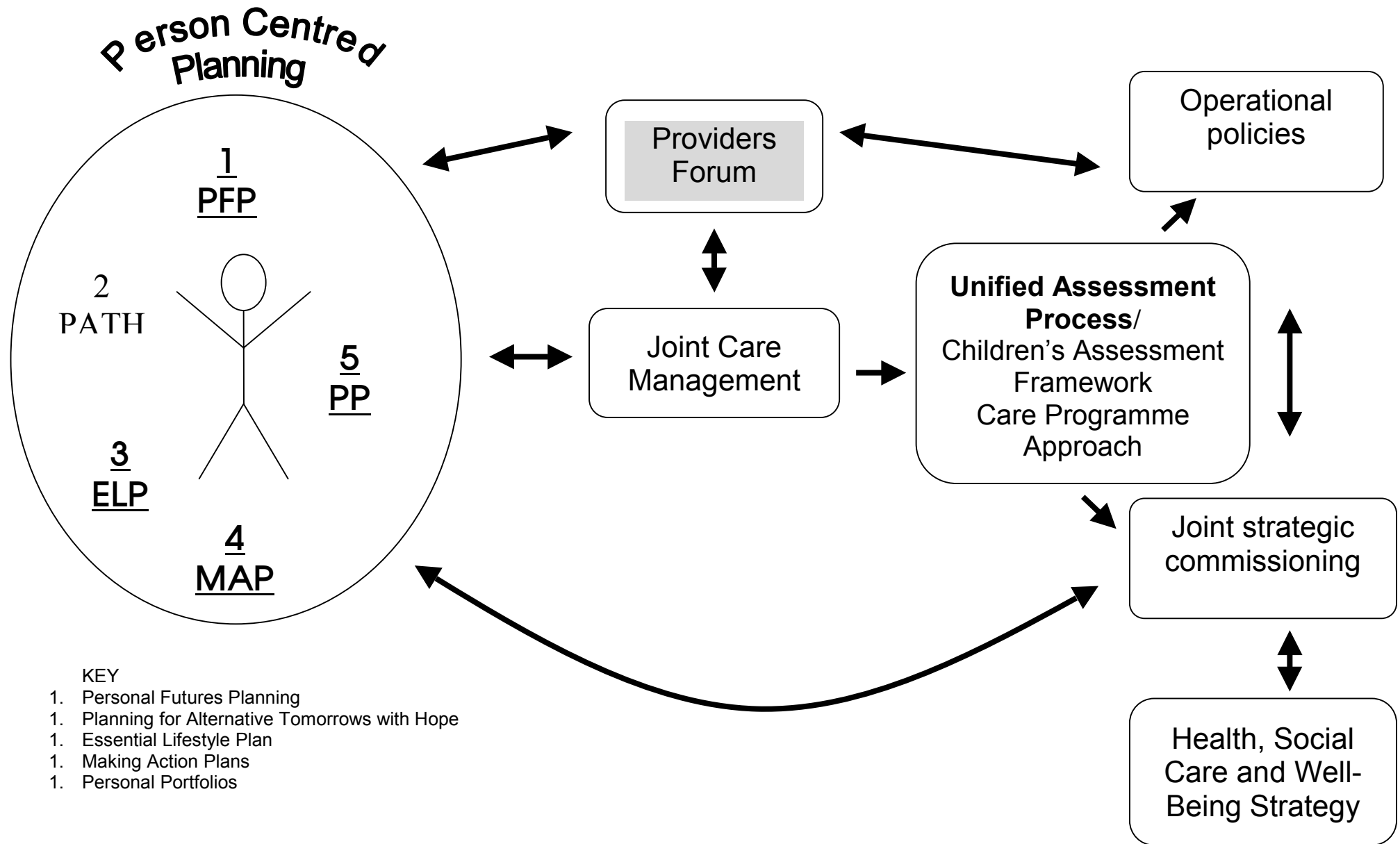


Figure 2: An example of the links between Person Centred Planning and other planning processes. (Carmarthenshire)



## Joint Planning Arrangements

Local Authorities taking a lead role for commissioning services for people with learning disabilities need to ensure that Joint Planning arrangements are in place. Carmarthen have established a Joint Planning and Commissioning Team with the following membership and arrangements:

- Chaired by the most senior Local Authority Officer responsible for learning disability services
- Persons with learning disabilities with support
- Carer representation
- NHS Trust (Health) representation
- Voluntary sector representation
- Local Health Board representation

Other key members who can be invited include:

- Representation from leisure services
- Representation from housing services
- Representation from employment services
- Representation from children's services
- Local representation from ELWA
- Local representation from provider forum

➤ The Joint Planning Team:

- Agree the framework for establishing PCP
- Agree plans for modernizing other services simultaneously
- Set priorities for developing Person Centred Plans
- Agree the training strategy for PCP
- Receive feedback from the Chair of the Implementation Group
- Ensure that information from Person Centred Plans are incorporated into strategic commissioning for services
- Develop plans to support people with learning disabilities and their carers / supporters to develop skills to facilitate plans using leadership programmes such as partners in policy making (NDT)
- Ensure that there are increasing numbers of positive life changes for people with learning disabilities
- Review the role and function of the Community Learning Disability Teams
- Develop different models for care managements that would accommodate intensive and brief involvements in Person Centred Planning
- Build good links with other departments like housing, leisure, work etc. so that care managers can access services more readily
- Shift resource allocation systems to promote more individualized funding.



**This table is an example of an implementation plan. (Carmarthen)**

**Service Response :**

<b>Actions/ Objectives</b>	<b>Performance Indicators</b>	<b>Estimated cost per annum</b>	<b>Potential Funding Source</b>	<b>Organisatio n Responsibl e</b>	<b>By Whom</b>	<b>When By</b>
1. Set up and convene an Implementation Group with representations from all stakeholders in order to establish PCP	1. An Implementation Group exists with the following membership: Persons with learning disabilities					
	Parent / Carer representation					
	NHS Trust representation					
	Local Authority representation					
	2. Appoint a skilled facilitator to head the group to help problem solve					
2. Develop and deliver depth and breadth training in PCP to all stakeholders	1. Establish a PCP awareness revising / introductory training					
	2. Have a group of skilled people including person (s) with learning disabilities to deliver introductory training					
	3. Have a regular training programme					
	4. Have a group of people who are trained in-depth in the use of PCP tools – to act as facilitators.					
	5. Deliver introductory and depth training to a group of people with learning disabilities, their carers and supporters.					
3. Develop and deliver a PCP Implementation Plan	1. Establish a group of users who want a plan (with little support)					
	2. Facilitate the development of four plans a year that meet all criteria for successful planning					
	3. Prioritise a group of users who have lots of needs and who do not get a good service at present					

Actions/ Objectives	Performance Indicators	Estimated cost per annum	Potential Funding Source	Organisatio n Responsibl e	By Whom	When By
	4 Facilitate the development of two plans a year that meet all criteria for successful planning					
	5. With people's permission, write some of the six plans a year for other people to read					
4. Evaluate the usefulness of Person Centred Plans for the person	1. Develop a set of criteria / standards for successful Person Centred Plans					
	2. Develop a set of standards representing person centred service					
	3. The local people first (or self-advocacy) group audits local services: Day Service					
	Hospitals					
	CTLDs					
	Leisure Services					
	Community Facilities					
Award charter marks annually						

