

MAKING IT PERSONAL FOR EVERYONE

FROM BLOCK CONTRACTS
TOWARDS INDIVIDUAL
SERVICE FUNDS

Steve Scown and Helen Sanderson

© Copyright Dimensions and HSA Press, 2011

Dimensions, 9-10 Commerce Park, Brunel Road, Theale, RG7 4AB.
HSA Press, 34 Broomfield Road, Heaton Moor, Stockport, Cheshire, SK4 4ND.

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise without the prior permission of both the copyright owners and the publisher.

ISBN 978 1 906514 62 4

Acknowledgments

The following people were part of the personalisation journey group and contributed to the development of many ideas in the book; Simon Blyghton, Sharon Brown, Julie Campbell, Jay Dixon, Claire Fender, Jackie Fletcher, Ray Fletcher, Marcus Harbut, Becky Harding, Gaynor Hayward, Steve Inch, Chris Ingram, Steve McConnell, Sanchi Murison, Paul Pargeter, Helen Sanderson, Steve Scown, Vivienne Soave, Trisha Stanley, Laura Sylvester, Kerry Walsh and Carolyn Wilkinson.

Thank you to other people who have contributed along the way: Anne-Marie and everybody who lives at Old Street; Carolyn and the staff team there who have shared this journey with us; Sian Lockwood for helping us to explore the possibility of work and social enterprises for the people we support and Michelle Livesley for helping us work towards becoming a person-centred team.

Published by HSA Press
Designed by Julie Barclay Design

In going from early drafts to finished book, we also want to thank Sanchi Murison, Claire Fletcher and Hilary Todd.

CONTENTS

1. INTRODUCTION	1
2. SETTING THE SCENE	3
Anne-Marie's story	
Becky's view	
Carolynn's approach	
How did we start?	
What did we hope would change?	
What did we hope to achieve?	
3. MAKING THE MONEY WORK	14
The Old Street context	
Means for allocating the funding	
What we tried	
What we learned	
What we were pleased about	
What we were concerned about	
So what did we do?	
4. PLANNING TO PUT PEOPLE IN CONTROL	20
'What', 'when' and 'where'	
Using person-centred thinking to gather information	
Learning with Anne-Marie, her family and her team	
Planning Live	
What' and 'When' - pulling together the first draft of the 'perfect week'	
Thinking about social enterprises and work	

5. PROVIDING 'JUST ENOUGH SUPPORT'..... 32

The concept of 'just enough support'

Generating ideas for providing 'just enough support'

The 'ideas' group

A different process

Testing the ideas

6. IMPLEMENTATION AND ONGOING LEARNING..... 43

A new relationship circle - a different way to choose staff

Matching staff to what Anne-Marie wanted to do

Creating a personalised rota for Anne-Marie

Supporting Carolyn and the staff to make this work

1 Working towards being a person-centred team

2 Changing supervision

3 Getting more from meetings

4 Making connections with the community

7. WHAT CHANGED FOR ANNE-MARIE?..... 53

The person-centred review

Anne-Marie's relationships

Anne-Marie's places

New things Anne-Marie is doing

Reflections on the success criteria

8. WHAT DID WE LEARN? AND WHERE NEXT?60

How to make a start?

- 1 Person-centred thinking - making this a 'habit' within the team
- 2 The importance of independent challenge in the planning process
- 3 Focus on relationships and contribution, not just activities

What this means for support staff

What this means for front-line managers

What this means for senior managers

Where next?

9. OUR TOP TIPS FOR THOSE TAKING A SIMILAR JOURNEY ...73

Finance

Human resources

Rota planning

Foundation skills for staff

On-going support

Employment for the people we support

Dealing with 'home truths'

Success criteria

APPENDICES81

Appendix 1 Individual Service Fund Agreement

Appendix 2 One-page profiles: guidance for all Dimensions employees

Appendix 3 One-page profiles - top tips

Appendix 4 Progress for Providers: Checking your progress in using person-centred approaches: Managers

I. INTRODUCTION

The future of traditional care services has been the subject of heated debate for longer than Dimensions has been in existence. Enabling people to have a greater say over the services they receive and a role in their delivery is a central theme of the government's 'personalisation' agenda. Dimensions wholeheartedly supports this policy and has been working for a number of years to make it real. However, this agenda does present us with some fundamental challenges we must face up to.

As is the case with many providers, we support large numbers of people who live, and will probably continue to live, in what we describe as a traditional (shared) service (sometimes called residential care homes or group living). While some services provide very good support, there is no escaping the fundamental flaw: the people have not chosen who they live with and, because the team on duty works with everyone, they have a limited choice about who supports them and how their time is spent. Therefore it is perhaps not surprising that few people with a personal budget want to be supported in such a traditional service.

Despite this, we decided, albeit very reluctantly, to face the hard reality that in the current financial climate, closing all of our traditional homes and helping the people who live in them to acquire their own home and co-design and produce their own support was not going to happen. So what should providers with large numbers of traditional services do? We felt this was the most important challenge Dimensions would face over the coming years.

We had learned a lot from our work with Helen Sanderson in our first personalisation journey so that we could respond flexibly to people with a personal budget who would want to work with a

provider¹. In simple terms we had learned that letting go of the power that has rested within organisations like Dimensions was not the end of the world. So if we could work very differently with people looking for a support package designed for and around them, the question was clear: how could we help people in traditional services take control of their funding and determine and control their own support?

Setting out, we recognised this second journey was a real step into the unknown. It had the potential to radically improve the support we provide for people in traditional services and significantly change everyday practice for the 4,000+ people we employ. It has proved to be a longer and much harder journey for us than we initially thought, but our learning has been far greater and richer. We have no thought that Dimensions has ended its journey – far from it. We are still learning and continue to change what we do – slowly in some cases and more quickly in others.

This book is written for other providers, not because we think it has their answers - it almost certainly doesn't. What it does offer fellow travellers is a 'warts and all' story; about our learning, about what we tried, what worked well and what didn't, and how the participants coped. We've written this in the hope it makes others' journeys quicker and smoother.

"We decided, albeit very reluctantly, to face the hard reality that in the current financial climate, closing all of our traditional homes and helping the people who live in them to acquire their own home and co-design and produce their own support was not going to happen. So what should providers with large numbers of traditional services do? We felt this was the most important challenge Dimensions would face over the coming years."

¹ Making It Personal: A Provider's Journey from Tradition to Transformation by Steve Scown and Helen Sanderson. Dimensions and HSA Press, 2010

2 Making it Personal for Everyone

2 | SETTING THE SCENE

At the outset we wanted to test new approaches with a 'typical' service so as to work through the range of issues we'd find anywhere in Dimensions. After all, if we could make it work in a 'typical' home we would be more likely to make it work in any of our services. 'Old Street' with six people with learning disabilities and 16 staff became our pilot site and 'Anne-Marie' was chosen as a 'typical' person on whom to focus our thinking and assess our progress. This chapter describes the Old Street situation and what we set out to change.

Unlike our first journey this one did not start from scratch. We had already developed our thinking and carried out some preparatory work: we had identified Old Street², a traditional six-bed residential care home, as our pilot service. Old Street was commissioned in 1996 as part of a hospital closure programme. As a residential care home, this was run within a more heavily regulated environment than a shared supported living service. We had met the people being supported and gained their consent and met the local authority. We had also carried out some observations of existing support patterns and lifestyles.

We also consulted the families of the people living in the service and found two main concerns: that this project would lead to a reduction in the service's funding; and that people's personal details would be inappropriately shared. We reassured families on both counts.

Since we set ourselves this challenge in 2010, we've witnessed some seismic events and we will continue to feel the aftershocks for the next few years. Changes to UK governments and their policies and the introduction of a new regulator are not unusual

² This is a pseudonym

- but the recent reduction in public service expenditure is unprecedented within the UK. Our work during the last year has been against a backdrop of local authorities requiring immediate reductions in cost of anything up to 15 per cent.

Providers have approached these financial challenges in a variety of ways. Perhaps controversially we concluded that many of the people we are supporting are over-supported. Therefore we decided to aim to provide people with 'just enough' excellent support to ensure their experience of life matches their plans. This approach would, we felt, make clear our determination to achieve the right balance between quality and the price people are willing to pay.

"Providers have approached the recent financial challenges in a variety of ways. Perhaps controversially we concluded that many of the people we are supporting are over-supported. Therefore we decided to aim to provide people with 'just enough' excellent support to ensure their experience of life matches their plans."

Our Project Group, with Helen Sanderson as our facilitator, consisted of some senior operations managers, some of our heads of business support services, some of the people employed in our pilot service and a representative of Dimensions' Family Reference Group.

Throughout the book we've considered this journey from three perspectives - Anne-Marie³, who lives in the house, Becky, who works there and Carolynn, the newly-installed manager. It should be noted that while we focus on Anne-Marie's journey, we worked similarly with all the people living in Old Street.

ANNE-MARIE'S STORY

Anne-Marie came to live at Old street when the service opened in 1996 and had previously been living in the nearby long-stay hospital. Anne-Marie, who is now in her early fifties, moved to the

³ A pseudonym she chose

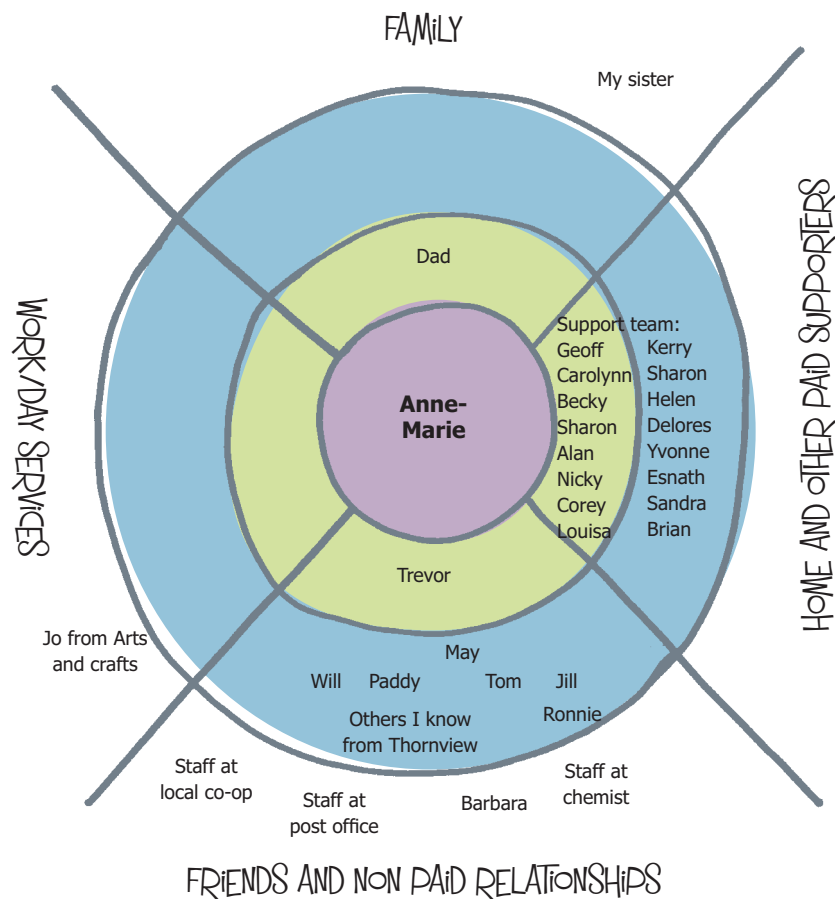
4 Making it Personal for Everyone

service along with others with whom she had lived in the hospital for many years.

We learned a lot about Anne-Marie and her life at Old Street including:

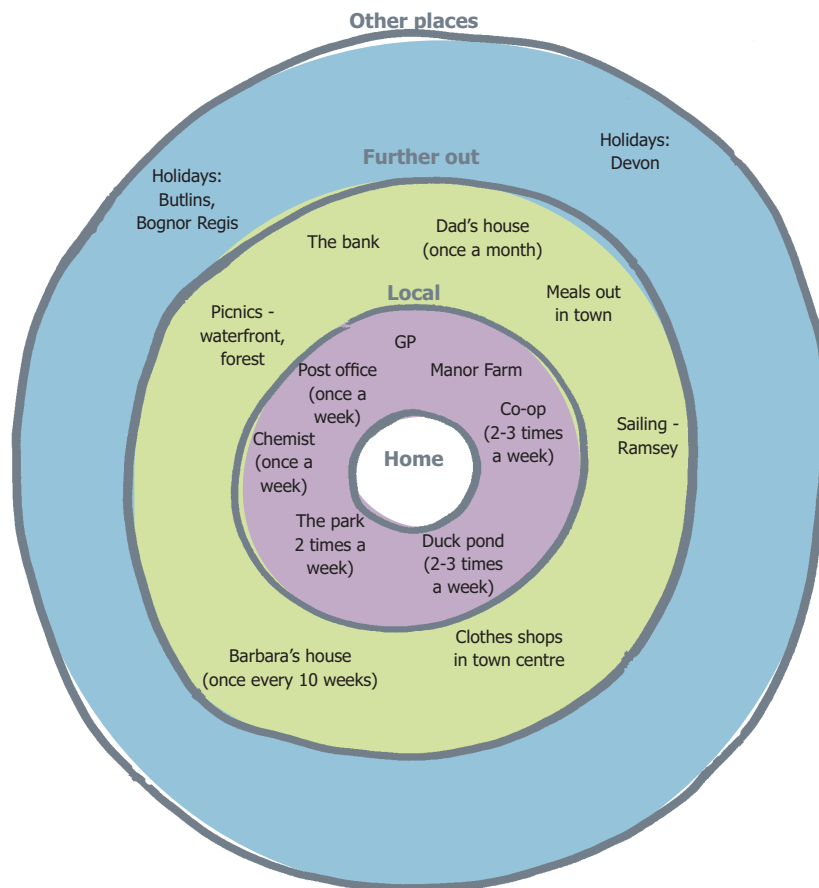
- her roles in life as a daughter, sister, housemate, friend, customer of local shops and as a spectator at her local sailing club
- her relationships with her Dad, her close friend Trevor, her friend Barbara and her support team

MY RELATIONSHIP MAP



- the places she visited, such as the local post office, her Dad's house, the park and duck pond

MY PLACES



- some of her favourite activities, such as having her nails painted, going to dances (in the past) and arts and crafts
- some of the things she wanted to do, including walking a dog and getting a job.

We also learned about how much choice and control Anne-Marie had over her support through a detailed analysis of how decisions

6 Making it Personal for Everyone

affecting her - everyday and longer-term - were made. A typical week was also drawn up and this highlighted some particular points, showing that Anne-Marie was always supported by a member of the team whenever she left the house, and that she had limited variety in how she spent her time.

My typical week			
	Mornings 	Afternoons  	Evenings
Mon	Arts and crafts (painting, textiles, making cards) with Jo	Walk to shops Hoover my room Watch TV	Eat dinner at around 6.00pm Watch TV, have a bath Go to bed around 9.00pm
Tues	Out for a walk to local park/pond Go to the post office	Out for a drive	Eat dinner at around 6.00pm Watch TV, have a bath Go to bed around 9.00pm
Wed	Out to feed the ducks Baked some cakes	Out for tea and cake Trevor visited	Eat dinner at around 6.00pm Watch TV, have a bath Go to bed around 9.00pm
Thurs	Some housework Talking to everyone in the house Relaxing	Pop out to Co-op Do jigsaws	Eat dinner at around 6.00pm Watch TV, have a bath Go to bed around 9.00pm
Fri	Watched sailing	See Dad (not every week)	Eat dinner at around 6.00pm Watch TV, have a bath Go to bed around 9.00pm
Sat	Walking to duck pond Listened to music Relaxed	Watched a DVD with pop corn Relaxed in lounge	Order a takeaway Watch evening TV - X Factor, Strictly Come Dancing
Sun	Went for walk Made bread and butter pudding	Went for a walk and had a roast dinner	Eat dinner at around 6.00pm Watch TV, have a bath Go to bed around 9.00pm

BECKY'S VIEW

Before the pilot started Becky found her role as a support worker to be quite frustrating. The approach to providing care was rather traditional and a former manager had been reluctant to 'move things on'. Becky remembers being told that the job of the support workers and managers was to keep the people they were supporting 'safe and well' which, for Becky, didn't seem good enough.

Becky's perspective on how the staff team operated during this time also exposes the frustration at not being able to change things. "I didn't like how it was, it wasn't good at all. In the end though, staff succumbed to it and went along with how things were, and

for new staff, this was just how the system worked. There was little structure to the support provided and much was down to the initiative of the support worker. The typical response to frustrated staff, like myself, was 'it's not our fault, it's the funding'."

Prior to the pilot, Becky had received no training in or had any experience of person-centred thinking and said that the prospect of using it to change how they operated as a team made her "so excited!"

CAROLYNN'S APPROACH

Prior to taking up her post as the manager at Old Street, Carolynn had run a supported living service for Dimensions. During her early time at Old Street, Carolynn had no doubt that the people who lived there "believed that life was good - there wasn't anybody there who would be unhappy", but partly because they had become used to the style of care that they had been receiving. Carolynn says that in the days before personalisation became the driving force, she found the style of caring to be somewhat frustrating: the level of care was very good, but the manner in which it was being provided was rigid and traditional.

Similarly, Carolynn felt that her staff had also become used to delivering and providing care in a way that felt out-dated and out of step with the new vision of what person-centred care really was. Carolynn constantly felt frustrated that the team's mind-set was of "early and late shifts" rather than focused on the needs of the people they were supporting.

Prior to the pilot Carolynn treated team meetings as a way of keeping on top of the running of 'the house' rather than focusing on meeting the needs of those being supported. She admits that at the beginning it was hard to get her "head around what was expected" of her as a team leader and manager, and in the early days of trying to foster change, she probably spoke more to the six people she supported than she did to her staff.

8 Making it Personal for Everyone

HOW DID WE START?

Prior to the first meeting of the Project Group, Paul (one of the group) carried out some direct observations of the Old Street team and analysed the decision making; how meetings and individual supervisions were structured and what these focused on; and how rotas and shifts were organised. We felt these main areas would be the key to unlocking any potential for a more personalised service at Old Street.

Our initial analysis indicated there was significant scope for increasing the degree to which support was planned around what was important to each individual. All supervisions followed a standard agenda; meetings had a fixed frequency and organisational/house matters dominated the agenda; rotas were drawn up mindful of issues such as minimum numbers on duty and driver availability.

“Our initial analysis indicated there was significant scope for increasing the degree to which support was planned around what was important to each individual. All supervisions followed a standard agenda; house matters dominated the agenda at meetings; rotas were based on minimum numbers on duty and driver availability.”

WHAT DID WE HOPE WOULD CHANGE?

This analysis and learning about life at Old Street helped us more clearly define the sort of changes we wanted the project to achieve from two perspectives - Anne-Marie's (and by implication everyone living at Old Street) and from the staff working there.

From Anne-Marie's perspective

What would we want to see?	What would this look like?
More choice and control for Anne-Marie in her life	An increase in the range and significance of the decisions that she makes
An increase in the activities that Anne-Marie is involved in each week (that reflect what is important to her)	An increase in the range and number of activities that she does
Anne-Marie chooses her support and the staff supporting her are well matched to her	A close match between Anne-Marie, her interests and how she wants to use her hours, with the characteristics and interests of the staff supporting her
Support being delivered exactly when Anne-Marie wants it, by the 'best matched' staff member, consistently (for instance so that she can attend the same weekly activity with the same member of staff)	Staff rotas being designed around how Anne-Marie wants to use her hours/ money
Anne-Marie spending more time with people other than paid staff and people she lives with	A few more people in her life (over time) and deepening existing relationships
An increase in Anne-Marie's links with the community (including groups that she might join or opportunities to contribute)	Anne-Marie going to more places in the local community that reflect what is important to her
An increase in the valued roles that Anne-Marie has	Anne-Marie takes part in more community activities and increases her role

10 Making it Personal for Everyone

From the staff team's perspective

What would we want to see?	What would this look like?
Staff members see that their skills and interests are better used to support each person	A match between each person, their interests and how they want to use their hours, with staff characteristics and interests
A more flexible rota system used	Staff rotas designed around how each person wants to use their hours
Clarity about each staff member's role and responsibilities in supporting each person - including where they can use their creativity and judgement	Job descriptions reflect the individuals supported, staff's core responsibilities to the person, and where they can use their creativity and judgement Contract between the individual and the service provider
Staff receive supervision that focuses on the outcomes that each individual wants to achieve	Supervision includes a review of outcomes that the staff are achieving - in relation to each person using their individualised hours
Staff record what they are learning about the person and their support, and this is used in supervision and person-centred reviews	Staff capture what is being learned, not just what happens
Team meetings focus on the people supported, how they are spending their hours and how they are being supported. Team meetings are an opportunity to share learning and problem solve	Team meetings focus on delivering outcomes for people and include sharing learning and problem solving

WHAT DID WE HOPE TO ACHIEVE?

At the outset we had some ideas about what good would look like at the end of the project from a range of perspectives – an individual who lived in the service, the other people in the service, their families and the people employed there. However, mindful of the broader agenda, we also aimed to capture our learning so we could enable everyone we supported to gain greater control over their lives, irrespective of their service model, and share our learning with others with similar aspirations about organisational change.

“The main changes we wanted to see were Anne-Marie having more choice and control over her life and everyone at Old Street working together to bring this about.”

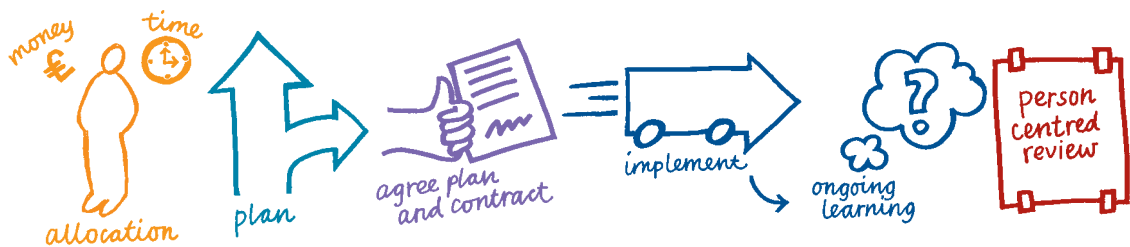
Our learning from earlier organisational change projects had shown the importance of developing criteria to establish the degree of success. For this pilot we identified the criteria for success as:

- Anne-Marie:
 - chooses her staff and is in control of her rota
 - has more planned time in her community
 - has a personalised service
 - has support that is not negatively affected by the people she lives with
 - is closer to her dreams and aspirations
 - is taking more positive risks and doing what she wants.
- Anne-Marie’s family understands and supports the change.
- Everyone in Anne-Marie’s life works together for Anne-Marie.
- We base our learning on Anne-Marie’s and her team’s journeys.
- People we employ are positive and clear about their roles.

12 Making it Personal for Everyone

- Everybody who needs to know about the project knows about it.
- We have an evidence-based transferable model for Dimensions and nationally.

Remembering that the use of graphics had helped to make our first journey so successful, we developed a graphical representation of our story and we used this structure for the rest of our journey.



3 MAKING THE MONEY WORK

A service can only be 'personal' if people have control over some funding to pay for support of their own choosing. In essence this means creating Individual Service Funds within a residential service that operates under a block contract. Finding an equitable way to divide the budget was one of our biggest challenges.

As part of this project we adopted and then refined an approach to making the money work. This was an absolutely essential step as we had to find a way of allocating each person an appropriate share of our income which they could then use to 'purchase' what they wanted. In essence we were creating a means to develop Individual Service Funds within a residential service. An Individual Service Fund is a sum of money managed by a service provider on behalf of an individual. The money provides support services for that individual which meet the criteria set out in their support plan. Services can be purchased from other providers. By creating individual funds we would be able to provide personalised support for people living in traditional residential services in an affordable way. In doing this we defined some basic characteristics for the allocation of funds: simplicity, transparency and reasonableness.

THE OLD STREET CONTEXT

Like many traditional services, Old Street was initially purchased under a block contract. As part of our on-going dialogue with our commissioners the block contract was withdrawn at the end of its term and replaced by spot contracts for each person living at the service. Until the advent of personalisation the pricing of places at

traditional learning disability services had been quite straightforward - the cost of a support package was the same, irrespective of the needs of each person living there. Put simply, the six places had a combined budget and each place (irrespective of the needs of each person) was assumed to cost one-sixth of the budget.

In the past, despite efforts to focus support through core and individual support hours, the model was not developed sufficiently to maximise any real sense of personalised support and the arrangements remained traditional, with collective use of resources. As a consequence, more resources could be 'spent' on supporting one or more people with higher support needs than others living in the home although this was not reflected in any systems nor in our contractual arrangement with our commissioners.

MEANS FOR ALLOCATING THE FUNDING

The challenge for the project team was to determine how to allocate our existing funding to individuals in a fair and equitable way to reflect their individual needs. Which costs must be shared? Which costs should be borne only by those needing that component of the service? How could we ensure that each person would be allocated some individual resource (from our budget) that reflected their needs and over which they could have as much choice and control as possible? We needed a framework that would identify an individual allocation for each person supported; core support and shared costs; and a budget that people could control ('in my personal control').

In applying the characteristics of simplicity, transparency and reasonableness we identified three tests:

- each person will pay an equal share of the 'core costs' and of any 'shared costs' they require
- each person will have choice and control over how their 'in my personal control funding' is spent, including the freedom to spend it with another provider

- if a person were to leave the service, the budget (including staff) could be reduced immediately by the value of his/her discretionary funding.

So having identified our characteristics, our framework and the tests we would apply, our starting point was to develop a means of allocating our existing funding fairly. To avoid reinventing wheels we decided to trial two existing tools - the Care Funding Calculator (CFC)⁴ and a Resource Allocation System (RAS)⁵ tool from In Control. Our intention was to use the two methodologies and then determine the most appropriate tool to use.

Unexpectedly the tools we trialled resulted in widely different allocations for everyone. Our review led us to conclude that these differences were most likely because each tool attempts to measure the same things, but from very different perspectives. Our conclusion was that the CFC allocation gave a much better reflection of what support people needed and the support they were getting day-to-day. The RAS system was quite subjective and was seen to tempt the person to choose the box that gave them the most support possible in any given situation, leading to an over-estimation of the amount needed for certain individuals. For our purposes we concluded the CFC tool offered a more stable and practical way forward.

WHAT WE TRIED

As we progressed we were aware of two key factors: the contractual framework between us and our local authority purchasers and the impact of the changing economic climate. Mid-way through the project we had to find a way of reducing our costs by up to 10 per cent.

We wanted to make the money work so that Ann-Marie and the other people living at Old Street were in control of as much

⁴ Care Funding Calculator, developed by the Regional Improvement and Efficiency Partnerships, 2008. Widely used by local authorities.

⁵ Resource Allocation System [http://www.in-control.org.uk/support/support-for-organisations/resource-allocation-systems-\(ras\)](http://www.in-control.org.uk/support/support-for-organisations/resource-allocation-systems-(ras))

of their funding as possible. Mindful of our 'just enough' and excellent support principle we wanted to ensure that no one was contributing to support they didn't need for themselves.

We identified:

- each person's share of the funding we received from our purchasers
- what support and other costs were necessary as a result of elements of the service being shared, broken down between core support and other shared costs
- where and how Dimensions' core costs should be allocated
- ways of enabling each person to maximise their control over their resources once they had paid their share of the shared costs ('in my personal control').

We then:

- used both the residential and supported living versions of the Care Funding Calculator to explore individual needs and ways of finding the best fit to ensure we were maximising personalised support
- developed our approach to ensure it was consistent with our regulators (Care Quality Commission)
- developed an approach that would see the necessary savings required by the purchasers.

"Mindful of our 'just enough' and excellent support principle we wanted to ensure that nobody was contributing to support they didn't need for themselves."

WHAT WE LEARNED

- Both versions of the Care Funding Calculator created anomalies in arriving at a consistent approach. We discovered the supported living version met our needs better for addressing personalised support.
- The night support arrangements were the most challenging to overcome. Where there was a mix of needs among the people who lived at Old Street, arriving at a fair and equitable way of funding night support required some variation to the Care Funding Calculator approach.
- As we developed the approach it became clear that the breakdown of existing costs opened up opportunities for dealing with traditional routes of funding more creatively and flexibly.
- Working to the new approaches for financial arrangements would not require extensive changes to our financial systems.
- By considering core support funding we developed an enhanced understanding of what constitutes active and passive support.

WHAT WE WERE PLEASED ABOUT

- The approaches used developed a fair and consistent way of allocating the money.
- The 'in my personal control' element of funding developed clearer focus and understanding of support for the staff team.
- The principles of support and its funding reinforced the person-centred approaches and reduced the potential for over-supporting people.

"We were pleased that the 'in my personal control' element of funding developed clearer focus and understanding of support for the staff team. The principles of support and its funding reinforced the person-centred approaches and reduced the potential for over-supporting people."

WHAT WE WERE CONCERNED ABOUT

- The night support arrangements drew a lot of available resource for those people who were deemed as needing waking night support.
- The differential in the 'in my personal control' element created difficulties for the people who lived at Old Street (and to some extent the staff team) because of the limitations on what some would be able to afford.

SO WHAT DID WE DO?

We met with our local authority purchasers to discuss how we were going to realise the level of savings they required of us and to review our initial work and the conclusions they were pointing towards. They were concerned that the two people with higher night time support needs were going to have less 'in my personal control' hours than the other people. We agreed to look again at the mechanism we used with the aim of achieving a more equitable distribution of 'in my personal control' hours.

4 PLANNING TO PUT PEOPLE IN CONTROL

The second stage was an investment in learning what matters to Anne-Marie: how she wants to be supported, how she wants her life to be different in a year's time, and what she wants her week to look like from now on. This chapter explains the tools and planning processes we used to understand the people we support more fully.

We set high standards for ourselves from the beginning (and sometimes felt the fear about whether we could achieve them). How we described success in enabling people to take control was rooted in the success standards for Individual Service Funds⁶. These are clear statements about the what, where, who, when and how of real choice and control.

What "I can use my hours/budget flexibly and can choose what I am supported with."

Where "I am supported where it makes sense for me, at home and out and about."

⁶ These success statements were developed by Groundswell, reflecting the work of disabled people in describing what choice and control means to people in practice.

Who "I choose who I want to support me, my support worker knows me and I know them."

When "I get support on the days and at the times that are right for me."

How "I choose how I am supported and my support workers know this is important to me."

Co-production "I am fully involved in decisions about my own support and how the wider service develops."

In this planning stage we first of all needed to learn what Anne-Marie wanted to be supported with, where she wanted to be supported and when.

'WHAT', 'WHEN' AND 'WHERE'

We wanted to learn:

- what is important to Anne-Marie and what good support looks like to her (we summarised this into a one-page profile)
- what good support looks like over a week (we called this a 'perfect week', as it describes when Anne-Marie wanted things to happen)
- where Anne-Marie wants to be in a year's time (these are her outcomes).

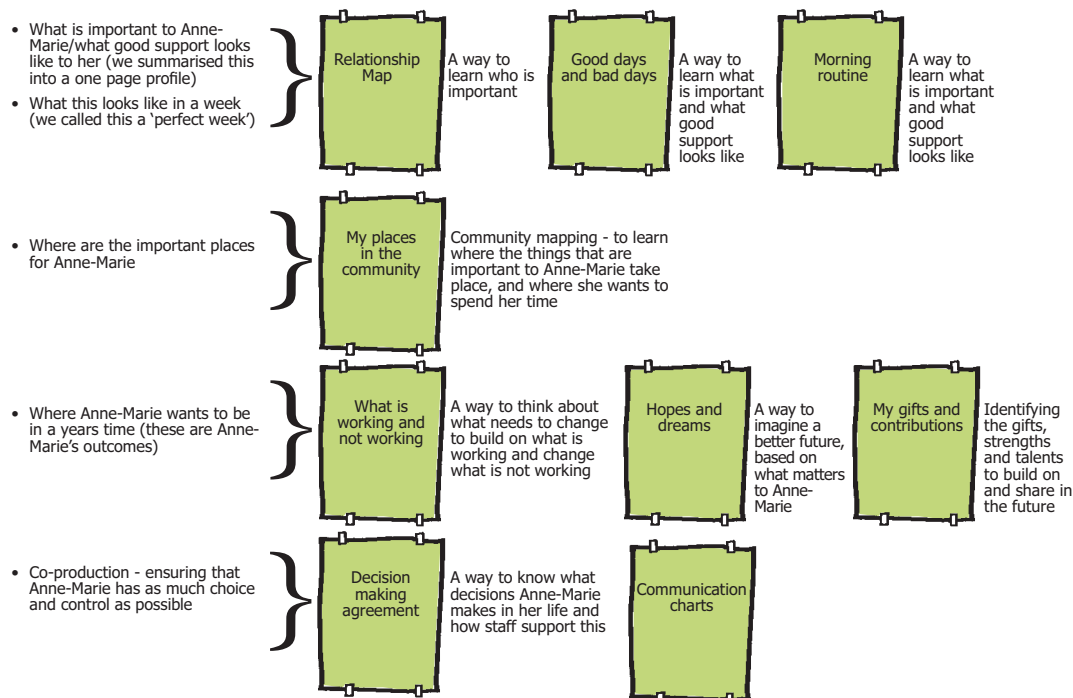
Added to this, we needed to learn about the important places for Anne-Marie, so that we can make sure that she is doing what she wants, where she wants to do this.

USING PERSON-CENTRED THINKING TO GATHER INFORMATION

In Dimensions we were already training managers and staff to use person-centred thinking tools⁷. We could see how some of these tools could help us to gather the information we needed, and to do this in a way that gives Anne-Marie as much choice and control in this as possible.

WE NEEDED TO LEARN

THE PERSON CENTRED THINKING TOOL THAT CAN HELP GATHER THAT INFORMATION



⁷ See www.thinkandplan.com

LEARNING WITH ANNE-MARIE, HER FAMILY AND HER TEAM

It was easy to assume that staff who had worked with Anne-Marie for a long time would know this information and that it was simply not written down. That was not the case. For Anne-Marie to be central to decision making in her life meant that she also had to be central to sharing the information about what matters to her and how she wants to be supported. We wanted to learn with Anne-Marie about her life 'all the way round', and fully involve her family and her staff in contributing their perspectives. At the same time, we were committed to working with the five other people that Anne-Marie lives with in the same way, and wanted to avoid using additional resources that would make it impossible to replicate at scale. A sizable challenge!

There were two possibilities. The first was to use a person-centred review process to gather the foundation of the information and then add the community map and decision-making agreement. This would mean organising six one and a half hour person-centred review meetings with a facilitator external to the team.

The second option was to use a process called 'Planning Live'.⁸ This meant getting the individuals, families and staff together for two days, to gather the information and plan. Planning Live balances sharing information and examples with the whole group with working in small teams around each individual (the person, family, key worker and other staff). There are also opportunities to share how people are doing with the whole group (and therefore give staff an opportunity to contribute information to everyone's planning). Working with six individuals in teams this way would require two external facilitators to both lead the session and support the individual teams. There were pros and cons to both approaches but in the end logistics won and we decided to use Planning Live. Carolyn then had the task of getting as many team members as possible on for the two days, the first of the 'rota

⁸ A process developed by Helen Sanderson Associates
www.helensandersonassociates.co.uk

challenges' that became a feature of this work. As well as that, she talked to Anne-Marie and the other people that she lived with about who they wanted to come. Anne-Marie's Dad was keen to be involved.

PLANNING LIVE

Planning Live took place with each individual, family members and most of the staff team, led by two facilitators (one internal to Dimensions, trained in person-centred thinking and person-centred reviews, and one from Helen Sanderson Associates).

One of the benefits of this approach is sharing the same information with everyone at the same time - about the person-centred thinking tools, about why these are important, about how the information will be used. We learned later that one of the significant challenges was keeping a staff team of 16 well informed, and Planning Live contributed positively to that. Would we do it that way again? The answer is a resounding yes!

"One of the benefits of Planning Live is sharing the same information with everyone at the same time - about the person-centred thinking tools, about why these are important, about how the information will be used."

Throughout the two days of Planning Live the group learned what is important to each individual and how they want to be supported, and this information was developed into one-page profiles. The group learned about how each person communicates (particularly if they do not use words) and how they make decisions (using a decision-making agreement) and used all this information to describe what 'best support' looks like for the person. Through the relationship circles, the group learned about the important people in each person's life, and this information was added to the community map of the places that matter to each person.

As well as this day-to-day information, the group learned about what is working and not working and how to change what is not working. This information was put together with what Anne-Marie and her housemates want in the future – how do they want their lives to be in a year's time (dreams and aspirations)? Together this gave us the outcomes that the person wants for the following year. The group looked at the person's dreams and aspirations and, with an appreciation of their gifts and skills, considered whether paid work or enterprise opportunities could be included in the outcomes. An action plan was developed for each person we support at Old Street.

Here is what Carolynn and Becky thought about Planning Live.

Carolynn

"In a word, Planning Live was fantastic! It really felt like the start of the journey for us all. My staff and I spent two whole days listening - and that's it, just listening to the people we support. We gleaned so much information over those two days and enabled the people we support to think more about how their life was for them and their families."

It was at Planning Live that Carolynn really felt that personalisation had begun. It was also a really important watershed moment for her staff team, because there was still uncertainty about the philosophy behind personalisation. Carolynn says that the sessions "opened people's eyes to the fact that there was more out there, and that people could have more control over their lives".

The other essential aspect of Planning Live was the first-ever frank conversation about how much money was available to each supported person: "Because of Planning

Live, we were able to say: 'You have 'x' amount of money - how do you want to spend it?'. Carolynn stresses the importance of sorting out the money side of things as a prelude to discussion about empowering people and changing their lives.

Carolynn also felt that the action plans, each with between two to five points for each person, gave staff something tangible and 'real' to start focusing on. "Unlike before, actions were actually starting to be worked on and carried out - change was happening!" said Carolynn.

Becky

Becky thought that Planning Live "sounded fab!" when it was first explained but didn't want it to be "another paper exercise". So she was delighted to discover that it really was an exciting and important moment in the team's journey. She also recognises that it was hard work: "Planning Live was really good, but quite hard work. After the event, I think that at least half the staff team panicked that everything was going to change and I think for some people that was a difficult prospect".

Throughout the Planning Live event, Becky worked with Anne-Marie, whom she was supporting, along with all the important people in her life. As a group they went through Anne-Marie's preferences and fully discussed what would help to improve her life. One of the most poignant moments for Becky was hearing what Anne-Marie wanted in her 'perfect day'.

“It turned out that one of the things on Anne-Marie’s ‘perfect day’ list was that she’d like to put make-up on every day. That upset me a bit, because I’d worked with her for all these years and it had never occurred to me before Planning Live that she wanted to put make-up on every day. Of course we did her hair and make-up when we went out, but without Planning Live and the open environment it created, I don’t know if we would have found that out.”

For Becky, Planning Live was an absolute turning point, a shift from seeing the week as revolving around the staff rota to one that revolved around what the people being supported needed and wanted.

“For some staff, Planning Live was an absolute turning point, a shift from seeing the week as revolving around the staff rota to one that revolved around what the people being supported needed and wanted.”

‘WHAT’ AND ‘WHEN’ – PULLING TOGETHER THE FIRST DRAFT OF THE ‘PERFECT WEEK’

The person-centred thinking tools used in Planning Live resulted in clear outcomes for each person, what they wanted to do each week and how they wanted to spend their money to achieve this. We put this information into an adapted version of the agreement that Dimensions had been using with people who have a personal budget. An easy read example of this is in Appendix 1.

Our next step was to work out how to deliver this. First, we used this information to develop a first draft of the ‘perfect week’ for Anne-Marie to check and amend and we did this for each individual, working with their family and team. Our priority

was to develop a robust process and the most that we could do was to make a 'best guess' and then check that out with Anne-Marie for her to adapt. The process also needed people with local knowledge (provided by the team) and people prepared to challenge our assumptions (contributed by various members of the project group).

The notion of 'a perfect week' (or month) is to try and create someone's ideal week, assess what is affordable through their Individual Service Fund then see how we can be creative to deliver 'just enough support', within budget. We could have started with what was affordable and built from there, but we decided to start with the 'ideal' and then think differently about support or, if absolutely necessary, prioritise. The idea was to push us to think differently rather than take things off the week's activities because they were not affordable.

We created the first draft of Anne-Marie's perfect week in three steps, starting with relationships, then what she wants to do and where, then outcomes. Finally, we checked what this would cost. Thinking differently about support and what is affordable is covered in the next chapter.

"The person-centred thinking tools used in Planning Live resulted in clear outcomes for each person, what they wanted to do each week and how they wanted to spend their money to achieve this."

Step 1 - Looking at relationships

We started by thinking about who was important to Anne-Marie and how often she saw them. This information was recorded on her one-page profile and relationship map. For Anne-Marie this was her Dad, whom she saw on a Friday night, and her boyfriend, whom she saw on Wednesdays. This went onto the draft perfect week first.

Step 2 - Looking at what Anne-Marie wants to do

Anne-Marie's one-page profile showed some of the activities that were important to her and also gave us some ideas about how often she wanted to do them:

- dancing (every week)
- walking dogs
- going to see films
- doing crafts and making jewellery
- doing jigsaws.

Then for each activity we asked:

- **Where would this usually take place?** This helped us to focus on making sure we were using the same community places and resources that anyone would use, not those particular to people who have a disability.
- **What time of the day would this typically happen?** Again, we wanted to make sure that Anne-Marie would be going to places at similar times to other people, for example, not 'special needs swimming night' at the swimming baths.
- **How much would it cost?** This was to ensure that it was affordable from Anne-Marie's budget.

By now we knew that we were looking at a 'perfect month' rather than a perfect week, as not everything would happen on a weekly basis. When we looked at this in relation to dancing, we thought about the kind of dancing Anne-Marie liked and when she had done this in the past. She had attended a nightclub on Wednesday nights, which was an evening for people with learning disabilities. We had a spirited discussion about whether it was best to consider dancing with other people with learning disabilities or whether to explore other dancing opportunities. When we looked at going to see films, Wednesday nights also looked like a good possibility, as Anne-Marie could use the Orange Wednesday '2 for 1 offer' to make her money go further.

These gave us the next lot of 'things and places' to put onto the draft perfect week/month.

Step 3 - Outcomes

Finally, we went to Anne-Marie's outcomes to assess what these meant for the staff rota. For example, Anne-Marie wanted to get a job. She also loved walking dogs but did not have a dog of her own. So we talked about whether Anne-Marie could:

- get her own dog? This provoked lots of conversation and the group decided that if she lived with five other people this would not be possible
- volunteer to walk dogs in a dog's home?
- develop a micro-enterprise walking dogs for other people?

As she both wanted to walk dogs and get a job, the last one seemed the best option. The group thought that it was most likely that people would pay for this service around lunchtimes, so we tentatively put lunchtimes for walking dogs as a business.

This gave us the ideal month, as far as we could guess from the information we had.

The next question was could she afford it? With the first-draft monthly planner on the wall, we went to each activity and wrote down the costs for entrance fees and other costs, and what support Anne-Marie would need to participate.

Already, it looked so different. When we started, Anne-Marie's regular activity was a craft session on a Monday and watching sailing on a Wednesday afternoon, both with her housemates. Her week was now full of activities and people that mattered to her. We knew that Anne-Marie needed to dictate the pace of the change and decide what from this list she wanted to try. We were keen to hear her views of our work.

Anne-Marie told us she was excited about the plans and wanted to do everything!

30 Making it Personal for Everyone

THINKING ABOUT SOCIAL ENTERPRISES AND WORK

One of the discussions in the leadership team was about the role of providers and paid work. Given how few people with learning disabilities have paid work and the life chances that work gives people, what was our position on this in Dimensions? Should we support people to get jobs if they specifically asked for this, or should we automatically assume that adults of working age should work and therefore be proactive about this for everyone?

We decided to offer Anne-Marie and the other housemates an opportunity to explore social enterprises and work, and invited Sian Lockwood from Community Catalysts to work with them and the staff team to think together about what was possible. There was some initial reluctance among the people we support when asked if they'd like to get a job because they felt as though they were being 'sent out to work', as it were. It was only after discussing working in the sense of empowerment and earning their own money that they began to feel that it would be a good addition to their newly-personalised lives.

Carolynn felt that it was a real 'eye opener' to work with Sian during these sessions and while it could only enhance the new situation, she saw the outcomes as still very much in their infancy: "I think that it was quite hard to do [encouraging employment] because there was such a huge change going on within the service to even start to think about getting people jobs". Becky also found that, in the context of the numerous structural changes to Dimensions' working methods, the micro-enterprises felt like too big an ask: "The two days on micro-enterprises were really interesting. I think that it scared everybody into thinking 'oh my goodness, how are we going to get them all to start a business' in amongst all this change? To be honest, it was just too much. But maybe it would work better a year down the line?"

Despite these reservations, we decided to try to find Anne-Marie a way to be paid to walk dogs rather than just doing this as a volunteer.

5 PROVIDING 'JUST ENOUGH SUPPORT'

Having learned what was important to Anne-Marie, and when and where she wanted to spend her time, we then needed to think about how to make this happen. How could we provide 'just enough support' to ensure that Anne-Marie could enjoy a life of her choosing, within her budget? How could we support her to become a valued and contributing member of her community, and part of a network of family and friends, without relying solely on paid support? It was time to look creatively at ways of providing support.

THE CONCEPT OF 'JUST ENOUGH SUPPORT'

'Just enough support' means the optimum level of support that will increase the chances of people connecting with local people in their communities. Over-supporting people is detrimental in many ways - it risks:

- undermining people's confidence and abilities
- reinforcing paternalistic support
- using unnecessary staff resources
- lack of community involvement in people's lives, and
- believing that the staff are there to do everything.

If we use resources effectively and actively reduce reliance on paid support, while working in ways that enhance relationships and involve people in their community, then we can achieve a 'win-win' situation for:

- the person - who will have a wider variety of connections and relationships
- the organisation - which will be able to target scarce resources most effectively, and
- the community - which will benefit from the contributions and presence of disabled people.

"Over-supporting people is detrimental in many ways. It risks undermining people's confidence and abilities and uses unnecessary staff resources."

GENERATING IDEAS FOR PROVIDING 'JUST ENOUGH SUPPORT'

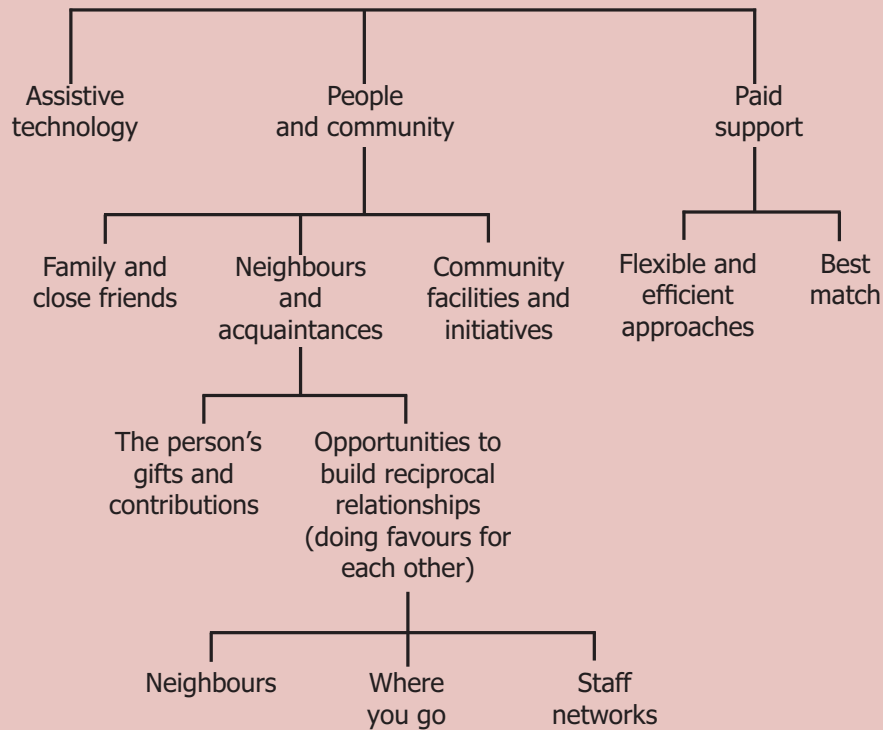
There are four stages to providing just enough support: generating ideas, testing them (do they work for the person? do they provide enough support?), trying them in practice and reviewing them⁹. To generate ideas, we first of all clearly identify what, how much and when the person needs support, then think about three possible ways of providing it – starting with assistive technology, then people in the person's network and in the community, and finally paid staff.

⁹ A process developed by Helen Sanderson Associates
www.helensandersonassociates.co.uk

IDEAS

PROCESS

Support - Why? What? When?



PERSON-CENTRED THINKING TOOLS



THE 'IDEAS' GROUP

When it comes to generating ideas, many heads are better than one. Ideally you need to bring together a group of people who know the person really well, and/or know the area and community where the person lives. Alongside them, you need one person who knows about assistive technology and someone who can facilitate the process and act as a gentle (or strong!) challenge to the group. The person that this is focused on may want to be part of this too but if they do not, their expert role is to see if the group's ideas work for them. It is vital to include family members whenever possible and ideally people who do not think along the same lines as staff and managers. The cliché is 'people who think outside of the box', and however you choose to describe them, it is those people that we mean!

Anne-Marie's 'ideas group' had a facilitator skilled at challenging us, some people who knew Anne-Marie well, staff who knew about the local area (but probably not as much as we needed), and a range of people used to challenging the status quo. The human resources manager was particularly good at doing this – not because of her role, but because of the way she thought.

A DIFFERENT PROCESS

Once the group is together, the process begins with the person supported, or if the person is not present, looking at their one-page profile together. The group should see the support that the person needs for each hour of the day and pose the following questions.

1. Exactly what support does the person need?

Many of us remember when planning was called 'Individual Programme Planning' and at the end of the meeting we filled in a form called 'unmet needs'. This form was intended to inform future service planning and we would describe what people needed in terms of services; for example, where we struggled to understand the person's communication, this was recorded as 'Needs more speech and language therapy'.

In developing 'just enough support' we have to go beyond this and accurately describe exactly what support the person needs, how much and how often, not how we currently provide it. For example, instead of stating that the person needs 'waking night support' we would put that the person needs to be turned four times a night, or needs support if they wake up distressed, and how often this usually happens.

It can be very useful and illuminating to talk about and understand why we provide some of the support that we do. We quickly learned how 'custom and practice' had led to assumptions about the levels of support Anne-Marie needed. She had been supported 'two-to-one' when going for walks. From listening to the history of why this had started, it was quickly obvious that this was no longer required and we immediately put into action a person-centred risk assessment to review and change this.

Another example in Old Street was Josephine for whom we provided waking night support. When, in Planning Live, we looked with Josephine at what was working and not working for her, she said she disliked being woken up at night by the waking night staff! It transpired that when she went home at weekends her parents did not sit up all night with her, obviously making us question why we were providing this service for her.

"We quickly learned how 'custom and practice' had led to assumptions about the levels of support Anne-Marie needed. She had been supported 'two-to-one' when going for walks. From listening to the history of why this had started, it was quickly obvious that this was no longer required."

2. Could assistive technology help?

Our colleagues in older people's services are much more advanced in their use of assistive technology and telecare, for example using bed sensor pads, automatic toilet flushes, motion detectors, automatic links to monitoring stations and call centres. For some people this can make a huge difference, to both the quality and

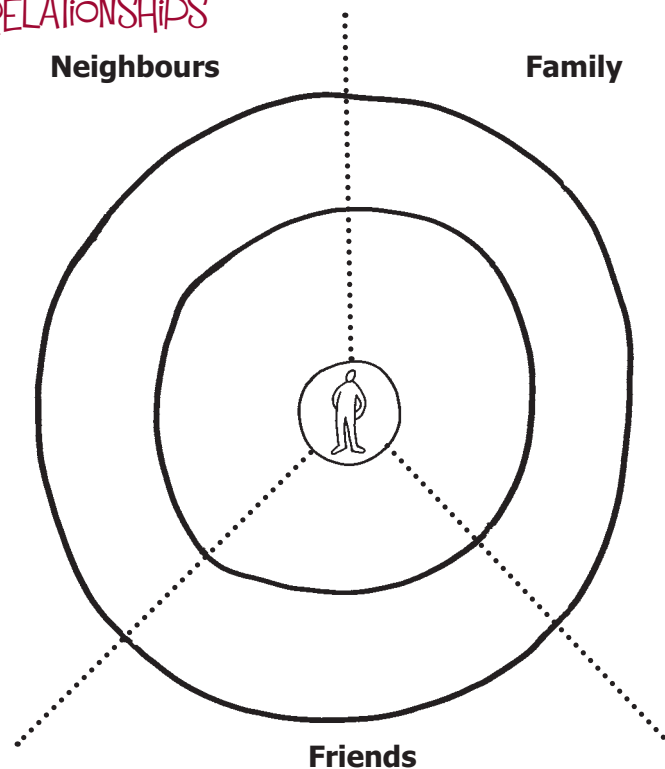
cost of support; for example, a bed can gently turn someone as they sleep instead of waking night staff doing that manually four times a night.

For Anne-Marie, there were some opportunities to use assistive technology. By using an anti-flood bath plug Anne-Marie was able to have baths without any support from staff. Later, a talking photo book meant that Anne-Marie could have her personal rota, know what her plans were and who was going to support her in a way that made sense to her.

3. Are there other people or community initiatives that could help?

We used the relationship map developed during Planning Live to start thinking about the people already in Anne-Marie's life, to assess the opportunities there.

MY RELATIONSHIPS



Family

The first place to start is with the family. Owen Cooper suggests that we should talk to families about their own resources - time, connections, interests, skills and money, and think together about whether any of these could be used to support the person. As he puts it:¹⁰ "Asking families to think about their own resources pays dividends. Worrying about offending people by asking, gets in the way". Anne-Marie's Dad is very important to her and they see each other every week, so we wondered whether this visit could take place without staff support in the future.

"We should talk to families about their own resources - time, connections, interests, skills and money, and think together about whether any of these could be used to support the person."

Neighbours and acquaintances

After family, we thought about neighbours and people who share the same interests or who go to the same places. The gifts and contributions person-centred thinking tool helps us to consider whether there are any gifts or resources that could be shared, and possibly lead to reciprocal favours. For example, if the person has a car, could they offer lifts to the local meetings in return for help while they are there, instead of having paid staff there all the time? This tool also helps to identify possible opportunities for people to contribute by being good neighbours and take on responsibility. For example, this could mean taking in parcels for neighbours or holding spare keys.

Another helpful person-centred thinking tool is a community map which shows where the person goes already and where there might be opportunities for connections and contributions. One of Anne-Marie's goals was to learn to bake and also to continue going to weekly coffee mornings at the church, where Becky normally supported her. We wondered whether a place to start was baking cakes to share at the coffee mornings. "Initially I had to convince the lady at the church that we could be helpful," explained Becky.

¹⁰ Owen Cooper and Sally Warren, *All Together Now*, 2010.

Recently Anne-Marie and Becky met the church lady in the street, who told them that there was going to be a special coffee morning and asked if Anne-Marie could go and help out. She suggested that Anne-Marie could cope on her own, and that Becky may not need to come along.

Community initiatives and opportunities

A third area to consider is whether there are local community initiatives that provide opportunities to share skills, talents and resources. One example is timebanks. A TimeBank is a way to share skills and time across a community, based on the principle that everybody has something to offer of equal value. It's a simple equation: an hour of anybody's time is as valuable as an hour of anyone else's time, and people can offer help to each other by trading hours.

TimeBanking UK supports over 200 TimeBanks across the country, each of them different, reflecting the local community. Innovative providers include, for example, Newsome Ward Timebanking, founded by members of Newsome Ward Community Forum and United Response in Huddersfield.¹¹ Another example is 'Never Watch Alone' in Wigan which connects fans with learning disabilities to fellow supporters to attend rugby or football matches.¹² If one is not available locally, or not available to everyone, is this an opportunity for the organisation to contribute and widen access to the TimeBank?

4. Are there ways we could think differently about paid support?

The ideas that we had generated so far for Anne-Marie looked promising, but it was very clear that she would still need considerable paid support. The last section of the generating ideas stage was to see if staff support could be provided in a different, flexible and innovative way.

There are different models of support to consider here, like

¹¹ To learn more about the Newsome Ward Community Timebank and the impact this has made go to <http://whatmakestick.wordpress.com>

¹² For more information go to <http://www.helensandersonassociates.co.uk/whats-new/all-together-now-paper.aspx>

homesharing models where someone who needs support but has a home is carefully matched with someone who is looking for a home and in return could offer support. One approach is to list all the radical and different ways that support can be offered. The list could include:

- Community Service Volunteers or other volunteers
- the KeyRing model¹³
- zero hours contracts to offer maximum flexibility
- 'life sharing' possibilities.

As Anne-Marie's service is registered care, we wanted to see if there were ways that we could offer maximum flexibility through changes to the staff rota, as other options did not feel possible at this stage. We also wanted to make sure that we could get the best match between Anne-Marie and her staff.

TESTING THE IDEAS

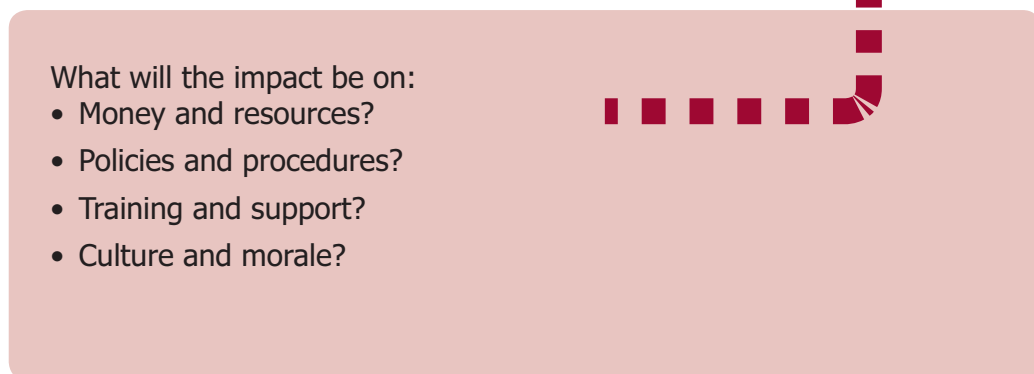
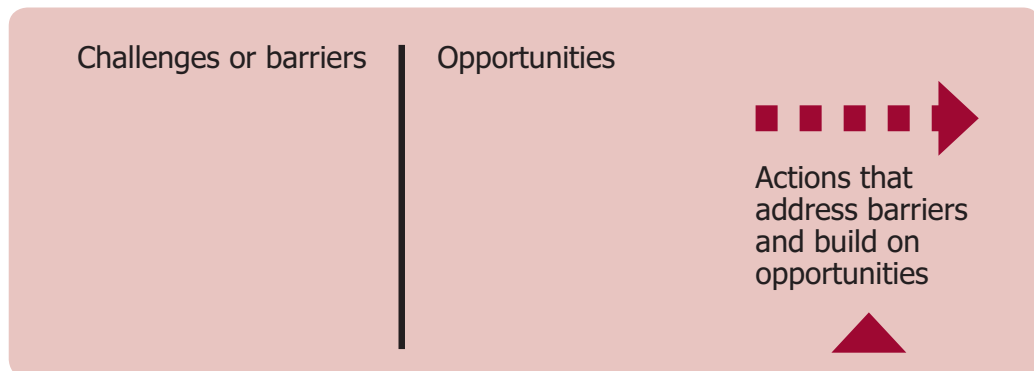
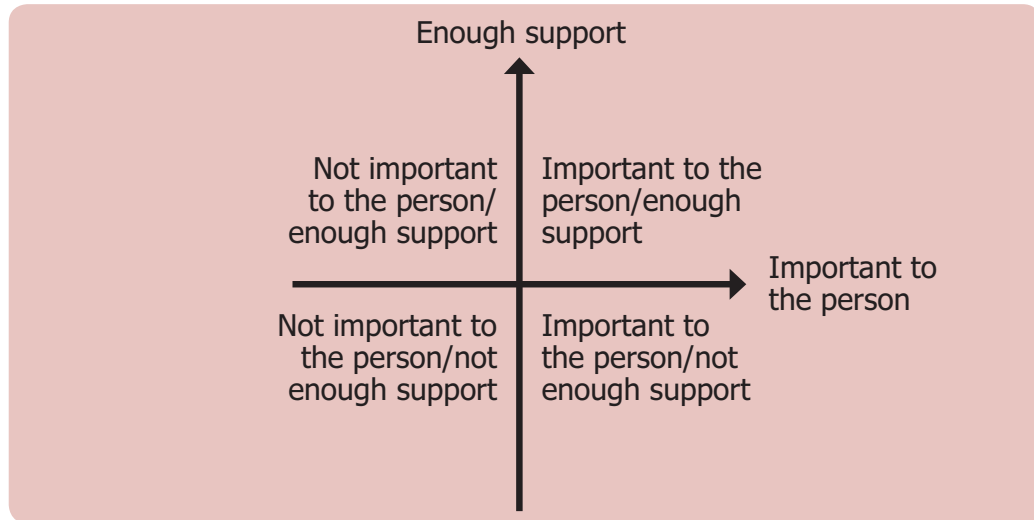
The 'ideas group' provided a list of ideas and the next step was to test these out before seeing whether Anne-Marie wanted to take them forward. The best solutions would be those with a good fit with what matters to Anne-Marie and how she wants to be supported, that also provided the right amount of support, when and where she needed it. A one-page profile is a good way to check this.

One way to test the ideas is to plot them onto a grid which shows what is important to Anne-Marie on one axis, with the other axis showing whether solutions offer enough support.

We were looking for ideas that fitted into the top right-hand quadrant - ideas that offered enough support to give Anne-Marie what is important to her. For ideas that fell in the bottom right-hand quadrant, we asked what it would take to move the idea to the top right-hand quadrant (is there anything that we could do so

¹³ www.keyring.org

IDEAS TO ACTION



that this idea would offer enough support?). Ideas that fell on the left-hand side, which did not fit with what matters to Anne-Marie, were discounted.

With a new list of ideas that looked 'promising', we could then think more deeply about the challenges and barriers to implementing them, as well as the opportunities they present. How would implementing the ideas affect the immediate people (staff and other residents) and the wider organisation? What resources might be required? Was any training or support required? Would we need changes to policies and procedures? Would there be any impact on culture or morale as a result of taking them forward? The end result of this should be an action plan that begins with directly checking the chosen ideas with the person (if they have not been part of the process) and then steps in implementing them.

Of course the most important test was what Anne-Marie thought. To check out the assistive technology ideas, Marcus, Dimensions' lead on assistive technology, went to meet Anne-Marie and spent time showing her the options. She decided to go ahead with the anti-flood bath plug, providing her with more independence, and a talking photo book.

Carolynn and Becky talked to Anne-Marie about the coffee morning and cakes idea, and she was keen on this as it fitted directly with her goals. Getting the most flexible rota and the best staff match is the story that we tell in the next chapter. All of these ideas were reviewed as part of the person-centred review, which we talk about in Chapter 7.

6 IMPLEMENTATION AND ON-GOING LEARNING

At this stage we knew what Anne-Marie wanted to do and how to support her to achieve this. Now we needed to think about how Anne-Marie could choose which staff she wanted to support her, and how to put all this into a rota. To support the staff through these major changes to working practices, we focused on improving supervision, team meetings and making connections in the community.

The best practice in Individual Service Funds requires that each person chooses their own supporters. One way to do this is to recruit new staff with the person supported being central to the recruitment process. This option was not open to us at that time and instead we wanted to find a way for Anne-Marie to choose who she wanted to support her, from the staff team of 16. We also wanted to work in a way that took account of staff members' individual hobbies and interests, and use these to think about getting the best match between the 'what' and the 'who' from the people Anne-Marie had selected.

A NEW RELATIONSHIP CIRCLE - A DIFFERENT WAY TO CHOOSE STAFF

Out of a group of 16 people, there would naturally be some people that Anne-Marie would gel with more than others. The decisions

about who supports an individual are arguably the most important ones that will impact on the person's quality of life. Doing a chosen activity or going to favourite places can still be a miserable experience if you are not with someone you like. It can be even better if that person shares that interest with you. That is what we wanted to achieve with Anne-Marie - her choosing the staff she clicked with most, and matching those staff to her chosen activities, based on who shared that interest.

As part of Planning Live we had looked with Anne-Marie at the important relationships in her life. Now we went back to that and asked her to do a relationship map of the staff who supported her. Carolyn supported her to put her preferred staff in the first circle, then in the second circle other staff whom she liked supporting her, and outside the circle anyone whom she did not want to support her. This gave us four staff names in her inner circle of supporters. This also gave Carolyn information about a staff member that Anne-Marie clearly did not want to support her. Naturally, this was important for Carolyn to discuss with that member of staff to understand why this was the case. We talked about whether it could be:

- a 'personality clash'
- that the staff member was not supporting Anne-Marie in the way she wanted to be supported
- that the staff member did not understand the crucial importance of having good relationships with the people she supports.

The project team immediately began to see the workforce implications of this, and we talk about this more in Chapter 8.

"The decisions about who supports an individual are arguably the most important ones that will impact on the person's quality of life. Doing a chosen activity or going to favourite places can still be a miserable experience if you are not with someone you like. It can be even better if that person shares that interest with you."

MATCHING STAFF TO WHAT ANNE-MARIE WANTED TO DO

We could simply have asked Anne-Marie who she wanted to support her to do her chosen activities. However, Anne-Marie did not necessarily have all the information about different staff members' individual interests and hobbies, and as this way of working was new to us, we wanted to learn about it first. So we decided that we would make recommendations to Anne-Marie, and through trying the 'matches' out, Anne-Marie could then make the final decisions and changes herself.

To help the staff learn about person-centred thinking, we had asked each staff member to develop their own one-page profile. This information included hobbies and interests, as well as personality characteristics, people and important routines.

We put the final version of Anne-Marie's perfect week/month on the wall, looked at the four one-page profiles of the individual staff she had selected and tried to work out the best match. It was an inexact science but a great way to get started. Here are two examples:

- Baking is an activity in Anne-Marie's perfect week. One person had listed cooking as something that was important to her - that looked like a promising place to start.
- Anne-Marie wanted to set up a dog walking service. One of the four people mentioned that they loved walking their dog, so this looked like a sensible match.

Obviously this did not work out neatly for everything on Anne-Marie's list! Where there was no clear shared interest, we acted as detectives and made some judgements about what could be a good enough match. We also took account of how Anne-Marie could get to where she wanted to go and any transport implications. Now we had names next to everything on Anne-Marie's perfect month. The next step was to create the rota from this.

CREATING A PERSONALISED ROTA FOR ANNE-MARIE

The rota in place was somewhat traditional with long-standing shift patterns that were either an early, late or a 9 - 4 pattern. Staff had become used to this system and the support was planned around these traditional shift patterns, resulting in people not always being supported to do what they wanted to do, or when.

Carolynn's challenge was to adjust the shift times to make sure that Anne-Marie had the right support when she needed it, together with support for the other five housemates. Once all of this had been checked out with Anne-Marie, Carolynn set about creating a new personalised rota version 1, and entered it onto the Dimensions Time Management System, with a version for Anne-Marie in a way that worked for her.

Crucially, Carolynn checked the rota with each of the supported people to ensure that their rota matched their new personalised aims and objectives. Each person was asked "Does this look like your perfect week?" before she launched it.

Carolynn admits that this was a "hairy moment of truth", especially because the team were blighted with 'flu in the first week! There is also a lot of work involved with planning weekly rotas, because by nature they change frequently to fit with people's new and more refined versions of their 'perfect week'. Ultimately though, the new personalised rotas worked excellently and staff felt as though they were delivering a better and more person-centred, attentive service. Anne-Marie and her housemates felt a new lease of independence and felt in control of their lives. Carolynn says that her team "are now at the point of seeing how much better life is for people they're supporting and it is that momentum that keeps them going".

SUPPORTING CAROLYNN AND THE STAFF TO MAKE THIS WORK

From the beginning we obviously knew that this pilot would mean a change for staff. The size of that change was becoming clear – it was a huge change. It meant a difference to who was in control – Anne-Marie – and a change to what staff did, when they did it and how. With such a big change for staff, support for Carolynn was crucial. We wanted to support Carolynn to think about how she could use supervisions and team meetings as ways to embed these changes and demonstrate the cultural change that this inevitably required, and track and respond to on-going learning. We organised training and support in person-centred supervision for Carolynn. For the whole team, we arranged training in 'positive and productive meetings', 'community connecting', and what it meant to work as a person-centred team.

"The size of that change was becoming clear - it was a huge change. It meant a difference to who was in control - Anne-Marie - and a change to what staff did, when they did it and how. With such a big change for staff, support for the manager was crucial."

1 Working towards being a person-centred team

Michelle (a trainer from HSA) worked with the team to clarify:

- the purpose of the team
- what was important to the team as a whole
- what was important to each individual in the team and
- what best support looked like.

The team then analysed how well they were doing in relation to these areas, prioritised what they needed to work on and developed an action plan. It was clear that differences of opinion within the team had contributed to some internal conflict. People

still weren't getting regular opportunities to come together because of the difficulty of coordinating whole-team meetings, so some team members' anxieties or assumptions were not being addressed. Michelle worked with the team to explore the issues and clarify practical next steps.

2 Changing supervision

Carolynn believed that staff had a historical perception of supervision being punitive and therefore a negative experience, regardless of how she had tried to approach it.

Staff saw supervision as a time to be 'told off', so there was a reluctance to attend and contribute. Carolynn said that sessions were often one-sided, with her setting the majority of the agenda. She made up for this by ensuring that lots of informal, unplanned support was given with an open-door type of philosophy. Because of this, there was a tendency for structured supervisions to be infrequent although informal guidance was available at any time.

The point of supervision of staff is to allow for time and space to focus on supporting them through the structural and ideological changes taking place and to focus on the outcomes for the individuals being supported. Staff needed to understand their role within the changes and the one-to-one time afforded by supervision should ensure opportunities to reflect on this. Michelle had an individual session with Carolynn to equip her with a person-centred process that she could follow which would help her to better support her staff team.¹⁴ They explored how the content of supervision should focus on:

- what we are learning about the people we support
- what we are learning about the team and
- how we are progressing towards the outcomes developed via the support planning and subsequent planning opportunities.

Carolynn said that she felt more confident to support people by using this supervision process as its structure really helped her to have more meaningful conversations with staff. Carolynn realises

¹⁴ Person-centred supervision www.helensandersonassociates.co.uk

now that before this process of change, her supervision of her staff and also those she supported was not always 100 per cent person-centred – despite aiming for it to be so. Originally staff meetings focused on policy and procedures because that was what staff were most concerned about. This support focused Carolynn's management style and made her feel her efforts were more productive and meaningful. As Carolynn put it: "This was the best training I have ever done! Being able to say to my staff: 'What do you want to get out of your supervision?'- and moving away from the negative associations of staff supervision, was great!"

"The manager believed that staff had a historical perception of supervision being punitive and therefore a negative experience. The training focused her management style and made her feel her efforts with her staff were more productive and meaningful."

3 Getting more from meetings

The team had a session with Michelle looking at how they spent their time together in meetings, following the model of Positive and Productive meetings.¹⁵ Prior to the training, meetings were infrequent and weren't particularly valued by team members. The manager held the majority of responsibility for related tasks. When meetings did happen they were unruly, with people talking over one another and veering off on various tangents. The training session aimed to highlight the value of meetings as an important way to focus on plans and outcomes and to show that, because of this, they needed to be robust in structure and happen frequently.

After the session, Michelle coached the staff using the principles they had learned in this meeting. This included introducing processes for ensuring that everyone was listened to, for example, using 'rounds' and 'timed talk', and sharing the responsibility for making meetings successful by allocating different roles to team members (for example time keeper, hospitality, recorder, agenda developer and ground rule coach).

¹⁵ See www.positiveproductivemeetings.com

Michelle commented on the profound changes this training had. "I noticed massive changes ... Staff members were keeping to the ground rules and holding each other to account. ...[Their] ownership and experience of what a successful meeting was like was a huge improvement and achievement. Previously, the team were not accustomed to meeting regularly, therefore when they did, they took the opportunity to say their piece ... and staying focused on the agreed agenda would be problematic. Stronger team members managed to have their say while quieter team members didn't get much chance to contribute.

When the team agreed their own ground rules and roles for their meetings, they initially approached this in a tongue-in-cheek fashion. However, when they started to implement their roles, they could see the benefit ... and started to take things more seriously. The most notable change was in the use of the 'thinking rounds'. ...The rounds leader did a really good job of ensuring that every person had an opportunity to speak. In particular, one young support worker said that the new structure made him feel empowered and able to voice his opinion."

"The training session on Positive and Productive meetings aimed to highlight their value as an important way to focus on plans and outcomes and to show that, because of this, they needed to be robust in structure and happen frequently."

4 Making connections with the community

We wanted to enable Anne-Marie to connect more with her community in a way that made sense to her. She wanted to go to coffee mornings and dancing and, at the time, needed support to do both. We wanted to work towards her developing reciprocal relationships so that, in time, she would not need staff to go with her. To achieve this meant that staff needed to see building links as their role. The same staff member also needed to support Anne-Marie as far as possible to go to the church and to dancing, to maximize the opportunities to spot and develop connections and friendships. This was a challenge for staff and the rota! We

50 Making it Personal for Everyone

had already addressed the consistency of who supported her and when, now we needed to think more about how we supported staff to see their role differently.

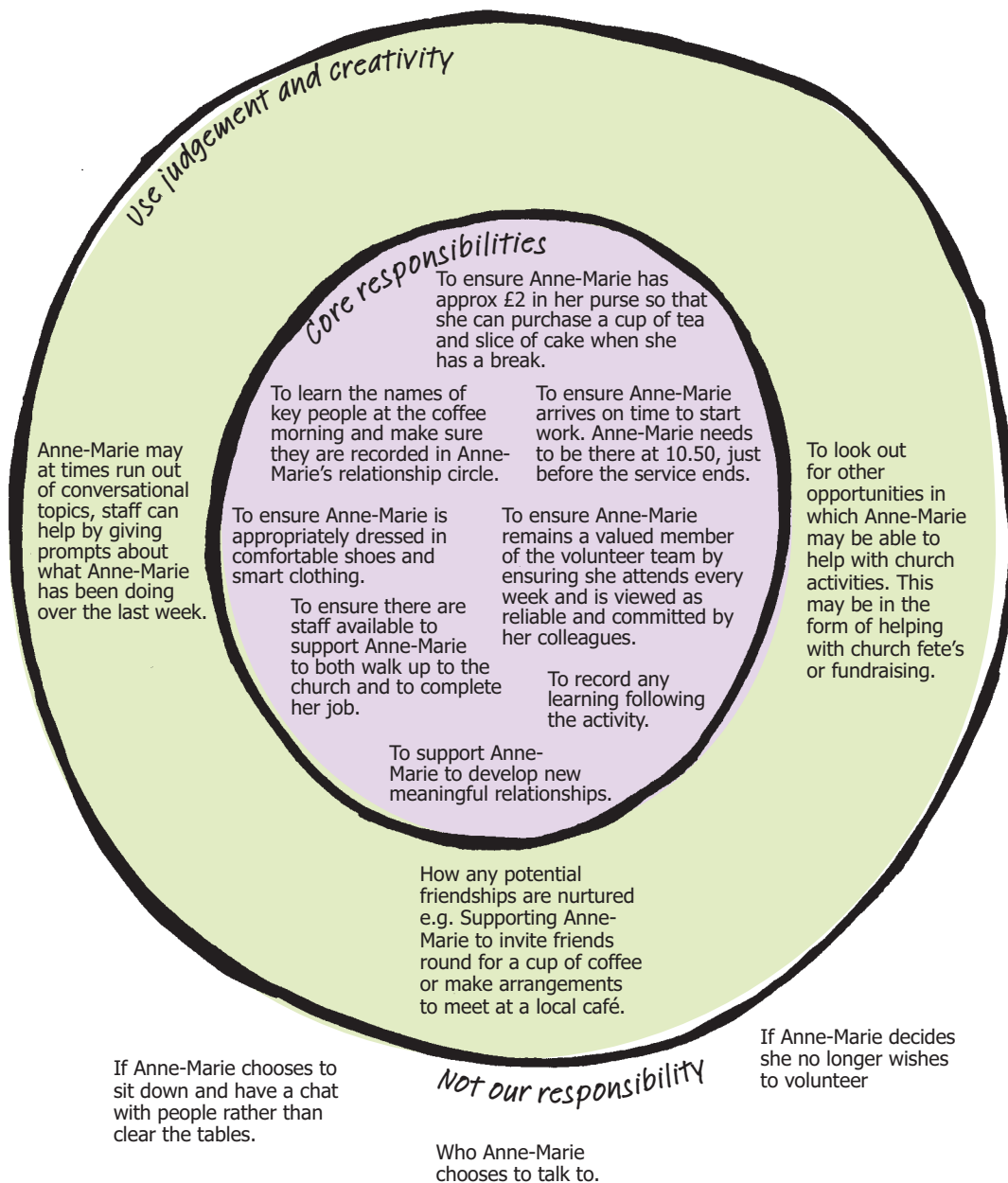
At the time staff were more accustomed to taking people out in the van together to watch sailing than thinking about the subtleties of making connections. We decided that we needed to provide more support for Carolynn and the team to think about their role and how to evolve it from solely providing direct support to including more of a coordinating and connecting role.

Through the training it became clear that some staff already saw their role as being there to take people out into the community as well as providing care. They had begun to think about this during the Planning Live sessions and the new training helped to shift this perspective further, as well as providing practical person-centred thinking tools like 'Presence to Contribution'¹⁶ to help them think about and plan how they could support Anne-Marie, and the others, to make connections.

We did a series of 'community activity doughnuts' as a way of clarifying roles and responsibilities for the new things that people were doing. We had explored how the staff had been matched to what Anne-Marie wanted to do but noted that it would be difficult for other team members to seamlessly pick up the support if the people allocated to Anne-Marie could not be there. The team developed 'doughnuts' to make it clear what their responsibilities were for community connecting and where they could use their creativity and judgement.

¹⁶ For more information about the Presence to Contribution tool see www.thinkandplan.com and www.helensandersonassociates.co.uk

Anne-Marie has a voluntary job at the local church coffee morning following the church service, she works between 11.00 and 12.30. Anne-Marie clears the tables and takes the biscuits round the tables. Anne-Marie is usually supported by Louisa however we have decided to do this doughnut chart so that Anne-Marie is well supported in Louisa's absence. Staff who support Anne-Marie need to have a chatty, friendly nature to ensure Anne-Marie is supported to build connections within her local community.



7 WHAT CHANGED FOR ANNE-MARIE?

Anne-Marie's support and life in the eight months since our pilot work shows clear signs of significant and positive changes for her. Not only is she doing more activities of her own choice, she is also beginning to realise some of her aspirations.

THE PERSON-CENTRED REVIEW

Towards the final part of our journey, we stood back together to see what outcomes had been achieved for Anne-Marie, what had worked and not worked, and what Anne Marie wanted for her future now. The person-centred review is the most structured way to approach this. We wanted to make sure that there was a strong focus on the outcomes and our accountability to Anne Marie on achieving these, and in how she was spending her money.

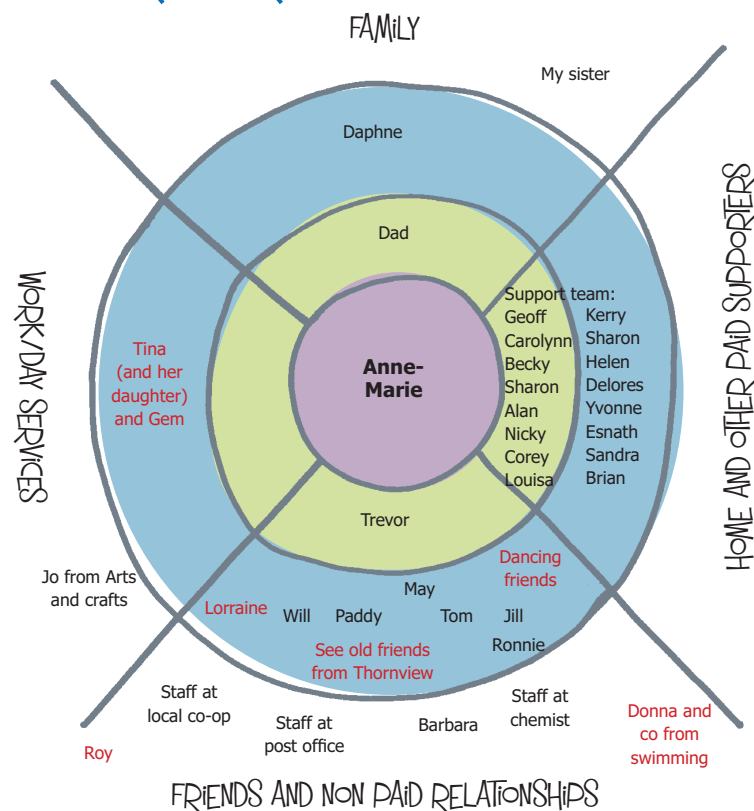
In a person-centred review, the person shares their own perspective, and then everyone adds their information (including family and friends). So, rather than sitting formally around a table, information is shared and built together around the key questions. But on the day that the review was organised, Anne Marie did not feel like spending time with people, and did not want the review to take place in the way that had been planned. Carolyn discussed this with her, and in the end, Anne Marie decided that she wanted to have a chat at the local café just with one person instead. It was very important that we reviewed the outcomes with Anne Marie, accounted to her about her money, and sought the perspectives of her family and others. It was also crucial that although Anne Marie had prepared for her meeting, that on the

day we completely respected her decision to achieve this in a different way. One of the important things we learnt in this journey was that we had to go at Anne-Marie's pace.

Through this process, we learnt what outcomes had been successful and less successful, and what had changed for her. We also found that Anne-Marie wanted to extend some of her outcomes or achieve them in different ways. For example, one of Anne-Marie's outcomes was to look good and wear make-up. Now that wearing make-up and having her nails painted is part of her daily and weekly routine, she wants to extend that to having her hair coloured every six weeks.

Here are some of the detailed changes that have taken place in Anne-Marie's life.

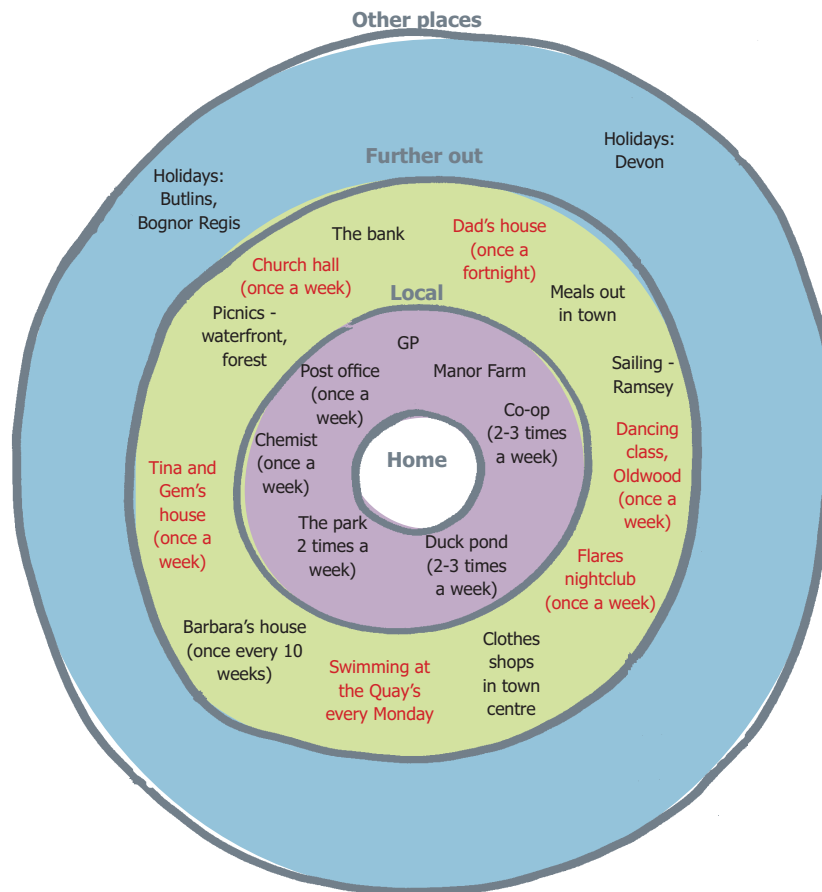
ANNE-MARIE'S RELATIONSHIPS



The Relationship Map (new relationships in red) shows that Anne-Marie gained four new relationships and re-established contact with old friends from the hospital where she used to live. These have been facilitated through some of Anne-Marie's new activities and by ensuring some of her occasional activities have become more regular. There is clear evidence that relationships are much more likely to be established through regular routines. If you visit the same shop on the same day at the same time, you are much more likely to meet the same people and the resultant familiarity often leads to interaction, the foundation for any relationship building.

"Anne-Marie gained four new relationships and re-established contact with old friends from the hospital where she used to live. These have been facilitated through some of Anne-Marie's new activities and by ensuring some of her occasional activities have become more regular."

ANNE-MARIE'S PLACES



The Places Map illustrates the new places that Anne-Marie visits in her local community. These range from her Dad's house where she is able to spend some quality time with her immediate family to local amenities where she has been able to broaden her social network.

NEW THINGS ANNE-MARIE IS DOING

	My typical week		
	Mornings 	Afternoons 	Evenings 
Mon	Swimming at the Quays	Doing puzzles, at home	Out for a walk, stop and have a drink at the pub
Tues	Out for a coffee	Walking Gem the dog!	Flares nightclub (once every 4 weeks)
Wed	Dance classes	Out for a walk	See Dad
Thurs	Catch up at home, do housework, cups of tea	Clothes shopping, make a day of being out and about	If sunny, I go out for a nice stroll
Fri	Coffee morning at church	Stay in, do housework, play board games, make Dad a card	Relax at home Games night/popcorn...
Sat	Arts and crafts at home	Have nails done	Take away
Sun	Work at church	At home and plan my week	Relax at home

In addition to doing the new activities that have helped Anne-Marie gain new roles, she has also broadened and consolidated other activities that she had previously done in an ad hoc way.

Anne-Marie has more contact with her Dad and now phones him on a planned basis once a week and sees him once a fortnight.

Anne-Marie has paid work, walking someone's dog once a week. This option was developed as a way of not only helping Anne-Marie seek meaningful paid employment, but also to help her gain a better understanding of keeping a dog - something she has expressed a wish to have. Anne-Marie has told us she likes to walk the dog, Gem, and is going to buy new clothes with the money she has earned.

Her regular activities include two which are quite active – dance classes and swimming sessions and a monthly night out at a local disco for people with a disability. Anne-Marie voluntarily helps out at the local church coffee morning and helps collect the cups and clears the tables once a week. Currently she is still being supported to do this, albeit at a distance with a view to withdrawing support in the near future.

“Anne-Marie now has paid work, walking someone’s dog once a week. This option was developed as a way of not only helping Anne-Marie seek meaningful paid employment, but also to help her gain a better understanding of keeping a dog.”

REFLECTIONS ON THE SUCCESS CRITERIA

At the outset of this journey we identified 12 success criteria, five of which related directly to Anne-Marie. It is clear that significant progress has been made in all of these.

Anne-Marie’s service is much more personalised

Anne-Marie’s support plan looks very different and is based on what is important to her, and on her skills and gifts. She has chosen a small team of support workers who are working with her towards her personal aims and who support her with the things she has chosen to do. She is more involved in the planning of her life including such issues as when she sees her Dad, where she goes and how she travels.

The team discuss Anne-Marie separately from others, not caught up in one general conversation about ‘the people we support’. The team are beginning to use thinking tools that keep them focused on Anne-Marie.

Anne-Marie’s chosen support is not negatively affected by the people she lives with

Anne-Marie’s support is better organised and planned activities always happen unless she decides otherwise.

Anne-Marie gets on with the people she lives with; often she will change her mind about what she wants to do in order to spend more time with them - renting a DVD to watch together for example.

It is notable that Anne-Marie is still getting used to the changing pattern of support, as are the others she lives with. It perhaps feels more organised with fewer decisions each morning about what to do with the day.

Anne-Marie is closer to her dreams and aspirations

Anne-Marie's one-year desired outcomes were all about the things she loves and aspires to: being with her Dad, joining groups and socialising, and working. These are all things she made progress with over the last eight months.

Anne-Marie is taking more positive risks and doing what she wants

Anne-Marie has taken her first step into employment through dog walking. She takes part in inclusive groups where she is welcomed based on who she is and not on her disability. She exercises more choice over when she sees her Dad and has a much stronger sense of control than before.

Anne-Marie's family understands and supports the change

Anne-Marie's Dad and partner were heavily involved in the Planning Live work and this helped increase the contact between the staff team and the family. This relationship is steadily and sensitively building.

8 WHAT DID WE LEARN? AND WHERE NEXT?

Our pilot exercise at Old Street was a rich learning experience for everyone involved. This chapter summarises what staff at all levels learned - from senior managers to support workers - and how this will shape the roll-out to other services across the country. And it highlights the value of both person-centred thinking and independent challenge to long-held assumptions.

HOW TO MAKE A START?

For anyone embarking on personalising services within the residential care sector, the challenge can seem utterly daunting. We have learned that the priority is to change the way people think.

1 Person-centred thinking - making this a 'habit' within the team

Carolynn, the Old Street manager, is extremely clear about what she has learned and what advice she would give other people who want to ensure that Individual Service Funds are successful. She gave us her four top lessons (we come back to the others in the next section), the first two being:

- the manager and the team should be familiar with and should be using person-centred thinking tools and
- all staff should attend all relevant training prior to implementation.

Dimensions had been introducing person-centred thinking tools into the organisation for two years prior to the pilot, for different areas of work and management. Carolyn and the project team could see that these tools must be used in day-to-day work and in the management of the support staff team. When we started, Carolyn had been on a person-centred reviews course, but person-centred thinking tools were not embedded in the working practices at Old Street and many of the staff were unfamiliar with them. Planning Live was a huge learning curve for the staff, who were new to the person-centred thinking tools. The waking night staff who were not able to attend felt even further behind and therefore disconnected to what was happening.

So, when the staff team were asked to do their own one-page profile, they struggled and the quality of the information was insufficient to get a real understanding of them. We had to ask people to revise the profiles and put in more detail. Staff were unsure what to write down and were perhaps a bit suspicious about why we were asking them to do this. Why did we suddenly want to know more about their lives?

"I don't think that we appreciated quite how important an activity the one-page profile really was. In the future, I think that it needs to be stressed to staff exactly what one-page profiles are, rather than ask them to do one and then explain." Becky (support worker)

The project team developed the following to address this:

- written information explaining why we ask people to develop their own one-page profiles and how they will be used to match them to people who use the service and in supervision and appraisal to ensure staff get the support they need (see Appendix 2)
- a page of 'top tips' in developing a one-page profile. This clearly explains each heading and the amount of detail needed (see Appendix 3)

- sample one-page profiles, available on the intranet. We asked each of the senior leadership team to do to their own one-page profile, using the top tips (you can see an example of Steve Scown's one-page profile on the Dimensions website¹⁷).

We knew from Carolyn that we needed to ensure that managers had not just attended a course on person-centred thinking but were 'fluent' in using the tools themselves, and in coaching and supporting their team to use them. Jackie Fletcher, part of the leadership team, worked with Helen Sanderson and three other providers and commissioners on a second Progress for Providers.¹⁸ This new tool is for managers to self-assess their own level of knowledge and skills in the use of person-centred thinking and approaches; how they are supporting their team to use them; and how they are doing in creating a person-centred team and culture at work (this tool is included as Appendix 4). Carolyn tested this tool for us and it proved an excellent way to identify what support or training managers may need, as well as providing a baseline assessment of managerial competence in person-centred practices. In Dimensions we will embed this within our management performance expectations and use it to target training and support resources. The lesson for us is that everyone needs to understand and be able to apply the range of person-centred practices. We know now that we need to see, and expect, a level of competence in our managers before we can fully implement Individual Service Funds and see these really making a difference to people's lives.

"We needed to ensure that managers had not just attended a course on person-centred thinking but were 'fluent' in using the tools themselves, and in coaching and supporting their team to use them."

¹⁷ www.dimensions-uk.org/management

¹⁸ The first Progress for Providers can be seen at www.progressforproviders.org/ Dimensions' score against this tool is shown as Appendix 1 in Making it Personal: a provider's journey from tradition to transformation by Steve Scown and Helen Sanderson. Dimensions and HSA Press, 2010. Download it from: www.dimensions-uk.org/publications

2 The importance of independent challenge in the planning process

One of the reasons why Planning Live was successful was the degree of challenge from the two independent facilitators. You could call this being with 'critical friends', but this is vital to really understand what matters to people and thinking through what the future could hold, by gently but firmly stripping back assumptions and sometimes 'asking the obvious'.

Michelle, the lead facilitator, was introduced to 'Mandy' on Planning Live, who lives with Anne-Marie. Michelle asked her what she preferred to be called. She clearly said, 'Amanda'. The staff member who was supporting her was shocked and surprised, and said that everyone calls her 'Mandy'. As neither facilitator had worked directly with the team, it made it easier to explore why someone 'always had their support provided that way' and why 'we would never be able to do that' and how we knew that 'that was the way he wanted it'.

Another example of the importance of fresh eyes was the issue of waking nights in the household. Josephine was said to require waking night support. When, as part of Planning Live, the group looked at what was working and not working for Josephine, she said that she disliked being woken up in the night by staff. During weekends with her parents, she was not checked up on at night. This suggested that Josephine was either being over-supported (not needing waking nights in Old Street) or under-supported (needing but not getting night support at home). The facilitators worked with the team to look at this and the result was to invite an occupational therapist to assess Josephine, explore her need for support at night and see what was possible with assistive technology.

As well as challenge, the facilitator needs to be able to help people think creatively about problems. One person we support, Jim, said that what was not working for him was not speaking to his brother enough. His brother lives in America and calls are costly. One of the outcomes of Planning Live was to use Jim's budget to buy a computer and to use Skype to call his brother, as this is free.

It also means that he can see his brother on the screen, which increases the sense of connection.

The job description for the facilitator role in Planning Live would include:

- being independent from the service provided (working for the organisation is fine, but not directly part of that service)
- strong values that align with the organisation's vision, mission and values
- excellent facilitation skills and being able to gently but firmly challenge assumptions
- great knowledge of national best practice
- excellent knowledge and practical experience of person-centred thinking
- creativity and tenacity - keeping going until solutions are found that work for everyone.

Training and supporting many teams means building the capacity of facilitators who meet these requirements to ensure the roll-out of Planning Live. Without this, the planning process could easily turn into 'business as usual'.

"One of the reasons why Planning Live was successful was the degree of challenge from the two independent facilitators. It was easier for them to explore why someone 'always had their support provided that way' and why 'we would never be able to do that' and how we knew that 'that was the way he wanted it'."

3 Focus on relationships and contribution, not just activities

It would be easy for the Planning Live process to be diluted to simply 'activity planning'. Making sure that Anne-Marie's life, and therefore week, reflected what mattered to her, meant

considering her relationships and contributions. Thinking about an individual's roles, gifts and contributions is crucial in this approach to Individual Service Funds. This is what makes it different from typical rota planning around someone's interests. In putting the 'perfect week' together, and then the rota to support this, we are asking:

- what are the important relationships in her life? How can we support these during the week/month? Who would be the best person to do this?
- what are the opportunities to make further relationships? How can we make this happen? Where, when and who is best to provide support?
- what are her gifts and contributions? Where could these be used and valued in the community? How could we explore this? When, where and who is the best to provide support?

Anne-Marie got a Christmas card from her sister as a result of our focus on relationships - the first time in seven years. This is so much more meaningful than considering what activities someone wants to do. Thinking about someone's potential contribution includes careful discussion about paid work and making sure that people we support have opportunities and an expectation to work. We talk more about this in the next chapter.

"Fostering relationships is so much more meaningful than considering what activities someone wants to do."

WHAT THIS MEANS FOR SUPPORT STAFF

Personalising services for people living in traditional services means that staff need to learn new skills and new ways of seeing their role.

1 Thinking differently about power and accountability

The changes we were making were fundamentally about power and accountability, not a new way to fill people's weeks – they were about shifting the power into the hands of the people we

support and trying to eradicate institutional practices. Change can be more effective when the people we support are enabled to be drivers in the change process and not simply passengers. The key is that such change is more likely to become accepted and embedded when Anne-Marie says it needs to change than when the CEO says so!

Putting Anne-Marie in the driving seat of her service naturally meant a significant change for staff. For some it was easier to accept Anne-Marie choosing what she wanted to do every day than choosing who she wanted to support her. This marked a shift in accountability within the team. The following account from Carolyn illustrates this point very well.

"The facilitator was delighted when I told her that a staff member who had been 'coasting' had been identified through this process as none of the people using the service had chosen her. It is immensely frustrating for staff to see colleagues 'getting away with' poor attitude and performance. She was excited that this process may be a way of doing this if people who use services were supported well to choose their staff. The staff member that no one chose is now only doing background 'core' hours. Of course it was pointed out that if 'I don't like that person and have not chosen them to support me in my activities, it's not great that they would still be supporting me in personal care.'"

This story has a happy ending. Carolyn worked with this staff member to develop her 'offer'. At the end of the project, she had made such efforts to improve her work that she was regularly being chosen by some people as their preferred supporter for some activities. Under-performing staff can change if they are challenged and supported.

"One benefit of enabling people to choose their support staff is that it can help to identify under-performing staff. When none of the people in Old Street chose one member of staff to support them, the manager successfully worked with her to improve her 'offer'."

2 A different purpose - focus on relationships

The process of moving to Individual Service Funds required staff to see their role differently, as they now had a different purpose. Rather than providing care, activities and taking people out and about, their new role took them from community escort to community connector. The doughnut (see page 52) that staff did together expresses how they now saw their new core responsibilities.

3 New skills - community connecting

This new role requires different skills and to support this we trained staff in how to provide sensitive support that could create, support or maximize opportunities for connections and making contributions. For Carolynn, this was some of the most powerful training:

"The community building training has made the biggest impact on all that has been achieved at Old Street. The staff benefited enormously from the training and I feel the results speak for themselves when it comes to looking at people's relationship maps before and after. The team got a true grasp of what we were looking to achieve for the people we support."

4 Providing a greater degree of flexibility - a new style of rota

When we started this process, the people who lived at Old Street would often settle down to watch Eastenders together with the three staff and would then go to bed early. As a consequence fewer staff were on rota in the evenings. This changed radically with the new rota, which required staff to support those people with evening activities they had chosen (such as Anne-Marie's disco nights). For some staff the different times and flexibility required for the new rota was very difficult.

5 Bringing the 'whole person' to work - sharing hobbies and interests

Asking staff to develop their own one-page profiles and to include their hobbies and interests marks a change in the 'psychological contract' between staff and the people they support. From seeing

them as 'workers' it shifts the focus to wanting to know and understand the 'whole person' and consider together where there are opportunities to share and use their interests and passions.

WHAT THIS MEANS FOR FRONT-LINE MANAGERS

This is best summed up by Carolyn, whose other top tips are:

- 'positive and productive' team meetings must happen on a regular basis
- person-centred supervision must take place on a regular basis.

This journey emphasised how vital it was to support staff to make and embed these changes, to think together, problem solve and celebrate successes through supervision and team meetings. When supervision and meetings were ad hoc and infrequent there was a significant price to pay. It sent a message to staff that they were not being invested in as individuals, reinforced the idea that supervision was punitive, and encouraged a crisis culture to develop.

Using person-centred thinking tools within the management role helped to establish a different, person-centred way of working, for example, using the doughnut to clarify responsibilities (see page 52). Fundamentally, there needs to be an alignment of values and practices in the way that both staff and people we support are listened to and supported. We learned that one of the key roles of managers in this process is to make person-centred thinking and practices a habit within the team - an established part of the culture that enables people who receive support to have choice and control in their lives.

The process also shifts the manager's accountability to the individuals supported, not just the senior management. Carolyn needed to routinely check how things were working out for the people at Old Street, whether they were spending their time (and money) in the ways that worked for them, whether staff were

supporting them as agreed and whether that worked for the person, and what else they wanted to try or do. Part of a person-centred approach to supervision is for the manager to start with feedback from the individuals supported.

“Making person-centred thinking and practices a habit within the team shifts the manager’s accountability to the individuals supported, not just the senior management.”

WHAT THIS MEANS FOR SENIOR MANAGERS

As we have found and described in this book, unpicking something which has been around for some time is no easy thing. Everyone involved will experience difficulty, uncertainty and even discomfort as they try to come to terms with the change involved. Fundamentally we have challenged our way of thinking about the way we approach our job. Several of our colleagues described the nature and extent of the adjustments we had to make as ‘scary’.

Our first responsibility when we embarked on this pilot was to be mindful of its impact on the people we support, their families, the staff and those who commission our services. Our approach had to acknowledge and accommodate many areas of anxiety.

The people we support often found the experience disorienting, especially at the outset. Being told that you really can control the resources at your disposal was a daunting prospect for someone who had never enjoyed that freedom. And even where people did embrace the principle, it could face them with some difficult choices. Do you really want a job if your income goes down? Do you want to move away from a group of people with whom you have lived for many years?

For families who, in earlier years, struggled against the odds to establish an acceptable level of service, the proposed changes could seem threatening and destabilising. There was a suspicion, in the current economic climate, that the basic reason for making these changes was simply to save money.

Staff members found that long-established routines and work patterns were overturned. The things people wanted from them - support late at night, for example - affected what they hitherto regarded as their personal space. There was also the potential embarrassment of finding oneself 'unwanted' when people expressed preferences about who should support them.

There were potentially major difficulties, too, for local authorities and their staff. In many areas, personalisation seems not to be thriving in the chilly economic climate. Does the notion of allocating a nominal Individual Service Fund suggest that the service provider is going beyond its remit? And there are fundamental issues of control: if everyone living in a shared service decides to take real decisions in relation to the available resources, will the existing system of commissioning services unravel dangerously?

"The first responsibility of senior managers is to be mindful of the impact of change on the people supported, their families, the staff and those who commission our services. The approach has to acknowledge and accommodate many areas of anxiety."

WHERE NEXT?

The new challenge is to extend our learning from the first two journeys to our services across most of England and South Wales. These services have very different origins and provide for a group of people with a diverse range of needs, very few of whom have individual budgets, who live together under the same roof and share the support they receive. We are determined to ensure they have as much control and choice over their lives as possible. This journey highlights that, for some people, 'possible' can be a lot more than they currently have. And so despite the discomfort, difficulty and uncertainty we shall continue to strive to find ways of resolving the contradictions and overcome the obstacles. We shall, however, have to allow for the possibility that we may not be able to do so to everyone's satisfaction. In any event,

communicating clearly and appropriately is a major prerequisite of the implementation phase. If these changes are to be installed in hundreds of locations we shall need to proceed with great determination, mindful of those lessons we have already learned and the pace of change that we can realistically introduce.

- **Preparing the ground:** if our staff members do not understand how to use person-centred thinking tools or the principles of person-centred reviews, there is no basis for moving forward. They will have difficulty assessing progress or achievement, let alone conveying it to people we support or their families.
- **'Technical' issues:** fair allocation of both financial resource and of the available hours is a tricky business. We found a model that worked for Old Street, but cannot be sure that it will be equally effective for all the services we would like to include in the programme. Families and care managers will want to assure themselves that the resource is being divided up equitably and that may require some level of local flexibility. Either way, 'buy-in' from those two groups is absolutely essential to the success of the project.
- **Circles of support:** not everyone has a ready-made circle of support. For the project to succeed, we shall need to find ways to harness recent learning within the sector. To achieve the fairness mentioned above, everyone must have proper personal support which goes beyond their complement of paid staff.
- **Community connecting:** this element is closely connected to the one immediately above. Unless our ability to help people make real connections gets smarter, we shall not succeed.
- **'Just enough support':** we must think differently about how we support people and make sure we do not over-support. The use of assistive technology, being clear about the role of paid staff, the importance of helping people into employment, linking people into natural and inclusive networks within their local community will become increasingly important components of our traditional services.

This is a huge agenda. If we really mean it, we have to make it just about the single most important area of change in our organisational life. So what are the next steps? Well, simply issuing the command to roll things out simultaneously across the whole country would probably produce very patchy results. Nor is it enough to have a small number of 'flagship' services while everyone else carries on doing what they have always done.

The project group that has discussed and monitored all the changes we have made to systems, processes and people's daily activities, has become an Implementation Project Group, tasked with creating a plan and deadlines. They are developing a carefully phased plan, based on getting the key ingredients right and learning from our experience to date. The plan will focus on both breadth and depth of learning and preparation. In terms of breadth, it is our intention to ensure that the basic tools for the work (person-centred thinking tools and support plans) are thoroughly understood everywhere. We shall work more deeply in selected areas in different parts of the country. The project will be overseen by a central group which includes senior managers from each of the areas. In each case, the programme will include up to ten services from the area in question. On a regional level, the participating services will all be involved in an implementation group. Their managers will be part of externally-facilitated local action learning sets. We shall measure progress using person-centred review tools. Once those areas accommodate to the changes we will roll out the programme nationally. And we shall continue to learn...

"We must think differently about how we support people and make sure we do not over-support. The use of assistive technology, being clear about the role of paid staff, the importance of helping people into employment, linking people into natural and inclusive networks within their local community will become increasingly important components of our traditional services."

9 | OUR TOP TIPS FOR THOSE TAKING A SIMILAR JOURNEY

FINANCE

We began by trying to work out a method of financial allocation that we felt would make sense to everyone. This changed in the light of our experience and the concerns of the purchaser about ending up with different levels of service for the people who lived in Old Street (not the real name of the establishment). However, the process of working through the details and developing answers to the questions and challenges we expected proved to be really beneficial.

Delays in resolving the allocation of funding caused the biggest headache as it proved almost impossible to have meaningful discussions with the people who lived in Old Street and their circles of support without that vital information.

Top tip: Develop your own views as to how you would allocate a budget, what should constitute core services and what people can have under their own personal control.

Top tip: Agree the Individual Service Funds before tackling any other issues.

Our toughest challenge was not the detailed working out of the allocation, it was changing the generally-held expectation that

everyone in a service should receive the same level of support. By their very definition individual budgets are personal and everyone does not get the same money, consequently they will get different levels of support. This concept is hard to accept for people who have been used to experiencing, providing and commissioning equal levels of support.

Top tip: Provide people with clear information about the principles of personalisation, individual budgets and Individual Service Funds at the outset.

The challenge gets tougher when you consider the limitations your contract places on your flexibility and the financial environment we are all currently working under. We had to recognise the local authority's position on cost savings and the inevitability of reducing our budget as we undertook this change programme.

Top tip: Engage with the purchaser as early as possible to establish their expectations and agree some basic shared ground rules about cost and allocation.

HUMAN RESOURCES

This element of the journey, as expected, gave us tougher challenges than our work with a person looking for their own service. We were working with staff who were part of an established team, who had been employed by us for many years, and who had developed a way of working that was based upon supporting people in a group, not six individuals living together.

There are major human resource implications when people choose their own staff and when we are more explicit about the importance of relationships for the people we support. The staff team realised that if they weren't chosen by the people they were supporting, there could be implications for their continuing employment.

However the project also highlighted how frustrating it is for staff to see colleagues 'getting away with' poor attitude and

performance. The example described on page 66 of someone who was not chosen to work with any of the people we support on specific activities, led us to recognise our duty to help people develop their own 'offer' so they can find a role that is seen as valuable by the people they are supporting. For those who cannot develop a wanted 'offer', there needs to be a robust and legal approach to help them move on.

Top tip: Develop your organisational response to dealing with a member of staff whom nobody wants to support them.

Top tip: Help your staff understand they must have their own personal offer for the people they are supporting. If they haven't got one, help them to develop one.

ROTA PLANNING

If the people we support are to find their place in life and have the best opportunities to connect with others, they need to pursue regular activities of their own choice. If the 'right' staff consistently support them we can figure out how best to enable them to increase their engagement and involvement with their local community. To help this become a reality in a traditional service requires an approach to matching staff to people and rota planning that places the person being supported at the centre of the process.

During the last two years we have developed a software system (Dimensions Time Management System or DTMS) for our managers to use in planning their rotas. It offers significant benefits in simplifying many process including recruitment, payroll, invoicing, workforce planning and performance management. While we have great expectations for the efficiencies it will help us achieve, it has now also proved itself as a valuable resource in strengthening our work to become more person-centred.

It works like this. Information about who can best support people for specific activities can be easily built into rotas and diaries by using the DTMS: enter an activity, a time, and a fit and able person for the job! Put more simply it ensures managers take account of what someone wants to do, when it is best to take place and who is best to support the person to do it.

Top tip: Develop an approach to rota planning that puts the people you are supporting at the centre. Use the Matching Tool¹⁹ to match the right staff member for each activity - and make sure this support happens consistently.

FOUNDATION SKILLS FOR STAFF

The journey for the manager and team was much steeper than it needed to be because person-centred thinking was not day-to-day practice within the team. Initially they lacked understanding of person-centred thinking tools so that, for instance, they could not write satisfactory one-page profiles that we could use for matching staff to people. Developing some guidance on one-page profiles proved very helpful (see Appendices 2 and 3), as did the sample profiles (see Dimensions' website for examples).

The concept of 'just enough support' proved to be quite difficult and the use of the 'Gifts and contributions' person-centred thinking tool proved to be very helpful. It helped the team think about their role in connecting people to their community and offering 'just enough support'.

Another key skill for the manager and staff was turning their somewhat unfocused meetings into 'positive and productive' meetings where they could focus on further developing a person-centred service.

¹⁹ See www.thinkandplan.com and www.helensandersonassociates.co.uk

Top tip: The manager and the team should be familiar with person-centred thinking tools and should work towards becoming 'fluent' in them. Managers can use Progress for Providers to self-assess their level of competence and what support they need to improve (see Appendix 4).

Top tip: Positive and productive meetings must be held on a regular basis.

We were in the early stages of rolling out a tool called Person-Centred Performance Management which is designed to help managers include the views of people we support in the supervision and appraisal of their support staff. Carolyn, the manager at Old Street, had only just started to use this with her team. We provided some additional support to use Progress for Providers and Carolyn found this useful in helping the staff adjust to their new roles and giving them feedback.

Top tip: Person-centred supervision must be used on a regular basis. Having the feedback of people being supported as an explicit component of individual staff supervision and appraisal is very beneficial.

ON-GOING SUPPORT

As we all know, leading change is tough and challenging. Yet despite this understanding we under-estimated the level of support, independent challenge and coaching that would be required. During this journey we were undergoing significant organisational change internally and this resulted in inconsistent levels of local support. Without doubt this made it more difficult for Carolyn and the team to overcome the barriers and obstacles.

During our journey it became evident that Carolyn was a very good manager. Indeed without her leadership and determination,

many of the improvements we have observed in Anne-Marie's life would not have happened. But even with her skills and commitment Carolynn needed on-going support from her line manager as well as from the project group throughout this pilot. So looking ahead, we have a much clearer understanding of the scale of the challenge and the implications if we are to support the degree of change required.

Top tip: Be prepared to provide higher levels of support, training, independent challenge and coaching than you think necessary.

Top tip: Don't under-estimate the impact of broader organisational change upon local services and their attempts to improve how they provide support.

EMPLOYMENT FOR THE PEOPLE WE SUPPORT

This journey helped us to consider fully our position on helping the people we support to gain paid work and the potential contribution social enterprises can make. We had recently developed a separate part of the organisation to develop employment opportunities for people with learning disabilities and autism, but had focused this on new people coming in to our services. Our work with Anne-Marie and the other people at Old Street made us consider whether we should continue with our previous passive approach, 'only if they express an interest', or whether we should more positively encourage and support people into some kind of work activity, preferably paid.

Our thinking was enhanced by gaining a better understanding of Getting a Life²⁰ which led to the clear conclusion that organisations like Dimensions should be positive and proactive about paid work -

²⁰ The Getting a Life programme ran from April 2008 to the end of March 2011, as part of the Valuing People Now employment work. See www.dh.gov.uk/en/SocialCare/Learningdisabilities/Valuingpeoplenow/DH_119017

because if we're not, the people we support will never benefit from this opportunity and the advantages it confers.

Top tip: Develop your understanding of your position on paid work for the people you support and if it is 'passive' explore why it is so.

DEALING WITH 'HOME TRUTHS'

As you'd expect when putting services under a microscope and looking at day-to-day practice in great detail, you find things that are not unacceptable, but which could be much better. We anticipated this and made significant efforts to reassure Carolyn and the team that this would be part of our journey together and our joint learning. However, again not unexpectedly, such reassurance doesn't remove all the concerns someone might feel when exposed to such levels of scrutiny. Carolyn recalls that she often found the experience to be "an extremely uncomfortable process". Along the way we became aware of some practices that we considered to be dated and not person-centred, and frustrated at the non-adoption by some team members of new systems and processes. To an extent we all found some 'home truths' uncomfortable.

Top tip: Recognise and feel comfortable with accepting you will discover some things that must change.

Top tip: Approach these issues openly and resist the temptation to accord blame and fault. You'll learn much more and achieve positive change more quickly by clarifying your expectations and engaging in honest and open dialogue.

SUCCESS CRITERIA

At the outset of this journey we identified five criteria which we felt would enable us to reflect upon our broader learning and our

intention to offer Individual Service Funds to everyone we support in our traditional services. Of these we've concluded that in three areas - basing our learning upon the journey of Anne-Marie and the team at Old Street; everyone who needs to know about the project does; and having an evidence-based transferable model - we have made significant progress. Indeed there is now a real desire to get on with the roll-out across all of our services and our learning will enable us to progress from pilot to project - a key milestone in our broader organisational journey.

In two other areas - everyone in Anne-Marie's life is working together for her; everyone we employ is positive and clear about their roles - we have made tangible strides forward, but there is still room for further progress. This last conclusion may appear downbeat. In reality we don't feel downbeat because if everything had been achieved, it would have indicated our aspiration hadn't been bold enough. The one thing that really matters is whether Anne-Marie and the people we support at Old Street are closer to having the life they choose - and after the eight months of the pilot there is no doubt that they are. And that is reason enough to be upbeat and positive about moving forward.

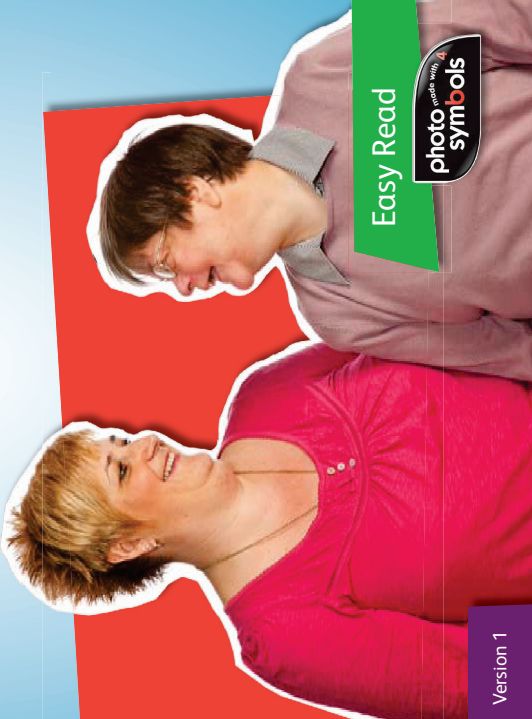
Top tip: Establish your criteria for success at the outset, based on what you want to achieve for the people you support and for your organisation.

Top tip: Be realistic about your progress and achievements. Major change to working practices takes courage, determination - and time.



Dimensions
there for the people we support

Individual Service Fund Agreement





Easy Read

Version 1



About this agreement



This agreement says how we will spend your money on your support.



Individual Service Funds are one way of managing your personal budget.



This agreement has some difficult words in it. We explain what these words mean, but you can ask a member of staff if you are still not sure.



This agreement says what we must do.



We are Dimensions the organisation that supports you.

Appendix 1 Individual Service Fund Agreement

3	4
 This agreement is made between:- Please write your name and address in here _____ _____ _____ _____  and Dimensions (UK) Ltd  Please ask the person who pays for your service to write their name here _____  Date _____  Dimensions manager Please ask the manager responsible for your service to write their name here _____  Date _____ If you have any questions about this document please email dimensions.standards@dimensions-uk.org	 What we will do  With an Individual Service Fund we look after your money.  You choose when and how we support you.  We will only spend your money as we have agreed with you in your Support Agreement.  Your Support Agreement says how you want to be supported.  There is information about how much things cost and exactly what you pay for in the rest of this booklet.

5	6
How much things cost  Hotel and management costs  This is the money you pay to us to live in your house and to look after your house. It is nothing to do with hotels!  Your hotel and management costs might pay for things like fixing the roof in your house or painting the walls. Your hotel and management costs are: Please write how much	Core costs  Core costs is the money you pay for staff.  Sometimes these costs are shared with the other people you live with.  This money pays for your support with personal care needs and keeping you safe and healthy. Your core costs might pay for things like helping with your medication and supporting you to eat healthily. This is what your core costs are Please write how much

7	 Individual costs Individual costs is the money you pay for the things that you choose to do.  This might pay for things like going out and meeting people in your local community or support with things you are interested in like photography or painting.  You do not share these costs with other people.  This is what your individual costs are Please write how much 
8	 If you want to end this agreement If you do not want Dimensions to organise your support you must tell us _____ before you want to end this agreement. Please write how long  If we want to stop organising your support we must also wait _____ before we end this agreement. Please write how long  We will carry on supporting you until you find someone else to support you.  You will need to carry on paying us while you find someone.  We will help the new organisation that supports you with your move.  Jackie Fletcher Dimensions Easy Info June 2011

One-page profiles - guidance for all Dimensions employees

Quite simply a one-page profile tells us about you as a person. It tells people what others like and admire about you; what is important to you and how to support you well.

We all work as part of a team. This may be a number of people working closely together, or a number of people who are dispersed around a number of locations, often working alone or regularly with different people. Each team of people may come together for different purposes and have different agendas but each team will be made up of a number of unique people. Each of us have gifts and talents; each will have things that are very important to us and will have unique support requirements. One-page profiles help us to share this information with our managers and team colleagues so that we can get to know each other better and support each other well.

Completing a one-page profile can be something you do on your own but often it is best to ask others to contribute. It can be completed with your manager, with other team members, people you support, your family and/or friends. We have designed our induction training programme for new staff to include an opportunity to start on their one-page profile.

Each section should be completed following the Dimensions Top Tips and using the Dimensions template.

One-page profile	What this section is	What this section is not
What people like and admire about me.....	What are your gifts and talents? What do others value about you? What are the positive contributions that you make?	A list of accomplishments or awards – instead it is a summary of your positive characteristics.
What is important to me.....	This tells people in your own words what is really important to you, what your hobbies and interests are, who is important to you and what makes a 'good' day for you.	Simply a list of things you like – instead it is a summary of what really matters to you.
How best to support me.....	What do others need to know to make sure you get the best support possible?	A list of very general hints – instead it is the specific information that would be useful for other people to know about to make sure you feel supported.

How will we use this information?

A one-page profile is not just another paper exercise but a way of getting to know more about each other. We want to know each other well enough to be able to work together as an effective team, whatever our roles are.

We will use one-page profiles in many different ways. Some of these are listed below:-

- In recruitment, so we can best match people and teams. This could be for their gifts and talents, their interests or the role they may play in the team.
- In supervision and appraisals to make sure you are being supported in the way you want to be and to make sure your manager knows what is important to you and what others think of you. Your manager will ask you what is working and not working about the support you receive (as described in your one-page profile) and what needs to change for you to feel well supported in your role.
- With teams and in team meetings to make sure we all know each other really well and know what we need to know or do to support each other well.
- To inform person-centred team plans so we all know what our roles are and how to get the best from each other.
- In the development and support of project teams and specific project work.
- To be able to match staff well to the people we support.

For operational support staff it's important to share relevant personal interests and hobbies, to get the best match between what is important to the people you support and the person providing the support. Putting something on your profile does not automatically mean you will be asked to do this, but it could inform conversations about how you could use your individual interests or hobbies in your work to support people. We will never use a one-page profile as a tool to judge people or to profile them in or out of specific roles and/or environments.

Each one-page profile will be different in content. A senior manager's one-page profile or a business support person's one-page profile may contain different information more relevant to the role they have in the organisation. The fundamental principles though remain the same.

The one-page profile has been introduced across Dimensions and is a recognised Dimensions standard. So, we expect everybody to have completed and have available, an up to date profile that has been reviewed with their line manager.

You can see different examples of one-page profiles on the Dimensions website.

Dimensions, One-page profile guidance, Jackie Fletcher/Helen Sanderson, June 2011

Appendix 2 One-page profiles: guidance for all Dimensions employees

Tips for developing your one-page profile

- Insert your photo here to make your one-page profile more personal.
- This is particularly helpful if you are sharing your profile with people before you meet them.
- Enter your name on top of the profile.

What people like and admire about me...

- This needs to be a proud list of your positive qualities, strengths and talents.
- Make it clear and avoid using words such as “usually” or “sometimes” – be positive.
- It is often helpful to ask colleagues, friends and family what they like and admire about you.
- Do as an exercise in a team meeting or use positive feedback from emails or supervision.

What's important to me...

- This section needs to have enough detail that someone who does not know you could understand what matters to you, and if you took the names off the profile you could still be identified.
- Add things about your whole life that is important to you (your hobbies, interests, passions), as well as things that relate to what's important at work.
- Add detail that will help in matching you to the people we support; giving people an idea of who you are and what you value most.

Instead of this	Write this
Solving problems	Trying to solve difficult problems - in my spare time, I like things like Sudoku and crosswords. At work, I relish finding the right wording for a letter or report, or getting the right angle on the way to present a tricky situation to others.
Having fun	Having fun at work – I enjoy harmless practical jokes and time to sit and relax with people over lunch or coffee.

How to support me well at work...

This section includes information on...

- What is helpful? What is not?
- What others can do to make work time more productive and positive?
- Specific areas of development you want to identify for support. For example, you may be working on better time management and have specific things that others can do to support you.
- The help you need to create the best environment and outcomes for the people you support.

Instead of this	Write this
Stay positive	I'm invariably a glass-is-half-full person and it helps me enormously when people look for solutions and not problems. I find it very energy sapping if I'm the only optimist.

Progress for Providers

Checking your progress
in using person centred
approaches

Managers

Acknowledgements

Progress for Providers – checking your progress in using person centred approaches (managers) was developed by: Ben Harrison (United Response), Ruth Gorman (IAS Services and HSA), Jackie Fletcher (Dimensions), Michelle Livesley and Helen Sanderson (Helen Sanderson Associates), Kim Haworth (Commissioner for Lancashire County Council), Lisa Keenan (Joint Commissioning Support Manager for Leeds City Council) and Andy Rawnsley (Head of Service, Leeds City Council).

Thank you to the following people for providing valuable feedback on draft 1: Jonathan Ralphs, Gemma Else, Max Neil, Boo Dendy, Neil Woodhead, Bob Tindall, Ian Hart, Sarah Baiden, Jodie Allen-Cawley, Philip Ball, Stephen Stirk, Justine Watkins, Mike Cleasby, Tracey Bush and Robin Bush.

We are happy for you to copy and use Progress for Providers freely, but please contact us first if you are planning to make any changes to the text or design (Helen@helensandersonassociates.co.uk).

HSA Press, 34 Broomfield Road, Heaton Moor, Stockport, Cheshire, SK4 4ND.
Published March 2011

ISBN 978 1 906514 54 9



Progress for Providers - checking your progress in using person centred approaches (managers)

Progress for Providers

Checking your progress in using person centred approaches (managers)

Introduction

Progress for Providers – checking your progress in using person centred approaches (managers) is a self-assessment tool is for managers to use individually and with their team. It accompanies the original *Progress for Providers – checking your progress in delivering personalised services* (2010) and was developed following feedback from managers and commissioners for more detail on how managers use person-centred approaches with individuals receiving support, and their teams.

Using person-centred thinking and approaches helps the people you support to have more choice and control in their lives, and for staff to provide the best support they can in ways that reflect what is important to the person. Working in this way is not about doing more, but doing things differently. In difficult economic times, our experience is that implementing person-centred thinking and approaches makes it more likely that people will want to buy your services, and that good staff will stay with you.

Progress for Providers – checking your progress in using person centred approaches (managers) reflects the Department of Health's guidance *Personalisation through Person-Centred Planning (2010)*. Using person-centred approaches with individuals and teams directly contributes to achieving the Care Quality Commission's regulatory outcome framework: Supporting People (Quality Assurance Framework); the Health and Social Care Diploma; the Reach standards and other quality assurance and development frameworks (see the resources section at the back for more details).

The group who developed this are commissioners and providers from local and national providers for any service supporting people who use health and social care. They consulted with a wide international group of providers and commissioners during the drafting process.

Progress for Providers – checking your progress in using person centred approaches (managers) is divided into four sections looking at:

- The knowledge and skills required for person-centred thinking and approaches.
- How to help people have choice and control in their lives.
- Creating a person-centred culture within a team.
- Action planning tools and resources.

How to use it

If you are a first line manager, then all the sections will be relevant to you.

If you are a middle or senior manager, then the first, third and fourth sections will be relevant.

Progress for Providers – checking your progress in using person centred approaches (managers) can be used:

- By yourself, for individual self reflection.
- With your manager, to agree goals within supervision.
- With your team to agree team and individual goals.
- With other managers, for example as a practice group, or as part of an organisational development programme.
- As a follow up to using *Progress for Providers – checking your progress in delivering personalised services*.

As with the first *Progress for Providers*, you choose the statement in each section that best corresponds with your progress to date (statement 1, 2, 3, 4 or 5).

For example:

- If you are **Getting started** you are likely to tick the first one or two statements.
- If you are making **Some progress**, then perhaps the third statement.
- **Good progress** is likely to mean that you would tick the fourth box.
- **Excellent progress** would mean that you are ticking the fifth statement.

Progress for Providers - checking your progress in using person centred approaches (managers)

Appendix 4 Progress for Providers

Actions and resources

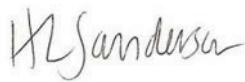
Once you have assessed your progress you can use this information to develop an action plan. At the end of the book is a list of resources that could help inform your actions. These resources include publications, examples from providers and commissioners, podcasts and web resources, courses and free downloads.

The action plan should describe how you are going to develop and change to move towards statement 5 (excellent progress). There is a blank action summary on page 22. You may want to focus on a few actions in more depth. There are three more detailed action planning pages for this on pages 24 to 26.

You might want to record your scores electronically, to compare them over time, or see a summary from several managers. We can send you a free format to use on Excel so that you can create pivot tables from your scores. Please email Kerry@helensandersonassociates.co.uk if you are interested in this.

Please also contact Kerry if you want any support implementing this within your organisation or training and support to achieve your action plans.

I hope you find this useful as a way of thinking about the progress you are making using person centred approaches to achieve change.



Helen Sanderson

Section 1

Person centred thinking tools and approaches

Knowledge, skills and understanding

Tick one box ✓

1	No one in my team has any understanding or experience of using person centred thinking tools or approaches.	
2	I know that we need to develop our skills, knowledge and understanding of person centred thinking tools but have not developed any plans to do this and I am not sure how to begin.	
3	I have a plan to develop our understanding of person centred thinking and some of the team have begun to use person centred thinking tools and approaches. We have started to look at some of the information available on person centred thinking (for example Michael Smulls podcasts on You Tube).	
4	I am using person centred thinking tools and approaches myself, and all the team know and are successfully using several of the tools. I have a one page profile and so do each of the team, and we are using this in our work together.	
5	We all have our own one page profile and we use this to inform our practice, and we are all confident and competent in using person centred thinking tools. Everyone can describe at least 5 person centred thinking tools (why and how you can use them and the benefits to the person) and talk about their experience of using them and the outcomes doing so achieved. As a manager I demonstrate enabling people supported to have as much choice and control as possible in their lives; working in a consistently person centred way and proactively and competently using person centred thinking tools in all areas of my work.	

Supporting team members individually

1	No one in the team has a personal development plan and we are not using any process to reflect on how we work and how to develop our skills.	
2	I recognise that all staff need ongoing support and opportunities for development to build their skills and knowledge and a way for their progress to be monitored. I am not sure how to go about this.	
3	I have started to talk to each team member about how they are doing in using person centred thinking tools and approaches in their work. This is on an adhoc basis.	

Progress for Providers - [checking your progress in using person centred approaches \(managers\)](#)

Appendix 4 Progress for Providers

Tick one box ✓

4	I talk to each team member on a regular planned basis about how they are developing their skills in using person centred thinking and approaches and how I can support them in this. I have a record of the progress that team members are making (for example, using the person centred thinking rating scale).	
5	Each staff member has a regularly reviewed individual development plan that includes how they are developing their competence in using the person centred thinking tools and approaches. This includes celebrating successes and problem solving difficulties. I ensure that each team members reflect on their own practice and are accountable for this. We use a range of ways to ensure each team member has individual support in using person centred thinking tools and approaches (for example peer support, mentoring, and person centred thinking as a standing agenda item for supervision). There is a mechanism for recording and sharing best practice across the organisation.	

Support and development as a team

1	We don't meet as a team and or when we do meet, we solely focus on processes and procedures.	
2	I recognise that it is important that we meet and reflect about the teams ongoing development but were struggling to prioritise this or find the resources to allow this to happen.	
3	I make sure that we set aside time during team meeting to reflect on practice and sometimes this includes how we are using person centred thinking tools and approaches.	
4	I use person centred thinking tools and approaches in our team meetings. I also have other ways that we work together to develop our understanding of person centred thinking tools and approaches, and to reflect on successes and challenges together.	
5	We have a strong culture of reflective practice around our experience of using person centred thinking tools and approaches. In the team we have a variety of ways (e.g. standing agenda item in team meetings, sharing best practices and problem solving, practice groups, person centred thinking tool of the month) to support team members to develop their skills in using person centred thinking and approaches. The information is gathered and collected to inform organisational training and development planning.	

Progress for Providers - Checking your progress in using person centred approaches (managers)

Appendix 4 Progress for Providers

Section 2

Using person centred thinking tools and approaches to support individuals to have choice and control in their lives

Seeing the person as an individual and appreciating gifts and qualities

Tick one box ✓

1	We have information about the person support needs – this is usually provided by the person that commissioned the service. This information is focused on their needs. Staff struggle to describe the person in a positive way and feel uncomfortable doing this.	
2	We recognise the importance of seeing the person a whole person including their gifts and qualities but we don't record this.	
3	We have a commitment to see the person as a whole person and to develop ways of gathering a range of information in our care plans about the person including recognising their gifts and attributes.	
4	We collect person centred information about each person we support. This includes recording the person's gifts and skills (for example in a one page profile). We don't just record this information, we try to use it, for example in conversations with the person.	
5	We know and recording each individual's gifts and qualities and we have found a variety of ways to communicate this to them and people important to them (for example appreciation books, one page profiles). We actively use this information to support people to develop relationships and become contributing citizens. People are described positively, and individually, as a matter of course, and encourage others to do the same.	

Understanding the person's history

1	All we know about person comes from the care plan, commissioners or our recent experience of supporting them. If we know anything about their history it is more likely to be in the context of negative experiences or behaviour.	
2	We understand the value of knowing the person's history and background in a balanced way, so we can support them better but do not have any way to do this at the moment.	

Progress for Providers - [checking your progress in using person centred approaches \(managers\)](#)

Appendix 4 Progress for Providers

Tick one box ✓

3	We've a commitment to finding out about the person's history and have started to work with a few people to talk about their history and record this.	
4	We have recorded histories for some of the people we support. We have different ways to share this information, and are working to having recorded histories for everyone we support.	
5	We know and have a record of each individual's personal history. This is recorded in a way that works for the person, for example on a history map, life story book, timeline, scrapbook, memory box or DVD. We always use this information as the foundation of current and future approaches to support.	

What matters to the person now

1	We know and focus on how to keep people healthy and safe, but do not know or record what is important to each person as an individual.	
2	We know we need to recognise what's important to people and support people to have what is important to them, and to record this. We are looking at how we can do this.	
3	We have started to use some person centred thinking tools to gather information about what is important to each individual we support (for example good day and bad day, relationship maps and learning about peoples routines). This information is starting to change how we support people.	
4	We have information about what matters to most of the people we support and this is recorded (for example in a one page profile). Team members use this to support people.	
5	We know what is important to each individual we support. This is clearly recorded and includes specific, detailed information including relationships, routines and interests. Everybody we support has a one page profile. Staff intentionally work to make sure what is important to the person is happening in their day to day life and identify where there are obstacles to achieving this (including where it is our organisations own procedures and practices that cause these obstacles).	

Appendix 4 Progress for Providers

Working towards the outcomes that the person wants for the future

Tick one box ✓

1	We provide support based on the care plan and commissioning, we are unsure what people want for the future.	
2	We realise that in order to support people effectively we should understand their aspirations for the future. However we are not sure how to do this or whether it is really our role.	
3	We are trying different person centred approaches to enable people to think about their future and we have recorded goals for some people, and we are working on our role in achieving these goals.	
4	We have made good progress in ensuring that everyone we support has an opportunity to think about their future by using person centred thinking and planning. This is recorded for most people, and there are clear outcomes that we are working towards.	
5	We know what individual wants for their future – their dream, hopes or aspirations, we have gathered this information from the person and those who know and care about them (using person centred thinking, planning or person centred reviews). There are specific, measurable and achievable outcomes that move in the direction of these future aspirations and we are working with the person to achieve these. We are clear about our role in this, and review progress with the person and our manager. The information is used to develop a strategic plan and to hold the organization to account. All the people we support have outcome focused reviews.	

How the person wants to be supported

1	We have established policies and procedures for how we support people and we support everyone in the same way.	
2	We know that to support people effectively we need to find out how people would like to be supported, we are unsure how to do this and record the information. Currently our approach is not flexible enough to allow this to happen. We are task orientated rather than people orientated but we want to change this.	

Progress for Providers - [checking your progress in using person centred approaches \(managers\)](#)

Appendix 4 Progress for Providers

Tick one box ✓

3	We acknowledge the importance of finding out from people what good support looks like for them individually, and we have begun to explore with people what this looks like and have developed a plan to gather this information for everyone, using person centred thinking tools and approaches.	
4	Everyone in the team is clear about what good support looks like for each person they support. We have started to record this (for example in one page profiles), staff understand what this means for their practice on a day to day basis, and are using this information to inform how they support people.	
5	We know and act on how the person wants to be supported. This is clearly recorded, is detailed, specific to the person and staff use this to deliver individual support. The information includes the support people want in their routines, in their relationships and interests, and how to help people be healthy and safe. We review team members performance on their ability to provide support in the way that someone wants.	

How the person communicates

1	We support people following our policies and procedures; we do not specifically record how people communicate.	
2	We realise that we need to understand more about how people communicate and what they are trying to tell us.	
3	We have started to introduce communication charts as a first step, staff are now beginning to understand that all behaviour is communication and are developing their skills in observing recording and communicating with people.	
4	We use communication charts with the majority of the people we support, increasingly staff understand their own role ineffective listening and communication.	
5	We know and respond to how the person communicates (particularly if they don't use words to communicate). This is clearly recorded, for example on communication charts, or communication passports, and staff know what the person means when they behave in certain ways and how staff should respond. All staff consistently use this on a day to day basis and update regularly.	

Progress for Providers - Checking your progress in using person centred approaches (managers)

Appendix 4 Progress for Providers

How the person makes decisions

Tick one box ✓

1	The people we support are not involved in significant decisions about their life.	
2	We realise that people should be involved and included in any decisions about their life, we also recognise that this could help people feel more in control. We do not know how to do this yet. We use best interest meetings.	
3	We have started to develop decision making agreements with people and tried out different approaches to help people to make decisions. We are using best interest meetings and engaging families to assist in the process.	
4	The use of decision making agreements is common, and we have many examples of people making decisions about what is important to them. We are struggling to ensure that this is for all people with capacity or communication issues. Staff are engaged and support people to record their decisions.	
5	Staff know the decisions that are important to the person, how to support the person with these decisions and how the final decision is made. This is recorded, for example, in a decision making agreement. We make sure people get representation if they need it. We have supported some people to make decisions that we didn't agree with and manage the tension in this.	

Acting on what is working and not working

1	We do not know what is working or not working for the people we support.	
2	We want to learn what people are think is working and not in their lives. We are not sure how to do this and are fearful we will not be able to respond and make the changes they want.	
3	We have started to routinely asking people what is working and not working from their perspective about their life and the service they receive (for example as part of a person centred review).	

Progress for Providers - [checking your progress in using person centred approaches \(managers\)](#)

Appendix 4 Progress for Providers

Tick one box ✓

- | | | |
|---|---|--|
| 4 | Staff are confident in supporting people to tell us what is working and not. This happens for everyone at least once a year. There is an action plan developed from this, we have created a system that will gather this information from people so that we can plan strategically what needs to happen in the service. | |
| 5 | We have a process for asking and recording what is working and not working from the person's perspective. We have actions (with a date and a named person responsible) to change what is not working. The action plan is regularly reviewed and this information is shared to inform change in the organisation. | |

Supporting people in their friendships and relationships

- | | | |
|---|--|--|
| 1 | The only people in the person's life are paid staff. We don't see it as our responsibility to support people with relationships. | |
| 2 | We realise that people might want to meet and make more friends but we are fearful that this could expose people to harm and risk and we are not prepared to accept the responsibility for this. We are not sure how we would begin to find out who is important in the person's life. | |
| 3 | We have started to work out how we can support people to build and maintain relationships; we are still worried about the risk and how to manage this. We have started to understand what's in the local community and developing relationship maps. Staff are putting a greater focus on people's interests and friendships. | |
| 4 | We have tried a number of approaches to support people with their friendships and relationships. We know who is already important in the person's life (for example by using a relationship map) and people are now having opportunities to meet new people (who are not paid to be with them). We are gathering the learning and sharing good practice. | |
| 5 | We support people to meet new people and make new relationships and friendships in their community (outside of staff and any other people who live with the person). We know who is important to the person and support them to maintain these relationships. This is recorded, for example on a relationship circle or Inclusion Web. We have a strategic approach to friendships and relationships staff see this as a main purpose in their role. | |

Progress for Providers - Checking your progress in using person centred approaches (managers)

Appendix 4 Progress for Providers

Being part of their community

Tick one box ✓

1	It is not our job to connect people in the community.	
2	I think it would be good if people we support were out and about in the community more but I can't see how we can do this within our current resources.	
3	We are committed to exploring ways of people being part of their communities, and we have started thinking about how to do this with a few people we support (for example using community maps, recording gifts and 'presence to contribution').	
4	We support some people to go out and be part of their community and we use person centred thinking tools in the way that we approach this.	
5	We know the places in the community that are important to the person, and other places they may like to be part of. This is recorded, for example on a community map. We have a specific, measurable plan to enable the person to be fully part of their community, and making a contribution (for example through using 'presence to contribution'). This is regularly reviewed and there is evidence that people are becoming part of their community.	

Progress for Providers - [checking your progress in using person centred approaches \(managers\)](#)

Appendix 4 Progress for Providers

Section 3

Using person centred thinking tools and approaches to create a person centred culture within teams

Clear purpose

- | | | |
|---|--|--|
| 1 | We have an organisational mission statement created by the senior manager/ management team/owner. This complies with requirements. We have not considered how this should be reflected in the way we work. | |
| 2 | We think it would be helpful for the team to think about our purpose as a team but I am not sure how to go about this. | |
| 3 | We have begun to talk with staff about what our purpose is and to think about how we can record this. | |
| 4 | We are clear about our team's purpose and how this fits with the organisations mission statement. We have developed this together as a team and with people using the service. | |
| 5 | The organisations mission statement informs the team's purpose. Everyone understands the connection between the mission and their individual purpose and role. The team know what their team purpose is – what we are trying to achieve together and all team members know their purpose in relation to the people they support, their team and the rest of the organisation. This is recorded, for example in a purpose poster or team purpose statement. The team's purpose informs the work of the team, and there is evidence of this in practice. | |

An agreed way of working that reflects values

- | | | |
|---|--|--|
| 1 | We don't really think about values, we just get on with the job. | |
| 2 | We realise that we need to explore our values and beliefs as a team and how this can inform our practice. | |
| 3 | We have started to think together about our team values and how we work together. We know what is working and what needs to change. | |
| 4 | We have agreed our values and team principles and developed an action plan that addresses what needs to change, in partnership with people we support. | |

Progress for Providers - Checking your progress in using person centred approaches (managers)

Tick one box ✓

- | | | |
|---|---|--|
| 5 | <p>The team has a shared set of beliefs or values that underpin their work, and agreed ways of working that reflect these. These reflect working in a person centred way and include working in ways that ensure people have maximum choice and control in their lives, as part of their local community. The team principles and ways of working are clearly documented (e.g. ground rules, team charter, person centred team plan, team procedure file etc).</p> <p>The team regularly evaluates how they are doing against these agreed ways of working (for example, by using what is working and not working from different perspectives).</p> | |
|---|---|--|

People know what is important to each other and how to support each other

- | | | |
|---|--|--|
| 1 | My team do not know each other very well. | |
| 2 | I have started to work on ways that I can help them team know more each other – about what matters to them as people and how they can support each other at work (for example starting with one page profiles for everyone). | |
| 3 | I am learning what is important to my team and how best to support them. We are all aware of how to support each other and what is important to each other and we are working at putting this into practice. | |
| 4 | My team and I have all documented how best to support each other and what is important to each of us. We know how we make decisions as a team, and the best ways to communicate together. | |
| 5 | <p>As a team we know and act on what 'good support' means to each person. This information is recorded, for example, in a person centred team plan.</p> <p>We regularly reflect on what is working and not working for them as a team, and what they can do about this. We have a culture where we appreciate each others gifts and strengths and use these in our work wherever we can.</p> | |

Staff know what is expected of them

- | | | |
|---|--|--|
| 1 | I think that each team member has a general sense of what is expected of them. | |
| 2 | All staff have a generic job description and work to organisational policies and procedures. | |

Progress for Providers - [checking your progress in using person centred approaches \(managers\)](#)

Appendix 4 Progress for Providers

Tick one box ✓

3	I know that staff need to be clearer about what their important or core responsibilities are and where they can try out ideas and use their own judgement. We have started to have discussions in the team about this.	
4	Some staff are clear about what is expected of them and where they can make decisions themselves. There are still some grey areas that we need to explore more. We are using person centred thinking tools (for example the doughnut) in clarifying expectations and decision making.	
5	Staff know what is expected of them – they are clear about their core responsibilities are and where they can try new ideas in their day to day work. Staff are clear about their role in peoples lives and know what they must do in their work – around the people they support, and any team, admin or finance responsibilities. Staff know how to use person centred thinking to deliver their core responsibilities Staff know where they can use their own judgment and try new ideas or approaches and record what they are learning about what works and does not work when they use their own judgment. Roles and responsibilities are clearly recorded (for example in a doughnut) and this is reflected in job descriptions.	

Staff feel that their opinions matter

1	I make all decisions I don't involve my team. I chair team meetings and set the agenda. I set the agenda for supervision and appraisal.	
2	I recognise the need to find a way to listen to my staff team, value their opinions and engage them in decision making. I am trying to improve how I do this.	
3	My team have some involvement in setting team meeting agenda's. I still make most of the decisions.	
4	I regularly meet with my team and discuss issues that they raise (in team meetings and other day to day opportunities). They contribute to team meeting agenda's and make suggestions for supervision discussions. Some staff make suggestions for new idea's or changes. We are starting to use person centred thinking tools to listen to each other.	
5	Staff feel that their opinions are listened to. Team members are asked for their opinions and consulted on issues that affect them. Team members feel confident in suggesting new ideas or changes to me. We regularly use person centred thinking tools in the team to listen to each other's views and experience (for example the 4 plus 1 tool).	

Progress for Providers - Checking your progress in using person centred approaches (managers)

Appendix 4 Progress for Providers

Tick one box ✓

Rotas - staff are thoughtfully matched to people and rotas are personalised to people who are supported

1	I write staff rotas based upon staff availability. The rota meets the requirements of the service. There is a system for staff and people who use the service to make requests of the rota.	
2	I have identified the preferences of people who are supported and the staff (for example using the matching tool/one page profile). I write the rotas and take these preferences into consideration where possible.	
3	Sometimes people who are supported are matched to people with similar interests but service need still takes priority.	
4	My team and I know what peoples preferences are, how they like to be supported and what is important them. These preferences are acknowledged in the way that the rota is developed, so that we get a good match between the person and the staff who support them. The rota times are based around how people want to be supported.	
5	Decisions about who works with whom are based on who the person supported wants to support them. Where the team leader makes this decision, it is based on which staff get on the best with different individuals, taking into account what people and individual staff members have in common (e.g. a shared love of country music) as well as personality characteristics, (e.g. gregarious people and quieter people) necessary skills and experience. Rotas are developed around people using the service based on the support they want and the activities they want to do, and who they want to support them.	

Recruitment and selection

1	Staff are recruited to the team based on formal job descriptions that have been developed by the organisation.	
2	I know I should involve the people who receive a service in recruitment but I am not sure how to go about this.	
3	I have started to look at 'good practice' examples of ways to involve people in recruiting their support staff. We have started to explore how we can develop job descriptions that reflect what is important to people we support.	

Progress for Providers - [checking your progress in using person centred approaches \(managers\)](#)

Appendix 4 Progress for Providers

Tick one box ✓

4	We have worked with people and identified ways for them and their families to be involved in recruitment and selection of their staff. This happens some of the time. We have developed personalised job descriptions and adverts based on what is important to the person and how they want to be supported. We use the matching tool in our recruitment processes.	
5	Our recruitment and selection process demonstrates a person centred approach. We recruit people who can deliver our purpose by selecting people for their values and beliefs, and characteristics, not just their experience and knowledge. Job descriptions are individualised to the people who are supported wherever possible, using information from 'matching staff'. It is a common practice for people to be involved in recruiting their own staff, in a way that works for them.	

Enabling risk

1	I encourage my team to make sure people are safe and do not take risks. We adhere to all required legislation.	
2	I am aware that I need to encourage my team to become less risk averse. I am not sure how to do this.	
3	I am working with the team to help them take a responsive and person centred approach to risk. We are starting to use this in some situations.	
4	We use a person centred approach to risk most of the time. We involve the people, family and others in thinking this through. I ensure everything is documented and adheres to the relevant legislation.	
5	We ensure that risks are thought through in a person centred way that reflects what is important to the person and decisions are clearly recorded. The person, and their family are centrally involved in the way that we do this.	

Progress for Providers - Checking your progress in using person centred approaches (managers)

Appendix 4 Progress for Providers

Tick one box ✓

Training and development

1	All training is based on statutory requirements. I make sure that we meet minimum legal and statutory requirements.	
2	I recognise that I need to find a way for training and development opportunities to reflect the needs of the service we provide to people and motivate the staff.	
3	I have started to think about how I can introduce learning and development opportunities to staff that will reflect people who receive a service needs and also engage and develop the team member. I have begun to look at what is working and what is not working for individuals and also researching what is available.	
4	We have identified all training needs, learning and development opportunities and have a plan in place. Training and development opportunities reflect the needs and wishes of people who receive a service and have been agreed with team members. Person centred thinking and approaches are central to our approaches to training. We are compliant with all legal and statutory requirements.	
5	We provide development and training opportunities to all staff that focus on increasing choice and control for people we support and delivering an individual, person centred service. Within a few months of starting with the organisation, new staff have induction training that includes using person centred thinking and approaches to deliver our purpose. Our training enables staff to be up to date with best practice in delivering choice and control, and using person centred thinking to enable people to live the lives they want. We know that the first line managers are key to delivering a person centred service, and we have specific training and support to enable them to use a person centred approach in all aspects of their role, and to be able to coach their staff in using person centred thinking skills.	

Supervision

1	I set the agenda and make the arrangements for staff supervision. I meet the minimum requirement.	
2	I am aware that staff support and supervision practice needs to be reviewed. I am not sure how I can change the current arrangements.	

Progress for Providers - [checking your progress in using person centred approaches \(managers\)](#)

Appendix 4 Progress for Providers

Tick one box ✓

3	I have started to think about involving people who receive a service in staff supervision. I have talked to people and staff about we might go about this. Most members of staff have supervision meetings.	
4	All staff are supervised, and people who staff support usually contribute through sharing their views with me before the supervision session. Supervision results in actions and the meetings are documented. I have started to use person centred thinking tools in supervision sessions.	
5	Each team member has regular, planned, individual supervision. Supervision includes giving staff individual feedback on what they do well, as well as what they can improve on (e.g. coaching staff to develop their skills in working in a person centred way). There is a clear link between training and supervision and what people do when they are at work (i.e. when people attend training, managers expect to see a difference in their work, and this is discussed in their individual supervision). The views of people supported are very important in the supervision process, that people are asked their views before supervision.	

Appraisal and individual development plans

1	Most of my staff have an appraisal. I set the agenda and assign objectives.	
2	I have recognised that people who receive a service and their families should be given the opportunity to feedback on the support they receive from staff. I am not sure how I should go about this. Staff have an appraisal but do not really contribute to the agenda or any development plan.	
3	I have a plan in place to ensure that each member of staff receives an annual appraisal. Where possible I try to seek the views of people who receive a service and their families.	
4	We have a variety of ways for people who receive a service and their families to contribute their views to staff appraisals. All staff are asked to reflect on what they have tried, what they have learnt, what they are pleased about and if they have any concerns. We then agree what actions need to be taken from the all the information gathered.	
5	Team members get positive feedback about their work and have annual appraisals and individual development plans. Annual appraisals include feedback from people supported about what is working and not working about the support they receive and results in an individual development plan with clear goals that build on strengths, focus on working in a person centred way, and further developing skills.	

Progress for Providers - Checking your progress in using person centred approaches (managers)

Appendix 4 Progress for Providers

Tick one box ✓

Meetings

1	We have occasional team meetings but not everyone attends or contributes.	
2	There are frequent team meetings. I set the agenda and chair the meeting. There is little structure to the meeting and they are not as well attended as they could be.	
3	I schedule regular team meetings. The meeting tends to be an information giving forum and does not often include problem solving or celebrating successes.	
4	We have regular structured team meetings which are documented. Actions are agreed, recorded and followed up on. They are well attended and most people contribute.	
5	Our team has regular, productive team meetings that are opportunities to hear everyone's views, and everyone contributes. Team meetings include sharing what is going well and problem solving difficulties (for example practicing using person centred thinking tools to solve problems).	

Progress for Providers - [checking your progress in using person centred approaches \(managers\)](#)

Appendix 4 Progress for Providers

Section 4

Action planning tools and resources

Action plan

Top priority

Why is this your top priority?

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

What will have changed? What will you see? What will you feel? What will you hear?

Progress for Providers - Checking your progress in using person centred approaches (managers)

Action plan

Next priority

Why is this your next priority?

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

What will have changed? What will you see? What will you feel? What will you hear?

Progress for Providers - checking your progress in using person centred approaches (managers)

Appendix 4 Progress for Providers

Action planning summary

Section	What do we want to work towards? (the next statement in the section)
1 Person centred thinking tools and approaches Knowledge, skills and understanding	
Supporting team members individually	
Support and development as a team	
2 Using person centred thinking tools and approaches to support individuals to have choice and control in their lives Seeing the person as an individual and appreciating gifts and qualities	
Understanding the person's history	
What matters to the person now	
Working towards the outcomes that the person wants for the future	
How the person wants to be supported	
How the person communicates	
How the person makes decisions	
Acting on what is working and not working	
Supporting people in their friendships and relationships	
Being part of their community	
3 Using person centred thinking tools and approaches to create a person centred culture within teams Clear purpose	
An agreed way of working that reflects values	
People know what is important to each other and how to support them	
Staff know what is expected of them	
Staff feel that their opinions matter	
Rotas - staff are thoughtfully matched to people and rotas are personalised to people who are supported	
Recruitment and selection	
Enabling risk	
Training and development	
Supervision	
Appraisal and individual development plans	
Meetings	

Appendix 4 Progress for Providers

How this Progress for Providers relates to the Outcomes and regulations from the Health and Social Care Act 2008 (Regulated activities) and Regulations 2010

- Outcome 1 (Regulation 17) Respecting and involving people who use services.
- Outcome 2 (Regulation 18) Consent to care and treatment.
- Outcome 4 (Regulation 9) Care and welfare of people who use services.
- Outcome 13 (Regulation 22) Staffing.
- Outcome 14 (Regulation 23) Support workers.
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision.
- Outcome 17 (Regulation 10) Complaints.
- Outcome 21 (Regulation 20) Records.

How this Progress for Providers relates to Supporting People (QAF)

C1.1 Assessment and support planning

All clients receive an assessment of their support needs and any associated risks. All clients have an up-to-date support and risk management plan. Assessment and support planning procedures place clients' views at the centre are managed by skilled staff and involve other professional and/or carers as appropriate.

Standard	Performance level	Essential requirements (C) or indicative evidence (A/B)	Evidence
----------	-------------------	---	----------

This standard supports the service to meet outcomes in the following outcome domains: Achieve economic well-being, enjoy and achieve, be healthy, stay safe and make a positive contribution.

C1.2 Security, health and safety

The security, health and safety of all individual clients, staff and the wider community are protected.

Standard	Performance level	Essential requirements (C) or indicative evidence (A/B)	Evidence
----------	-------------------	---	----------

This standard supports the service to meet outcomes in the following outcome domains: Be healthy, stay safe and make a positive contribution.

Progress for Providers - checking your progress in using person centred approaches (managers)

Appendix 4 Progress for Providers

C1.3 Safeguarding and protection from abuse

There is a commitment to safeguarding the welfare of adults and children using or visiting the service and to working in partnership to protect vulnerable groups from abuse.

There is a difference between safeguarding vulnerable adults/children and adult/child protection. Safeguarding is everybody's responsibility, and includes measures to prevent or minimise the potential for abuse occurring. Protection is a statutory responsibility in response to individual cases where risk of harm has been identified.

When it comes to a service's safeguarding responsibilities towards children, it may be helpful to think of services as one of four types:

Services where children are known to live.

Services where children may live.

Services where children may visit

Services where children neither live or visit, but clients may have access to children.

While we recognise the variable degree of contact different services will have with children, all the following standards are relevant to all services. How you implement them, and how detailed your policies are, may depend on the nature of this contact.

Standard	Performance level	Essential requirements (C) or indicative evidence (A/B)	Evidence
----------	-------------------	---	----------

This standard supports the service to meet outcomes in the following outcome domains: Be healthy, Stay safe and Make a positive contribution (at level A only).

C1.4 Fair access, diversity and inclusion

There is a demonstrable commitment to fair access, fair exit, diversity and inclusion. The service acts within the law and ensures clients are well-informed about their rights and responsibilities.

Standard	Performance level	Essential requirements (C) or indicative evidence (A/B)	Evidence
----------	-------------------	---	----------

This standard supports the service to meet outcomes in the following outcome domains: Enjoy and achieve, be healthy, stay safe and make a positive contribution.

C1.5 Client Involvement and Empowerment

There is a commitment to empowering clients and supporting their independence. Clients are well informed so that they can communicate their needs and views and make informed choices. Clients are consulted about the services provided and are offered opportunities to be involved in their running. Clients are empowered in their engagement in the wider community and the development of social networks.

Involvement and empowerment will mean different things to different people. Some clients wish not to get involved at all and some wish to play a very active role, for example in future planning and governance. It is the responsibility of each provider to offer an opportunity to each individual to get involved.

Standard	Performance level	Essential requirements (C) or indicative evidence (A/B)	Evidence

This standard supports the service to meet outcomes in the following outcome domains: Enjoy and achieve and make a positive contribution.

How this Progress for Providers relates to the Health and Social Care Diploma

The new health and social care diploma is well equipped for supporting staff in gaining knowledge and skills in person centred approaches and thinking.

There are a variety of optional units which may support a full diploma, or could be used as individual units towards a programme of continuing professional development.

The initial mandatory units are generic across both adult and childcare.

Table 2 group A mandatory units

SHC21 Introduction to communication in health, social care or children's and young people's settings.

SHC22 Introduction to personal development in health, social care or children's and young people's settings.

SHC23 Introduction to equality and inclusion in health, social care or children's and young people's settings.

SHC24 Introduction to duty of care in health, social care or children's and young people's settings.

Progress for Providers - [checking your progress in using person centred approaches \(managers\)](#)

Appendix 4 Progress for Providers

The following five units are mandatory for all learners undertaking the health and social care Diploma at level 2 in England.

HSC024 Principles of safeguarding and protection in health and social care.

HSC025 The role of the health and social care worker.

HSC026 Implement person centred approaches in health and social care.

HSC027 Contribute to health and safety in health and social care.

HSC028 Handle information in health and social care settings.

Section B (possible units for showing knowledge and understanding)

HSC 3046 Introduction to personalisation in social care.

Section C (Possible units for showing competence)

LD 202 Support person-centred thinking and planning.

LD 203 Provide active support.

LD 314 C Support individuals with self-directed support.

HSC3020 Facilitate person centred assessment, planning, implementation and review.

HSC2031 Contribute to support of positive risk-taking for individuals.

HSC 3019 Support individuals in their relationships.

Area Section 1 Person centred thinking tools and approaches	 Publication Habits for highly effective staff – making person centred thinking a habit www.helensandersonassociates.co.uk Practicalities and possibilities – using person centred thinking with older people www.helensandersonassociates.co.uk	 Example There is a course in Hull for managers to develop their skills in person centred thinking and support their staff to make person centred thinking a day to day habit. Contact: Tracy Meyerhoff – tracy.meyerhoff@hullcc.gov.uk In IAS managers use the 'Achievement Tool' to think about successes in using person centred thinking. Teams have a 'person centred thinking tool of the month' and focus on this within team meetings and supervision. Contact: Ruth Gorman – RGorman@iasservices.co.uk In Dimensions managers use the person centred thinking rating scale to self assess how well they know the person centred tools and how they want to develop. Contact: Jackie Fletcher – jackie.fletcher@dimensions-uk.org
Section 2 Using person centred thinking tools and approaches to support individuals to have choice and control in their lives	Department of Health Guidance (2010). Personalisation through person centred planning www.dh.gov.uk	In United Response they have built their capacity in person centred thinking by training their own person centred trainers. As well as making sure all the staff and managers are trained in person centred thinking, the trainers are local champions for person centred thinking and offer support for managers to develop their skills and implement change. There are regular 'surgeries' for managers; to think together about how they are using and implementing person centred thinking. United Response won a National Training Award for the difference that person centred thinking had made in the lives of people they support and the way staff worked. Contact: Ben Harriossn – Ben.Harrison@unitedresponse.org.uk Commissioners in Lancashire worked with a range of providers to enable them to develop their skills and knowledge in person centred thinking and approaches through a programme called 'Good2Great'. This was linked to their 'Preferred Providers' programme. Contact: Kim – Kim.Haworth@lancashire.gov.uk
Section 3 Using person centred thinking tools and approaches to create a person centred culture within teams	Person centred organisations – what are we learning? www.helensandersonassociates.co.uk Making it Personal for Everyone www.dimensions.org.uk	In Dimensions all staff are expected to have one page profiles. This started with the Executive Team and the Trustees. They also produced one page of guidance on what a great one page profile needs to have in it. Contact: Jackie Fletcher – jackie.fletcher@dimensions-uk.org Commissioners in Lancashire expect providers to talk about how they are using person centred thinking in tender interviews. Contact: Kim Haworth – Kim.Haworth@lancashire.gov.uk
Progress for Providers - checking your progress in using person centred approaches (managers)		

Appendix 4 Progress for Providers



Web resources

Michael Smull. A series of films on each person centred thinking tool. www.youtube.com/user/helensandersonHSA

Think and Plan – a free website for people to use person centred thinking online. www.thinkandplan.com/

Mary Beth Lepkowsky. A series of films on person centred coaching. www.youtube.com/user/helensandersonHSA



Courses/consultancy

Person centred thinking. www.helensandersonassociates.co.uk

Managers – making person centred thinking a habit. www.helensandersonassociates.co.uk

Coaching for managers. www.helensandersonassociates.co.uk



Free downloads

Person centred thinking minibook. www.helensandersonassociates.co.uk

Habits pack for managers and staff (this includes the Achievement Tool and the Person centred thinking rating scale). www.helensandersonassociates.co.uk

Think and Plan – a free website for people to use person centred thinking on line. www.thinkandplan.com/

Michael Smull. A series of films on each person centred thinking tool. www.youtube.com/user/helensandersonHSA

Person centred thinking. Person centred reviews. www.helensandersonassociates.co.uk

Person centred thinking minibook. www.helensandersonassociates.co.uk

Community connecting minibook. www.helensandersonassociates.co.uk

in Community Standards. www.helensandersonassociates.co.uk

Michael Smull films for managers. 'A Rock in a Pond' and 'Person centred plans that make a difference'. www.youtube.com/user/helensandersonHSA

Transforming teams. Person centred teams. Positive and productive meetings. Person centred supervision. Person centred risk. Person centred recruitment. www.helensandersonassociates.co.uk

Examples of person centred team plans. www.helensandersonassociates.co.uk

Progress for Providers - Checking your progress in using person centred approaches (managers)

