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Alzheimer's Society
Leading the fight against dementia

Progress in Personalised Care and Support Planning

Checking your progress in delivering Personalised Care and Support Planning

Forewords

Sally Percival

Chair of the Think Local Act Personal Partnership and chair of The National Coproduction Advisory Group

One of the most important people in my life is my mum, and I want her to be as happy as possible, she has several long-term health conditions and requires a high level of care. The only way to ensure my mum is supported the way she wants is to work together in partnership with everyone involved with her life. Mums voice has to be central to every conversation we have. Traditionally professionals have been hesitant about personalised care and support and relinquishing control, but professionals need to work with people and turn "I" in to "we".

Personalised care and support planning doesn't just happen by chance there needs to be several vital components for it to work well. One important aspect is co-production; co-production values everyone as equals and is built around people, not around systems and processes. Instead of fitting people into existing services and boxes, we must all work together to find the best way to achieve the outcomes that matter to each individual and although coproduction isn't rocket science, it is absolutely necessary if personalised care and support planning is to be effective. It must start with the important question "what is most important to the person to have the life that they want"; of course that question cannot be answered without us all working together with each other as equal partners, but importantly putting the person at the centre. Everything within the care and support plan must be designed and developed with the person receiving care and support, that is the only way it can be authentic. The plan must then be shared with all the appropriate people; it is no good having a great plan that remains hidden and unread.

So what is the impact of good personalised care and support planning? Well it is life transforming; it gives people a life that's worth living. Having a really good care and support plan will not give my mum more days to her life but it has given her more life to her days!

Jeremy Hughes
Chief Executive at Alzheimer's Society

One thing has been clear to me for some time. Now is the time to take action.

There are 850,000 people in the UK with dementia, by 2021 it will be over one million and by 2051 this figure will reach over two million. The annual cost of dementia to the economy is estimated at £26.3 billion, £10.5 billion more than the cost of cancer.

When confronted with these staggering figures, it's easy to lose sight of the cost to the individual. Each of these 850,000 people has their own concerns and fears, but they also have their own hopes, strengths and connections too.

Today people with dementia are not getting the help and support they need. Often they struggle to be part of their community, receive poor care and have their most basic needs and preferences overlooked. People with dementia are treated as second class citizens and this must change.

Alzheimer's Society's Personal Choice Programme, has been looking into the experiences of people with dementia and personal budgets. We concluded that whilst many local authorities are starting to get good cards, none can yet be said to be holding a good hand. We must act now. We must use what we know works and make it real for all people affected by dementia, at all levels of need and wherever they live.

By having new person centred conversations, professionals in dementia care can collectively make better interventions and deliver more meaningful outcomes for people, based upon choice, control and community.

Too often assessments are focused on revealing deficits and problems. They are often shaped too much by eligibility and budgets and not enough by what really matters to people. Instead we need open conversations, alive to new possibilities to be found in each person's individual circumstance. Health and social care services need to be properly resourced, genuinely

integrated and individually responsive to the diverse range of needs the system must do more to meet.

The simplicity of this toolkit is deceptive. Its clarity and practicability is very likely to hold the key to significant and transformational change.

The way ahead is likely to be beset by challenges and setbacks, some structural and others born of prevailing cultures and mindsets. The real benefit of a resource such as this is in the way it acknowledges that each organisation will be starting from a unique place. The most important thing is building on what works, moving as quickly as possible away from what is holding progress back, and working together to get to where we need to be for the future.

Alzheimer's Society, through our Personal Choice Programme, is proud to support this toolkit. We are looking forward to working with Think Local Act Personal, Helen Sanderson Associates and others to ensure these person centred principals and practical steps have a real and measurable impact on care and support planning for people living with dementia.

Our vision is simple: a world without dementia. We make no apologies for our ambition and we believe that moment will come. We work relentlessly for a cure and every day we get a bit closer.

Until that day, we are determined to create a society where those affected by dementia are supported and able to live the life they want, without prejudice. The approaches laid out in this toolkit are an important step along this bigger journey.

Introduction

"Personalised care and support planning is part of the different relationship being forged between people with health and care needs and services. It recognises and values lived experience, alongside clinical and professional expertise and empowers and enables people to shape and manage their own care. Personalised care and support planning is set out as a legal right in the Care Act 2014, alongside personal budgets, for everyone with eligible social care needs, including carers. It is also part of the vision for the future of the NHS in the Five Year Forward View, which describes the importance of people and communities gaining far greater control of their care. It is a key ingredient in a variety of transformation programmes, grappling with issues of improvement and sustainability across the NHS and local government, including New Care Models, Pioneers and Integrated Personal Commissioning Programmes."
Sam Bennett, Deputy Director of Personalisation & Choice, Head of Integrated Personal Commissioning and Personal Health Budgets, NHS England

Personalised care and support planning is about starting a different kind of conversation about health and care which is focused on what's important to each person, leading to a single plan that is owned by the individual. It is delivered through multi-disciplinary teams, with a single coordinator supporting the person through the process. It is about having different conversations; it is focused on community rather than just services, and is rooted in co-production.

Getting care and support planning right is essential for people to gain more choice and control in their life and over the support they are receiving. This self-assessment tool will help you to evaluate how well you are delivering personalised care and support planning at the moment, highlighting areas of strength and any areas where you might be able to improve your services for the people you support.

Personalised care and support planning in health, social care and education

In **health**, personalised care and support planning is expected to become the routine way in which traditional health care and support for self-management is brought together for each person, by signposting to activities within a supportive community and coordinating with social care when necessary. This approach will apply to both l**ong-term health** and **immediate wellbeing**.

In **social care**, personalised care planning has become a central component of government policy. The Care Act 2014 introduces a duty for councils to make sure that a personalised care and support plan and personal budget is provided for anybody who is eligible. Statutory guidance describes in detail how this should work to put people in control and enable a more holistic approach to meeting needs and promoting wellbeing. It also plans how a person's needs will be met in the ways that work best for them as an

individual and for their family, and determines how the person's **personal budget** will be spent.

In **mental health settings**, the **care programme approach (CPA)** has long been used with people with enduring mental health issues to ensure that long-term care and support is organised around their wishes. This process can be enhanced and improved through incorporating personalised care and support planning.

In **educational settings**, when a young person is 18 years old, they are eligible for an **Education, Health and Care Plan**. This can be integrated into a personalised care and support planning approach, bringing all the resources together around the individual.

About Progress in Personalised Care and Support Planning

"Personalised care and support planning is a 'meeting of experts'. It brings together those with lived experience and those with technical expertise to identify all the issues, develop solutions and initiate actions…Essentially, PCSP builds on the person's assets and resources, ensuring they are in the driving seat of decision making." TLAP, Personalised Care and Support Planning tool

Progress for Providers[1] is an established and well-regarded series of self-assessments. This version of Progress for Providers is a self-assessment directly based on the Think Local Act Personal/Coalition for Collaborative Care resource on personalised care and support planning[2]. This edition of Progress for Providers was commissioned by NHS England in order to bring together the current thinking and resources on care and support planning, and to co-produce a personalised and integrated care approach. It was initially developed to support the Integrated Personal Commissioning sites in their efforts to develop new approaches to truly integrated care.

This resource also reflects the Care Act 2014[3], which requires that everyone has one plan and that every plan results in outcomes, not just actions or service prescriptions. As part of this work, the co-production groups from TLAP and the Coalition for Collaborative Care developed a set of statements about what good looks like in relation to personalised care and support planning.

Throughout Progress for Providers you will see a range of detailed examples from different characters. This version of Progress for Providers features Kathy, an older woman living with dementia. The sections of this version of Progress for Providers are the same for anyone using personalised care and support planning, and by using it with different character examples, we hope that it will be useful for many people, not only for those supporting people who are experiencing dementia.

Here is the link to the TLAP Personalised Care and Support Planning Tool that this self-assessment is based on www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/

There are three sections to this Progress for Providers self-assessment:

The first stage looks at what needs to be in place for the five stages of personalised care and support planning.

The second section looks at the workforce - in particular, what needs to be in place to enable teams to deliver personalised care and support planning.

The third section looks at what needs to be in place at an organisational or systemic level to introduce personalised care and support planning.

Each section covers a key area of change, and has five statements to choose from.

You choose the statement in each section that best corresponds with your progress to date (statement 1, 2, 3, 4 or 5). If you are Getting started, you are likely to tick the first one or two statements. If you are making some progress, then perhaps you will tick the third statement. Good progress is likely to mean that you would tick the fourth statement. Excellent progress would mean that you are ticking the fifth statement. Few organisations will be able to score 5s in every area.

Once you have assessed your progress, you can use this information to develop an action plan. The action plan should describe you how you are going to develop and change to move towards statement 5 ('excellent progress'). For example, if you score a 3 in one area, your action plan should focus on how you could move from a 3 to a 4 or 5. In this way, Progress for Providers can help you to decide where to focus your energy and resources. This makes Progress for Providers a practical tool to support you to move from evaluation and thinking through to action and change.

There are a range of resources to support you to develop and move towards 5s - from e-learning to face-to-face training and support. Helen Sanderson Associates and the Alzheimer's Society are the Integrated Personal Commissioning England (NHS ENGLAND) Voluntary and Community Support Partners for care and support planning (please contact Jo@helensandersonassociates.co.uk), the Coalition for Collaborative Care and their partners have support offers as well.

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Personalised Care and Support Planning Process

There are five stages to personalised care and support planning – preparation, the conversation, recording, making it happen, and the person-centred review.

1 Preparation

In order to hold different conversations, it is necessary that both the individual and the practitioner are prepared and fully understand the purpose of personalised care and support planning, as well as what will happen when. This step is the key to effective personalised care and support planning, and there are three elements to this: preparation for the process, preparation by the individual, and preparation by the practitioner and the team.

a Preparation for the process

This step involves making sure that each individual knows the purpose of personalised care and support planning, what to expect and when, and how to ensure that the person is at the centre of the process and the decision-making. Preparing for the process includes considering whether the person needs any support to prepare for the conversation - and, if they do want support, deciding how and by whom this will be provided.

	Tick one box ✓
1 We don't share any information with the person about personalised care and support planning at the moment.	
2 We know we need to have a way to explain the process to people, but we are not sure how to get started.	
3 We have a standard way to share information about personalised care and support planning; for example, everyone is sent a letter that tells them about it.	
4 We have a clear process established for introducing people to care and support planning, and this includes telling people why it is important, what it is, and what will happen when. We find out the best ways for the person to receive information (for example, by email, letter or phone call), and schedule appointments to fit in with the person. We make sure that consent issues are addressed, and know when and how to involve advocates. We assign someone to each person to support them if they want help to prepare for the conversation.	

		Tick one box ✓
5	We have a flexible process that is tailored to each individual. We have a range of ways to share information about why we are introducing care and support planning, how it works, and what will happen when (for example, accessible information in different formats and languages, or a visual of the timescale). We find out the best ways for the person to receive information (for example, by email, letter or phone call), and schedule appointments to fit in with the person. We make sure that consent issues are addressed, and know when and how to involve advocates. We talk about what support the person may need to prepare for the conversation, and have a range of resources that we can share with the person to choose from. If the person wants support, we also talk about who they want to support them. We can offer people support from peer supporters, volunteers and advocates if required.	

b Preparation by the person

1	We don't have any ways to support the person to prepare.	
2	We know that we need to develop support for people to prepare, but are not sure how to start.	
3	We have a standard way to support people to prepare – for example, we send out questions that we ask people to complete before the conversation. We arrange who will have the conversation, the date and the time, and we send this information to the person.	
4	We have some resources to help people to prepare for the conversation. The person can prepare with their family, and we also have a team member with the role of supporting people to do this. People cannot choose who they want to help them prepare.	
5	The person has information and resources to think about what matters to them now, what their aspirations are for the future, what is working and not working for them now, and what they want to change. The person has a range of resources available to help them to do this (for example, written prompts, short films on YouTube where peer supporters talk through the process, and a group process called Planning Live). The person can choose who they want to support them to think about this – whether this is family and friends, a practitioner who they already work with, a peer supporter or a volunteer. The person confirms who they want to have the conversation with, when and where.	

c	Preparation by the practitioner	Tick one box ✓
1	The person who is doing the conversation has the person's notes with them. We don't do any further preparation.	
2	We know we need to do more to prepare, and we are looking at how to do this.	
3	The practitioner involved checks whether the person has had all of their tests, and makes sure that this happens.	
4	We cover preparation at a multidisciplinary meeting when we look at each person's case and make sure that tests have been done, and everyone can comment.	
5	The practitioner reviews all the information about the person - including any previous plans - and identifies any gaps in tasks, tests or assessments, involving other team members as necessary. If further tests or assessments are required, she ensures that these happen in a way that reflects what the person wants, and that the person is central in the process. If it looks like the person could be eligible for a personal budget, she arranges for an Adult Social Care Assessment with her colleagues and the person. She checks that the person has received the results of any tests, and explanations about what these results mean, before the conversation. She summarises what is working and not working, from her perspective and from the team's perspective, based on her preparation before the conversation.	

2 The Conversation

The conversation is between the person and a practitioner (coordinator), along with whoever else the person wants to involve (e.g. family members, peer supporters). The conversation reflects the principle that people are the experts in their own lives, and decide on their own priorities. They are the primary decision makers about the actions that they take in relation to managing their long-term condition, their support and services. Therefore, the conversation starts with what matters to the person. The focus on health and care practitioners is not simply on meeting the person's health and social care needs, but enabling the person to achieve their outcomes. Each individual's outcomes are informed by what matters to the person, their aspirations and their needs. People are more likely to act upon decisions that they have made themselves, rather than those made for them by a practitioner.

There are three areas that are covered in the conversation. The first step is to establish what matters to the person and their priorities; the second involves looking at ideas and options to get to outcomes. Once the outcomes have been agreed, the conversation moves to deciding on next steps, contingencies, recording, and when and how to review progress.

a Starting with what matters to the person and their priorities

		Tick one box ✓
1	We start by only looking at the health information and diagnosis.	
2	We know we need to include what matters to the person, but we are not sure how to do this yet.	
3	We have a checklist that we go through that starts with what matters, and covers health, risks, contingencies and actions. It still feels like a health conversation with health-related actions.	
4	We have a flexible process and always start with what matters to the person, and we are getting more confident about not going straight to actions and making sure to put health issues in the context of the whole of the person's life.	
5	We start by hearing from the person about what matters to them, what they want in the future and their priorities for change. We think together about how to build on what is working and change what is not working. We explore the person's health needs and the impact on their life, and talk about the health information in relation to this. We don't go straight to actions; we explore what the person has already tried and learned. This happens at the person's pace, and it feels like a conversation between equals.	

b From ideas and options to outcomes

Tick one box ✓

1 The practitioner suggests actions to address the person's health needs.	
2 We know we need to look at options, but we are not sure how to go about this.	
3 The practitioner suggests options for the person to choose from, and we set actions around these - but we are not confident about the difference between outcomes and actions, or personal budget information.	
4 We always look at different options, and ask the person for their ideas. We agree on outcomes, but these are not always as well-defined and clear as we would like. We talk about what is available in the community.	
5 We know what the person's priorities are, and look at the resources that they have available to address these (e.g. friends, family, community). If the person is eligible for a personal budget, we talk about the indicative allocation and the different ways that it can be spent (e.g. direct payment or Individual Service Fund). We look at ideas and options for meeting the person's priorities using the resources available and what is available in their local community. This includes support for self-management if needed. We agree clear and specific personal outcomes.	

c Next steps, contingencies and review

1 The practitioner records actions at the end of the meeting.	
2 We agree on actions with the person, and that the practitioner will send them a date for the review.	
3 We agree on actions and look at potential risks, and set a date for the review.	
4 We agree on actions to meet the person's outcomes, and look at risks and any contingency plans. We take a person-centred approach to risk. Reviews always take place six months after the conversation.	
5 Based on the ideas we talked about, we put together an action plan to achieve the outcomes. We talk about any risks and contingencies that we need to put in place, what we need to record and who this will be shared with. We take a person-centred approach to risk. We look at how we will know if things are going well, what would tell us that we need to review, and decide how to keep track of progress and review (in a way that fulfills our requirements of a six-month review, but has more frequent and informal reviews if the person wants these), specifying who is responsible for this.	

3 Recording

There needs to be one single plan that is recognised by the person as 'their plan'. Even if there are separate assessments, the personalised care and support plan is the overarching plan. If the person has a personal budget, the care and support plan needs to be agreed by the relevant authorised person/people.

To comply with the Care Act, the personalised care and support plan needs to clearly show the person's indicative budget, as well as their assessed care and support needs and outcomes. It must also include the budget option decision (direct payment, Individual Service Fund, or managed account) and the budget itself. The plan needs to include the services provided by the council, along with any further advice or information that needs to be provided to them in order to support their wellbeing. The plan has to be signed, and must include the next review date.

a One plan

		Tick one box ✓
1	We have multiple places where we record information, in order to reflect what different stakeholders need.	
2	We know that we need to streamline our recording, but we are not sure how to do this.	
3	We have aligned our paperwork and streamlined it, it is accessible to most of our colleagues but not the person themselves.	
4	We have our records on an electronic system that is accessible to staff members and to the person in question. We don't have the flexibility to print out one-page profiles or other information for the person if they want it.	
5	The personalised care and support plan is a summary of the decisions, outcomes and actions agreed through conversations with the person. The outcomes are person-centred and clearly link to what matters to the person as well as their assessed needs. The information is recorded in a format that is useful to the person (for example, a one-page profile) as well as to the practitioner. The record is easy to navigate, can be produced electronically and in a paper format as needed, and can be accessed by the person and the health and social care practitioner (with permission).	

Tick one box ✓

b Signing off the personal budget element of the Personalised Care and Support Plan (in accordance with The Care Act)

1	The personal budget has to be signed off by a panel/multiple people, and this is a long process.	
2	We are streamlining our signing off process, but it still takes more than one person to sign it off and the process takes over four weeks. Plans often have to be changed and re-submitted because they do not meet the criteria.	
3	We keep the person informed of progress with their plan getting signed off, and plans are signed off in a panel within four weeks.	
4	We keep the person informed of where their plan is up to, and aim to have plans signed off within two weeks.	
5	We have a co-ordinated, streamlined process for efficiently and quickly agreeing personalised care and support plans in under two weeks. The person is involved in the process as much as possible, and we keep people informed of what is happening.	

4 Making it happen

Tick one box ✓

The actions to be taken to achieve the person's outcomes are built from the person out. They begin with supporting self-care – seeing whether the person would benefit from health coaching, assistive technology or other approaches to enable them to more easily manage their long-term condition. Then, actions may focus on the person's natural supports and any actions that they are happy to take, as well as exploring whether further support could help; for example, Community Circles or Side-by-Side Volunteers. Then, we look at what is available in the community – local resources, such as TimeBanks, and opportunities to connect and contribute. Some actions may include making use of voluntary and community services, universal services, and specialist health and social care services. Finally, if the person has a personal budget, there will be actions using the budget to achieve their outcomes

a Self-care

1	We only focus on existing health and social care resources.	
2	We know self-care is important, but we are not sure about how to address this in planning and action.	
3	We make sure that the person is aware of the importance of self-care as part of our conversation with the person.	
4	We talk to the person about improving their self-care as part of the conversation, and we are building ways to actively support self-care.	
4	During action planning, we always explore what could enable the person to manage their long-term condition. We have a range of options to offer people; for example, health coaching and assistive technology.	

b Support from family, friends and community

1	We only focus on existing health and social care resources.	
2	We want to think more broadly than just using existing services, but we are not sure how to do this.	
3	We make sure that we talk about support from family and friends as part of the conversation, but don't usually have any actions that relate to this.	
4	We have started to invest in community, and make sure that everyone involved in planning knows what is possible and available. We are seeing more plans that include actions around family support and community.	
5	When planning, we think broadly and creatively about ways to support the person, including exploring whether family and friends can provide support, as well as community opportunities. We have invested in a wide range of options - both for helping families to coordinate their support (for example, Rally Round and Community Circles), and for opportunities within the community such as TimeBanks, Spice, and support from Side-by-Side.	

Tick one box ✓

c Facilities and services that are available to all in the community, such as parks, libraries, cafes and leisure centres, specialist health and social services

1 We only focus on existing health and social care resources.	
2 We want to think more broadly than just using existing specialist services, but we are not sure how to do this.	
3 We are starting to pay attention to the facilities and services available in the community and we can see how to use these more in addition to specialist services.	
4 We are getting a much better balance in supporting people to use community resources as well as specialist services.	
5 We always focus on community resources before looking at specialist health and social care services. When the person's outcomes require specialist support from health and social care, we work to design this around the person, rather than simply slotting people into existing services.	

d Using a personal budget to buy support

1 Personal budgets are usually allocated as managed budgets with social workers.	
2 We offer managed budgets and direct payments.	
3 We are trying to make the processes for using direct payments easy and straightforward, and we have an organisation that can help people to broker their support and recruit PAs.	
4 We can support people to use direct payments and Individual Service Funds, and people can choose from different organisations to support them in this.	
5 We are able to support people to easily use direct payments and Individual Service Funds, and have a range of ways to support people to employ personal assistants and choose providers for Individual Service Funds. There is lots of information about what is possible, examples of people using their budgets creatively, and support from peer supporters.	

5 Person-centred review

Personalised care and support planning is not a one-off event, but a continuous process of discussion and review reflecting the ongoing changes and priorities in a person's life. The decision about when and how to review the personalised care and support plan is made during the conversation stage. This is in addition to a more formal review every six months – a person-centred review. If an independent advocate was involved in the preparation and conversation stages, then they should be involved in the review as well.

In addition to the six-month review, other reviews might include self-review (with family and friends) or telephone review. These reviews should be proportionate, reflecting the person's needs and circumstances. They can also be built into support programmes such as peer-to-peer or community activities, rehab, 'staying steady', weight management groups, or other elements of a local 'More than Medicine' programme.

The Care Act states that reviews can be planned (i.e. agreed in advance through conversation with the person), unplanned (i.e. triggered by a crisis or sudden change in circumstance) or requested (i.e. called for by the individual or their carer or family member when deemed necessary).

a Reviewing progress

		Tick one box ✓
1	We only do the required statutory reviews.	
2	We want to build in more flexibility around how we are doing reviews, but are not sure how to do this.	
3	We include the topic of how the person wants to review their progress in the conversation, and have a few different standard ways to do this.	
4	We have a range of ways to enable people to reflect on their progress in a planned way. We make sure people know how they can request a review, or what could trigger a review.	
6	We co-design with the person where and how often they want to review their progress, and offer a range of ways to do this. This includes simple ways to keep in touch about progress (e.g. texts, calls and emails), as well as supporting people to get together and look at how they are getting on. We specifically ask people how we would know if a review was required – what their personal triggers would be (for example, a health crisis or change) and how they could request a review.	

b Person-centred reviews – starting with what is working and not working

Tick one box ✓

1 We do our reviews in a standard way – often by phone or through a brief meeting.	
2 We want to put more emphasis on reviews and introduce a more person-centred approach, but we are not sure how to do this.	
3 We have started to introduce person-centred reviews. These always begin with a reflection on what is working and not working from the person's perspective.	
4 We always use the person-centred review process, and make sure that we support the person to think about who they want to involve.	
5 We always use the person-centred review process, starting with what is working and not working from different perspectives. We support the person to decide who they want to be involved, and when and where they want to have the review. We see the review as just as important as the conversation – a way to keep exploring what matters to the person and what they want to change.	

c Reviewing and updating outcomes

1 We do our reviews in a standard way – often by phone or through a brief meeting.	
2 We want to put more emphasis on reviews and introduce a more person-centred approach, but we are not sure how to do this.	
3 We check outcomes in every review to see whether they have been met or not.	
4 In our person-centred review, we look at outcomes – what has worked and not worked, and what has changed. This would trigger a re-assessment if required, and fulfills the review requirements for personal budgets.	
5 We always use the person-centred review process, looking at the outcomes agreed in the conversation, what has worked and not worked in achieving these, and what has changed. We check whether the outcomes need to change and be updated (including a reassessment if required, and fulfilling the requirements for personal budgets).	

d Options, next steps and updating records

Tick one box ✓

1 We do our reviews in a standard way – often by phone or through a brief meeting – and use this to update our records.	
2 We want to put more emphasis on reviews and introduce a more person-centred approach, but we are not sure how to do this. At the moment, we update our records to add more actions.	
3 At the end of the person-centred review, we look at the outcomes/ updated outcomes and decide together who needs to do what to move towards them. We then record this and update our records.	
4 We make sure that we look at different options to achieve the outcomes/updated outcomes, and then decide which ones to take forward. We decide together who needs to do what to move towards them, and we record this and update our records.	
5 For each outcome, we look at options and decide which ones to prioritise. At the end of the person-centred review, we clearly know where the person wants to be in a year's time, and have clear outcomes and SMART actions to move towards this. We make sure that there are actions to update the records, ensuring that the person has access to any information that they want as part of this.	

e Using this information to co-produce service and system change

1 We only use this information to complete our records.	
2 We know that there are opportunities to use this information further, but we are not sure how to do this.	
3 We are introducing processes such as Working Together For Change as a way to use information from person-centred reviews to co-produce change.	
4 We work in partnership with our co-production group to use processes such as Working Together For Change on at least an annual basis to systematically look at information from person-centred reviews – working with service users, practitioners, managers and commissioners to look at what this means for service and system change.	
5 We have six monthly review sessions using processes like Working Together for Change that we deliver in partnership with our co-production group. We make sure we include service users and carers, along with people from health and social care and from the community and voluntary sector, to systematically look at information from person-centred reviews and co-produce priorities for services, systems and commissioning. The priorities and actions are communicated throughout the system regularly, so everyone knows both what has been agreed and the progress being made. This information is included in annual reports for the relevant stakeholders.	

Developing and enabling teams to deliver personalised care and support planning

This section looks at what is needed to enable teams to have the values, capacity and competence needed to deliver personalised care and support planning.

Values and behaviours of practitioners

The TLAP personalised care and support planning resource2 identifies key assumptions and beliefs that drive the behaviour of practitioners. In order to improve, services should therefore be designed to support this new way of working. These values should be at the heart of the training and support programme for staff, and need to be the organising principles for local design teams.

These are:

- People are in charge of their own lives and self-management of their condition/s and are the primary decision makers about the actions they take in relation to the management of these and their support and services.
- People are the expert in their own lives and aspirations and decide on their own priorities.
- The focus on health and care practitioners is not simply to meet the person's health and social care needs, but enabling the person to achieve their outcomes. Their outcomes are informed by what matters to the person, their aspirations and their needs.
- The person is more likely to act upon the decisions they make themselves, rather than those made for them by a practitioner.
- Practitioners need to recognise people's assets, strengths and abilities, and aspirations not just their needs, and support them to live their lives as well as possible, in a way that reflects what matters to the person.
- People are interested in their lives rather than devices or diseases and care needs to be coordinated around the whole person's needs, aspirations and outcomes.
- The conversation between a practitioner and a person is a meeting of equals and experts.
- Care and support should be focussed on helping people to live in a way that reflects what matters to them as part of their community, stay well, and manage their conditions.
- Where deterioration and death are inevitable this can be a helpful component of a care and support planning conversation.
- The personalised care and support planning conversation (how the care plan is agreed) is more important than the plan itself.

Service design principles for personalised care and support planning

When designing care and support plans, it is important to provide a range of people/options for the person to choose from during the planning process – making sure there is a balance between overall continuity and effective use of the practitioner's time and skills.

The following principles will also help to guide the care and support planning process. Naturally, these are linked to the values and behaviours that staff need to display, but have an increased focus on the process itself:

- Everyone involved must understand the care and support planning process, know what to expect and their role in it.
- No major allocation of resource should be made until the views of the person about what's important in their life and the outcomes they want to achieve have been identified and recorded.
- Tasks, tests/assessments should be separated in time from discussion on outcomes and what is important to the person.
- Where relevant and possible assessments should be joint/shared between health and social care. Assessment by itself is not an intervention but could lead to some immediate problem solving and early actions.
- Care should be organised holistically around the person in ways that connect the NHS, public health, social care and community and voluntary organisations, so people tell their story only once, and the focus is on supporting the person to achieve their outcomes.
- Care and support planning is a generic approach appropriate to a variety of contexts which should be linked together as they are introduced as routine (one or more long term conditions, recovery model, preparation for ageing, last years of life and dying).
- People should see the minimum number of different care practitioners, understand the roles of those they see in supporting care delivery and be kept informed during the whole process, in a way that works for the person.
- Decisions should be made as close to the person as possible.
- The process should be proportionate to the person's needs and circumstances - there is no one-size that fits all.
- Where people have a personal budget, they have choice and control over how this is used, and have whatever support they need to decide how to spend it to meet their outcomes.
- Care and support planning is a continuous process, evolving over time - not a plan that happens only once. The plan is not the outcome.
- Documentation must be owned and accessible by the person, as well as to health and care colleagues.
- Practitioners should assume capacity unless otherwise assessed.

What does the workforce need to know in advance in order to effectively deliver personalised care and support planning?

This mix of values, behaviours, process principles and knowledge means that it is crucial for staff to be well-informed and trained before implementation of personalised care and support planning can be a success. It is therefore important that:

- Everyone understands the whole personalised care and support planning process, including the philosophy, and is able to explain the purpose and process to the person as well as their own role in this process.
- Everyone involved in personalised care and support planning needs to be trained appropriately. Training is best undertaken within each team to cover the flexibility of roles and functions that are needed.
- People have knowledge and skills in person-centred practices; for example, one-page profiles, person-centred reviews and Working Together For Change.

Training needs

- Learning about what works needs to be provided using methods which model the personalised care and support planning approach itself – i.e. they should be solution-focused, and recognise assets and strengths of the learners and local community.
- It is the responsibility of the practitioner to reflect on their style of consultation/conversation and assess how it is supporting the person.
- Embedding new habits/skills takes time and support for self-reflection, and reinforcement needs to be provided using a facilitation approach.

Models of learning delivery

A variety of models could incorporate these principles. For example, blended learning could be designed, providing e-learning about person-centred thinking alongside face-to-face sessions to embed attitudes and practice skills.

Ongoing supervision

As organisational roles become flexible, decision-making is delivered closer to the person and specialist skills become spread across teams. As a result, formal arrangements within teams for supervision and support will become even more important. Using a person-centred approach within a supervision model, and embedding person-centred principles and practices, is an essential component of changing the underlying philosophy of care delivery.

1 Preparation

This step involves new roles and ways of working within a team. There needs to be someone responsible for preparing for the process, discussion, coordinating appointments, and working closely with the practitioner/coordinator. We have called this person the administrator. Part of the administrator's role is making sure that the person gets the support they need to prepare, and this could include support from one or more other people in the team. We have called these people supporters – they could be practitioners in the team that already know the person, volunteers, or peer supporters. The voluntary and community sector have an important role here. The third role is the practitioner/coordinator, a named person who ensures that any tests and assessments are completed, including Adult Social Care Assessments, as required. She makes sure that these happen in ways that reflect the discussion that the administrator had about how to keep the person at the centre of the process, and how they want their information.

a Preparation for the process – administrator

Tick one box ✓

1 We don't have a specific role for preparation.	
2 We expect people who are already doing similar roles in the team to cover this.	
3 We have looked at the requirements for this role, and decided whether to review existing roles or create a new role.	
4 We have a person specification and job description for this role, and we are recruiting people/assigning this role and looking at any training requirements.	
5 We have at least one administrator, who holds a warm, friendly, person-centred conversation with the person to explain the process and ensure that they are at the centre of decision making. She is confident in explaining the different resources available and using person-centred thinking tools to help (for example, a relationship circle). She can support the person to decide who they want to support them, and can help them choose a peer supporter or volunteer if needed (for example, she has personal profiles of volunteers who can provide support and can help the person decide who they want to help them). The administrator coordinates appointments and supports the practitioner, ensuring that they have the information that they need from the conversation (for example, how the person wants information).	

b Preparation for the person – supporters

Tick one box ✓

1 We don't have a specific role for supporters.	
2 We know we need to have people available, but are not sure how to make progress on this.	
3 We have clearly identified the role requirements, and are having conversations with peer supporters and colleagues from the voluntary and community sector about this.	
4 We have agreements in place with organisations from the voluntary and community sector, as well as peer supporters, and know how practitioners can fulfill this role as well. We have identified people and are putting training and support in place.	
5 We have a range of people who are supporters, and have the capacity to support anyone who wants help. The supporter enables the person to think about what is working and not working for them, their aspirations for the future, and what matters to them now. She is able to use a range of person-centred practices and resources (e.g. FINK cards, one-page profiles, YouTube clips) to do this. If she is a peer supporter or from the voluntary and community sector, she feels confident working alongside people with other roles within the multidisciplinary team. She supports the person to think about how they want to share the information as part of the conversation, and who else they might want to involve.	

c Preparation by the practitioner and team

1 We don't see this job as requiring a specific role.	
2 We recognise that this is a different way of working, and have added this to everyone's role.	
3 We have identified who in the team is best placed to take up this role, and what capacity we will need.	
4 We have practitioners with this role, and are providing training to enable them to do this.	
5 We have practitioners/coordinators in place who are confident and competent in sifting and reviewing clinical and social care information with their colleagues, and can make proportional judgments about whether additional tests and assessments (including Adult Social Care Assessments) are required, ensuring that these happen in a person-centred way that reflects the preparation for the process. Practitioners take an asset-based approach to their work, can use a range of person-centred practices, and can pull together a 'working and not working' summary from their perspective and from their team colleagues' perspectives.	

2 The Conversation

a Starting with what matters to the person and their priorities

Tick one box ✓

1	We expect our staff in existing roles to be able to do this.	
2	We know that we need to look at different roles, competencies and capacities, but we are not sure how to do this yet.	
3	We have identified the values and competencies related to the conversation, and what matters to the person and their priorities. We have started a programme of face-to-face training for staff.	
4	We have a programme of training and support designed with our co-production group, and co-delivered with them. This includes blended learning, and is focused on training teams.	
5	We have a blended training and support programme for health, social care and voluntary and community colleagues. It has been designed and is being delivered in partnership with our co-production team, or 'experts by experience'. We are focused on training people within their teams, so that we resolve issues and build the team at the same time. Some of the learning is experiential, including listening skills to enable the person to share what matters to them, as well as health coaching. Our programme includes specific person-centred practices; for example, using one-page profiles, facilitating person-centred reviews, and shared decision-making. We provide ongoing mentoring and coaching, support through online communities, and opportunities to reflect (e.g. through action learning sets). All training and support is based on performance outcomes, and we evaluate these.	

b From ideas and options to outcomes

1	We expect our staff to be able to do this already.	
2	We know that we need to look at how to enable staff to know about different options and generate ideas together, but we are not sure how to do this yet.	
3	We have created resources for the coordinator to use to share different options, and we have a face-to-face training course that shows different ways of generating ideas with the person.	
4	We have a wide range of local resources available for people and coordinators. We have worked with the co-production group to make sure these are accessible to people and useful. We have developed local training and support with the co-production group for people to practice and become competent in generating ideas and options, evaluating them together, deciding on priorities and then matching this to local options and possibilities. We have specific training on outcomes, and test people's competence with this in practice.	

	Tick one box ✓
5 We ensure that our range of resources (people, places, community opportunities, and services) are accessible in different formats and reflect the different ways that people prefer to have information. We have a blended training and support offer, co-developed with the co-production group, that focuses on performance. Coordinators are competent in generating ideas and options, evaluating them together, deciding on priorities and then matching this to local options and possibilities. We have training on outcomes, and are confident that all outcomes are specific and person-centred, linked to assessed need, changing what is not working, and moving towards the future the person wants. Everyone involved can talk about different ways to have a personal budget, explain the pros and cons of each, and support the person to make a decision.	

c Next steps, contingencies and review

1 We expect our staff to be able to do this already.	
2 We know we need to look at how to look at contingencies and take an enabling, person-centred approach to risk, but we are not sure how to do this yet.	
3 We have face-to-face training on person-centred approaches to risk, developing contingencies and different ways to think about reviews.	
4 We have worked with the co-production group to develop our enabling, person-centred approach to risk and thinking about contingencies, and our blended training and support reflects this.	
5 We have a blended training and support offer, co-developed with the co-production group, that focuses on our enabling person-centred approach to risk and developing contingencies. We have support for coordinators as they develop their skills and competence, and this includes lots of opportunities to practice and get feedback. Our training and support includes a range of ways for people to be supported to review their progress, and everyone can give several different examples of how people can do this.	

3 Recording

a One plan

Tick one box ✓

1 We can still only record in multiple places to have no need to train staff to do anything differently.	
2 We know we need to train staff to think differently about recording and try the shared system, but we are not sure how to do this.	
3 We are delivering face-to-face training to all our colleagues, both in health and social care and in the voluntary and community sector, about sharing a single record and having one plan. We are introducing people to the person-centred practices that they will find useful (e.g. one-page profiles, relationship circles, communication charts). People are trained to agree on the detail and wording that works for the person and the practitioner.	
4 We have blended training to support everyone to use the shared, single record. This includes the person-centred practices that people need.	
5 We have worked with the co-production group, health and social care workers, and the voluntary and community sector, in order to think about the language that we use and how we create one plan together. Our blended learning and support enables consistency of recording across all sectors, and keeps the person at the centre of this.	

b Signing off the personal budget element of the personalised care and support plan (in accordance with the Care Act)

1 The personal budget has to be signed off by a panel/multiple people, and we expect them to know how to do this without training.	
2 We know we need to do more to make sure that signing off is consistent amongst the different people involved, but we are not sure how to do this.	
3 We have face-to-face training to make sure that everyone involved in signing off plans knows the criteria to use, and does this consistently. We know that anyone presented with the same plan would sign it off in the same way. Staff are conversant with Care Act requirements and expectations around PHB usage and management, as well as local data collection requirements.	
4 We have blended learning opportunities to make sure that everyone signs off plans according the criteria in the Care Act, and the values that underpin them. People are aware of a range of ways to keep a person informed of where their plan is up to.	
5 We have blended learning and ongoing support so that our coordinated, streamlined process offers consistency for people in how their plan is signed off. Staff are able to suggest and agree ways to keep people informed that fit with their communication preferences, so that they know what is happening with their plan at all times.	

4 Making it Happen

a Self-care

Tick one box ✓

1	We expect practitioners to know this without training.	
2	We know self-care is important, but we are not sure about how to address this in training for staff.	
3	We have training to make sure that all practitioners are aware of the importance of self-care as part of the conversation.	
4	We have learning opportunities for colleagues from health, social care and the voluntary and community sector to learn about specific practical strategies to support self-care; for example, health coaching.	
5	We have ongoing blended learning opportunities, coaching, mentoring and support to ensure that there is always a conversation about self-care – and we can offer practical ways for the person to develop their motivation, skills and knowledge in doing this, if they so wish.	

b Support from family, friends and community

1	We expect staff to know this and do it already.	
2	We want to think more broadly than just using existing services, but we are not sure how to do this, or how to equip our staff in this.	
3	We make sure that colleagues know the range of community resources in the area, and can share these with people when they are thinking about options. We have training on how to support and involve family and friends.	
4	We have worked with the co-production group, and local community groups and leaders, to provide training and support on using community resources to help people achieve their outcomes. We have training sessions on options for engaging with families, friends and neighbours, as well as initiatives like TimeBanks, Spice, Community Circles and Rally Round.	
5	Our blended learning, support, coaching and mentoring enables people to think broadly and creatively about ways to support the person – including exploring whether family and friends can provide support, as well as community opportunities. Our staff are all confident in knowing what could help, and explaining the options (TimeBanks, Spice, Community Circles, Rally Round) to people so that they can make an informed decision. Staff know exactly how to connect people with the community resources that they want to use.	

c Using a personal budget to buy support

Tick one box ✓

1	We expect staff to know about personal budgets without training.	
2	We know that not everyone is confident in talking about personal budgets or how to use them, but we are not sure how to get started on changing this.	
3	We have some face-to-face sessions for staff on personal budgets, how to use them, and how to talk about them in care and support planning conversations.	
4	We have co-designed training with the co-production group, who help us deliver it. People are able to talk confidently about direct payments and Individual Service Funds, the pros and cons of these different ways of having a budget, and where to go/what to do to take these options forward.	
5	We have blended learning and ongoing support so that everyone is confident about personal budgets and the ways that they can be deployed (for example, direct payments and Individual Service Funds), as well as what they can and cannot be used for. Staff can help with the next steps to support people to employ personal assistants, and to choose providers for Individual Service Funds. The ongoing support includes up-to-date stories and examples to share with people about the difference that personal budgets can make.	

5 Review

a Reviewing progress

Tick one box ✓

1	We expect staff to know how to do this without training.	
2	We want to build in more flexibility around how we are doing reviews, but we are not sure how to train and support staff to do this.	
3	We have awareness training for staff on different ways that reviews can take place.	
4	We have training for staff on different ways to do reviews, what should trigger a review, and the person-centred practices that can help – for example, 'working and not working from different perspectives' or 4 plus 1.	
5	We have co-designed blended learning with the co-production group, offering staff a range of ways to develop their competence in different approaches to review and the person-centred practices that can help. We have action learning sets and other reflective processes for people to share progress and problem-solve together.	

b Person-centred reviews

1	We do our reviews in a standard way, often by phone or through a brief meeting, and staff do not need training in this.	
2	We want to introduce the person-centred review process, but we are not sure how to do this.	
3	We offer training in person-centred reviews for all coordinators.	
4	We have training for person-centred reviews, and the co-production group are involved in delivering this.	
5	We have blended learning approaches to enable coordinators to deliver person-centred reviews, and ensuring that everyone knows what they are and why they are important. We provide ongoing support through coaching, mentoring, online communities and action learning sets.	

Tick one box ✓

c Using this information to co-produce service and system change

1	We do not co-produce change, and therefore do not need any training on this.	
2	We know that there are ways to use information from person-centred reviews to develop services, but we are not sure how to take this forward.	
3	We have awareness training in Working Together For Change, and we are training local facilitators.	
4	We work in partnership with our co-production group to use Working Together for Change, and have a training and support programme to enable them to deliver this.	
5	We have blended learning opportunities for everyone to learn about what Working Together For Change is, as well as providing facilitators to deliver the sessions. We are part of a larger community of people delivering Working Together For Change, so we have lots of opportunities to reflect on practice and keep developing based on best practice.	

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