Community Living Transition Plans

Context

The Congregated Settings project plan requires Organisations who are supporting people to move into the community to submit an Organisation Plan to the Local Implementation Teams (LIT) for approval.

The Organisational Plan will include key relevant information and evidence how it will implement the plan. Appendix 1 identifies the key requirements of this Organisational Plan and this guidance refers to Organisational Requirement 9.

Purpose

This guidance;

- aims to inform and guide Organisations when supporting People to develop their plan to move into the Community.
- sets out the key ingredients required within these plans to ensure that the Person is fully supported and assisted to have a successful and sustainable move into the community.
- aims to inform and guide the LIT when reviewing Organisational Plans to ensure all Community Transition Plans meet the requirements within this guidance. Appendix 3 provides a checklist of questions that might be used in this process.

Rationale

The Congregated Settings Report highlighted the below variances in existing practices with regard to Person Centred Planning.

"Person-centred planning"

According to the survey, in about a third of units residents had limited access to person-centred planning or no person-centred planning” and the table showed the following stats re PCP practices.
### Table 10: Person centred-planning (PCP)

<table>
<thead>
<tr>
<th>Description</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>no PCP planned or implemented</td>
<td>9%</td>
</tr>
<tr>
<td>limited, ad hoc, person-centred planning, implementation and review</td>
<td>23%</td>
</tr>
<tr>
<td>Structured planning and implementation of PCPs, some gaps</td>
<td>43%</td>
</tr>
<tr>
<td>Structured planning, implementation and review of PCPs with little or no gaps</td>
<td>25%</td>
</tr>
</tbody>
</table>

It is clear from the above data that not all Organisations are using the PCP model; however this is a requirement of the Organisational Plan. The LIT may advise Organisations on the PCP options available - Appendix 2 identifies some ‘brands’ of PCP and further exploration of such resources should take place with relevant bodies e.g. Disability Federation of Voluntary Bodies (? Pooling of existing tools and resources currently used).

There will be a variety of models of PCP’s presented to the LIT from different organisations and it is neither reasonable nor feasible that a particular model is recommended by the National Implementation Team (NIT); therefore this guidance clarifies the key ingredients required in all plans.
Key Ingredients of Community Living Transition Plans

1. The role of the ‘Independent’ Person
2. The Support Staff – The Right Relationship
3. Circle of Support
4. Communication Strategy
5. Vision
6. Risk Assessment
7. Transition Plans & PCP’s
8. Implementation & Review
9. partnerships & Funding
1. The role of the ‘Independent’ Person

The Toolkits Sub group highly recommend the inclusion of an Independent Person in a Community Living Transition Plan.

This Independent Person will be supported to carry out their functions by the LIT.

When identifying the Independent Person the NIT will need to consider the options available to them:-

- Citizen Advocacy Model
- Reciprocal Co-ordinating Model – Champion Model
- Role of existing HSE staff members such as the Occupational Guidance Officers or Liaison Nurses.

(Proposed Reciprocal Co-ordinator Model - Organisations will identify a number of trained Champions proportionate to the size of the service to the LIT. A register of trained Champions will be established by the LIT who will then allocate accordingly from this register. This approach would need further exploration regarding boundaries, role, confidentiality and employment issues)

**Whichever model is chosen the Independent Person will need to have:-**

- Adequate training – have an awareness of range of Community Living Options.
- Problem solving ability
- Commitment to Values
- Independence – not compromised by Organisation
- Risk Management skills – Risk Minimiser and Rights Maximisation
- Ability to mobilise the plan
2. The Support Staff – The Right Relationship

The ‘Right Relationship’ between the person and the staff member involved is key in the development of a transition plan in order to increase the likelihood of successful and sustainable transitions into the community.

Organisations must display ‘person centred thinking’ within policies and practices. In order to identify the relevant staff members responsible to support transitions.

The organisation will show:-

- Relevant Staff training has taken place
- Policy to Practice is evident – the values of the organisation are apparent within the practice of the staff team – the quality of the plans will reflect this clearly.
- Staff have access to PCPs and Person Centre Thinking toolkits to inform their practice
- The matching of the Person with their ‘Keyworker’ has been informed by the Person’s preference and the skill set of the worker [or those who know the person best would deduce as a good match based on their direct contact with the person].
3. Circle of Support

Evidence suggests that when the ‘right’ people are supporting the person then there is a far greater chance of a plan being developed in line with the Person’s will and preference. This is particularly key where the Person does not use verbal language to communicate. People who know the person well and can share their knowledge of the person will be valuable contributors to the transition process.

The circle will need to:

- Include Informal Supports - Family, Friends, Significant Others, Volunteer, Community Members
- Include Formal Supports – Independent Facilitator, Service Provider staff, relevant professionals (OT’s, Physio, SLT’s),
- function in a participatory manner and include the person at all times possible.
4. Communication Strategy

Evidence suggests that ‘fear’ of the unknown is very disempowering for People. Cases highlight that in situations where unplanned or unknown ‘change’ takes place this has triggered anxieties in people. Naturally this, in turn, causes people to display their ‘fear’ or anxieties in behaviours that have been to detriment of them. Clear pathways of communication needs to be established to alleviate fear and inform the person of due changes.

Factors that would assist people through changes include:-

- Appropriate communication delivered using the Person’s communication system
- Change Management Strategies – Proactive Identification of possible anxieties/fears and strategies to alleviate/support these e.g. front loading of supports in transition etc
- Pacing – specific for the person’s needs e.g. gradual exposure to change

Support for Decision Making – exploring other alternatives

People who have not had the benefit of experiential learning or exposure to real ‘choice’ must be given support and opportunities for such. BILD have produced a document and CD called ‘Involve Me’ which identifies ways in increasing the involvement of people with profound and multiple learning disabilities in decision-making and consultation – further exploration of other resources is required to identify tools which enhance involvement for the Person.

To ensure ‘informed choice’ the following must be considered:

- how Person communicates their will and preference
- the person’s preferred lifestyle option
- the supports required to enable the Person to express their will and preference
- the alternatives ‘Living Options’ identified and explored
- the level of involvement the Person has had in the decision making process
- Use of Assessments grounded in a Quality of Life Assessment/Occupational Therapy tools
5. Vision

Evidence suggests that a Person’s transition to communities have often been predetermined by the organisation and rooted in an ‘Accommodation’ move rather than a ‘Lifestyle’ change. Plans have been disproportionately developed in line with the person’s ‘vulnerability’ and ‘safeguards’ as opposed to being directed by the Person’s skills, supports and wishes.

Plans need to be developed in line with a ‘Lifestyle’ change for the person. Cases show that a Person’s ‘Hopes and Dreams’ and ‘Vision’ are often informed by low expectations, a paternalistic approach, a lack of ‘Imagining better’ and organisational constraints (staff/resources). An Independent Person will bring with them an unbiased perspective of the Person and will have the ability to question and challenge.

The Independent Person will:

- display a belief in the Person’s ability for lifelong learning,
- identify supports needed for the Person to ‘grow and develop’
- identify most ‘pressing’ supports required – What will have most impact to effective positive change for the person
- uphold the right to dignity of risk
- hold commitment to ‘Imagining better’
- ensure the plan is a ‘Lifestyle ’ plan
6. Risk Assessment

Evidence has shown that some organisations are risk adverse. Risk Assessments have been completed that have resulted in rights restrictions as opposed to enabling risk. Cases showed that often ‘perceived’ risk is what limited People’s rights to pathways to full inclusion. These ‘perceived’ risks impacted on the opportunities for the Person to make choices, experience, grow and develop.

Good risk management supports people to participate in the community like any other person while keeping risk at the lowest possible level. As risk is a natural reality of community living the key is to proactively identify practical support measures that intentionally safeguard against high level risk.

The Independent Person will:

- employ good risk analysis
- recommend risk management strategies – intentional safeguards
- hold a high degree of objectivity and skills to challenge
7. Transition Plans & PCP’s

Case evidence has shown that PCP’s are often absent or were limited, ad hoc, lacking person-centred thinking, lacked implementation, were not SMART and not reviewed. Some cases evidence that a move to the community may result in the person feeling more isolated and restricted if not ‘connected’ into the community. Other cases highlight how the focus for community living has been rooted in ‘structural access’ and ‘staff rosters’ rather than the Persons’ ‘choice’.

Given that not all Organisations will have PCP’s and that there appears to be a variable in the quality and implementation of PCP’s the Toolkits sub group would strongly recommend that it would be a minimum requirement to have a Community Living Transition Plan in place for all People who are being supported to move into the community.

This Plan can be a ‘stand alone’ plan which specifically supports a person through a transitional period in their life; however this document should inform the holistic PCP’s to ensure continuity and standardisation for the Person. Key to the success of any Transition will be the quality of the planning, implementation and reviewing of the plan.

A Transition plan must be specific, clear in purpose and identify:

- Personal Profile including past, present and future - including life history, uniqueness, identity, culture, preferences

- Person preferred Living Option - A place to live that’s home – Why, Where, Who, When, & How
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- Timeline reflective of the needs of the Person – e.g. Individual Living Skills Program prior to move
- A circle of support
- A plan ‘B’
- Links to holistic PCP

Considerations regarding which Community is considered must be given to:-

- The suitability of the community in offering a ‘valued social role’ for the person
- The suitability of the community in terms of local connectedness
- The suitability in terms of the Person’s interests, wants, skills and supports – opportunities to facilitate community relationships
- The size of the community
- The readiness of the community
- Availability of supportative services such as ‘Lifestlye Coaching’ or ‘Befriending’ Services

(Befriending Services can offer a link with the community via the matching of a person with a volunteer, the NIT may need to establish the gaps of such service provisions nationally and make a recommendation to the developments of such supports.

The Community Living Plan Model which identifies the following key ingredients includes:

- The Person’s Dreams & Vision
- A Network of family, friends and supporters
- Clarity and Support in Decisions making and governance
- Opportunities to ‘imagine better’ and explore new alternatives
- Plan for participation, contribution and community engagement
- A practical plan including resources required to support community living
- A place to live that’s home – Where, How & How
- Partnerships and shared responsibilities
- Safeguards.
A Community Living Transition Plan must be developed in a format that meets the needs of the Person.

8. Implementation & Review

Evidence suggests in some cases where PCP’s in place they were not SMART and it was unclear who was responsible for what action, unclear timelines, lack of monitoring implementation, lack of implementation.

Transition Plans & PCP’s should be viewed as ‘live’ documents which are continually reviewed, edited, modified and are responsive to the needs of the Person.

The Coach will:

- Ensure the plan meets the wants and needs of the person
• Ensure the plan is SMART

• Ensure the plan is implemented

• Ensure the plan is reviewed (reviews every 3 months)

• Ensure the changing needs of the person is considered within all reviews

9. Partnerships & Funding

Some case evidence shows that when People have been supported to move the community the funding of services has been problematic.

The transition plan will:

• Identify what resources are require to support the plan – funding, equipment, community resources/facilities, circles of support resources, and staff skill sets

• Identify which Service Provider best meets the needs of the Person
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- Identify who is funding this plan
- Identify the Person’s financial contribution
- Identify who will co-ordinate Funding for the plan and the timelines for such
Appendix 1

**Organisational Concept Plan**

This should include:-

1. Clear point of focus – Governances and Ownership, Timeframes, Policies and Procedures
2. Funding
3. Criteria for selection
4. HR plan – Mobilisation of staff and resources/organisational re-structuring
5. Interagency Collaboration - Community Readiness - How they have measured the readiness of the community?
   What links have been made with mainstream services?
   (SIMS, CIS’s, Primary Care Teams etc)
6. Housing Options
7. Mapping of Gaps – identify additional resources/training.
8. Training and Education
9. Assessment Tools - Quality of Life/Needs Assessment/Person Centred Planning Tools
10. Community Living Transition Plan

Appendix 2

Models of PCP
**Essential Lifestyle Planning** (ELP): essential lifestyle planning is a tool that lets you know how someone wants to live and shows you how they would like it to happen through an extremely detailed action plan.

ELP lets you discover what is important to service users, what support they need (from their perspective) to remain healthy and safe. A good plan reflects the perceptions of the service user and those who love and care for that person. Essential lifestyle plans look at:

- what people like and admire about service users
- what is important to service users
- communication
- how to provide support
- identification of successful methods
- how to solve problems.

ELP is a good way of starting to get to know someone, and work out what is needed on a day-to-day basis. It does not focus on 'dreams' unlike some of the other methods.

**Personal Futures Planning:** this is similar to essential lifestyle planning, and includes access to community resources. It is a way of describing life now and looking at what the person wants in the future. It provides more of an overview than the detail of some of the other approaches.

**PATH:** PATH stands for Planning Alternate Tomorrows with Hope. This is a fast-moving tool that can be quite graphic and powerful. It pays most attention to the process of change, and helps a group of people who are committed to the person to understand the plan and how it will progress. This is not so much about gathering info, but planning action. It focuses on the 'dream' and works its way back from there, mapping actions required along the way.

**MAPS:** this is similar to PATH, below, in that it focuses on desirable futures or dreams, and how people might try to achieve these. It covers people's history and identifies their gifts.
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- **Circles of Support**: a circle of support is a group of people who meet to help someone along the path to their hopes and dreams: a support network. The focus person asks the support group to help them to leap over barriers that they might come across. The support group also helps the person by opening new doors to opportunities and experiences.

- **IPlanit** – Offers web based ‘live’ plans ([www.paradigm-uk.org](http://www.paradigm-uk.org))

Appendix 3

**Questions Cheklist for Community Living Plans**

**The Person's Dreams and Vision for their life**

1. Has the person’s preferred method of communication been identified?
2. Have you used this method to inform the person about their move to the community?
3. What evidence do you have for this?
4. Is there a detailed Personal Profile including past, present future including life history, uniqueness, identity, culture, preferences?
5. What are the person’s Vision and Dreams for community living?

**A Network of family, friends and supporters**

1. Has the considerations informed the matching of the Person and the Independent Person?
2. Has the ‘Right Relationship’ considerations informed the matching of the Person...
3. How has the person been supported to identify a Circle of Support?

4. Does this Circle of support have involvements from
   a. Informal Supports - Family, Friends, Significant Others, Volunteer, Community member?
   b. Formal Supports – Independent Facilitator, Service Provider staff, relevant professionals (OT’s, Physio, SLT’s),

5. How will the ‘Circle of Support’ function?

**Plan for participation, contribution and community engagement**

1. What tools were used in the planning of this transition?
   (Communication system of the person, Person Centred Plan, ‘Person Centre Thinking’ toolkits)

3. How did you use the preferred method of communication to involve the person in their assessments?

3. Has a ‘needs’ assessment been completed using the organisations preferred tool?
   “What is important for this Person?”

4. Has a ‘wants’ assessment been completed using the organisations preferred tool?
   “What is important to this Person?”

5. Have the ‘needs’ for continuity and security been identified in these plans

6. Was the variables considered when assessing including preferred environments, preferred staff, time of day, differing locations, appropriate pace etc

7. How was the process of exposing, exploring and educating used to clarify uncertainties?

8. Have these assessments been agreed and signed off by the Circle of Support?

9. Is the plan SMART?
10. Is there a clear map of how the person will participate and contribute to each stage of their transition?

11. Is their evidence of choice, inclusion, maximum participation and independence?

12. Is the ‘change management’ support identified and available for the lifestyle changes?

**Community Participation – Belonging**

1. Does the plan identify the pathway to work/meaningful activity for the person?
2. Does the plan identify the pathway to sustain and develop relationship?
3. Does the plan identify the pathways to housing for the person?
4. Does the plan identify the pathway to health for the person? (including holistic health professionals)
5. Does the plan identify the pathways to social and leisure for the person?
6. Does the plan identify the ‘valued role’ the person will offer the community they are moving into? Opportunities to ‘imagine better’ and explore new alternatives

**Opportunities to ‘imagine better’ and explore new alternatives**

1. Choice - How will the process of exposing, exploring and educating be used to clarify and support the Person in decision making? Meaningful choice = array of options proposed

**Clarity and Support in Decisions making and Governance**

1. What is the person’s preferred lifestyle option?
2. How did they communicate this preference?
3. How has the person been supported to make lifestyle decisions?
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4. Was this supported grounded in a Quality of Life Assessment/Occupational Therapy assessment tool?

5. Risk – Have potential and actual risks been identified?

6. Is there a risk management plan that identifies the risk and support measures?

A practical plan including resources required to support community living

1. Who is funding this plan?

2. What financial contribution has the person to make?

3. Does the plan have short, medium and long term goals?

4. Are these Goals SMART?

5. Will this circle of support continue to support the person through the transition?

6. Does the plan highlight the resources required?