A National Framework for Person-Centred Planning in Services for Persons with a Disability

New Directions

Building a Better Health Service

Seirbhís Sláinte Níos Fearr á Forbairt

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1 Introduction and Background

1.1. Why do we need a framework for person-centred planning?

For persons with disabilities receiving support services, person-centred planning is a key process to focus the delivery of services and supports on the person and how they want to live their life. This framework has been developed in response to an identified need for a more consistent approach to person-centred planning in Ireland.

The framework is designed to support adults with disabilities with person-centred planning. Person-centred planning can be carried out within or separate to services. This framework is guidance for when it is carried out within an organisation which supports persons with a disability.

The framework will be of interest to anyone involved in person-centred planning, in particular:

- persons with a disability, their families, circles of support and advocates
- organisations that provide services and supports to persons with a disability
- managers and staff who wish to review and develop their approach to person-centred planning
- the HSE
- the Department of Health
- HIQA

The framework is relevant for all services for persons with a disability, including day, residential, home and community.

For the purpose of this document, the term 'organisation' will be used to refer to organisations providing services and supports to persons with a disability.

1.2. What are the aims of the framework?

This national framework is intended to inform and guide how person-centred planning is implemented across services for persons with a disability in Ireland. The framework sets out to give a clear picture of what good practice looks like and to support individuals, teams and organisations to identify areas for improvement.

The aims of the framework are to:

- support the achievement of positive outcomes for persons with a disability
- support individuals and teams to consistently deliver good practice in person-centred planning
- foster an ongoing commitment to person-centredness and person-centred planning
- identify the key beliefs and foundations which are at the centre of good person-centred planning
- embed and sustain the main elements of good practice in person-centred planning
- encourage individuals, staff teams and managers to evaluate and critically reflect on their organisation's policies and practice in relation to person-centred planning
- make practical recommendations to support effective person-centred planning
- identify tools and resources that support good practice

1.3. What is the context for this framework?

1.3.1. Transforming Lives

The HSE is undertaking a major reform of services for persons with a disability entitled **Transforming Lives**. At the heart of this reform is to support persons with a disability to live a life of their own choosing in the community, and to make services genuinely person-centred. The approach is grounded in a move from organisation-led services to community and individualised supports, which are focussed on the achievement of meaningful personal outcomes.

The reform programme is based on a number of key reports, including:

- New Directions, Personal Support Services for Adults with Disabilities
- Time to Move on from Congregated Settings
- Value for Money and Policy Review of Disability Services

Following a public consultation on the Draft HSE Interim Standards for New Directions in 2015, the New Directions National Implementation Group identified the need for a national framework to support a consistent approach to person-centred planning.

The need to develop guidance on person-centred planning was also identified through the work of the HSE Social Care Division / Quality Improvement Division Quality Improvement Programme, which is working across HSE residential services for persons with intellectual disabilities.

1.3.2. Research

This framework builds on the 'NDA Guidelines on Person-centred Planning in the Provision of Services for People with Disabilities in Ireland', published in 2005, but is also informed by research on learning in the intervening period.

In 2016, three strands of research were carried out to inform this framework for person-centred planning in Ireland, these can be viewed on www.hse.ie/newdirections

- A review of the literature since the publication of the NDA Guidelines on Person-Centred Planning in 2005
- A 360 degree look at a series of person-centred plans as case studies of current practice, along with interviews with key informants with knowledge of person-centred planning in residential services for persons with a disability
- An analysis of 50 HIQA inspection reports to ascertain what they say about person-centred planning in residential services for persons with a disability.

This research identifies the key aspects and principles of good practice in person-centred planning, providing a valuable insight into current practice in Ireland and highlighting the strengths, gaps, opportunities and issues evident at this time.

1.3.3. Outcomes

A focus on outcomes is considered to be an essential part of the recommended service delivery framework under Transforming Lives.

The National Disability Authority, following a request from the Department of Health, is developing a draft framework for outcomes measurement for the proposed model of person-centred disability services.[1] Nine outcome measures have been identified, as follows.

The persons who use disability services:

1. Are living in their own home in the community
2. Are exercising choice and control in their everyday lives
3. Are participating in social and civic life
4. Have meaningful personal relationships
5. Have opportunities for personal development and fulfilment of aspirations
6. Have a job or other valued social roles
7. Are enjoying a good quality of life and well being
8. Are achieving best possible health
9. Are safe, secure and free from abuse

In person-centred planning, these outcomes may be a useful reference point to support a person to set their goals, and to understand how these goals may lead to positive outcomes.

[1] The NDA paper on outcomes for disability services – http://nda.ie/Publications/Disability-Supports/NDA-paper-on-outcomes-for-disability-services.html

1.3.4. National and International policies and issues

The framework has also been informed by a number of national and international policies and issues, which have influenced thinking and practice in relation to person-centred planning in Ireland. These are listed in Appendix 1. For example, the framework is mindful of the provisions of the Assisted Decision Making (Capacity) Act, 2015.

The issues identified are outside the scope of the framework, but their influence on outcomes is acknowledged.

1.4. How can the framework help?

The framework is designed to promote a consistent standard of practice. It signposts information and evidence from research, and supports the reader to transfer this into effective, everyday practice.

It sets out to provide support for culture development that promotes and honours the beliefs and foundations of person-centredness and person-centred planning. The framework seeks to assist organisations to embed self-evaluation and reflective practice into their person-centred planning policies. It provides tools to support individuals, teams and organisations to identify strengths in person-centred planning and to address areas for improvement or further development.

1.5. How should this framework be used?

As part of a person-centred approach, context should be a determining factor when individuals or teams are engaging with the framework. Most of the elements of good practice will be applicable to all contexts. In this document, context means the environment where practice takes place including all the factors that impact on that such as culture, leadership, physical environment and relationships.

Some recommendations for good practice may relate to persons with specific support needs. At all times, the user must decide if each statement of practice in the guidance and/or evaluation tools is meaningful to the person and their context, and to improving the effectiveness of person-centred planning for the individual.

A key principle of the framework is that services and supports are tailored to individual need. The scale of needs is most diverse as it covers all people with disabilities that are in receipt of HSE funded supports through disability funded services.

This framework does not give detailed guidance on the implementation of person-centred planning. Specific resources to support organisations and staff at the different stages of person-centred planning are available at www.hse.ie/newdirections

The framework does not provide templates to record person-centred planning. Examples of different planning tools and approaches are listed in Appendix 3.

1.6. The structure and content of the framework

Section one outlines the rationale and background to the development of the national framework. In section two of this framework, a number of key terms are explained in detail. In section three, the beliefs and foundations that underpin person-centred planning are summarised.

Section four outlines organisational culture, structures and processes, which strongly influence the quality of the person-centred planning process and the achievement of outcomes.

In section five the essential steps to achieving good practice are discussed. Person-centred planning is broken down into four stages:

- **Stage 1 - Getting ready to do a person-centred plan**
- **Stage 2 - Putting a person-centred plan together**
- **Stage 3 - Putting a person-centred plan into action**
- **Stage 4 - Finding out if person-centred planning is working**

Section six outlines an evaluation process which can be used to assess the implementation of the framework and current person-centred planning practices, and to determine planned changes and actions.

2. What is person-centredness, person-centred planning and a personal plan?

2.1. Person-centredness

Person-centredness is part of an overall approach to enable person-centred cultures that benefit all individuals; those who use services, their families and staff. It recognises the uniqueness of all individuals when planning and providing services. The values of person-centredness underpin person-centred planning and form the overall approach to providing personalised care and support.

The HSE, in its commitment to enabling cultures of person-centredness throughout the system, adopts the following description of person-centredness:

> ..." an approach to practice established through the formation and fostering of healthful relationships between all providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development"
>
> (Adapted from McCormack & McCance, 2016:3[1]).

The description refers to the need to foster 'healthful relationships'; these are relationships that enable possibilities for all individuals; those who use services, their families and staff, to achieve maximum wellbeing and flourish in all aspects of their lives. The description also acknowledges that person-centred practice requires cultures that continuously support person-centredness by enabling individual staff and teams to develop their person-centred practice at all levels within their organisations.

2.2. Person-centred planning

Person-centred planning supports and enables a person to make informed choices about how they want to live their life, now and in the future. It supports the person to identify their dreams, wishes and goals, and what is required to make those possible.

Person-centred planning requires the supports available to be responsive to the person and to focus on the outcomes they want to achieve. It is vital that the entire person-centred planning process is accessible to the person, and that all information provided is in a format that is meaningful to them.

This framework for person-centred planning sets out the key stages of the process and what is important at each stage for person-centred planning to be effective. However, the best measure of success for person-centred planning is whether the individual at the centre of the planning process has experienced a real change for the better in his or her life, as a result of their person-centred plan being implemented.

2.3. Personal Plans

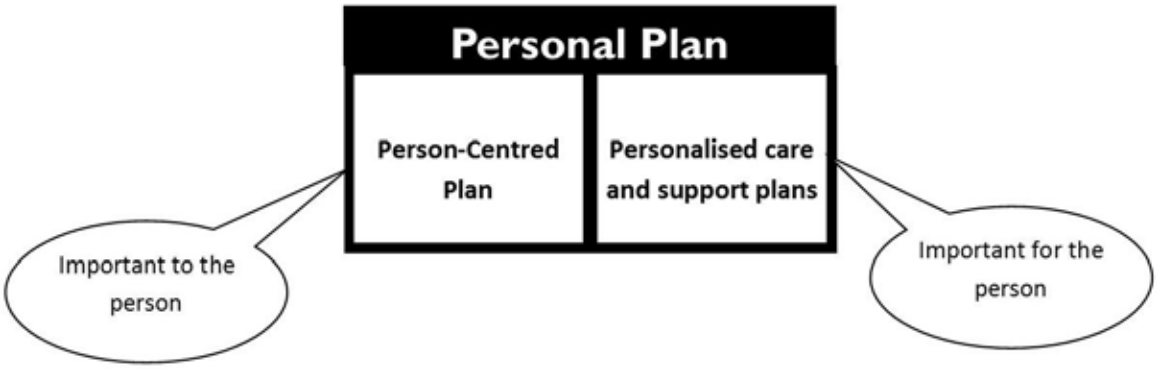
The standards and regulations for residential services for people with disabilities in Ireland require each person using residential services to have a personal plan. An overarching personal plan can contain a number of different types of plans, depending on the person's individual needs. The personal plan also includes the person-centred plan.

'Personalised care and support plans' is a term used in this framework to cover a range of different support plans that respond to a person's everyday needs. They could for example include a person's communication passport, intimate care plan, medication management plan or positive behaviour support plan. Personalised care and support plans also form part of a personal plan.

Figure 1.1 below illustrates that personalised care and support plans and a person-centred plan both form part of a personal plan. Recognising what is important to a person and what is important for them can help to understand the difference between person-centred planning and personalised care and support plans.

Person-centred planning is about what is important to a person, what really matters to them, from their perspective. Personalised care and support plans are about what is important for the person, the support they need to stay healthy, safe and well.[2]

Figure 1.1: Illustration of personal plan containing personalised care and support plans and the person-centred plan



2.4. What are goals and outcomes?

For the purpose of this framework, a goal is defined as a desired result a person wishes to achieve. Goals can be short or long term. Goals are the things set to reach an outcome.

An outcome is defined as the possible end result of what someone wants to do. An outcome can have many goals. For the purpose of this framework, outcomes are a positive change in a person's life.

It is important to note that having a person-centred plan is not in itself either a goal or an outcome. Rather the person-centred plan is a means to achieving goals and outcomes.

[2] http://sonoranucedd.fcm.arizona.edu/sites/sonoranucedd.fcm.arizona.edu/files/Roadmap_Resource_Materials/Chapter3_PersonCentredThinkingTool.pdf

3. The core beliefs and foundations of person-centred planning

Person-centred planning is grounded in a rights-based approach to the provision of services and supports. Organisational culture is a key influencing component of person-centred planning. The research identified a number of beliefs and philosophies that are considered to be at the foundation of good practice in person-centred planning. The beliefs and foundations outlined below should be adopted at all stages of the process.

3.1. Beliefs

These beliefs are at the centre of good person-centred planning:




Individuality; each person is an individual with their own life experience, skills, gifts, talents and culture.

Equality; each person with a disability has the same rights as all others in society. Each person is given information and support to understand and claim their rights.

Respect; each person is treated as an adult. Relationships are built on respect.

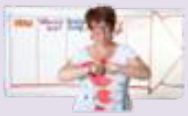
Dignity; the privacy and dignity of each person is respected. Each person with a disability is given the chance to take risks and try new things.

Empowerment; person-centred planning supports the person to take control of their life. Each person is supported to have their say and their views are respected.

Choice; everyone is given the chance to make choices and decisions about their person-centred plan and about their lives. Individuals are supported to communicate their choices and decisions.

Inclusion and active citizenship; each individual is an important member of their community, trusted to hold valued social roles. Person-centred plans support the person to take part in their community, to make new friends and have new experiences.

Independence; each person is supported to be as independent as they can be.

3.2. Foundations

These foundations are the building blocks of person-centred planning:




Beliefs; organisations have a person-centred culture. They believe in individuality, equality, respect, dignity, empowerment, choice, inclusion and independence.

Person-centredness; services and supports are built around the needs of each person rather than a group.

Outcomes; person-centred planning is about achieving outcomes for the person. Outcomes are good changes that give each person a better life.

Planning across an organisation; person-centred planning is important at all levels of an organisation. It is part of how the whole organisation works and is not a new or separate service.

Every plan is different; every person-centred plan is a one-off. It shows the individual's strengths, needs, goals, dreams and wishes.

Listening; individuals, staff teams and managers really listen to and respect the choices that each person makes. They accept and respond to the decisions of the person, and their family where appropriate. The person decides if they want their family to be involved.

Responsibility; individuals, staff teams and managers show how they support each person to achieve their personal goals and outcomes. They answer any questions that a person may have about their supports.

Expectations; there are high expectations and hopes for each person. Person-centred planning encourages each person to believe in themselves and supports the person to be the best they can be.

Relationships; individuals, staff teams and managers make sure that each person has the time, space and chance to build meaningful relationships.

Partnership; individuals, staff teams and managers work together with persons with a disability – this is called partnership. Power is shared and there is open communication. Each person can get the information they need to have a say in services and supports.





4. Organisational Culture, Structures and Processes

This section of the framework outlines person-centred organisational culture, structures and processes which strongly influence the quality of the person-centred planning process and the achievement of outcomes. Organisational culture, structures and processes are directly related to the beliefs and foundations identified in section three.

Many of the aspects of organisational culture, structures and processes outlined below are addressed by the HIQA National Standards for Residential Services for Children and Adults with Disabilities, and the HSE Interim Standards for New Directions.

4.1. Organisational culture and transformational practice development

Person-centred practice values all persons as individuals and values the right of all persons to participate fully in their life choices. It promotes healthful relationships between providers and the person, his/her family, staff and community members. Healthful relationships are relationships that enable individuals to achieve maximum wellbeing in all aspects of their lives.

Person-centred practices are enabled by cultures of empowerment that foster continuous approaches to practice development. The HSE is focusing on enabling and enhancing cultures of person-centredness in practice throughout the organisation.

When developing a person-centred culture in an organisation, there is a need to look at the whole system. It is not possible to develop a person-centred culture by focusing solely on implementing solutions that address one aspect of ineffectiveness. To bring about fundamental change in complex organisations requires the recognition of patterns that drive thinking and behaviour.

Patterns are connected to the distinctive behaviour present in the values and beliefs of individuals and teams in an organisation. The five key patterns that strongly affect the organisation's ability to bring about whole system change[3] include:

1. **Relationships**: energising or draining?
2. **Decision making**: rapid by those who best know or bogged down in hierarchy and role positions?
3. **Power**: to do and be creative and innovative, or power that is coveted and mainly used for self-interest?
4. **Conflict**: seen as an opportunity to explore new possibilities and ideas, or seen as negative and to be avoided?
5. **Learning**: welcomed as positive and a necessary part of the organisation's work, or viewed as threatening and risky to the status quo?

Traditional training approaches often have minimal quality impact on outcomes for the person as practice patterns can go unchallenged and taken for granted routines and practices remain unchanged. To enable cultural change requires the transformation of systems, processes and patterns.

The HSE is using a transformational practice development approach to enable and enhance cultures of person-centredness throughout the organisation. This approach works with individuals and teams to encourage a change in thinking and in practice (see Appendix 2 for more information on the HSE national programme to Enable Cultures of Person-centredness and links to documentation on culture development).

Transformational practice development uses active learning to support individuals to first understand themselves and what is happening in their practice and then support colleagues to discover what drives patterns and assumptions in their practice.

[3] Plsek PE. (2001) Redesigning health care with insights from the science of complex adaptive systems. In: Crossing the Quality Chasm: A New Health System for the 21st Century. Washington: National Academy Press

For a team, this can act as a starting point for making changes. There is further information on active learning in section 5.1.

An evidence based person-centred planning policy is an integral part of transformational practice development and will underpin a team's approach. Implementing a person-centred planning policy is discussed in more detail in section 5.1.3.

4.2. The environment and approach to services and supports

The environment and the approach to providing services and supports are important in enabling person-centredness. For example, person-centred planning is more likely to be successful for persons with disabilities if they live in pleasant, stimulating environments, which offer new and different experiences and promote meaningful engagement, independence and community participation.

4.3. Governance and leadership

Organisations have a clear structure with defined roles and lines of accountability. There is a proactive, confident management style, where leaders are transformational, meaning they help change thinking and practices. A culture of person-centredness is promoted by supporting team working, innovation, risk-taking that is calculated and continuous learning and development.

4.4. Communication

The organisation promotes good communication between persons using services, their families, advocates, staff, community members and other key stakeholders. In particular, where someone uses more than one service, there should be well-established lines of communication between the different organisations, for example between residential and day supports. There are clear guidelines regarding the sharing of information and the consent of the person is sought.

4.5. Support for staff

Organisations have a performance management system in operation which includes supervision and appraisal for staff.

As part of this:

- staff and managers recognise and champion good practice
- staff, persons using services, family members and advocates are provided with the opportunity to share examples of good practice
- all staff accept accountability for their work
- staff feel valued and supported by their organisation and colleagues
- leaders appropriately address incidences of poor practice in a constructive way

Managers seek to have an appropriate skill mix within a staff team. A 'skill mix' is the mix of posts, grades or occupations in an organisation – the right people with the right skills doing the right jobs at the right time to provide effective supports.4 All roles are valued and the contributions of individual staff members recognised. The culture of the organisation should be reflected in job descriptions and should support all staff, regardless of position or grade to work in a person-centred way. Team working is promoted, with policies and practices facilitating trust and respect between team members irrespective of grade or position.

4.6. Working collaboratively

The engagement of persons with disabilities in decision making and in developing services is central to person-centred planning. Good practice highlights the importance of organisations seeking to ensure that persons with disabilities are aware of, and involved in all meetings and communications about them if they so choose.

[4] Buchan & Dal Poz (2002)

The level of engagement may vary for different individuals, depending on their support needs and their expressed wishes regarding the level of engagement they want. All individuals are encouraged and supported to participate in decisions that affect all aspects of their lives.

Persons with disabilities and their families are viewed as experts by experience. There is a system in place to gather feedback from persons who use services and those supporting them, for example in relation to the supports provided day to day, what is working well and not working well in the organisation, how information is shared, how individuals, staff teams and managers engage with those using their services and get feedback. Individuals, staff teams and managers are proactive and creative in engaging persons with communication support needs and/or severe and profound disabilities to ensure they can contribute to the evaluation of services and supports.

Supporting systems in the organisation ensure that the person and their family where appropriate, always feel that they are empowered. The policies and practices in place in the organisation support those using services to become involved in the day to day running of the organisation and persons with a disability are consulted about, and participate in, key organisational decisions that affect them and their lives. Opportunities are created for those using services to influence service design and development, for example through advocacy groups and representation on organisational committees. Persons using services are represented on the Board of the organisation. They are involved in auditing, inspecting and evaluating services and supports.

4.7. Access to self-advocacy and advocacy supports

Person-centred planning should be considered as a form of self-advocacy. Individuals, staff teams and managers promote self-advocacy and provide access to a range of supports, including independent advocacy supports.

Organisations and facilitators should work on broader systems change to increase the options for people with disabilities to participate in employment, education, community life, etc. Person-centred planning should be implemented along with other strategies that enable the person to accomplish goals, such as inter-agency collaboration and connections with wider self-advocacy networks.

4.8. Positive risk management

Persons with disabilities are afforded the 'dignity of risk'. Individuals, staff teams and managers enable positive risk-taking through assessment and risk management policies. It is recognised that as individuals lead more independent lives, the risk associated with the activities in which they are involved is likely to increase. Robust risk management policies and procedures ensure individuals are protected yet supported by staff and families to make decisions about the level of risk they wish to take, to develop skills to manage their risks, and to take responsibility for risks. A step by step approach is practiced to enable the person to gradually build the skills necessary to partake in different tasks, activities and experiences.

4.9. Resources and finances

Adequate funding and resources support the development and implementation of quality person-centred plans. There are systems in place in the organisation to support the effective management of resources. Services are evaluated to ensure they are cost-effective and represent good value for money.

Financial systems, policies and budgetary constraints do not restrict the amount of control and choice which individuals experience, for example procurement, access to credit cards and petty cash, policies on the safe management of a person's monies. The financial systems and policies in place in the organisation should support person-centred planning and independence, and provide opportunities to use resources in a flexible way to ensure the person can be supported to achieve their outcomes. The person who owns the person-centred plan has access to their personal finances and can make choices about how to spend their money.

4.10. Supporting service improvements and managing complaints

There are mechanisms in place to ensure continuous reflection, evaluation and improvement. There is a formal complaints policy and procedure which is accessible to all. If complaints cannot be managed at the local level, there is a mechanism to channel them 'up the line' to the senior management team. Complaints are managed respectfully and are responded to in a timely fashion. Areas of dissatisfaction are acted upon and result in tangible changes.

4.11. Community engagement

Individuals, staff teams and managers advocate for improved opportunities for persons with a disability to meaningfully engage with the community. They actively seek to create community connections and social networks, and to promote inter-agency collaboration. They strive to develop circles of support beyond staff and family members.

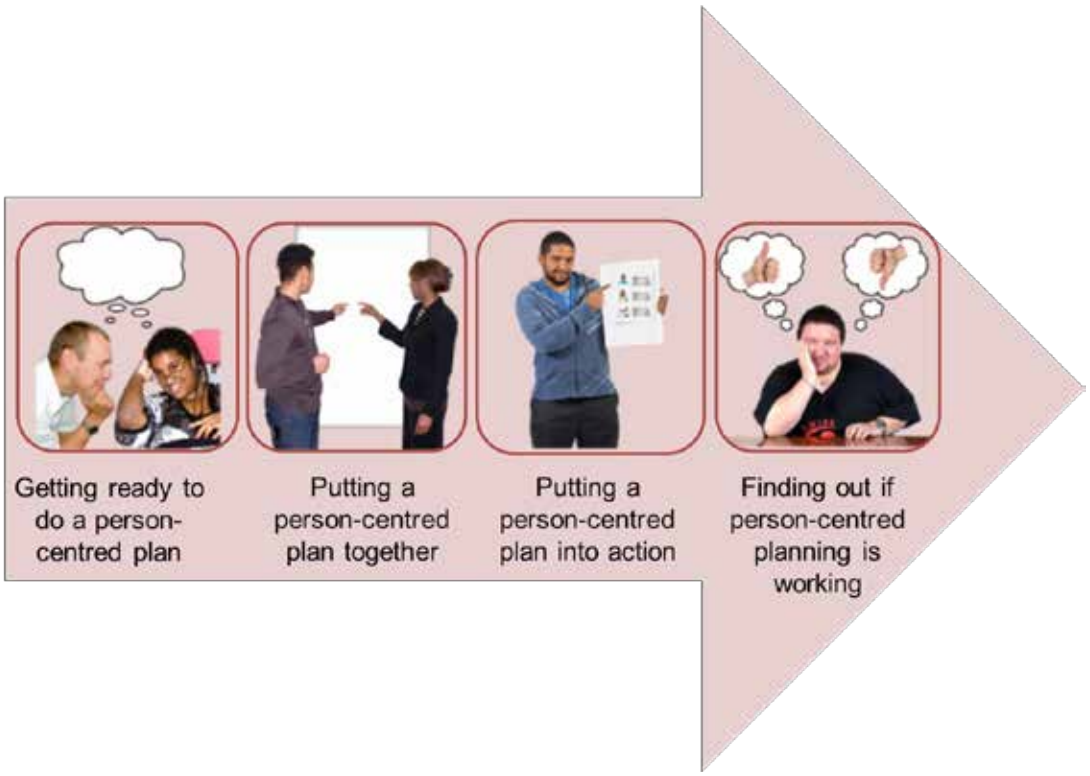
5. Key elements in person-centred planning

In this section, the essential steps to achieving good practice in person-centred planning are discussed.

Person-centred planning has been divided into four main stages:

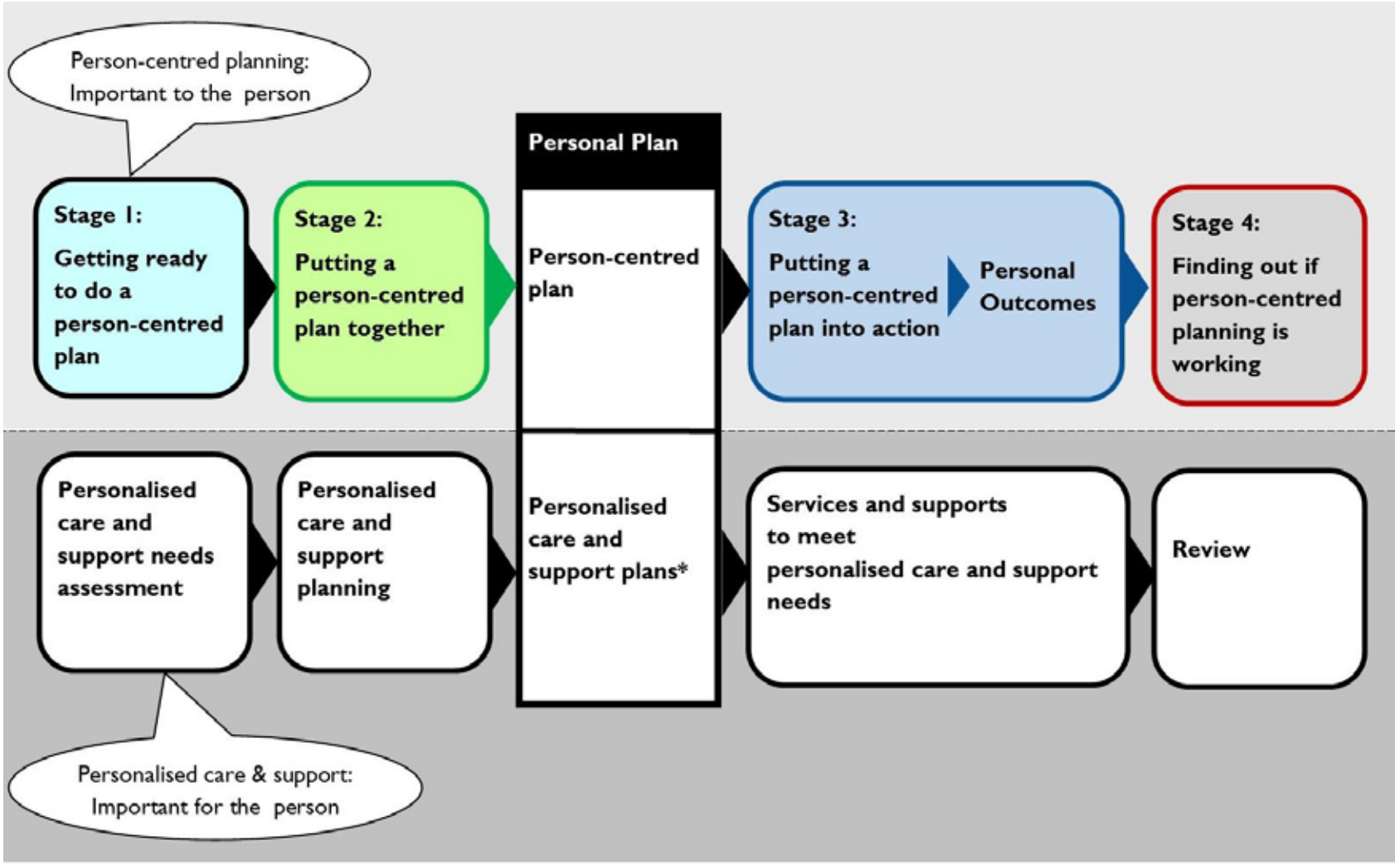
- **Stage 1 - Getting ready to do a person-centred plan**
- **Stage 2 - Putting a person-centred plan together**
- **Stage 3 - Putting a person-centred plan into action**
- **Stage 4 - Finding out if person-centred planning is working**

Figure 1.2. The four stages of Person-centred Planning



The key elements of good practice at each stage of the process have been informed by research. Figure 1.3 illustrates the person-centred planning process, including how person-centred planning fits within a personal plan. It also highlights how person-centred planning and personalised care and support work together to achieve the best outcomes for the individual.

Figure 1.3. How person-centred planning and personalised care and support work together



*Personalised care and support plans should be developed within 28 days of a person starting to use a HIQA-registered residential service. Person-centred planning may take considerably longer, depending on the individual.

5.1. Stage 1 - Getting ready to do a person-centred plan

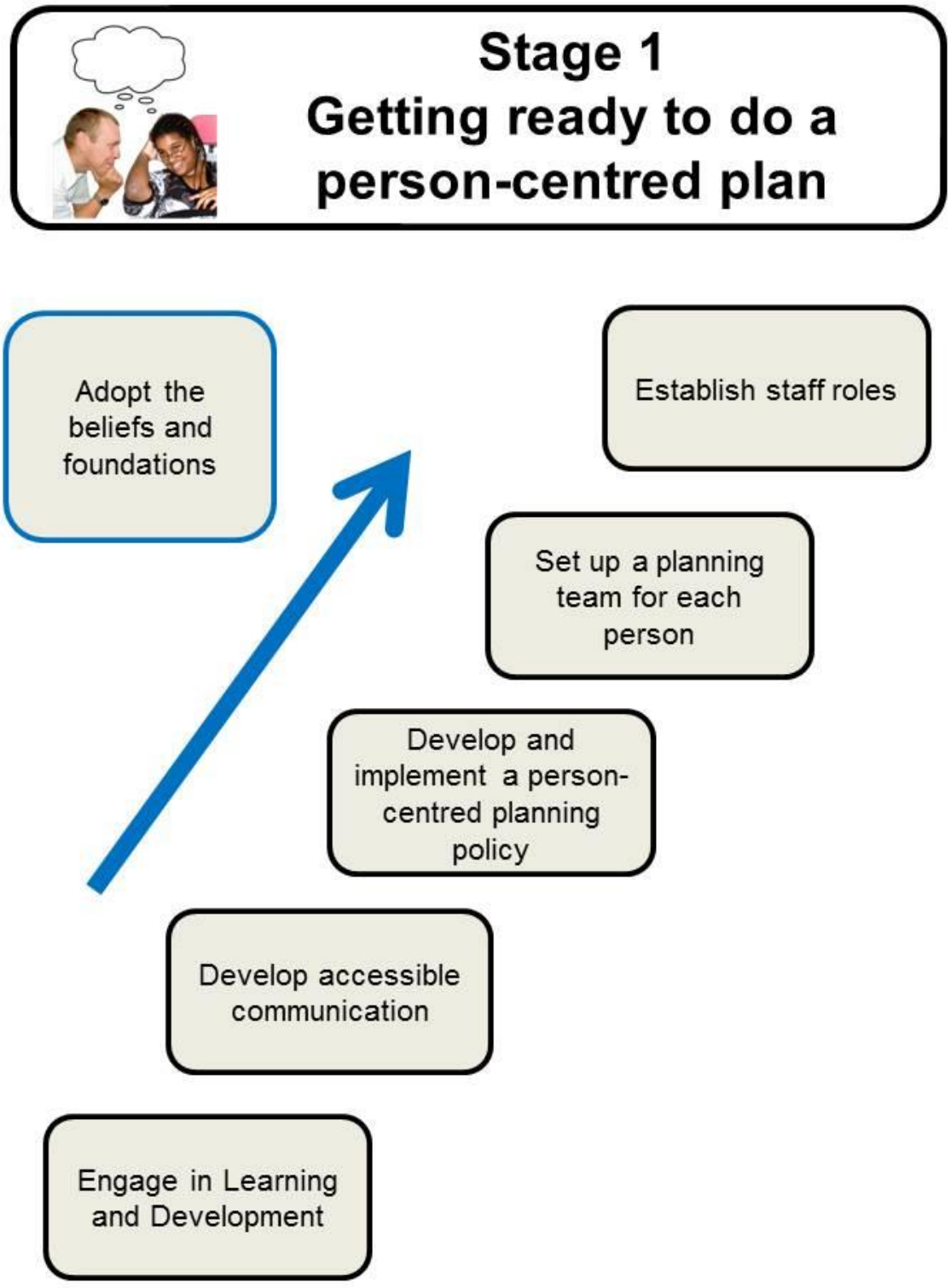
During this stage, the individual is supported to understand what person-centred planning is about and how it might work for them. Learning and development enables the person and those supporting them to engage meaningfully in person-centred planning.

The person should decide if they wish to develop a person-centred plan. An individual does not have to have a person-centred plan if they do not want to. Where a person declines to engage in the person-centred planning process, the service provider should ensure, using a person-centred approach that arrangements are put in place address their aspirations and wishes in so far as these can be ascertained. A record should be kept of all attempts to engage each person in the person-centred planning process. The person should be able to change their mind about having a person-centred plan at any point.

At stage 1, it is important to identify the key person to support the individual to put their person-centred plan together. All actions undertaken should facilitate the person and their circle of support to engage as fully as possible with the process from the outset.

The beliefs and foundations should be adopted at the beginning of the person-centred planning process.

Figure 1.4. Stage 1 of person-centred planning



5.1.1. Learning and Development

Opportunities for learning and development are crucial to support the person to engage fully in person-centred planning. Opportunities should be available not only to staff, but to those who own the person-centred plans, their family members and circles of support.

Learning and development has been shown to contribute to the development of high quality person-centred plans and to positive outcomes for the individual.

5.1.1.1 Learning and development for the person who owns the plan

Each person will come to the person-centred planning process with skills, understanding and expectations. For some individuals, it may be the first time they have had the opportunity to be involved in decisions that affect their life or to express their wishes. Some individuals may need time and support to learn about themselves and to discover their interests, preferences and dreams.

Those interested in developing a person-centred plan may have:

- different types of disabilities
- different support needs
- different life experiences and situations
- different support networks
- different experiences of making choices and decisions
- different experiences of using services and supports

At the outset of the process, staff and managers should make sure that the person using the service, their family members and circles of support understand what person-centredness and person-centred planning are.

The person who owns the plan should be provided with opportunities and supports to build capacity for self-advocacy and decision-making. Self-advocacy learning for persons with intellectual disabilities has been identified as critical in enabling individuals to articulate the lives they want to have as part of the person-centred planning process.

Organisations should provide education and learning opportunities, relevant to person-centred planning, for persons using services. These will be wide and varied to meet different needs and may depend on the individual's strengths, life experience and situation. For some individuals learning and development may be formal.

The following areas should be considered:

- The meaning of person-centredness
- Individualised supports
- Making choices and decisions
- Advocacy and Self-Advocacy
- Funding options
- The person-centred planning process

For others, the 'here and now' may be the most appropriate learning environment and learning will be primarily experiential. Skill development may involve everyday opportunities to experience choice making and a sense of control, the development of communication skills, the chance to engage in new activities and experiences, or the opportunity to develop new social connections and relationships.

5.1.1.2. Learning and development for families, circles of support and communities

Families and circles of support will also bring different knowledge, skills and experiences to the process. It is essential that circles of support have adequate information on the person-centred planning process, and are clear on their roles within it. Active learning is one way to involve and engage the person who owns the person-centred plan and their family/circle in discovering new ways to be person-centred together. Active learning is discussed in more detail in section 5.1.1.3.

Families and circles of supports may find it helpful to have specific learning and development in:

- the meaning of person-centredness
- the person-centred planning process
- individualised supports and funding
- positive risk taking
- meaningful social roles
- community participation

It is important to be aware of the learning and development needs of the community in order to achieve positive community engagement as part of the person-centred planning process. Organisations should work in collaboration with community groups to promote inclusion.

These are examples of how learning and development can support a person who owns a plan to engage in the person-centred planning process:

Emma is a sociable young woman but her communication circle is largely confined to paid staff and to family members. Joanne would like to support Emma to widen this circle and to develop new social relationships. This in turn may allow Emma to build a better understanding of community and to develop a circle of support. Working with those supporting Emma, she identifies a number of potential opportunities in Emma's community, including regular visits to a local community centre and coffee shop, joining a youth group and taking part in the local Tidy Towns organisation.
Emma is a 19-year-old woman, living at home with her family. She recently started to attend a small day service in her local community. She has profound and multiple disabilities.

Joanne is responsible for facilitating and supporting Emma to develop her person-centred plan. Joanne is employed by the organisation which provides Emma's day service, but she does not work in the day service. Joanne is looking at different ways to increase Emma's understanding of person-centred planning and control over the process. She talks to a number of people who know Emma well including her family, the staff that support her in the day service and clinical staff. Some people feel that Emma does not have the ability to understand what person-centred planning means or to make choices and decisions about her life. Most of Emma's needs are anticipated by those supporting her and her communication is described as 'very limited'.

Joanne is keen to make sure that Emma is given an equal opportunity to learn and develop skills which can help her to engage with the person-centred planning process. She notices that Emma makes very few decisions in her life and decides to start by increasing the opportunities that Emma has to make choices during the day. Joanne feels that this will allow Emma to experience control and to communicate her likes and dislikes. It will also be a way for Joanne to get to know Emma better and to find out about her preferences.

She liaises with clinical and day service staff, and with Emma's family, and they decide that choice making through objects would be the most appropriate way forward for Emma. Emma is given the opportunity to engage with objects by looking at them, holding them, touching them and smelling them. Over time, Joanne and others notice that Emma will hold on tightly to objects of interest but will drop to the floor objects that she does not like.

Emma selects the clothes she will wear each day, her preferred shower gels, sensory objects and favourite blankets in this way. Those supporting Emma also build up a small set of objects to represent different activities and locations. Eventually, it is hoped that Emma will use these to select preferred activities or places to visit, and to develop person-centred planning goals. Those supporting Emma will observe her interactions and responses in these settings to determine her interest and levels of satisfaction over time. Evidence will be recorded through photographs, videos and observation notes.

Jacob is a 24-year-old man receiving support from an Outreach Support Service in a large organisation providing services to persons with a disability. Jacob has a mild intellectual disability. Jacob's skills in developing his own person-centred plan have increased significantly since he began accessing the service. Over the last few years, Jacob has attended self-advocacy courses and become involved in a self-advocacy group. Through this learning and experience, Jacob has developed the skills needed to advocate for himself and express his opinions on how he wants to live his life.

Jacob's progression was evident in the development of his most recent person-centred plan. Jacob identified that he would like to work towards becoming more independent in his daily life. In particular, Jacob highlighted that he would like to move out of the family home and live in an apartment on his own. This goal presented some challenges, and both Jacob and his mother were apprehensive of how independent living would work in practice.

To gain more knowledge and to explore how living independently would work, Jacob and his mother attended a workshop on self-directed living in Dublin. This gave them a great insight into how independent living can work successfully for a person with an intellectual disability.

With the end goal in sight, Jacob has started to put plans in place to gain the skills he will need to live independently in the community. He is learning to use public transport and has started a university course. He is in the process of securing an apartment in the local town to rent, and has been working with his support worker to build up practical living skills like cooking, cleaning, budgeting, with a view to working towards his first overnight stay in the apartment on his own.

Tom, the person supporting Jacob to put his plan together, was also acquiring new skills. Tom attended a course which focused on empowering the individual and on supporting persons using services to lead.

He used this learning to facilitate Jacob to have more choice and control over the way he wanted to live his life, and to encourage Jacob's circle of support to identify their role in supporting him to achieve his goals. It is a gradual process but Jacob is moving closer towards his goal of independent living and the supports he needs from the service and his family are reducing.

5.1.1.3 Learning and Development for staff

Learning and development can contribute to culture change and positive practice developments. By focusing on learning from and in practice, active learning creates an emotional connection between the learner and practice thus creating greater ownership and responsibility for the proposed change and outcome. Active learning focuses on adult learning methods rather than 'showing' and 'telling'.

The four main activities that enable active learning to take place for individuals and teams are:

1. Dialogue with self [about person-centred planning]
2. Dialogue with others [about person-centred planning]
3. Experience of doing [person-centred planning]
4. Experience of observing [person-centred planning process in action]

Engagement in active learning enables individuals and teams to supportively challenge practices that are no longer deemed acceptable and in this case that would relate to the correct approach to undertaking a person-centred planning process. This is best achieved when staff and managers work together to change their thinking and then practice around person-centred planning. Practice development is a continuous process of developing person-centred cultures.

Staff will require practice development processes to become familiar with elements such as:

- how to promote self-advocacy and self-determination
- supporting decision making
- human rights awareness
- goal setting and action planning
- person-centred communication
- positive risk taking
- strategies to promote community inclusion and participation
- building social capital

As well as the specific areas of learning outlined above, staff will also require facilitated practice development to fully embrace the concept of person-centredness that includes:

- knowing self and others values and beliefs
- reflective practice
- looking at the practice environment, quality of leadership and opportunities for learning and innovation for both staff and persons using services
- providing opportunities for staff to experience person-centredness for themselves within a culture that supports person-centred practice.

This is an example of learning and development in practice for staff:

A Manager and team meet to identify the practice development implications for them when implementing the person-centred planning framework. The team compare the person-centred planning framework to current practice in person-centred planning in their organisation. They identify a number of areas that are similar and some that are new. The team discuss the distinctions between the person-centred plan and the personalised care and support plans, and realise that they treat both as one. Using collaboration, inclusion and participation, they explore what changes they would need to make to clarify the distinction between both plans. Everyone has the opportunity to express opinions and make suggestions. They consider their own context, being a large residential setting and agree that they would provide a series of short workshops on how to use the framework, and at the same time review their current practices to see if they are in line with the recommended approach.

They also agree that everyone needs to be involved in the change to get buy-in and embed the new practice in their workplaces, and that individuals and their families might also like to avail of learning opportunities to become familiar with the process. It is agreed that two members of staff would facilitate information sharing to residents and their families on the new process and invite anyone who would like to attend to come to the workshops.

Managers recognise the supporting role they need to provide during this transition period of embedding the new process into practice. They feel that they need to attend the workshops to get familiar with the framework so they will have a better idea of what is involved and how they can support staff through the process. They discuss how they would like to evaluate the process and how soon this needs to happen after introduction. It is agreed that the first wave of formal evaluations would take place after three months and that they would like to involve everyone in the process.

Learning and development programmes that are centred on person-centred planning should be constantly refreshed to take account of new and changing terminology and developments in relation to good practice. They should aim to develop consistency between the organisational policy and practice on the ground. All learning and development opportunities, provided through internal supports or external facilitators, should be fully evaluated.

5.1.2. Accessible communication

Individuals and teams should ensure that person-centred planning is meaningful and accessible to each person. In the first instance, those supporting the person need to be familiar with the communication strengths and needs of the individual so they can provide the appropriate supports.

The person who owns the person-centred plan may need access to supports such as the expertise of a multi-disciplinary team, skilled interpreters, communication assessments and communication passports. Information should be provided in ways that the person can understand, using 'Total Communication', for example, objects, photos, video, audio, Easy to Read materials, Plain English materials, Lámh, Irish Sign Language.

Persons supporting the development and implementation of person-centred plans need to be skilled in facilitating interaction with individuals who communicate in different ways. For those with complex communication needs, specialist learning opportunities and supports may be required to facilitate the person's understanding and enable them to express their preferences and choices. Individuals will have different levels of symbolic understanding, and the use of objects, mementoes and sensory cues may be more meaningful than pictures, signs and symbols. For other individuals, the key to developing a good person-centred plan lies in the establishment of meaningful relationships, where those supporting them to put together a person-centred plan, observe and listen to all forms of communication.

In addition, those supporting the development of person-centred plans should be willing to record the responses of the individual to different stimuli and experiences and to find ways to support the person to share this information with other communication partners, for example through personal profiling, photos or DVDs.

5.1.2.1. Access to technology

The person who owns the person-centred plan and those supporting them may need access to assistive technologies and information technology.

These supports can enable the person to engage fully in person-centred planning, for example by facilitating the creation and use of communication supports, providing access to information, supporting the use of planning tools and resources, establishing ways to gather evidence of progress and outcomes. Examples of supports might include high and low tech communication devices, symbols software packages, projectors, computers, internet access, digital cameras, colour printers, PowerPoint, mobile phones, iPads. Access to such resources can make a significant difference to the level of engagement of the individual and to the overall quality and accessibility of the person-centred plan.

The use of technology can support multi-media profiling; this is where individuals with high communication support needs are supported to communicate more independently using video, photos, symbols and words, accessed through a computer.[5]

Organisations may also wish to access software and/or business systems to record and evaluate information from person-centred planning.

Access to technology can also be an essential component in supporting a person to achieve their goals and to be as independent as possible.

[5] Mencap- Multi-media profiling 2008

This is an example of using accessible communication tools and technology to support person-centred planning

Tara is a 53-year-old woman who has a moderate intellectual disability. Tara lives in supported accommodation and works in a local café three days a week. Until recently, Tara travelled independently to and from work. Tara has good picture recognition skills and basic literacy skills.

Staff noted that Tara had not been herself recently - she was becoming upset at the prospect of going to work, she had lost interest in doing things for herself and was struggling with finding the words she wants to say. Tara became lost on her way to work one morning and had become irritable and emotional at work and at home. She appeared to have difficulty with remembering day to day events. Tara's keyworker suggested a visit to the GP and this was followed by an assessment at a memory clinic. Tara received a diagnosis of early onset dementia.

Tara sits down to do her person-centred plan with her keyworker, Lynn. Lynn has completed additional training on supporting people who have received a diagnosis of dementia. She uses an approach from a tool called 'Jenny's Diary'[6] to support conversation with Tara about her diagnosis. She builds on Tara's foundation of knowledge: Tara's mother had dementia and died with dementia. She is highly distressed that she will lose all her skills immediately. Lynn gives her bite size chunks of information about the diagnosis, based on the information Tara is seeking at that moment, and reassures her throughout the discussions. She supports other staff to engage with Tara in a supportive way and ensures that Tara receives consistent information from all staff.

One of Tara's major goals in recent years was to work on the tills in the café. Tara had completed a lot of learning and development and began working on the till a year ago. When work is explored with Tara as part of her planning meeting, she becomes quite distressed and states that she wants to give up work immediately. Tara's keyworker Lynn explores why Tara wishes to give up work using Talking Mats.[7] Through this process they identify that travel is now an area where Tara needs support and this is causing her a lot of anxiety. Another issue in work is that Tara is struggling to remember people's orders.

[6] Watchman K., Tuffrey-Wijne I. & Quinn S. (2015) Jenny's Diary: a resource to support conversations about dementia with people who have a learning disability. London, Alzheimer's Society.

[7] www.talkingmats.com

Tara and Lynn identify the following goals through their discussions:

1. Support with travel to and from work: Lynn sourced an app which will give Tara verbal directions which she can follow to support her to continue to get to and from work.

2. Tara has agreed to talk with the staff in the café about her diagnosis. Lynn and Tara organise a meeting with the manager to request a change in duties which would be less demanding on Tara's memory and communication. Tara expressed that she would prefer to clean down tables and do some work in the kitchen for now. A regular meeting is set up between Tara, Lynn and her manager to make sure this is still manageable for Tara. Tara's new duties are listed on a visual checklist to make sure she can understand and remember the changes, and she can review them at any time.

3. Tara wants to learn a bit more about her dementia. Lynn supports her to get information which is easy to understand. She writes down any questions which arise for Tara and brings these to her medical appointments.

4. Tara wishes to make plans for her future and to make a will. Lynn supports Tara to do this using photographs and language which is easy to understand. Lynn supports Tara to prepare an end-of-life care plan. This forms the basis of a discussion with the solicitor when she goes to make her will.

5. To support Tara on a daily basis, she begins to use a diary. At the beginning of the day, staff support Tara to know what day it is and what is happening on that day using verbal, visual and written information.

6. Tara and Lynn begin the process of making a Life Story Book. They contact her family and friends and ask for photographs and stories about Tara to put in her book. During this information gathering, Tara and Lynn put together a 'playlist for life' of all of Tara's favourite music from her childhood, teenage years right up to the current day. This is a very enjoyable activity for both of them which they share with the other people in the house.

This is an example of technology in use to support person-centred planning:

Keith is a 38-year old male with excellent communication skills, who can fully articulate his needs and wants. He has a mild intellectual disability. Keith meets with his person-centred planning facilitator on a regular basis to discuss his life and his goals.

In the 20 years since he left school, Keith has been supported in various ways by a large disability service provider. He has had an opportunity to complete training courses, participate in social and leisure activities in his local community, engage in supported employment and experience the world of work. Most significantly, he has had the opportunity and support to move into his own home; a one-bedroom bungalow, situated around the corner from his parents' house. He is very proud of this achievement.

When Keith first moved into his house, he had some home support to help with shopping and cooking, but as he grew in confidence and skills, he identified that he no longer needed this support and now he manages to run his home independently with minimal encouragement and support from his family and key worker.

Over the past few years, Keith has embraced technology as a way of helping him in his daily life. He has a video monitor on his front door so he can see who is outside before he opens his door, this helps him in feeling safe and secure in his own home and helps him maintain his independence. Keith also has a smart phone, which he uses to keep in touch with his friends and family through calls and text messaging. He also uses the internet to help plan his social life, for example, cinema times or things to do at the weekend and to keep in touch with friends through social media.

In the area of technology Keith has embraced a web-based planning tool, used by his service provider as a means to record important information about his support needs, and to help inform the people who support him about the actions that need to happen to help him achieve his goals for the future.
Keith believes the advantages of using this web based planning tool are that it can make his plans come alive through videos, photos, pictures and sound and make it more likely that his plan happens as staff focus on those things which are really important to him.

The web-based planning tool can also facilitate Keith to decide what information goes into the plan and who sees the information, so he is fully in control. It can also support him to keep track of outcomes - what he is achieving and doing.

Keith's story on how he uses the web-based planning tool has been made into an information video for those who may be interested in using technology to help them plan for their lives.

5.1.3. The person-centred planning policy

Organisations should have a person-centred planning policy in place across the service. The policy should be evidence based and reviewed on a regular basis. It is important that the policy emphasises the difference between personalised care and support needs planning and person-centred planning, and there should be consistent use of language around person-centred planning and person-centred plans.

The policy should recognise that while there can be more than one organisation supporting a person, a person should have just one person-centred plan, which they own. The policy should state who takes overall responsibility to support the person-centred planning process when a number of organisations are supporting the person.

Person-centred planning is a continuing process and not an annual event, and this should be reflected in both policy and practice. Person-centred planning, and the different roles within it, should be clear for everyone to understand; this includes the person who owns the plan, family members and other members of the circle of support.

Staff and managers should ensure that person-centred planning does not become a paper exercise, but that the focus remains on outcomes for the person.
Good person-centred planning involves the use of both formal and informal methods of information gathering. There should be evidence of persons with disabilities becoming more actively involved in person-centred planning as they gain more confidence and experience.

5.1.3.1. Embedding the person-centred planning policy

The organisation should have a clear strategy for embedding the person-centred planning policy. Managers and leaders should actively engage in embedding the policy both within the organisation and with key stakeholders such as persons using services, staff, families, community members, mainstream agencies and supports.

They should demonstrate a commitment to the policy, and to ensuring it transfers to practice.

Valuing the importance of good person-centred practice at all levels within the organisation, along with experienced staff as role models on how to undertake this process effectively, can encourage and enable change to traditional practice patterns.

5.1.4. The planning team

A planning team should be identified for each individual. The planning team is made up primarily of individuals or staff members who are paid to support the person with their person-centred plan, and so assist the person to achieve dreams and wishes from a service or support aspect.

The planning team could consist of:

- the person who owns the plan
- The person who supports putting the person-centred plan together
- the person who supports putting the plan into action
- family (if the person wants this)
- multi-disciplinary team (if appropriate)

Where possible, the person who owns the person-centred plan should decide the membership of this team. There should be a process in place to facilitate the person who owns the plan to change the membership of the planning team, without any risk to the person feeling uncomfortable about making this request. This may happen if the person's needs or goals change.

Organisations should recognise the importance of consistency in planning teams in order to see person-centred plans, goals and outcomes through.

Ideally, the establishment of a planning team should ultimately lead to the formation of a circle of support for the person who owns the plan (see section 5.1.4.4. for more detailed information on circles of support).

Person-centred planning should be reliant on paid staff only when necessary. There should be a gradual process where paid support reduces over time as a person gains more independence, has increased social networks and their circle of support becomes more established.

Staff from the planning team may continue to work with a circle of support, for example to establish or maintain communication within the circle, to provide administrative support to the circle, to support the person who owns the plan to co-ordinate the work of the circle.

5.1.4.1. The person who owns the person-centred plan

Persons with disabilities will bring a range of skills, gifts and talents to person-centred planning. Equally, each individual will have their own specific support needs and will engage with the process in different ways.

The person who owns the plan should lead out on the person-centred plan as much as possible. This will mean different things for different individuals. A significant number of individuals will need additional facilitation support at the different stages of person-centred planning.

Persons with severe or profound disabilities, autism or high communication support needs, can lead out on their person-centred plans. However, to do this they will need support from an experienced facilitator who has spent time getting to know them, can interpret their communication and can provide the necessary communication supports.

The person who owns the person-centred plan should:

- give their consent to be supported to put a person-centred plan together
- get involved in the person-centred planning from the very beginning
- understand person-centred planning and their role within it – some individuals will gain this understanding by being part of the process, and by experiencing real change over time
- find out how person-centred planning might work for them – again this knowledge may be gained through practical experience of goal setting and achievement
- decide if this is the right time in their life to develop a person-centred plan
- think about their needs, dreams and wishes – these may be communicated verbally or non-verbally, directly or indirectly. Some individuals will rely on their communication partners to observe and record their responses and interactions in order for their needs, dreams and wishes to be understood
- be motivated to achieve their goals and make positive changes in their life – this can be expressed in many different ways including everyday responses, emotions, behaviours, or actions

These are examples of how a person who owns the plan can lead out on the development of their person-centred plan:

Tony is a 63-year-old man. He has been living in residential services provided by a disability organisation since he was 2 years old. He has lived in a home in the community for the past 15 years with four other people. Tony has been living with dementia for the past 7 years and is now at the end stage of his dementia journey. He was previously a very independent, sociable man with a lot of friends. He worked for many years in a local shop but gave this up due to ill health. Tony has one sister, with whom he has a very close relationship.

Tony would have previously led out independently on his person-centred plans. However, his ability to communicate and engage in the person-centred-planning process has changed dramatically. Tony is now reliant on his communication partners to read his body language, facial expressions and vocalisations to connect with him, understand his preferences and ensure he is comfortable. Tony has a life book which documents all of his life history using photographs. Staff report that he enjoys looking at this with people who are familiar to him. In addition, staff have gathered all of his favourite music on an iPad which he enjoys listening to. From time to time, Tony may hum along to the lyrics or try to sing.

This year, Tony's keyworker Rebecca gathered all of the information relating to Tony's life, his previously expressed preferences and the choices in his person-centred plans. Tony completed an end-of -life care plan shortly after he received his diagnosis and this was reviewed. Staff have spoken with Tony's sister and others who know him well. The information gathered was used to formulate a person-centred plan which has a focus on end-of-life care.

The plan includes Tony's key preferences for where he lives (he has communicated previously his preference to be at home and not to be in hospital or transferred back to campus style accommodation), to have his favourite possessions with him and to have his favourite music playing. Tony has access to a local specialist palliative care team to support him to achieve his goal of living and dying in his home comfortably.
It focuses on maintaining relationships: Tony had previously expressed that his friends and colleagues from his work were important to him. Because Tony is no longer able to communicate in the way he did before, staff are now supporting his friends and colleagues with visits to ensure that Tony can enjoy their company (e.g. by ensuring that Tony's life book is to hand, by suggesting they listen to music and sing with Tony, by suggesting Tony may like a hand massage or to go for a walk). Staff are providing appropriate information and support about Tony's diagnosis to his housemates and answering questions as they arise.

Tony's person-centred plan is reviewed and updated on a monthly basis to ensure that he continues to be supported to live his life the way he chooses and that his end of life plan is followed. Communication partners, that know Tony well, observe his communication closely, so they can be responsive to his preferences and recognise his changing needs.

Through the process of getting ready to do the plan, staff identified that they needed additional training to communicate effectively with Tony. They began to use an approach called 'adaptive interaction'[8] with Tony and this is working well. Staff have learned to be 'in the moment' with Tony and to enjoy spending time with him using a focus on connection.

[8] Ellis, M. and Astell, A, (2017) **Adaptive Interaction and Dementia.** 1st ed. London: Jessica Kingsley Publishers

Rob is a 23-year-old male who uses a powered wheelchair, has excellent communication skills and can fully articulate his needs and wants. He has a mild intellectual disability. When Rob initially engaged with adult services, he attended a local day service. Through sampling activities and participating in the local service programme, Rob decided that the local service was not for him. Rob was supported by his person-centred planning facilitator to identify opportunities outside of the traditional service model. At this stage of the process, Rob was not completely leading the person-centred plan. Although he was advocating for himself in terms of what he did not want, he was unsure as to the direction he wanted to take. Rob continued to meet with his facilitator to determine potential goals and trial various possibilities.

Rob decided to pursue further education and was accepted into a local University as part of an Inclusive Learning programme, where he studied Geography & Music Technology. Rob was supported to interview his own personal assistant and to get involved in every aspect of college life. Over the course of his time at the University, Rob's self-confidence and self-awareness increased dramatically. It was particularly significant that he was in a fully accessible environment where he could get himself around independently without staff support. Prior to this Rob had never been in an environment without staff support. Rob consistently passed all assignments and exams, surpassing all expectations including his own. Realising his potential and capabilities has greatly helped Rob to have the confidence to lead his own plan.

Throughout the past 3 years, Rob has taken ownership of his life goals and has directed staff in relation to the opportunities he wants to pursue. He regularly meets with the staff that support him and is now comfortable and confident enough to lead meetings, follow up on actions and instruct staff as to the support he requires. Rob now has greater aspirations for his life; he plans to get a job, go on a sun holiday (without his mother) and most notably will be moving out into his own apartment towards the end of this year.

Rob has faced many barriers and obstacles over the years including transport, managing personal care support needs, inaccessible living environments and housing. Rob's story is an example of how an individual can be supported to live the life of their choosing and take full control of leading their own person-centred plan.

5.1.4.2. Involving the person's family

The support and involvement of family members (where this is the choice of the individual who owns the person-centred plan) is key to good person-centred planning. Quality person-centred planning should maintain and strengthen relationships with family.

Where the person has no family or community involvement, the organisation should prioritise and seek to address the lack of social relationships at an early stage of person-centred planning.

Family involvement in the development of the person-centred plan could include invitations to attend meetings, phone contact, practical support to work on goals, advocating for the individual, sharing information and ideas.
The role and autonomy of the family should be respected and the contributions of family members valued and respected. If the person chooses, families can be involved throughout the process to support the individual to manage change and to ensure a sense of continuity.

5.1.4.3. Multi-disciplinary and specialist supports

Multi-disciplinary and specialist supports are not always required in the development of a person-centred plan. However, the person who owns the person-centred plan should be able to access the expertise of a multi-disciplinary team or a specialist service, if this will support them to develop or action their person-centred plan. For example, this may be in relation to learning and development, communication, assistive technologies or accessibility.

5.1.4.4. Circles of Support

Quality person-centred planning also seeks to strengthen relationships with community members.

One of the strategies used to involve informal support in person-centred planning is through circles of support.

A circle of support is a natural arrangement that involves a group of friends, family – immediate and extended, and sometimes staff coming together to support an individual, assisting them to identify things they would like to achieve or alter in their life and then putting in place supports to make this happen. Circles of support are made up primarily of unpaid supports. Every circle is different because of the uniqueness of the dreams of the individual at the centre and the unique contribution of the circle members. Circles of support can be a key factor in enabling individuals to live well in their communities.

Establishing a circle of support is an opportunity for the person to recognise those that are most important to them, and a chance to draw these people together to support them with their choices and goals.

Where circles of support exist, the members need to be involved in person-centred planning from the outset, meet regularly, and make sure the necessary supports are put in place so that individuals can accomplish their goals.

This is an example of a circle of support in action:

Naomi has an individualised day service, from an organisation providing services to persons with autism. She is a 20-year-old woman with autism and a moderate intellectual disability. Naomi uses words, pictures and non-verbal communication to interact with those around her, and to express her needs and choices. Naomi is shy and it takes her a long time to get to know and trust people.

One staff member, Mary, supported Naomi to get ready to do her person-centred plan. Mary talked with Naomi about who she would like in her circle of support. They also talked to others who know Naomi well and support her in different situations.

Naomi recently moved out of her family home as both her mother and father have passed away. She moved into an apartment, where she lives with support from staff. This apartment is located in the community where Naomi grew up, and she has regular contact with friends and neighbours. Naomi has a part-time job in a local hotel, where she is supported by her keyworker, Karen. Naomi has a particular interest in music and is a member of her local choir.

Naomi said that she would like to have her sister, Aoife, in her circle of support. Naomi and Aoife spend time together at the weekends, and enjoy going out for coffee, going to the cinema and visiting extended family.

Naomi also wanted to have Mary and Karen in her circle of support. Naomi lived next door to Ann and Michael for almost twenty years. The couple know Naomi very well and she is very comfortable and relaxed in their company. They have lots of valuable information, stories and memories to share about the past and about Naomi's friends and family. Naomi asked Ann and Michael to be part of her circle of support.

At the local choir group, Naomi has built a friendship with a lady called Jane. Naomi and Jane share an interest in the same music and in drama. Naomi asked Jane to be on her circle of support.

The circle of support met a number of times and supported Naomi to decide on her goals. One of Naomi's goals is to attend a concert in Dublin. Naomi is a little anxious about the noise and the crowd at a concert. Ann and Jane have agreed to support Naomi to work towards this goal by accompanying her to small, local music and drama events. Karen and Naomi will research concerts and venues in Dublin that might be of interest. Aoife and Mary will support Naomi to attend the concert in Dublin when she feels ready.

5.1.5. Staff roles

The support of staff in person-centred planning has been found to be one of the most powerful enablers of outcome accomplishment. Managers should identify specific, formal roles for staff members within the person-centred planning process. These roles should be communicated clearly, recognised in job descriptions and valued.

There are two distinct roles for staff in person-centred planning:

- The person who supports putting the person-centred plan together
- The person who supports putting the person-centred plan into action

It is recommended that these roles should be undertaken by different people, as having a dual role of facilitating and implementing person-centred plans may lead to conflicts of interest. Only those with experience in person-centred planning should be responsible for putting person-centred plans together and for putting person-centred plans into action.

All staff involved in person-centred planning should have a clear understanding of what person-centredness means, and should recognise the difference between personalised care and support plans and person-centred plans.

In so far as possible, those supporting the development and implementation of a person-centred plan should be available throughout the process. The person who owns the person-centred plan should be given the opportunity for regular one to one time with both the person who supports putting the person-centred plan together, and the person responsible for making sure the person-centred plan is put into action.

5.1.5.1. The person who supports putting the person-centred plan together

This person is often referred to as the 'facilitator'.

The person who supports putting the person-centred plan together will:

- identify with the person who owns the person-centred plan, the potential to develop a circle of support
- ensure the person who owns the person-centred plan and their circle of support understand the person-centred planning policy
- work with those supporting the person day to day to ensure the individual has access to the information and supports they need before they start to develop a person-centred plan, for example learning and development opportunities, communication supports, accessible materials, specialist services
- act as a pair of 'fresh eyes' whose complete focus is on the individual and their person-centred plan
- spend time getting to know the person, their interests, strengths, likes and dislikes. This is particularly important where the person who owns the person-centred plan has significant communication support needs and requires time to build a relationship and trust
- facilitate the person to communicate to the best of their ability during the person-centred planning
- support the person who owns the person-centred plan to gather information in order to prepare a plan
- support the person to develop an action plan, which includes the person's goals and the names of those responsible for supporting the person to achieve them
- support the person to co-ordinate a formal review of the action plan and the evidence of progress on a regular basis
- provide up-to-date and accurate information to the organisation in relation to person-centred planning and the outcomes achieved for individuals

The person who supports putting the person-centred plan together could be from a range of different backgrounds. It is essential that the person who supports putting the person-centred plan together operates entirely independently of any potentially vested interest in the process. Best practice indicates that this role should be undertaken by a facilitator independent from the organisation, as this ensures the person is not influenced by service needs and constraints. However, it is acknowledged that this can be difficult to achieve in practice. Where a person-centred plan is being facilitated within an organisation, the autonomy of the person who supports putting the person-centred plan together must be adequately assured.

A number of competencies and attributes have been found to increase the effectiveness of the person who supports putting the person-centred plan together. These include their

- ability to focus on the needs of one individual rather than a group
- ability to completely focus on the person-centred planning process
- underlying advocacy values and beliefs
- experience of supported decision making
- education and training in community inclusion
- knowledge of the local community
- observational skills
- organisational skills
- communication skills
- experience of gathering and recording evidence
- knowledge of how to set SMART[9] goals
- ability to reflect on their practice

These individuals should be enabled to be person-centred within an organisation that supports person-centred practices.

[9] SMART – Specific, Measurable, Attainable, Relevant, Time-anchored

5.1.5.2. The person who supports putting the person-centred plan into action

There may be a number of people who support putting the person-centred plan into action, from different backgrounds, but one specific staff member should undertake to co-ordinate putting the plan into action. In many cases, this will be the person's keyworker.

It is important that all those involved in putting the person-centred plan into action are engaged at the stage where the person-centred plan is being developed, rather than staff implementing interventions which they had no involvement in planning.

This engagement should include sharing information with the person who is supporting the individual to put their person-centred plan together. The person who supports putting the plan into action will:

- engage with the process from the outset
- support the person who owns the person-centred plan to progress their action plan by ensuring they receive the necessary supports to work on their goals
- champion the person's abilities
- support the person to gather evidence of progress
- carry out regular informal reviews of progress
- support the person to update the person-centred plan as necessary
- support the person to overcome any barriers or problems that arise and if necessary report any barriers or difficulties to the relevant people
- seek out community connections and facilitate community inclusion as much as possible
- support the person who owns the person-centred plan to develop social relationships and networks
- support the formation of circles of support
- supports the person to be as independent as they can be by providing the right level of support

Those involved in supporting person-centred plans to be put into action should know the person well and demonstrate:

- a friendly approach
- respect
- good listening and advocacy skills

This is an example of one organisation's approach in ensuring a degree of autonomy for the person who supports putting the plan together:

Person-centred planning has been a key activity in our service since 1996. In 2013, we undertook a review of person-centred plans and other care plans in use in our service. We researched best practice and found an organisation in the Netherlands that had done similar work and we commenced communications with them. One of the key learnings from this alliance was the importance of the role of the facilitator in person- centred planning.

In 2015, we developed a new person-centred planning process for the organisation and a main component of this was to ensure a degree of autonomy for a staff member facilitating the person-centred plan – 'The Planner'. The responsibilities of the planner are to: complete an Assessment of Need (in consultation with others), write up the Assessment of Need report, discuss dreams and wishes with the person at the centre of the plan, prepare a draft person-centred plan, meet with the person at the centre of the plan, the service manager, the person's keyworker and other relevant members of the circle of support to finalise the plan.

We used this process initially for 52 individuals. Staff members identified as 'The Planner' do not work as part of the staff team supporting the individuals on a day-to-day basis. They are a member of a different team within the organisation. As we have had person-centred planning in our organisation since 1996, we have over the years identified one-to-one time for keyworkers to work on plans. In 2015, we started the process of using this resource differently by getting key staff from one part of the service to work as the planner in another part of the service.

The planner must have the skills to maintain autonomy; they cannot be swayed by other team members. They must focus on making sure that the person at the centre of the plan gets the supports they need to achieve their goals. Their negotiation skills when it comes to finalising the person-centred plan are vital and they must ensure that goals that could be perceived by the team as difficult are not delayed or dismissed. Senior management also have a key role in ensuring that the service manager is supported to identify the necessary resources to support goals.

The main benefit to this model is a comprehensive personal plan, which includes what is important for the person and important to the person. The person-centred plan is developed and facilitated by a staff member who is confident, motivated, enjoys a challenge and works with the individual and their team to develop the person-centred plan.

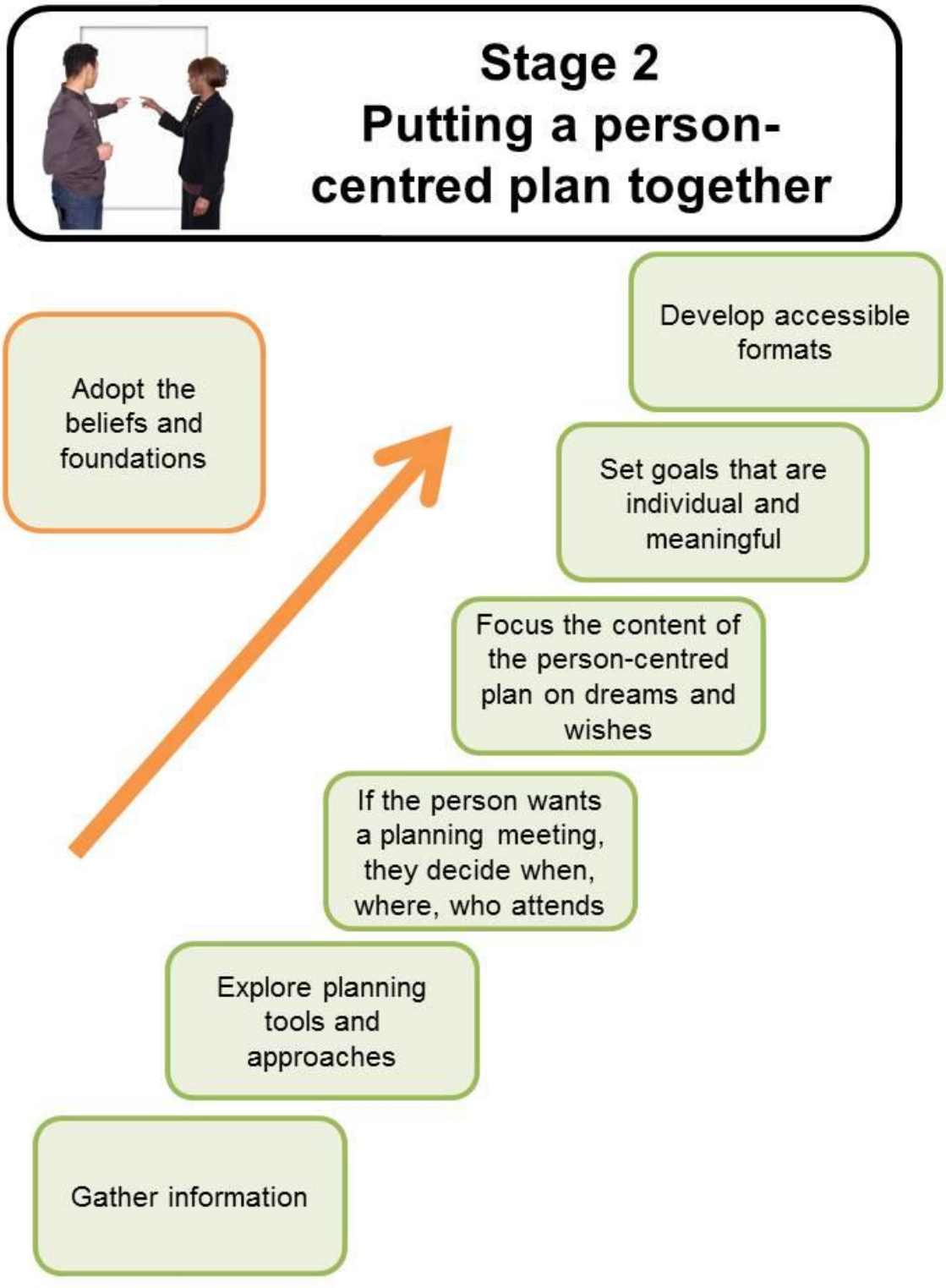
Challenges have included ensuring that all staff and managers across the organisation understand the role of 'The Planner' and the process, ensuring the planner can negotiate with staff at different levels within the organisation, and managers having the necessary resources to enable an individual to achieve their goals.

5.2. Stage 2 - Putting a person-centred plan together

During this stage, the person who owns the person-centred plan is supported to gather information, to decide on their goals and to develop an action plan for achieving goals and outcomes. As mentioned in Stage 1, individuals will need different levels and types of support and different timescales, to find out what they want for themselves and what is important in their lives.

The beliefs and foundations continue to be important at this stage of person-centred planning.

Figure 1.5. Stage 2 of person-centred planning



5.2.1. Gathering information

Person-centred planning is a continuing process and not an annual event. Information should be gathered with the person throughout the year with opportunities for constant review, reflection and evaluation. This is to ensure the person-centred plan meets the needs and wishes of the individual. Information should be gathered on the person's current routine, the activities they engage in, and the opportunities available to them, for example in relation to community engagement, education or employment. The person's strengths, likes and dislikes, dreams and hopes should be identified.

Information for person-centred planning is gathered by providing opportunities for new experiences, observing, actively listening to and responding with encouragement to all communication attempts from the person, making changes where required. Where the individual cannot communicate their choices and where their decisions are supported by others, decisions should be based on the person's known values and beliefs, the life experience they have had, and by engaging with the different people who know the person, both family and staff. Decisions should not depend solely on the perspective of the person supporting the individual to put their person-centred plan together.

Creating an environment that is relaxed and informal is considered more appropriate for undertaking person-centred planning and may enable the natural authority of the person to be more easily recognised and appreciated. A relaxed, comfortable environment can enable the person and their family to feel more empowered and be more conducive to promoting good relationships between the person, their family and organisations.

Person-centred planning should be formally recorded in some way, for example in a written or accessible person-centred plan, goals, update notes, review notes and evidence of evaluation.

5.2.2. Exploring person-centred planning tools and approaches

Planning tools can be a useful part of person-centred planning, however there should not be over-reliance on standardised tools that could restrict individualisation, and challenge the core beliefs and foundations necessary for the development of quality person-centred plans. Person-centred planning tools can be used to plan with a person, not for them. They are sensitive, reflective and forward thinking. The tools can be used to help the person think about what is important in their lives now and also to think about a positive future would look like. Examples include PATH, MAPS, Personal Futures Planning, Essential Life Planning and Person-Centred Thinking Tools.

All tools are similar in that they:

- ensure that the person is at the centre and in control of the process
- ensure that the person is listened to
- ensure the planning team has a shared commitment to taking agreed actions to support the person to achieve their goals
- ensure there is learning from the process and experience

The differences include:

- the way information is gathered
- the type of information that is gathered i.e. some focus on the present and the future, some also focus on the past
- the emphasis can be mainly on a person's current life or on a future dream

In addition, there are a number of approaches which can be helpful in person-centred planning. These include Discovery, Community Circles and Social Role Valorisation. More information on the different person-centred planning tools and approaches can be found in Appendix 3.

5.2.3. The person-centred planning meeting

For some individuals, a planning meeting can be a good way to bring all those involved in supporting them with their person-centred plan together, to share information and to begin work on goal setting and on developing an action plan.

The person who owns the person-centred plan should decide if they want a person-centred planning meeting. If they do, they should be given the time, space and necessary tools to prepare for their meeting. The person should be afforded the time to work at their own pace to develop their person-centred plan, and be recognised and respected as the expert on their own life. If the person does not wish to have a person-centred planning meeting, then alternative ways to support the development of a person-centred plan should be explored, for example working one to one with key supporters, or developing an action plan based on experiences and responses over time.

The person should decide when and where to have a person-centred planning meeting; they choose the type of meeting, the time and the venue, and should be supported to make these decisions where necessary. The setting for a meeting should be a valued space for the person who owns the person-centred plan. The person who owns the person-centred plan decides who should be at their meeting; they choose who they feel are best to support them to achieve their goals. The person should be involved in organising invitations and agendas.

If the individual needs support to make these choices, then the person supporting them to put their person-centred plan together should:

- facilitate the person to be as independent as possible in the process – the person may be able to undertake some steps in the decision-making and organising process – it is important that those supporting avoid taking over completely when some aspects of the process are difficult for the person.

For example, the person may not be able to articulate the names of those they wish to invite but may be able to choose from a set of photographs.

The person may not be able to write their own invitations but may be able to print them from a computer. The person may not be able to address the invitations but could deliver them if photos were included on the envelope.

- consider what they have learnt about the person as they spent time getting to know them – their preferences, relationships, skills, communication. They should use this information in planning and organising the meeting, for example, who does the person like to spend time with, where are they most comfortable and relaxed, what time of the day are they likely to be most engaged, how long does the person concentrate for.
- talk to others who know the person well
- observe the person's responses and reactions to different situations, events and stimuli.

The person who owns the person-centred plan should be given the chance to attend all meetings if they wish to. Some individuals may choose to attend for part of their meeting, or to move in and out of the meeting, as they feel comfortable.

The ability of the plan facilitator to support effective communication will have an enormous impact on the success of the meeting. Every effort should be made to involve the person who owns the person-centred plan in any discussions about the plan. Discussions should be conducted at an adequate pace, giving the person the space, and time they require to communicate their views. Additional facilitation strategies might include regular breaks, quiet space, timekeepers, or the use of a familiar room.

Staff should be aware of how the language and questions they use can influence information gathering and the person-centred planning meeting.

For example:

- the vocabulary used in questions and the meaning implied should be clear and simple
- questions relating to specific activities or events are easier to understand than ones referring to abstract concepts
- questions that require the person to indicate what 'usually happens' or how they feel 'in general' are difficult to reply to
- questions involving emotions are harder to answer
- time concepts and frequency are difficult to follow[10]

The person who supports putting the person-centred plan together should ensure that the meeting is accessible to the person who owns the plan, for example through the use of sensory materials, objects, mementoes, signs, photos, DVDs, PowerPoint presentations, music.

Members of the circle of support should be facilitated to attend all person-centred planning meetings. The person who will support the individual to put their person-centred plan into action should also attend the meeting.

[10] Finlay and Collins (2001)

This is an example of a person-centred planning meeting made accessible to a person who is non-verbal:

Eamon lives in a residential setting and attends a day service – both are provided by the one organisation. He is a 60-year-old man with a moderate intellectual disability. Eamon is non-verbal and has a hearing loss. He communicates through body language, facial expression, gestures and Lámh signs. Eamon can use photos and pictures to indicate his choices and interests. Eamon has comprehension difficulties but signs, photos and pictures can help him to process information.

Niall supports Eamon with his person-centred plan. Niall has taken time to get to know Eamon and to understand how he communicates. Niall has attended a Lámh course so he can use, recognise and respond to the Lámh signs that Eamon uses[11]. Niall and Eamon have identified Lámh signs, which are relevant to Eamon's goals, and they use these regularly as part of their everyday interactions and discussions. Niall has demonstrated these signs to other key people in Eamon's life.

Niall has also developed a number of different visual supports to assist Eamon with person-centred planning – these include a set of photographs of Eamon's preferred activities, the important people in his life, the places he visits and potential interests/activities. Eamon and Niall gathered photos and videos of important people, things and events in Eamon's life throughout the year. They look back over these often so they are familiar to Eamon.

Eamon indicated that he would like to have a person-centred planning meeting. Niall offered Eamon a choice of venues through photographs. Once Eamon had made a selection, they visited the chosen venue – a local hotel – to make sure Eamon was happy with his choice. Niall is aware that Eamon communicates best early in the day. As he gets tired, his concentration wanes and his listening and comprehension skills reduce. Eamon and Niall decided to have the meeting on a Tuesday morning as Eamon had no specific activities scheduled for this day of the week, and so there would be no time pressures. The date was marked on Eamon's visual calendar.

Niall and Eamon considered who to invite to the person-centred planning meeting. Eamon selected a number of individuals through photographs – his Father, Aunt, his keyworker from the day service. Eamon signed that he would like the local manager to attend also. Eamon and Niall worked together to print photo invitations which were easy for Eamon to understand. Eamon had a photo checklist so he could record replies to the invitations.

Eamon and Niall prepared a photo shopping list which identified the different refreshments which Eamon wanted for his meeting.

[11] www.lamh.org

Eamon was supported to be as independent as possible in the purchase and preparation of the refreshments for the meeting.

Eamon and Niall set out a visual agenda for the meeting, using pictures. This was prepared in advance of the meeting.

Eamon and Niall printed some of Eamon's favourite photographs for the meeting and put them up around the room. These provided a joint focus for conversation at the start and end of the meeting. They also put together a PowerPoint presentation, which included photos and videos from the past year. Eamon controlled the slideshow, deciding how long to spend on each item.

Those attending the meeting were encouraged to use Lámh signs to support Eamon in conversation.

After the meeting, Eamon and Niall put together a visual copy of his person-centred plan and his goals, using pictures and photographs. This showed the goals selected and the person who will support Eamon with the goal. Niall also marked key dates and timeframes on Eamon's visual calendar.

5.2.4. The content of the person-centred plan

Person-centred plans should focus on the personal aspirations of the individual and on outcomes for the person. They should describe a vision of a more positive future for the person together with a goal based action plan for the attainment of this more positive future.

Typical components of a good person-centred plan are a description of:

1. the person at the centre of the planning process indicating - at a minimum - their capacities, strengths, capabilities, what the person themselves and other people like and admire about them and what is important to them;
2. what is and is not working well in the person's life at present - what the person would like to change;
3. what the person wants for the future and how they would like to be supported in moving towards this future;

4. the specific changes required to attain the future the person desires, how these changes are to be made, by whom and when (to include: general strategies, specific activities, particular services, required support intensities and personal commitments by those supporting the person to put their person-centred plan together and into action, SMART (Specific, Measurable, Attainable, Relevant, Time-anchored) goals;
5. how the person-centred plan will be reviewed and kept live (to include: communication strategies on plan progression, a plan and progress review date and strategies for capturing ongoing learning throughout the process)

Person-centred plans should address:

- big life items such as where to live, employment, relationships
- everyday choices and how life is lived
- social and recreational events such as holidays, outings, concerts
- building independence
- milestones towards achieving personal goals and outcomes

Person-centred plans should be personalised and unique to the individual. The person is supported to decide who to share their person-centred plan with and how much information to share.

5.2.5. Setting goals

Goals are the things that a person does to obtain an outcome, a real and positive life change. By setting goals, a person can identify a desired result they wish to achieve. They can focus on the steps needed to reach their target.

Goals should be specific, person-centred, longer-term and developmental. Long-term goals should be broken down into a series of steps or smaller goals.

Goals are set based on the aspirations of the person. They are individual and meaningful to the person, and are not constrained by the services provided by an organisation, or by the resources available to an organisation. Opportunities for new experiences, social participation, education, development and employment should be facilitated and supported. The person supporting the individual to put the person-centred plan together should assist the person to select and prioritise aspirations and goals.

As stated in section 2, the nine outcomes identified in the draft outcomes measurement framework, developed by the National Disability Authority, may be a useful reference point to support a person to set their goals, and to understand how these goals may lead to positive outcomes.

For persons with a disability who use day services and supports, the twelve supports and HSE Interim Standards for New Directions (www.hse.ie/newdirections) will also facilitate goal setting and the identification of individual outcomes.

Where the person needs a high level of support to select their goals, consent should be viewed as an ongoing process. Continual reflection and evaluation is essential, and person-centred plans should be changed and updated to take into account the preferences of the individual.

Activities of daily living do not constitute goals in person-centred planning. In exceptional circumstances more basic goals may be appropriate for a period of time but there should be clear evidence of progression for the individual as time goes on.

Goals should not concentrate on the healthcare needs of the person. While a person-centred plan will be informed by a person's medical, clinical and care needs, they should not be the focus of a person-centred plan. In some exceptional cases where the individual is facing significant physical or mental health difficulties, goals related to health may be appropriate for a period of time.

These are two examples of goal setting in action in collaboration with circles of support:

Tom is a 24-year-old man, who is described as strong-willed, and who will make it very clear when he does not want to do something or is unhappy. He has a moderate intellectual disability and is non-verbal.

Tom has a person-centred plan, which identifies his wants, needs, dreams and wishes. This person-centred plan has been developed in conjunction with those who know Tom well - his family and other significant people in his life. It is important to Tom to gather evidence from others who support him, for example the local service staff, Occupational Therapist, Speech and Language Therapist, Physiotherapist, Psychiatrist, etc. These supporters can offer advice and guidance, which may support Tom to communicate or work on his goals.

Tom, his mother, sister and keyworker met to discuss goal setting. Tom's mother felt that communication was essential in supporting Tom to build and develop friendships. Tom spent many hours in the relaxation room and did not interact with peers or staff. His mother felt this was having a negative impact on his life and was something Tom needed support with. Tom and his planning team decided to develop a goal which looked at widening Tom's social experiences. The first step was a referral to Occupational Therapy and Speech and Language Therapy for advice and support on the best ways to facilitate this goal.

Through collaboration, guidelines were developed to ensure Tom's routine and activities were consistent, as this was noted to help him have a good day. It was identified that pictures have no significance for Tom so objects were introduced as part of Tom's daily timetable. These were used to support Tom to understand what was happening each day. 'Intensive Interaction'[12] was introduced to support Tom with his communication and to enable staff to interact with Tom at his level. This approach had a positive impact on Tom's ability to interact with others, and opportunities for social interaction were expanded. With support from staff, Tom now goes to his local coffee shop with a friend on a weekly basis. He also takes part in a music session each week and this has helped him develop friendships.

Tom does a weekly grocery shop for his lunch, using a wheelchair friendly shopping trolley, and he has the opportunity to interact with shop staff. This particular goal has had a huge affirmative impact on Tom's life. He no longer spends time isolated in the relaxation room in the local service. Instead, he prefers to spend time with his peers, be it out for a coffee in the community or interacting with staff and friends in the local service. Tom is happier and more engaged.

[12] Intensive Interaction is an approach designed to support persons at early levels of development, persons who have autism, who have severe, profound or complex disabilities. Intensive Interaction works on early interaction abilities and communication routines www.intensiveinteraction.org

Anna is a 45-year-old woman living in a community residential setting, Anna attends a local day service. Anna communicates through body language and movement, facial expression, eye gaze and vocalisations.

Anna has a circle of support to assist her to develop and action her person-centred plan. This team includes her person-centred planning facilitator, sister, niece, residential keyworker, a staff member from her day service and neighbours. The circle of support are anxious to ensure the goals they select with Anna accurately reflect her choices and wishes.

Over the past few months, the members of the circle of support have taken photos and video of Anna reacting and responding to different people, places, activities and things. They have gathered information from people who know Anna well and interact with her on a regular basis, and from those with 'fresh eyes' who are just getting to know her. They have shared their learning and understanding of how Anna communicates and of her choices and preferences.

The information and evidence gathered shows a number of important things for Anna. Anna seems happiest when she is outside – she shows this in her relaxed body posture, smiles, increased eye contact and in the sounds she makes. She loves trees, enjoying the movement of the leaves and the changing light patterns. Anna loves the smell of particular flowers and likes to hold the petals in her hands. Anna is most communicative when she is outside, enjoying nature, and she likes to share this experience with the people closest to her, for example her family and close friends. She shows this in her excited reactions to their arrival and presence.

The circle of support would like to extend the opportunities Anna has to engage with nature and her physical environment. They would like to include this in some way in her person-centred plan and goals. The first step is to extend the range of gardening and horticultural activities which Anna participates in at her day service. Then the circle will explore Anna's community to find out about local garden centres, accessible walks and trails, sensory gardens etc. The next step will be to arrange more frequent visits to such locations and to observe Anna in these environments. Anna's neighbour and family members offer to accompany her on these visits.

The circle of support will review progress on a regular basis and talk about longer term goals for Anna such as joining a community gardening group, volunteering with an environmental group, or employment in a garden centre or florist.

5.2.6. Accessible formats

The person who owns the person-centred plan should hold the main copy in a format and place which is accessible to them. The organisation(s) will have a copy of the person-centred plan. Organisations may use specific software or business systems to store copies of individual person-centred plans.

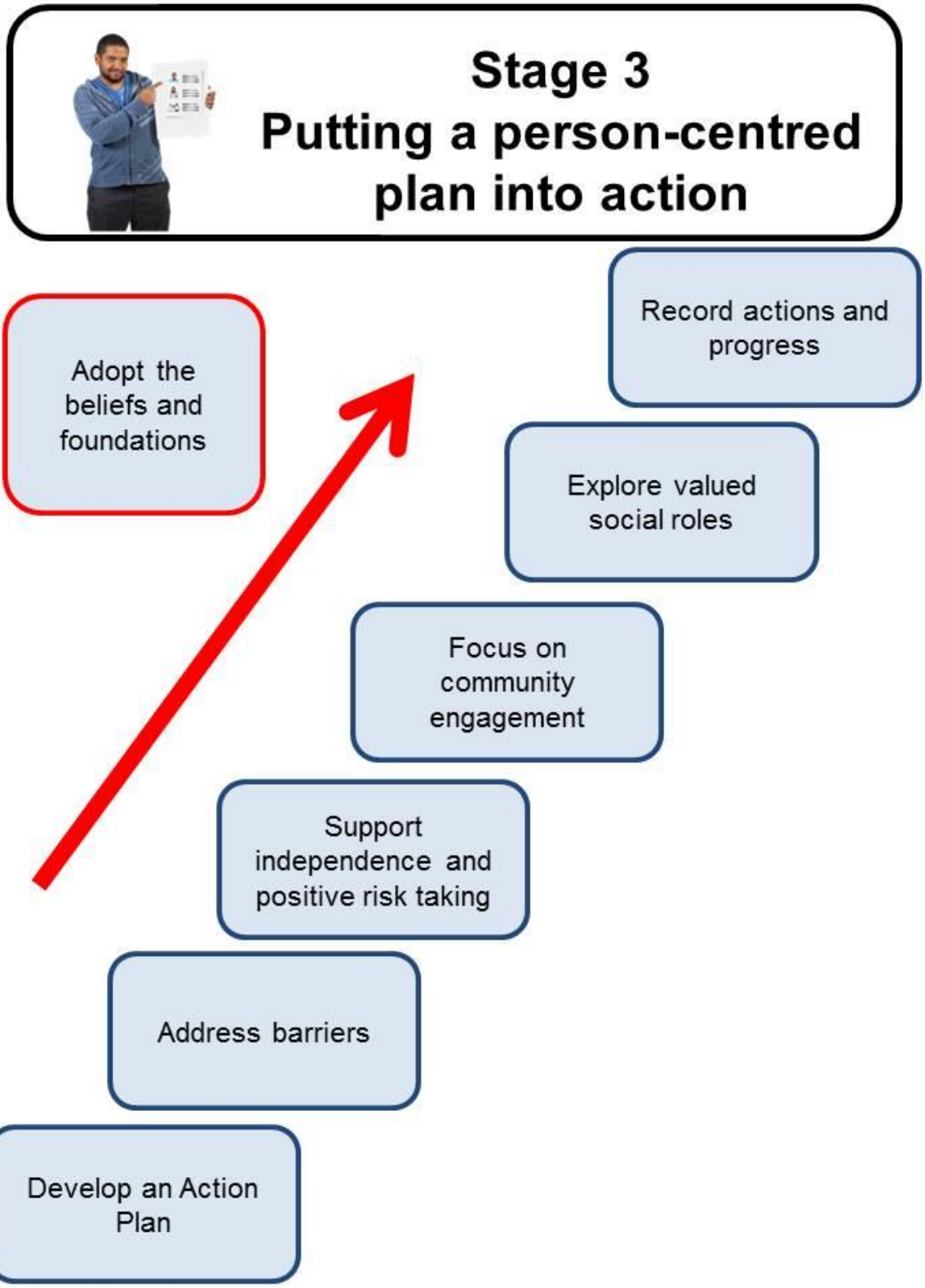
Accessible formats may include Easy to Read versions of a person-centred plan, photographs and slide shows, object and memory boxes, audio and DVD versions. In order to make person-centred plans accessible, some individuals may need one to one support to revisit their person-centred plan on a regular basis, for example to look back at photos and videos, to share mementoes, to go through Easy to Read information. The person's understanding of the person-centred plan may develop through discussion, repetition of information, practical experience and ongoing support to make connections between their person-centred plan and the things that are happening in their everyday lives.

5.3. Stage 3 - Putting a person-centred plan into action.

At this stage, it is important to identify those who are key in supporting the person to implement their person-centred plan. It is critical to have constant review and reflection, and that barriers are identified and addressed.

The beliefs and foundations are essential and should be adopted at this stage of the person-centred planning process.

Figure1.6. Stage 3 of person-centred planning



5.3.1. Action plans

The person who owns the person-centred plan and the person supporting them to put their person-centred plan together should set out a clear action plan and implementation strategy. This forms part of the person-centred plan. The action plan should be accessible to the person and should consist of a set of SMART goals. Clear timeframes need to be identified in the action plan within which goals will be worked on and achieved. Those responsible for supporting the person to achieve their goals should be clearly identified. The person-centred plan should focus on what is important now and into the future, and foster community engagement, in line with the person's choices.

Those responsible for supporting the person to put their person-centred plan into action need to be innovative and creative in how they support the individual to achieve their goals. This requires an organisation that is receptive to supporting innovation and positive risk-taking. Those supporting should provide guidance but should not criticise or replace goals. The action plan should be communicated clearly to the person who will support putting the person-centred plan into action. There should be a named person, responsible for ensuring each goal is achieved.

5.3.2. Addressing barriers

Planning teams and circles of support need to be committed to finding ways to achieve the person's goals, even if this is a challenge. Managers need to be responsive to person-centred plans and their implementation, and support creativity and innovation within teams to overcome barriers.

It is likely that barriers will arise as a person is supported to work towards their goals. Where barriers are identified during the implementation of person-centred plans, these issues should be addressed initially at the local level.

Where barriers cannot be addressed at the local level, a process should be in place to allow barriers to be escalated upwards and brought to the attention of appropriate senior managers. Every effort should be made to successfully address the issue.

In the event that the person does not feel that their issue was appropriately handled they should be given the opportunity to express this and if necessary be facilitated by the team to use the complaints policy and procedure in the organisation to express their dissatisfaction.

5.3.3. Supporting independence

At the outset, independence is supported by an accessible person-centred planning process, which enables the individual to participate as fully as possible. It is important that person-centred planning policies support persons with disabilities to maximise their autonomy and independence.

Person-centred planning provides opportunities for persons with disabilities to achieve more independence in their daily lives, for example by setting goals relating to specific skill development. These may include goals around finances, employment, travel, relationships. For some individuals, goals may focus on maintaining independence and control.

Key factors in supporting independence include the skills of those supporting the person with their plan, the attitude and approach of circles of support, available opportunities and choices offered.

This is an example of how one person, with the support of their circle of support, addressed barriers to their plan. In doing so, they were supported to be more independent.

Laura lives at home with her family and attends a community-based service in the nearest town. This service is provided by a large disability organisation. She is a 22-year-old woman with a moderate intellectual disability.

Laura is passionate about exercise and enjoys participating in a range of different sports. At a recent review of her person-centred plan, Laura explained to her facilitator, that she would like to increase her fitness. She is training with a local gymnastics team at the weekend and would like to try to make it into a squad for a national competition. Laura would like to start attending a gym during the week as she feels that training at the gymnastics club at the weekend is not enough.

There is a local leisure centre which includes a gym and pool, which is a short walk from Laura's home. Laura would like to use this centre as she knows some of the members and she feels she would be comfortable there. She aims to go to the gym twice a week. Laura's keyworker and the service manager feel she would need support at the gym, as she is not familiar with the building or equipment. They do not have enough staff to free one person up twice a week to attend the gym with Laura. The manager suggests that Laura could use a gym in a local day service but Laura is not keen on this idea. The staff are concerned that Laura may spend a lot of money on a gym membership but may not get value for money if she cannot attend regularly or does not like it.

Laura's mother is concerned about her safety in the gym. She is worried that there are health risks and that Laura may be more prone to injury due to her disability. Laura thinks her mother is being overprotective.

Laura's circle of support meet to talk about her goal and to explore ways to overcome the barriers. Laura and her mother agree to visit her Physiotherapist together so they can get advice and reassurance about her health and her exercise regime. The Physiotherapist suggests that initially one session a week is spent in the gym and one in the pool. Laura is happy with this.

Laura's sister agrees to accompany Laura to the local gym so she can get information on membership, fees and opening times. They decide to talk to the manager in the gym about a trial membership for a month or two.

The service manager agrees to provide a staff member to go to the gym with Laura four times. These sessions will focus on supporting Laura to become familiar with the facilities, for example using the membership pass, using the lockers and showers, finding the correct changing facilities. Laura's sister and neighbour agree to back up this work with a number of evening visits to the gym.

Laura's facilitator finds out about a scheme, run by the local council, which supports people with disabilities to use leisure facilities. A personal trainer would be available to work with Laura in the gym for a number of sessions to develop her personal programme. Laura decides to apply for this scheme. The service manager also agrees to explore the possibility of finding a volunteer to accompany Laura to the gym.

Laura is aware that she needs to build other skills in order to achieve independence with this goal. She asks her keyworker to support her to develop a visual checklist so she knows what to pack in her gym bag for each visit. She would also like to learn how to use the washing machine so she can wash her gym gear after each visit. Her Mother agrees to support her with this.

Six weeks on, Laura is walking from home to the leisure centre on her own. Once a week, she goes independently and has a swim in the pool. Laura has a gym programme, which has been set up specifically to suit her needs. On Wednesday morning, a volunteer meets Laura at the gym and supports her to complete her gym programme. Laura is becoming more familiar with the programme and she hopes that this support can be reduced soon. Laura is also getting to know the gym instructors and she is more confident to ask questions and ask for help if she needs it.

Next Laura would like to attend a yoga course in the gym independently.

5.3.4. Managing risk

Individuals, staff teams and managers should set out to afford those using their services the 'dignity of risk'. The dignity of risk is the right to take risks when engaging in life experiences, and the right to fail in those activities. Person-centred plans should address, as appropriate, positive risk taking and risk management. Positive risk-taking is taking risks to achieve positive outcomes. It involves weighing up the potential benefits and risks of exercising one choice of action over another, identifying the potential risks involved, and developing plans and actions that reflect the positive potentials and stated priorities of the person. It involves using available resources and support to achieve the desired outcomes, and to minimise the potential harmful outcomes. It is not neglecting or ignoring the potential risks; it is a very carefully thought out strategy for managing a specific situation or set of circumstances.[13]

Where risks pose a barrier to an individual achieving their goals, a proactive and flexible approach is required. A step by step approach is recommended which encourages and enables the individual to gradually build the skills necessary to take part in different tasks, activities and experiences. Family members are given the necessary time and supports to contribute their ideas and to allay any concerns they might have.

5.3.5. Community engagement

Those supporting the person with their person-centred plan should explore opportunities with the person for engagement with participation in their community. The person should be encouraged and supported to access the community as an individual, and to develop meaningful roles and relationships.

[13] HSE (2015) Interim Standards for New Directions, Services and Supports for Adults with Disabilities.

It is acknowledged that some people require purpose built facilities to support their needs and that community inclusion may be limited as a consequence.

Also, there are specific disability conditions that present challenges with regards to the level of community engagement that may be appropriate for an individual. These factors should not compromise the principles of community engagement or active citizenship but rather reinforce the approach to individualised planning and solutions, which will support appropriate and meaningful access to the community that is respectful of a person's needs, wishes and abilities.

Individuals and staff teams should seek to increase the involvement of community members and supporters from outside the service in person-centred planning and in circles of support.

Staff teams and managers should collaborate with other organisations to explore community-building approaches.

5.3.5.1. Valued social roles

Valued social roles are roles that enable a person to contribute in a meaningful way to their family and their community. Holding valued social roles enables people to be seen positively and become valued by others. Examples of valued social roles are being a club member or being a volunteer. The opportunity to take on, develop, and maintain a valued social role is central to social inclusion and belonging.

It is important that person-centred planning:

- promotes recognition of the person as a valued, competent individual
- facilitates the individual to undertake valued social roles of their choosing
- creates opportunities for the person to experience different valued social roles
- emphasises the need to perform these social roles in the community
- supports the person to maintain existing valued social roles

5.3.5.1.1. Exploring employment

Person-centred planning can be an important tool in the exploration of employment options and career choices for persons with a disability, if this is one of their goals. Information gathering about the person, their interests, needs, strengths and skills is relevant to the development of job seeker profiles. Person-centred planning can be complementary to other employment supports such as supported employment.

Community participation and valued social roles support individuals to gain valuable experience and skills, which they can take to the workplace. They also provide opportunities for individuals to build social networks, which can lead to employment opportunities within communities.

Goals relating to education, training, work experience, and career guidance can all form part of a person-centred plan.

This is an example of person-centred planning in action where positive risk taking, supporting independence and employment options are addressed:

Harry is a young man, who recently left school and started receiving supports from a community based service in his local town. He has a moderate intellectual disability. Harry can communicate his dreams and wishes verbally, and he has expressed clearly the desire to be more independent and to be treated as an adult. Harry would like to get a job but there are limited opportunities in his local town. He is aware of a number of positions available in the next town, which is much larger and which is a twenty-minute bus journey away. Harry would like to work in retail. He is excited about the prospect of earning and spending his own money. It is likely that he would require some job coaching and support initially but Harry feels confident that over time, he would be able to work in paid employment independently.

Harry's parents and keyworker are concerned about his road safety and travel skills, and feel it may be too big a step to consider Harry travelling independently on the bus to work. Harry is keen to try.

Harry and his person-centred planning facilitator sit down to talk about this goal. They complete a risk assessment. They break the journey to the next town down into clear steps, for example walking to the bus stop, waiting on the bus, getting on the bus, paying the fare, the bus journey, getting off at the right stop, walking to work, finding the bus stop for the return journey etc. They agree to look at one step at a time. Initially, they will complete a skills analysis on the walk to the bus stop.

Harry will participate in road safety training in the service. They feel they will need to focus on using the pedestrian lights, as there is one main road to cross on the way to the bus stop. Harry will complete this step with support at first. This support will be phased out over time. Harry's mother is reassured that phasing out the support will include staff shadowing Harry for a period of time as he learns to use the crossing, and peer support to use the crossing, before he walks fully independently to the bus stop. Once this step has been achieved, Harry will work on the next step in the journey.

Harry and his facilitator talk with his mother about her concerns, and she explains that her main worries centre around Harry's ability to problem solve. She worries about things like a change to the bus route, if a problem arises or if Harry gets anxious and needs support.

Harry has recently started using a mobile phone and they agree to explore this as a potential way to address some of the barriers. Harry will ring the service or his mother as he sets out on his journey and will make contact again by phone or text when he arrives safely at his destination. He will also practise making calls in the event of a difficulty arising.

Harry and his father will look at an interactive website at home which promotes road safety skills and provides a learning record which can be shared with service staff.

On Saturday Harry and his father usually take the car to the local GAA club to watch a match. Harry's father decides it would be a good opportunity to walk and to observe Harry's road safety skills in action. Harry's keyworker shares their approach to using a pedestrian crossing so Harry is getting consistent information. Harry's father is pleasantly surprised by his son's level of skill and his determination to master road safety.

In a short space of time, Harry is walking to the bus stop safely and independently. He quickly masters the skill of hailing the bus and of using his bus pass when he gets on the bus. He is presently working on the skills needed during the journey, for example finding a seat, appropriate interactions with other passengers, knowing when to get off and pressing the bell to alert the driver. The plan is that Harry will get on the bus by himself soon and staff will join him on the bus later in the journey so he has the supports he needs to get off at the right stop.

There is constant communication between Harry, his facilitator, keyworker and family. The strategies for risk management are explained clearly. This provides reassurance and makes sure everyone is consistent in their approach.

Harry is proud of his achievements so far and of his growing independence. He is glad that he persevered with this goal and persuaded others to support him to take up the challenge.

5.3.6. Recording actions and progress

All reviews of the person-centred plan, including ongoing informal reviews, should be formally recorded. Person-centred plans should be updated and amended to account for changing circumstances, new developments and in accordance with any changes recommended following a review. Recorded information should include any proposed changes to the person-centred plan, the rationale for any changes, the names of those responsible for pursuing objectives in the person-centred plan, agreed timescales.

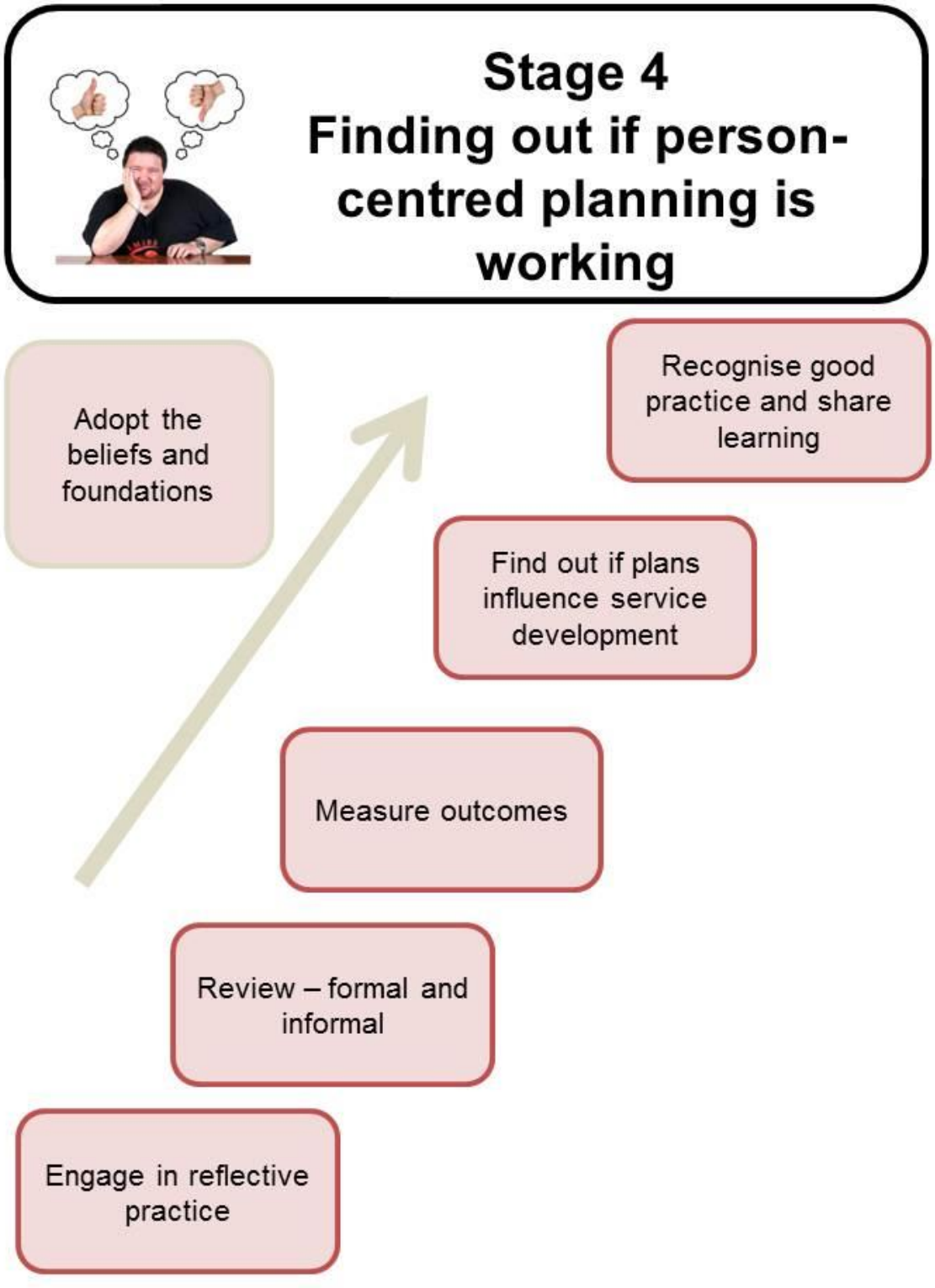
Monitoring evidence should be collected so a formal record of progress towards goals can be collated. There should be clear evidence to illustrate whether or not goals were achieved, for example written examples and notes, photos, or video evidence. The person supporting putting the person-centred plan together, and the person responsible for making sure the person-centred plan is put into action, should communicate and share relevant information and learning in relation to the person and their person-centred plan.

5.4. Stage 4 - Finding out if person-centred planning is working

Monitoring and evaluation should form part of the ongoing process of person-centred planning. However, once the plan is developed and implemented, there are a number of actions that should be taken to determine the success of the plan. This is stage four of the process.

At the final stage of person-centred planning, the beliefs and foundations are still important and should continue to be adopted.

Figure 1.7. Stage 4 of person-centred planning



5.4.1. Reflective practice

Reflection in and on practice is a process that enables individuals to systematically and critically review and evaluate their practice to find new insight and understanding.[14]

Every organisation should engage in critical reflection of their practice; this should include all staff, both managers and frontline, as well as multi-disciplinary teams, the person who owns the person-centred plan, their family members and circle of support. Individuals, staff teams and managers should consider what changes they may need to make to enable a culture that supports person-centred planning, innovation and critical reflection.

Staff should feel confident to reflect critically and constructively on their practice as a team and be able to supportively challenge practice that is not person-centred. This will require staff being facilitated to explore what person-centredness means to them as individuals and teams, what practices are acceptable and not acceptable and how they will supportively challenge practice they no longer consider person-centred. Practice evaluation should be ongoing and form part of what the organisation does to support good practice. In addition there should be an agreed and transparent procedure to evaluate the effectiveness of person-centred plans and the person-centred planning process.

Examples of aspects of person-centred planning which could be evaluated include communication, teamwork, the involvement of the person, family involvement, accessibility or goal setting.

[14] Bucknall et al (2008), Mazirow (1981), Schon (1983)

This is an example of one organisation's experience of using reflective practice:

Reflective practice is lifelong learning through the analysis of our experiences. It allows us to learn from these experiences, to analyse the work we are doing and to determine if it meets the required practice standards. Through reflection, we can decide if our practice is in line with our principles and values.

In our service, each member of the team participates in a specific reflective practice session every two weeks. During these sessions, staff get the opportunity to talk about their experience of a work-related issue - this could be something they are struggling with, or an interaction that left them feeling they could have done something differently. It is an opportunity to share a work related issue which may be on their mind.

For example, one staff member discussed an identified change in the behaviour of a person who is non-verbal following a visit to their family home. When they returned to the residential service, the staff member noted that this person became very upset and withdrawn. The staff team used reflective practice to discuss, observe, and analyse why this was happening and looked at more supportive options for the person and their family. They were able to use this practice model to offer more frequent opportunities for family visits and smoother transitions for the person when they returned from family visits. This led to a very positive solution; a better understanding of the individual's communication, a reduction in behaviour that could be perceived as challenging, and higher levels of engagement with the individual's family.

This is an example of critical reflective practice in a team meeting:

Siobhán is the person in charge covering six small residential houses. At a staff meeting, Siobhán brought along copies of the person-centred planning framework to discuss with the team. The initial reaction was to query the need to change the current process. This was an opportunity for Siobhán to facilitate a critical reflective discussion.

The team went through the process together, looking at what they were already doing in line with the framework and where they needed to make changes. Seán did not see the necessity to change. "We already take a lot of time doing person-centred planning and this will add to our workload". "But do we do it well enough at the moment?" asked Jo. "I don't think all this time is necessary. We have other work to do as well" said Seán.

"Think about what you have just said Seán" said Siobhán. "If we don't really know what is important to the person, how do we find out?" "I know all the clients here and what they want. I don't even need to ask them anymore," said Seán. "How would you feel Seán if we didn't ask your opinion on anything here anymore? If we excluded you from staff decisions because we felt we knew what your answer would be" said Siobhán. "It wouldn't be very person-centred of us or respectful of you" said Jo. "I never thought of it like that. Perhaps I need to re-think what I feel about person-centred planning" said Seán.

5.4.2. Systems of review

Person-centred plans should be reviewed on a regular basis, with both formal and informal review encouraged.

The frequency of review should be based on a number of key considerations:

- The needs of the individual and/or their family - the person who owns the person-centred plan should be able to seek a formal or informal review at any point in the process
- The needs of those supporting the person to put their person-centred plan into action– staff may call a review to share information or ideas, or to seek additional support
- The progress of the person-centred plan and achievement of goals – if goals are not achieved or if the person is encountering difficulties, there should be the option of a review. The person should not have to wait for a defined time period before this can happen
- The person-centred planning policy in place in the organisation

Formal review may involve formal meetings and reports. This should be co-ordinated by the person who owns the person-centred plan and the person who supports them to put their person-centred plan together, and should also involve the person who supports them to put it into action, family and circles of support. Formal review should take place at least annually.

Informal review should be ongoing and will be mainly between the person who owns the person-centred plan and the person supporting them to put the person-centred plan into action.

It may consist of telephone calls, written updates, an analysis of evidence, informal meetings between the individual and the person supporting them to put the person-centred plan into action, updates from family and/or others supporting the person with individual goals.

Ongoing informal review should provide an opportunity to look at monitoring evidence, to discuss progress and to address any barriers to progress.

Formal and informal review should provide for the maximum participation of the person, their family and their circle of support. The person's achievements and outcomes should be recognised and celebrated.

Ongoing communication is essential and the system for reviewing person-centred plans should enable staff to critically reflect on their practice as a team, along with their workplace and the structures within the system that do or do not support person-centred planning, and to take the necessary steps to raise issues identified from reflections. The focus should be on outcomes for the person and what is required to achieve them rather than outputs.

5.4.3. Measuring outcomes

There should be an overall system of evaluation in place across the service. This should include the measurement of outcomes; positive changes in a person's life as a result of person-centred planning.

Regular feedback opportunities should be in place with the person, their family (if the person chooses) and/or circle of support to find out if they are satisfied with the person-centred plan and its implementation. Feedback can then be used to ensure that person-centred planning is leading to action.

The senior management team in the organisation should be familiar with the review and evaluation of data in relation to specific outcomes and interventions arising from person-centred planning such as the number of goals achieved, levels of satisfaction, quality of life improvements, transitions, independence, employment supports, community involvement, barriers, and complaints.

The evaluation methods used to assess outcomes should be reliable and valid and be able to accurately provide the information sought. The quality of relationships, content of planning documents, experience of using process, and life-style related outcomes should form part of the evaluation process.

This is how one organisation approaches outcome measurement:

In our service, we measure the outcomes generated by person-centred plans in line with the themes in New Directions. They are captured on a quarterly basis from all persons who use day services. Managers track outcomes to determine if they are achieved, in progress or if they have been cancelled. Cancelled outcomes are reviewed in relation to any barriers that may have arisen and the actions undertaken. Outcome measurement contributes to wider planning of supports at a local and national level. Measuring outcomes helps the organisation to see where the priorities lie in relation to future planning.

5.4.4. Person-centred plans and service development

Individual person-centred plans should inform the delivery of services and supports, influence service development and the allocation of resources. The link between person-centred plans and organisational planning should be obvious.

For this to happen organisations need to develop cultures that have a sustained commitment to practice development, service improvement and ways of working that embrace continuous feedback, reflection and engagement methods that enable all voices to be heard. Person-centred planning provides opportunities for organisations to review the structures and processes they have in place to ensure that they support staff to provide a process for person-centred planning that has a measurable positive outcome for the individual.

It can be difficult to step outside service models and imagine futures that involve approaches that do not follow conventional service design and practices. Many organisations start with a service model in mind rather than asking questions about what is most needed by the person. Person-centred plans can be the catalyst for change and provide an opportunity for organisations to be creative and look at how they can support individuals through unique arrangements.

5.4.5. Recognising good practice

Where good practice in person-centred planning exists, it should be recognised and shared learning encouraged to support continuous improvement.

Persons who own the plans, their supporters and the wider community should have the opportunity to share knowledge and experiences. This can happen through participation in a range of different activities including:

- teams using critical reflection on practice
- coaching and mentoring programmes
- information and study days
- research studies
- advocacy groups
- learning and development programmes

Individuals, staff teams and managers should be willing to embrace new learning and to use this to make positive changes in the services and supports they provide.

6. Evaluating person-centred planning

6.1. Why is evaluation important?

If the framework is properly implemented and planning is done well, it should lead to the development of high-quality person-centred plans and the achievement of outcomes for individuals.

An evaluation approach can be used to assess the implementation of the framework and current person-centred planning practices. It can also be used to determine planned changes and actions.

Evaluation should:

- show the impact and outcome of implementing the person-centred planning framework.
- contribute towards an evidence base for person-centred planning in an organisation.

6.2. Who should be involved?

Evaluating person-centred planning in your organisation will require a collaborative approach that involves and engages the key stakeholders in this process - the person, their family and/or circle of support, and staff.

Evaluation should include gathering feedback from the individual who owns the person-centred plan, their family and/or circle of support and staff, on their experience of engaging together in person-centred planning. The feedback can be gathered through formal and informal measures, such as:

- dialogue with individuals using services, families and staff
- face to face meetings
- focus groups
- active learning sessions that critically reflect on practice
- staff support and mentoring sessions
- surveys

Managers and leaders are integral to the evaluation process, and should ensure that the evaluation process facilitates learning and understanding for the organisation about how they can improve their person-centred planning policy and practices. It is vital that organisations seek to learn from evaluation so that feedback can inform future strategic planning.

6.3. How can you evaluate person-centred planning?

The following evaluation questions, which are not exhaustive, may be helpful in planning what you want to evaluate:

1. What is the experience of the person in engaging in person-centred planning?
2. What is the experience of the person's family/ circle of support in engaging in person-centred planning?
3. What is the experience of staff using the person-centred planning framework?
4. What impact has the process on everyday practice around person-centred planning?
5. What impact has the process on staff experiences of undertaking and implementing a new process into practice?
6. Has person-centred planning benefited relationships between all key stakeholders - the person, their family and/or circle of support and staff?

There is evaluation built into person-centred planning which is clearly outlined within the framework. However, evaluation of the experience and utilisation of the framework is also recommended to assess impact, usability and implications for practice development.

It is advisable that more than one method is used to evaluate the process of using the person-centred planning framework and person-centred practices. The approach outlined here recommends different methodologies to gather evidence of positive practice, progress and change. Some of these methods have been discussed previously at stage four - finding out if person-centred planning is working.

- Measuring the outcomes achieved for individuals; it is important to remember that the best measure of success for person-centred planning is whether the individual at the centre of the planning process has experienced a real change for the better in his or her life, as a result of their person-centred plan being implemented. Organisations need to measure outcomes identified by persons with disabilities and become accountable for the achievement of these outcomes. The evaluation methods used to assess outcomes should be reliable and valid and be able to accurately provide the information sought.
- Critical Reflective Practice - as a means for staff to review their current practice in light of the introduction of new processes, including their awareness of their own values and beliefs about person-centred planning, a key driver or inhibitor for practice change.
- Examining the impact of person-centred planning on service planning and delivery; it is important to assess the contribution of the person-centred plans, developed and implemented in a service, to the organisation's strategic plan. Individual plans should inform the delivery of services and supports, influence service development and the allocation of resources. Evidence should be sought to clearly establish a connection between frontline plans and broader organisational developments.
- This information should be collated, reviewed and used by the organisation. Person-centred plans can provide valuable information in relation to:
    - what is most important to persons using services and their circles of support
    - what is important for staff to be able to undertake a comprehensive person-centred planning process
    - unmet goals and aspirations
    - the barriers and supports for person-centred planning, and the delivery of services and supports in general
    - how well equipped organisations are to support person-centred planning and any gaps in service and support models and delivery
    - identification of good practices and how poor practices are challenged

- Implementing the evaluation tools designed to accompany this framework; there is one tool for the person who owns the person-centred plan and one for organisations. The tools are divided into the four stages of person-centred planning.

  The tool for the person who owns the plan focuses on concrete elements in the process. It provides an opportunity for the person to report on their experience of different aspects of the person-centred planning process, and to identify gaps or areas of strength. The tool is available in an Easy to Read format. Persons with a disability could be supported by a member of their circle of support, or by those supporting them with their person-centred plan, to complete the tool.

  The tool for organisations enables them to measure their practice against statements of practice, and identify areas for attention and development – see Appendix 4. Alternative formats of this tool are available on request. Individuals, staff teams or managers may decide to use these tools:

  - with a random sample of persons using services
  - where the quality of person-centred plans are in question
  - to enable individuals and/or their families to gain a greater understanding of the person-centred planning process and good practice
  - as part of their overall audit of person-centred planning

- Reviewing the effectiveness of the education programme used to introduce a new practice into the organisation.
- Reviewing their documentation to identify any gaps in the process.

Following evaluation, staff and managers as well as the persons involved and their family and/or circle of support should review the findings together and agree on actions that may be necessary to enhance person-centred planning practice.

Appendices

Appendix 1 (A) – List of national and international policies and publications which have influenced the framework

1. Guidelines on Person-centred Planning: The National Disability Authority, 2005
2. United Nations Convention on the Rights of Persons with Disabilities: United Nations, December 2006
3. The Disability Act: Department of Justice, Equality and Law Reform, 2005
4. Equal Status Acts 2000–2015: Department of Justice and Equality, 2000
5. The Disability Bill: Department of Justice and Equality, 2016
6. Assisted Decision Making (Capacity) Act: 2015
7. The National Disability Inclusion Strategy 2016 – 2020: Department of Justice and Equality, 2017
8. Council of Europe Disability Strategy 2017 – 2023
9. New Directions Personal Support Services for Adults with Disabilities: HSE, 2012
10. Interim Standards for New Directions, Services and Supports for Adults with Disabilities: HSE, 2016
11. Value for Money and Policy Review of Disability Services in Ireland: Department of Health, July 2012
12. Time to Move on from Congregated Settings: HSE, July 2011
13. National Standards for Residential Services for Adults and Children with disabilities: HIQA, May 2013
14. Outcomes for Disability Services: National Disability Authority, 2017
15. The Comprehensive Employment Strategy for People with Disabilities 2015 – 2024: Department of Justice and Equality, 2017
16. A Programme for a Partnership Government: Department of the Taoiseach, 2016
17. The HSE Quality Improvement Division/ Social Care Division – Quality Improvement Programme: HSE, 2016
18. The National Programme to Enable Cultures of Person-centredness in the HSE: HSE, 2017
19. The Next Steps Project, The National Federation of Voluntary Bodies, 2014
20. National Housing Strategy for People with a Disability 2011 – 2016: Department of the Environment, Community & Local Government, 2011
21. Vision for Change: Department of Health, 2006
22. National Financial Regulations, HSE, 2014

Appendix 1 (B) – List of national issues that influence outcomes for persons with a disability

1. Transport
2. Access to housing and residential supports
3. Practices in relation to decongregation
4. Availability of respite services
5. Employment opportunities
6. Educational opportunities
7. Social welfare, for example Disability Allowance
8. Individualised funding
9. Access to multi-disciplinary supports, for example Psychology, Occupational Therapy
10. Access to specialist supports, for example Behaviour, Mental Health
11. Access to leisure opportunities and facilities in local areas
12. Rural issues
13. Government funding and the allocation of resources

Appendix 2 – Information on the National Programme to Enable Cultures of Person-centredness within the HSE

Quality Improvement Division – National Programme to Enable Cultures of Person-centredness within the HSE

Background

Person-centredness has meaning across all fields in health and social care with a sea change in the thinking around its importance and influence. However, the focus continues to be on 'care' and 'interventions', with less emphasis on how organisations create person-centred cultures. Evidence suggests there is a need to shift the focus away from person-centred 'care' in isolation to one of person-centred 'cultures'. Whole scale shifts in systems may be slow but it is clear that person-centredness as a concept plays a significant role in shaping the thinking of policy makers and strategic planners in the way that health systems are evolving globally.

Person-centred Cultures

Evidence indicates that person-centredness can only happen if there is a person-centred culture in place that enables staff to experience person-centredness and work and communicate in a person-centred way. Enabling person-centred cultures in organisations requires a sustained commitment to practice development, service and quality improvement, and ways of working that embrace continuous feedback, reflection and engagement methods where all voices are heard. The enablement of person-centred cultures requires sustained and integrated approaches to systematically addressing embedded patterns in workplaces that drive thinking and behaviour.

Transformational Practice Development

Practice developers have been aware of the pitfalls of top-down change alone, and so they pay attention to local practices in clinical/practice settings whilst at the same time focusing on the need for a systems-wide focus on person-centredness and the enhancement of person-centred cultures.

In particular, transformational practice development pays attention to what are increasingly acknowledged as 'the human factors' in healthcare - factors that focus on the relationship between staff well-being, leadership, team relationships, morale, experience and a sense of belonging among staff in the context of clinical/practice effectiveness and patient/service user outcomes.

The Programme Structure

The aim of this accredited Programme is to implement an effective approach to enabling cultures of person-centredness through facilitation and implementing a framework for person-centred practice system-wide within the HSE. By using an agreed approach system-wide we build capacity and expertise within the system, complementing and enhancing other development work taking place such as Values in Action, Caring Behaviours Assurance System - Ireland and Leading Compassionate Care, by focusing on workplace culture and practice development.

Programme Facilitators develop facilitation skills and expertise to lead change in their organisations. The structure includes 5-day Facilitation Development School followed by 10 Active Learning Module days, one per month, to learn and develop skills in transformational facilitation, necessary to co-create a workplace that supports person-centred practices.

Sustainability

The Programme builds capacity and ownership within services to become self-sufficient in facilitating ongoing enablement of cultures of person-centredness in their workplaces over time. It started with HSE Intellectual Disability Residential services in 2017 and is being rolled out system wide throughout the HSE. Approximately 50 facilitators engaging with 500 staff per year ensures that a substantial number of staff have exposure to and are involved in culture work each year.

For further details please contact the HSE Quality Improvement Division coordination team: Lorna Peelo-Kilroe, lorna.peelo@hse.ie 087 6601791 or Margaret Codd, margaret.codd@hse.ie 087 2276399.

Appendix 3 – Information on person-centred planning tools and approaches

Planning Tools

- **PATH (Planning Alternative Tomorrows With Hope),** developed by Jack Pearpoint, John O'Brien and Marsha Forest; "begins with the end in mind". It is a creative planning tool that uses both process and graphic facilitation to create a shared vision of a positive future for individuals, families, teams and whole organisations. The process focuses on ideals, values, passions, and dreams. PATH draws on people's ability to visualize different futures and to plan backwards from a future vision or dream, and tell stories about how that vision can come into being. It starts with the person's future dream, compares this with what their life is like now and produces an action plan to help that person to achieve their dream. Each session will be led by two trained facilitators - a process facilitator who guides people through the stages and ensures that the person is at the centre throughout, and a graphic facilitator who creates a large graphic record of each of the steps in the PATH. PATH can work really well for a person who has developed a vision of what they would like to do. It is a very results-oriented process, excellent for team building, and has been used to mediate conflicts.

- **MAPS (McGill Action Planning System aka Making Action Plans),** developed by Jack Pearpoint, John O'Brien and Marsha Forest; asks eight guiding questions from which a team works together to assist individuals to define their dream and build a plan to achieve it. Key questions address the individual's history, dream, nightmare, strengths and needs. The process culminates with a plan of action. MAPS gathers information for planning based on the personal history of a person. The individual and those who have known him or her contribute information by telling stories about significant events. The background map created helps the group to understand the life experience of the focus person and his or her family.

Participants gain a greater appreciation of the individual as a whole person, with a broad range of experiences, struggles, and achievements. The positive experiences point out opportunities upon which the group can build; the problems and barriers encountered give the group a greater sense of the effort required to make good things happen. The map helps to celebrate the accomplishments and to show how opportunities in the present are often a result of experiences and actions in the past. MAPS is a creative planning tool that also uses both process and graphic facilitation. The MAPS sessions are also led by two trained facilitators - a process facilitator and a graphic facilitator.

- **Personal Futures Planning,** developed by Beth Mount and John O'Brien; provides a way of helping to describe the person's life now and look at what they would like in the future. It contains a series of six tasks designed to help find capacities in individuals, identify options in their communities, and develop supports and services that will meet each individual's strengths and needs. It helps people to build on areas of their life that are working well now and to move towards their desired future. It is useful when people need to learn more about the person's life (unlike PATH, which assumes this knowledge) and to create a vision for the future (unlike Essential Lifestyle Planning that focuses on getting a lifestyle which works for the person now). It will not provide the detail about what the person requires on a day-to-day basis in the way that Essential Lifestyle Planning does, but provides an excellent overview from which areas of concern can be considered. The quality of the planning depends more on the skill of the facilitator than on choosing the 'right' style.

- **Essential Lifestyle Planning (ELP),** developed by Michael Smull and Susan Burke-Harrison; to support people who were moving out of institutions into their communities. ELP set out to ensure learning about what is important to people and what supports they need was captured and used.

An essential lifestyle plan focuses on what is important to someone now and balances this with things like keeping the person healthy, happy and safe. Plans are written in plain and clear language and focus on enabling the person to achieve what is important to them and on how to provide the support to do this. An essential lifestyle plan should always have an action plan and it is vital that the plan changes and grows with the person - it is a living document.

- **Person-Centred Thinking Tools;** can support people to think about a number of key questions. The information is then gathered to co-produce their plan. A range of people should be involved in the planning process, but the person being supported should always be at the heart of the process. Person-centred thinking tools and skills provide a practical framework you can use day-to-day to help people to have more choice and control in their life. Each person-centred thinking tool provides the basis for actions and further information about what is important to people and how they want to be supported. Key questions include:
    - What is important to you?
    - What do you want to change?
    - How will you arrange your support?
    - How will you spend your money?
    - How will you manage your support?
    - How will you stay in control?
    - What will you do next?

Planning approaches

- **Community Circles;** are a way of bringing people together around an individual with the support of a trained facilitator. Community Circles support the person to achieve an outcome or change that they would like to see happen in their life. The facilitator's role is to structure the Circle's meetings, and turn aspirations and ideas into action.

  The Community Circles process uses person-centred practices to enable conversations that lead to actions that make a positive difference.

- **Social Role Valorisation;** is a Theory of Practice that is extremely useful for making positive changes in the lives of people disadvantaged because of their status in society.

  It is based on the theory that the more social roles a person has, the better the chances of having access to the good things of life. The good things of life are universal across society and cultures, and are the typical things that most of us enjoy such as family, friends, a meaningful day, home, safety and security, the opportunity to develop, belonging, respect, ordinary social life, good health, access to community places, and having a say.

- **The Discovery Process;** developed by Hope Leet Dittmeier. Discovery is an approach which engages with the person to obtain and gain a deeper knowledge, insight and understanding of them. The Discovery process can look at all aspects of a person's life, dreams, wishes and preferences. It is an individualised journey of learning with and about the person, supporting them to gain knowledge and experience through family and community engagement and inclusion, and building circles of support. The Discovery Process is based on Social Role Valorisation Theory.

Appendix 4 - Evaluation Tool for an Organisation

Finding out how you and your colleagues are doing with person-centred planning

- This Evaluation tool is designed to support individuals and teams in the assessment of their person-centred planning practices. The tool is divided into the four stages of person-centred planning. The stages can be completed one stage at a time – there is space on the next page to record when each stage was completed and by whom.

- You should review each statement of practice and decide which rating is most appropriate for your team's practice:
  - □ **We are very strong -** no areas for improvement at this time
  - □ **We are strong -** minor areas for improvement
  - □ **We are fair -** moderate areas for improvement
  - □ **We are weak -** significant and major areas for improvement

- Then, identify the evidence to support this rating, for example, systems and policies in place and reviewed, resources created, learning and development opportunities on offer, information made available, initiatives or projects undertaken.

- If a gap in practice is identified, you should note the actions needed to support quality improvements.

- At the end of each stage, there is a quality improvement plan, where you can record key actions, those responsible, timeframes and the evidence which will be gathered to demonstrate change.

Stage	Date completed	Completed by
1 – Getting ready to do a person-centred plan		
2 – Putting a person-centred plan together		
3 – Putting a person-centred plan into action		
4 – Finding out if person-centred planning is working		

Stage 1 - Getting ready to do a person-centred plan

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
1	Our team supports persons using its service to build capacity for self-determination, decision-making and self-advocacy. Our team provides opportunities for learning and development in order that persons with disabilities and their circles of support can engage meaningfully with person-centred planning.	□ We are very strong □ We are strong □ We are fair □ We are weak		
2	Our team recognises the importance of, and provides education and learning opportunities in relation to person-centred planning to staff. These are grounded in the principles of active learning.	□ We are very strong □ We are strong □ We are fair □ We are weak		
3	Our team provides access to a range of advocacy supports.	□ We are very strong □ We are strong □ We are fair □ We are weak		

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
4	Our team ensures that the person-centred planning process is accessible to all those using its services.	□ We are very strong □ We are strong □ We are fair □ We are weak		
5	Our team provides information in accessible formats, for example, photo, video, audio, Easy to Read materials.	□ We are very strong □ We are strong □ We are fair □ We are weak		
6	Our team provides access to information and assistive technologies which support person-centred planning.	□ We are very strong □ We are strong □ We are fair □ We are weak		

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
7	There is a person-centred planning policy which is evidence-based and reviewed on a regular basis.	□ We are very strong □ We are strong □ We are fair □ We are weak		
8	There is a clear process for person-centred planning which everyone can understand.	□ We are very strong □ We are strong □ We are fair □ We are weak		
9	Staff in the organisation recognise the difference between personalised care and support planning and person-centred planning.	□ We are very strong □ We are strong □ We are fair □ We are weak		

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
10	Managers actively embed person-centred planning within structures and processes, engaging with key stakeholders i.e. the person, their family if appropriate, and staff.	□ We are very strong □ We are strong □ We are fair □ We are weak		
11	Our team establishes positive relationships with families and circles of support which enhance person-centred planning, and are in line with the wishes of the person who owns the person-centred plan.	□ We are very strong □ We are strong □ We are fair □ We are weak		
12	Where the person has no family or community involvement, our team seeks to address the lack of social relationships at an early stage of person-centred planning.	□ We are very strong □ We are strong □ We are fair □ We are weak		

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
13	Our team identifies formal roles for staff within the person-centred planning process and ensures they have the required competencies to carry out these roles.	□ We are very strong □ We are strong □ We are fair □ We are weak		
14	Our team explores ways to include independent facilitators as part of their person-centred planning process.	□ We are very strong □ We are strong □ We are fair □ We are weak		

Moving forward
Quality Improvement Plan - Stage 1 – Getting ready to do a person-centred plan

Statement of Practice	Action required	Person responsible	Due Date	Evidence to be collected

Stage 2 – Putting a person-centred plan together

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
1	Our team ensures that person-centred planning is an ongoing process and not an annual event. The person who owns the plan is supported to work at their own pace to develop their person-centred plan.	□ We are very strong □ We are strong □ We are fair □ We are weak		
2	Information is gathered throughout the year by observing, actively listening to and respecting all communication attempts by the person, and by offering new experiences.	□ We are very strong □ We are strong □ We are fair □ We are weak		
3	Person-centred plans are developed through ongoing reflection, review and evaluation.	□ We are very strong □ We are strong □ We are fair □ We are weak		

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
4	Our team creates an environment for person-centred planning that is relaxed and enables the natural authority of the person to be appreciated. The person who owns the plan is recognised and respected as the expert on their own life.	□ We are very strong □ We are strong □ We are fair □ We are weak		
5	Our team formally records person-centred planning.	□ We are very strong □ We are strong □ We are fair □ We are weak		
6	Our team explores different planning tools and approaches.	□ We are very strong □ We are strong □ We are fair □ We are weak		

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
7	Our team supports individuals who wish to have a person-centred planning meeting. The person is given the opportunity to lead the meeting where possible.	□ We are very strong □ We are strong □ We are fair □ We are weak		
8	Our team ensures that all aspects of the person-centred planning meeting are accessible to the person. Where necessary, Total Communication is used which includes objects, photos, pictures, symbols, video and assistive technologies.	□ We are very strong □ We are strong □ We are fair □ We are weak		
9	Our team facilitates members of the circle of support to attend the person-centred planning meetings.	□ We are very strong □ We are strong □ We are fair □ We are weak		

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
10	Person-centred plans focus on the personal goals and aspirations of the individual.	□ We are very strong □ We are strong □ We are fair □ We are weak		
11	Goals are set based on the aspirations of the individual. They are not constrained by the services provided by the organisation, or by the resources available to the organisation.	□ We are very strong □ We are strong □ We are fair □ We are weak		
12	Goals are individual and meaningful to the person. Long-term goals are broken down into a series of smaller steps.	□ We are very strong □ We are strong □ We are fair □ We are weak		

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
13	Our team ensures the person who owns the plan has the main copy of their person-centred plan in a format which they understand.	□ We are very strong □ We are strong □ We are fair □ We are weak		
14	The organisation holds a copy of the person-centred plan.	□ We are very strong □ We are strong □ We are fair □ We are weak		

Moving forward

Quality Improvement Plan - Stage 2 – Putting a person-centred plan together

Statement of Practice	Action required	Person responsible	Due Date	Evidence to be collected

Stage 3 – Putting a person-centred plan into action

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
1	Our team ensures that each person-centred plan has a clear action plan and implementation strategy.	□ We are very strong □ We are strong □ We are fair □ We are weak		
2	Managers are responsive to person-centred plans and their implementation, and support creativity and innovation within teams to overcome barriers.	□ We are very strong □ We are strong □ We are fair □ We are weak		
3	Where difficulties arise in the implementation of a person-centred plan, the issues are addressed initially at the local level. If barriers persist, information is fed up the organisation and the advice and support of management sought.	□ We are very strong □ We are strong □ We are fair □ We are weak		

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
4	There is a complaints policy and procedure in place. Persons using services can use this policy to express dissatisfaction with their person-centred plan or its implementation.	□ We are very strong □ We are strong □ We are fair □ We are weak		
5	Our team ensures that person-centred planning policies support persons who own the plans to maximise their autonomy and independence.	□ We are very strong □ We are strong □ We are fair □ We are weak		
6	Our team affords those using their services the 'dignity of risk'. Person-centred plans address positive risk taking and risk management.	□ We are very strong □ We are strong □ We are fair □ We are weak		

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
7	Where risks pose a barrier to an individual achieving their goals, our team adopts a proactive and flexible approach.	□ We are very strong □ We are strong □ We are fair □ We are weak		
8	Our team seeks to increase the involvement of community members and supporters from outside the service in person-centred planning and in circles of support.	□ We are very strong □ We are strong □ We are fair □ We are weak		
9	Our team collaborates with other organisations to explore community-building approaches.	□ We are very strong □ We are strong □ We are fair □ We are weak		

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
10	Our team supports persons using its services to develop and maintain valued social roles.	□ We are very strong □ We are strong □ We are fair □ We are weak		
11	Our team collects monitoring evidence. There is a formal record of progress towards goals. There is clear evidence of achievement, for example written, photo, video evidence.	□ We are very strong □ We are strong □ We are fair □ We are weak		

Moving forward
Quality Improvement Plan - Stage 3 – Putting a person-centred into action

Statement of Practice	Action required	Person responsible	Due Date	Evidence to be collected

Stage 4 – Finding out if person-centred planning is working

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
1	There is an overall system of evaluation in place across the organisation.	□ We are very strong □ We are strong □ We are fair □ We are weak		
2	There is a system in place that encourages reflective practice. This includes all staff, both managers and frontline, the person who owns the person-centred plan, their family members and circle of support.	□ We are very strong □ We are strong □ We are fair □ We are weak		
3	Our team ensures person-centred plans are reviewed on a regular basis. Formal reviews take place at least annually.	□ We are very strong □ We are strong □ We are fair □ We are weak		

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
4	There are structures within the organisation that facilitate both formal and informal reviews of person-centred plans which include dialogue with the person, staff and others involved in the process on their experience of using the process and what could be improved.	□ We are very strong □ We are strong □ We are fair □ We are weak		
5	All reviews are formally recorded. Informal reviews are ongoing throughout the year.	□ We are very strong □ We are strong □ We are fair □ We are weak		
6	Processes within the organisation encourage all stakeholders to focus on outcomes for the person who owns the plan.	□ We are very strong □ We are strong □ We are fair □ We are weak		

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
7	The instruments used by staff in the organisation to assess outcomes are reliable and valid.	□ We are very strong □ We are strong □ We are fair □ We are weak		
8	The senior management team in the organisation review and evaluate data in relation to specific outcomes and interventions arising from person-centred planning. They ensure that staff are informed and included.	□ We are very strong □ We are strong □ We are fair □ We are weak		
9	Individual person-centred plans inform the delivery of services and supports, influence service development and the allocation of resources. The link with organisational planning is obvious.	□ We are very strong □ We are strong □ We are fair □ We are weak		

	Statement of Practice	Rating Tick the appropriate box	What is your evidence?	Actions required to support quality improvements
10	The organisation has structures in place to recognise and share good practice in person-centred planning, to support continuous improvement.	□ We are very strong □ We are strong □ We are fair □ We are weak		
11	New learning is embraced and used to make positive changes in the services and supports they provide.	□ We are very strong □ We are strong □ We are fair □ We are weak		

Moving forward

Quality Improvement Plan - Stage 4 – Finding out if person-centred planning is working

Statement of Practice	Action required	Person responsible	Due Date	Evidence to be collected

Additional comments and notes

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