

Guidelines for Person Centred Support Planning

Scottish Borders Learning Disability Service Providers Group



Introduction

These guidelines were developed from work undertaken by the Scottish Borders Learning Disability Providers Group in 2006, with the assistance of Helen Wilson of Envision, working on behalf of ARC Scotland. Further work was carried out to produce two Accessible versions: one easy read, one with graphics. The aim was to put together information about Support Planning that would be useful to people with learning disabilities, families, staff supporting individuals, and services, and would help ensure a consistently person centred approach to the process.

All versions of the Guidelines were updated by the Providers Group in 2011, to ensure a strong focus on outcomes is threaded through them.

This latest version is the result of a further review by the Group to take account of progress in a number of developments, including Self-Directed Support, Keys to Life*, the Integration of Health and Social Care, the updated national Charter for Involvement and recognised best practice in areas such as Positive Behaviour Support and Risk Enablement. The importance of grounding all that we do in the context of Human Rights, and putting rights into action, is also reflected and reinforced in the document.

The content continues to focus on simple, relevant, practical approaches that work. We remain grateful to Helen Wilson for sharing her knowledge as someone skilled in assisting individuals to take control of their lives and strongly committed to the empowering impact of good support planning.

Scottish Borders Learning Disability Providers Group, April 2017



Keys to Life
<http://keystolife.info/>



Report of the Care Inspectorate's Inspection Focus Area 2014–2016
<https://goo.gl/eCFDfP>

Contents

Section 1 | The Purpose of Support Planning

In this first section, we will consider the overall purpose of Support Planning, taking account of where it fits with other forms of planning and clarifying some of the terminology. We will identify the basic principles of Person Centred Support Planning and the fundamentals of a good plan.

We will explore how to ensure there is a strong focus on the outcomes that the person wishes to achieve in their life, and how a good Support Plan can assist with this.

Section 2 | The Content of Support Plans

In Section Two, we will look more closely at what should be in a support plan, how it could be structured, and how to ensure that the plan's structure is fluid and flexible. We will consider the importance of using appropriate language, particularly when handling sensitive and confidential information. We will also cover the principles of person centred risk assessment.

Section 3 | Meaningful involvement of People who have Support Plans

Section Three invites us to think more about the process of Support Planning and how best to ensure the person is at the heart of the Support Plan and that other important people in their life are engaged with the process too. Outcomes based working involves everyone working together to achieve the best possible impact on the person's life. A focus on outcomes supports an emphasis that the person is a citizen with **rights** and **responsibilities**, not a "client" "service user" or "patient". This section also considers the crucial issue of making the plan accessible.

Section 4 – Using and Reviewing Support Plans

The last section relates to Support Planning in action; looking at how to keep the plan 'live' by constant monitoring, communication and review, and, finally, some guidelines for person centred outcomes focused review meetings.

Section 1

The Purpose of Support Planning

Human Rights

Human Rights principles underpin all support services and provide a strong baseline for the protection of people, ensuring that services are personalised, that people are treated with dignity and respect, and that they are able to exercise choice by being at the heart of decisions which affect their everyday lives.

Human Rights link directly with the National Care Standards and a Human Rights based approach is aimed at empowering people to know about and to exercise their rights, whilst also increasing the accountability of organisations with responsibility for respecting and protecting people's rights.

Human Rights are a shared responsibility for everyone and, by adopting this approach, we aim to ensure that the principles of Human Rights are integrated within our policies and procedures and embedded in our day to day practice.

Further information and guidance can be found at:



Scottish Human Rights
scottishhumanrights.com



Scottish Government
gov.scot/Topics/Health/Support-Social-Care/Regulate/Standards

Outcomes

The starting point of the planning process is to get a clear understanding of the outcomes which matter to the person, and the support they require to achieve these outcomes. This understanding is then used to inform key decision-making processes such as support planning and reviewing. Starting from the person's priorities supports enabling relationships, creates clarity and identifies goals at an early stage. Being **listened to**, **involved** and **respected** results in better outcomes.

We define an **outcome** * as something the person wants to achieve in their life, and also the difference or impact that the support makes on their life. Outcomes should be specific and understandable, highlighting the details of what needs to happen to assist the person to achieve the desired outcomes, and the time scales for action.

The philosophy of this approach is one which emphasises the **strengths, capabilities and resilience** of individuals, and builds upon natural support systems such as family and local community. By focusing on strengths, capacities and goals, the role of the person is maximised. Services do things **with** people.

* Links to further information on outcomes can be found on page 31.

Self Directed Support

An approach to commissioning services which encompasses the values and philosophy of outcomes focused working. It enables people to have control over their personal budgets and support services.

The Values of Self Directed Support are:

- Respect
- Fairness
- Freedom
- Safety
- Independence

The 7 Principles of Self Directed Support are:

- Collaboration
- Dignity
- Informed Choice
- Innovation
- Involvement
- Participation
- Reciprocity
- Risk Enablement



Scottish Government
gov.scot/Publications/2014/04/3249

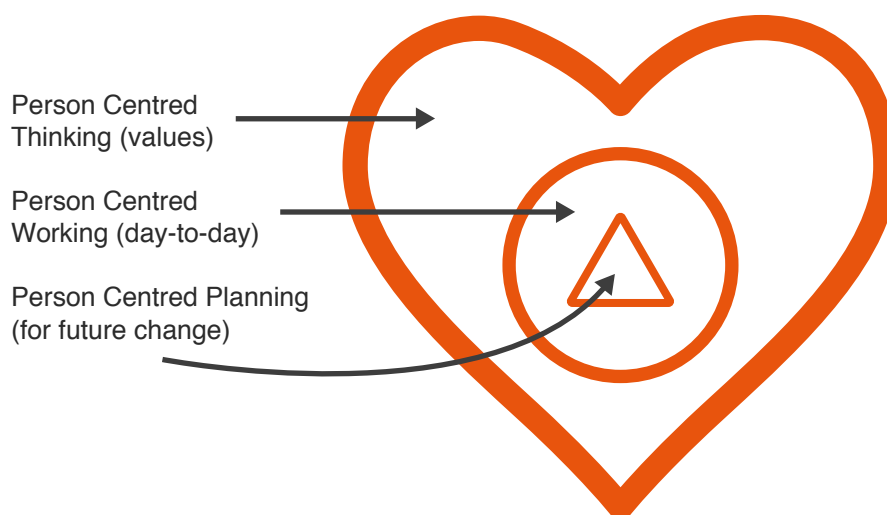
The planning and review cycle

The language of the planning and review cycle can cause confusion due to the range of terms used by different agencies and organisations, for example 'Personal Plans', 'Care Planning', 'Support Planning'. Some individuals choose to call their Support Plans by other names, such as 'All About Me', 'My Life' or 'How I Want You to Work with Me'. All these phrases are used to refer to the day-to-day planning that goes into supporting individuals with their daily lives and it is this type of planning that these guidelines relate to. For ease, we will use the term 'Support Planning' throughout the guidelines.

Distinctions between Person Centred Planning and Support Planning

There is one further confusion to clarify before we start! The type of Support Planning we are talking about is different and distinct from other forms of Person Centred Planning, such as MAP and PATH, which usually involve supporting people to plan for major change and have a future focus. This can perhaps feel like a maze of planning interventions and the differences between them can feel hard to distinguish.

The following diagram helps to explain this.



Person Centred Thinking (the values) are at the heart of everything. Your respect for individuals, your belief in human rights and social justice and your commitment to supporting people to take power and control are crucial. They underpin everything that you do and inform every interaction you have.

Person Centred Working (day-to-day) is informed by person centred thinking. Every aspect of your day-to-day support work is carried out in a way that is respectful of the individual's wishes and dignity. In everything you do, you strive to support the individual to take control.

Person Centred Planning (for future change) is the name given to a specific set of tools, including MAP, PATH, Personal Futures Planning and Essential Lifestyles Planning. These tools offer people profoundly empowering opportunities to build supportive networks to enable them to plan for positive, inclusive futures and to make changes driven by their own wishes and desires.

The Charter for Involvement makes it clear that people must know what a 'person centred plan' is and have one if they choose.

Support Plans sit within the second layer here. They are part of everyday Person Centred Working with an individual. It is likely that a good Support Plan will borrow ideas and questions from Person Centred Planning tools, but it is important to remember that Person Centred Planning is a distinctly different planning intervention.



The Purpose of Support Plans

Before we embark on compiling a Support Plan, we must be clear about why we are doing it – What is the purpose of the plan and who is going to use it? There will be lots of different answers to the first question because there are lots of different answers to the second question! Support Plans are useful in different ways to a range of different people. Understanding this will help us to get started.

Of course, the most important person is the individual whose Support Plan it is, but other people who will be interested in the Support Plan include:

- Family members and carers
- Advocates
- Support staff
- Personal Assistants
- Managers within organisations
- Social Workers and Care Managers
- Other services supporting the person.
- Other professionals – such as Physiotherapists, Doctors, hospital staff etc.
- The Care Inspectorate

The overall purpose of the Support Plan is to identify the things the person wants to achieve in their life and to measure progress towards that. The Support Plan serves a number of different purposes for each of the people / agencies mentioned above.

Empowerment

Making sure that the individual has as much control as possible over his / her own service and supporting the individual to make their voice and opinions heard. Should the person need someone to make decisions on their behalf, the Charter for Involvement states: ‘... we have the right to choose who that person is where the law allows it’.

Communication

Between the individual and staff and between all staff. This will help to ensure a consistent way of working and will offer a tool to help the person get the service he / she wants. Where services are working together to support the person, good communication is essential. This is particularly important with regards to health appointments and admissions to hospital.

Guidelines

Which will be useful for existing staff, new staff and relief staff and, again, help to support a consistent way of working. For relief and new staff, it is a good way of getting to know the person. Guidelines can also help the person to experience consistent support from different services.

Accountability

The Support Plan is the mechanism that keeps the staff accountable to the person (like a contract). It is also how the organisation accounts for how it is providing the service – to the Care Inspectorate, to funders and Care Managers, and to families. It is important to remember that the Support Plan is a legal requirement that service providers have to attend to.

Flexibility

To reflect the person’s changing needs and wishes. The plan is the place to record and reflect new learning about the person and how best to support them.

Fundamentals of a Good Support Plan

Support Planning is about helping people to get better lives not just better plans. It is not an exercise that is done once and then gets filed away in a drawer. The Support Plan should be used and added to on a continual basis.

Every Support Plan will look different, as we will find out later, but any good Support Plan will:

- Be a celebration of the person and will truly reflect their individuality.
- Describe how the person wants their life to be, the outcomes they want to achieve, and the support they need from others to help them get this.
- Take an assets based approach which considers the person's skills and abilities as well as the resources they have around them in terms of family, friends, community resources etc.
- Build upon what the person can do.
- Indicate what needs to change or to be maintained.
- Describe what support the person needs – and detail how that support should be provided and by whom.
- Demonstrate a commitment to keep learning. about the person and how best to support them.
- Promote active citizenship.
- Be clear and easy to navigate. The support plan should say at the beginning what is in it and where other information is kept – i.e. “in my support plan you will find... I keep my financial information in a separate folder...”

An individual might have more than one Support Plan if, for instance, they live in supported accommodation provided by one organisation and attend day services provided by another agency. It is important that organisations work together to ‘join up’ their planning where appropriate, whilst respecting the person’s right to privacy.

Not only will this avoid the person having to repeat the same information over and over again, but it will also help the organisations to work together to make things happen for the individual to get the life they want. It is also important that necessary information is shared in a timely way to make sure the person’s plan is updated and the right supports are put in place following a change (eg. where the person has been treated in hospital). Making sure communication, planning and delivery of support across services works seamlessly and supports good outcomes for the person is at the heart of integrating health and social care.



Health and social care integration

<https://goo.gl/98I6HD>

A further note on the Guidelines

Throughout these guidelines, the emphasis is on the person being in control of all aspects of the Support Planning process: planning to support needs and wishes and reviewing the support provided.

Where the person’s capacity to understand or to give consent might mean that this is not fully possible, those supporting the person need to ensure that every effort is made to involve the person as fully as possible in the process. They should demonstrate accountability to the person for any action taken on their behalf, and, in these circumstances, the views of people who truly know and care for the person the best should be given primary authority.

The Mental Welfare Commission's good practice guide on Supported Decision Making explains how people who may have difficulty making decisions can be supported to ensure that decisions made by or about them genuinely reflect their choices. The Commission believes it is important that everyone involved with individuals for whom making decisions is difficult is aware of the importance of support for decision-making and thinks about how best it can be provided. The guide refers to supported decision-making as *'any process in which an individual is provided with as much support as they need in order for them to be able to:*

1. *Make a decision for themselves; and/or*
2. *Express their will and preferences within the context of substitute decision-making (for example, guardianship or compulsory treatment for mental disorder).*

In both cases, the purpose of supported decision-making is to ensure that the individual's will and preferences are central to and fully respected in decisions that concern them'.



Good practice guide : Supported Decision Making
<https://goo.gl/4ZGwIH>

Section 2

The Content of Support Plans

What Should Be in a Support Plan?

There is no strict blueprint for how a Support Plan should look, or even for what must be in it. Every plan will be different according to what is appropriate or relevant for the person.

Broadly speaking, a support plan should aim to address the following areas:

- My Story – some information about my background, key events, key people and things that have or have not worked well for me.
- Likes and Dislikes – what’s most important to me. Things which are essential for me to have - or not to have in my life.
- Hobbies and Interests. Meaningful activities such as employment, volunteering - things I do now and things I might like to try.
- My Gifts and Skills – what I’m good at and what others like and admire about me.
- Communication - how I communicate and how I like others to communicate with me; ways in which I best understand information.
- Important People in my Life – my family and friends and how I keep in touch with them.
- Friendships and relationships - those I have and how I might want to develop more.
- What Support I Need – what I need help with, what I do for myself, how I like to be supported and by whom.

- Important Routines – daily and weekly, seasonal differences, special occasions and holidays.
- My Dreams and Goals – things I would like to do now and in the future.
- How I contribute to my community, what valued roles I have.
- How I participate in the design and delivery of my service and the organisations which support me.
- What Needs to Happen to Keep me Healthy and Safe (risk assessment), including Internet safety issues.
- Important Health and Medical Information - and how to ensure I have the highest standard of health possible (physical activity, oral health, regular health checks, attending regular screening, healthy eating, how I am supported to develop my well being and resilience). The Scottish Borders Learning Disability Service has developed a Hospital Passport which they ask all individuals who get support to fill in so that all important information about their health and other needs is recorded and can be shared when required.
- The kind of people I need to support me in terms of skills, personality, interests etc.
- How much control I want to have over my funding arrangements and my money.

A good Support Plan will always have an emphasis on the outcomes the person wishes to achieve. It is important to work with the individual to decide which of the above sections are important to include. Some people may wish to add in other sections on, for instance, financial information or fears and phobias. The Support Plan will keep growing over time. It is probably important to get some of the crucial sections done first and then to build up from there.

There should be an action plan attached to the Support Plan, with clear records of what needs to change or be maintained and outlining how personal outcomes are to be progressed with the person. This should record what action is being or needs to be taken and progress should be noted in the plan itself.

The Charter for Involvement highlights that nothing should be put in a plan without checking with the person first. Things the person does not agree with should only go into the plan if they are really important in helping to support them, and it should be recorded if they do not agree. The person should be able to choose to sign their plan, to confirm they agree with its content.

The Charter also emphasises that if things in the plan don't happen, someone must speak to the person to explain why, and the person must be free to change things in the plan if they change their mind about something.

Structuring a Support Plan

Again, there is no blueprint for structuring the Support Plan. It should, however, be structured clearly and in a way that makes sense to the individual. You should be able to see the important information straight away. The person might have a view as to what information they would like to be known about them as an introduction. With people who do not use words to communicate or who may have been negatively labelled in the past, it is especially important to get this right. A good person centred tool to use for this process is a One Page Profile*. The information in the One Page Profile can be used to further develop a matching tool and personalised person specification to be used in the recruitment of appropriate staff.



Person centred practice
<https://goo.gl/BqjjzQ>

There should be a guide or index at the beginning of the plan, to show what is in the plan and also where to go to find other information that you might need. For example, the person might have a medical record somewhere else or a financial folder which is only to be seen with specific permission from the individual.

Try to avoid the Support Plan getting 'clogged up' with irrelevant or out-of-date information. It is sometimes tempting to file everything in the plan, but remember that it is a working document. For example, the individual might need to have a separate folder for correspondence or for bank statements.

There are lots of different ways in which Support Plans can be put together to suit each person. The way in which the information is stored and presented needs to be clear, accessible and easy to update. It can be in any format the person chooses. Creative use of technology can help to get it right for each person.

Keeping the Plan Fluid and Flexible

As we have already said, the Support Plan will be changed and updated frequently, especially when the plan is still quite new. Of course, changes should only be made to the Support Plan if they are agreed with the individual whose plan it is. When changes are made or information updated, it is useful to put the date next to the amendment and an initial next to it to show who made the change. This will help everyone to use the plan effectively and to know which is the most up-to-date information.

The Language of Support Plans

A Support Plan should reflect the person's own language and the words they use themselves. Grammar and spelling are far less important than getting it right for the person.

You will need to think about whether the plan should be written in the first person (I like Coronation Street) or the third person (Helen likes Coronation Street). There is no rule about this but you will know what feels appropriate for the person. For example, if there are still gaps in staff's understanding of a person, then it might be better to write the plan in the third person to emphasise that you are still learning about the person's preferences. Where you are unsure of things, you could write "We think Stephen enjoys arts and crafts, but we're still finding out about this". On the other hand, if the plan is clearly written in the person's words and has come directly from them, it should be written in the first person.

A good Support Plan will have lots of detail in it. Try to avoid vague phrases which could be misinterpreted. For example, 'contact with family' could mean a once yearly visit to an Aunt or a daily phone-call to your Mum. Spell it out – who are the important people? How regularly are they in contact and how?

Handling Sensitive Information

Some people may be reluctant to write things down in a Support Plan because they don't want negative things to be recorded. They may have had experience of this in the past. So, it is important that the Support Plan is written using positive language and emphasises all the good things about the individual.

Language is very powerful and once something is written down, people assume it to be true. So, you need to make sure you write in the most positive terms about the person. By focusing very specifically on the person's gifts, you are already challenging negative perceptions of the person. In addition you will need to guard against reputations creeping in.

When you are dealing with sensitive information, it is often the best policy to:

- Be honest
- Be positive or at least neutral in your description
- Be specific and don't generalise

For example, if someone has been given the label of 'challenging behaviour', think about how useful this will be in their Support Plan? It doesn't tell you anything specific about the person or how to support them. It would be more useful in this instance to get a more detailed picture of:

- What annoys / frustrates the person?
- What indicates that the person is getting upset or anxious?
- How does the person like to be supported in these circumstances?

Think before you write something down. Read it back to the individual. If you're struggling, check it out with a colleague before you commit it to the plan.

Confidentiality

The Support Plan is a confidential document that belongs to the individual, as well as being a requirement of the service. Other people are allowed access to the Support Plan only with permission from the individual. The individual should decide where it is kept and who has access to it. In shared accommodation, this may be particularly important.

Principles of Positive Risk Enablement

Risk assessments will probably form part of the Support Plan for most people. This is the place to consider questions like:

- What risks does the person face in their day-to-day life?
- What matters to the person and what are the risks associated with achieving good outcomes?
- What does the person need to do to keep healthy and safe?
- What do staff and others need to do to help this happen?

Risk assessments should always be completed with the person, following the same principles of involvement and empowerment as with the rest of the Support Planning process. The Care Inspectorate does not stipulate any specific risk assessment procedure. They do suggest that other important people in a person's life (such as family and carers) may also wish to be involved in completing risk assessments and have a helpful role within this process.

Risk assessment is about supporting someone to make the most of their life in a way that is meaningful to them. On a very simple level, risk assessment is about **working with the person** to:

- Identify what it is they want to do
- Think through the possible problematic consequences
- Assess how likely it is that these consequences would arise and how severe the impact would be if they did
- Make a choice about what to do
- Manage the decision and outcomes

The Personalisation and SDS agenda has changed the conversation around risk enablement. 'Providers and Personalisation', a policy and practice change programme, published 'Risk and Self-Directed Support' (2014). This offers a modern insight, including policy background, references and commentary. They suggest some top tips for risk assessment:

1. Use ordinary language to talk about risk- what are we worried about? How worried are we? What can we do to worry less?
2. Develop the right tools for carrying out risk assessments.
3. Involve people who are receiving support in making decisions about their own lives.
4. Co-produce risk assessments.
5. Share responsibility for risk assessments between all stakeholders: individuals, providers and local authorities.
6. Promote positive risk taking, focus on outcomes and enabling choice.
7. Develop a risk enablement strategy for your organisation so that staff feel comfortable supporting people to take risks.

Further Reading from the Centre for Welfare Reform – 'Whose Risk is it Anyway?' (2011) and NHS Borders/Scottish Borders Council's 'Positive Risk Management Good Practice Guidelines' (2011)



Centre for Welfare Reform – 'Whose Risk is it Anyway?'
<https://goo.gl/8QZrtr>



NHS Borders/Scottish Borders Council's 'Positive Risk Management Good Practice Guidelines'
<https://goo.gl/6d98sp>

Section 3

Meaningful involvement of Individuals who have Support Plans

‘We must be at the **heart** of any plans about **our** lives’
Charter for Involvement*, Statement 1



Charter for involvement
<http://arcuk.org.uk/scotland/charter-for-involvement/>

Compiling the Support Plan

The process by which you gather information and put together the Support Plan is really important. You need to be thinking right from the beginning about how to involve the individual in everything you do.

You will need to think about:

- How to support the person to take ownership of their own plan
- How to make the plan accessible to the person
- How to support the person to direct their own support and select the right staff for them.

The first step is to make sure that you explain the purpose of the plan clearly to the individual and offer reassurance that it is to make sure that they get to live their life their way. We have already said that the Support Plan is a legal requirement and the onus is on provider organisations to make sure that everyone has one. However, the Support Plan must be compiled with the consent of the person. It is something that needs to be done in partnership with the individual – it is not an exercise that the staff member does alone in the office!

Starting off with one of the more ‘fun’ sections might help to engage the person. For example, making a collage of the person’s favourite foods or TV shows or even working on a cover for the Support Plan might help to engage the individual. Giving the whole plan a theme or colour scheme to reflect the person’s hobbies and passions might be a good way to make the plan more interesting. Even going out to choose the folder is a start!

To gather the information for the Support Plan, you will need to have plenty of time with the individual. You might set specific times aside to have one to one conversations to do the Support Plan, but it is most likely that you will gather most of the information whilst you are going about your daily support with the person. For example, if you are supporting someone to have their breakfast, keep asking questions about the choices they are making and be very conscious about noticing the way they like to be supported. Making this informal and a natural part of supporting someone will really help everyone to get into the habit of using and updating the Support Plan

Involvement of Family and Others

The person may wish to involve other people in putting together their plan – staff, family, friends etc. It is important that other people are involved because they are invited by the person – i.e. don’t just ask every member of staff for their input without checking this out with the person first. It will be important to have more than one staff viewpoint because different staff see things differently and you will get a richer, more accurate picture. There is a danger if you only get one staff perspective that it will reflect the staff member’s rather than the person’s opinions. The person might need your support to think about who else could be involved.

To make sure that you are speaking to the right people, you might find it useful to ask some introductory questions to get a sense of how well the person knows the individual and of how positive their relationship is. Asking questions like, ‘tell me about a good time you’ve had together recently’, ‘tell me some of the things you like about the person’ or ‘what do you think the person is good at’? If the person has little to offer in answer to these questions, their opinion on other matters might be less significant to the person.

Accessibility of plans

The more effort you take to make the plan make sense for the person, the more likely it is that the person will take ownership of it.

We have already talked about using simple language, but in addition, keeping the structure simple will be helpful to everyone who is using it. If you are using a lot of text, think about how to make the information easy to read. Marking headings clearly will certainly help and breaking up paragraphs into bullet-pointed lists makes them simpler to access.

You can also make the plan more efficient by avoiding repetition. For example, it could be that there’s a cross-over between what the individual likes to do, their weekly routine and what support they need.

So, you could link these things together in a simple table like this:

| What I like to do | When I like to do it | What support I need |
|------------------------|--------------------------------------|---|
| Swimming | Tuesday morning | Help me to get my swimming stuff ready. Walk with me to the top of Burnside Road and wait with me for my lift at 10.15 |
| Watch Cornation Street | Monday, Wednesday, Friday and Sunday | None |

Think creatively with each person about how they want their Support Plan to look and how they can best access the information in it. They might chose to use photos, drawings or pictures. Some people may choose to use film or video for their Support Plan so that they can access it whenever they like and can get really involved in making it.

Section 4

Using and Reviewing Support Plans

Day-to-day Monitoring and Sharing of Learning

For a Support Plan to be effective in empowering an individual to determine his / her own support service and to live the life of his / her choosing, it must be referred to daily and regularly reviewed, updated and amended. We must ensure that the Support Plan is a 'live' document, and not just one that is filed away and never referred to.

We need to focus on identifying if the outcomes that the person has specified are being achieved. It is also important to check how the person feels about the process of being supported – do they feel **listened to, involved, respected**? What has **changed** for them through the support they have received? Are they feeling more **confident** for example, healthier or safer, do they have more interesting and fulfilling things to do, do they have more meaningful relationships? In other words, what difference is the support they receive making to their life.

The experiences people have when they interact with staff are hugely important to the people who use services. The quality of this interaction can create a positive sense of well-being and a desire to take increasing control of their life. Conversely, a poor quality interaction can cause a person to feel anxious, less confident and consequently less independent. If there is no culture of empowering relationships, then it will be impossible to create a truly personalised service.

The Support Plan is also the place to record ongoing learning about a person: things you are discovering together that work and don't work for the person. It might also be a useful place to record dilemmas and difficulties in supporting the person or in understanding the person's communication.

Simple tables can again be useful for recording this kind of information.

For instance, the table below, based on a 'Learning Log' devised by Michael Smull, is useful for recording learning around a particular circumstance or 'activity' where there is a lack of consensus about how the person feels about it.

| What was happening | Who was there? | How did it go? | What have we learned? |
|--|----------------|---|--|
| List all relevant information - the activity, the time, the weather etc. | | Was it a good or bad experience for the person? | This column can only be completed over time. |

For example:

Someone who has always enjoyed swimming has recently been enjoying it less. As a staff team, you can't work out why this is.

You could use a Learning Log to record each visit to the swimming pool to see if there is a pattern or if there are any conclusions you can draw.

With any framework for recording ongoing learning, you must follow several important rules, otherwise the framework will not serve its useful function.

- Involve several people in recording learning. This will ensure that it isn't biased towards one person's view and will invite as much creative thinking as possible.
- Analyse the learning. There's no point in just constantly recording everything if you don't step back at some point and see what conclusions can be drawn. Have you learnt anything new about the person? Does something need to change? Do you need to find out more about something? Have you checked back with the person?
- Confirm your next steps. What are you going to try next? How will you use the new learning?
- Update the Support Plan to reflect the new learning.
- Apply the learning consistently. All staff involved in supporting a person must commit to applying the learning in the same way. This is the only way that you can test out what you think you are learning.
- Set a date to review. On the basis of your learning, you might decide to try a new approach. You need to set a timescale for this so that you can come back together and see how it's going.

Guidelines for Outcomes focused Person Centred Review Meetings

There will be times when you need or want to review the whole Support Plan and wish to gather together a larger group of people around the individual to do this. This would be particularly useful if the person wants to do some action planning for a major event or change.

Full participation of the person, and involvement of others as relevant to the person, in regularly reviewing the plan, and how the service is working for them, is an expectation of services registered with the Care Inspectorate. Different agencies and organisations may have their own review cycle that you need to work to.

An outcomes focused review is the place to record the outcomes that have been achieved, and what difference this has made to the person. It is the place to record what is and is not working from the person's perspective in terms of the support they receive. The review can be used to:

- Determine whether the service delivers the outcomes that the person wants
- Find out how the person experiences the service being provided.
- Discuss the person's plans for the future, and what needs to happen to help them achieve their dreams and goals.

Whenever you have the meeting, it is absolutely crucial that the individual is supported to be in charge of it – it is their meeting and anyone invited is invited by them on the basis that they know them well and care about their future.

The individual might need quite a lot of support to be in charge of the meeting and for this to happen effectively, good preparation is the key.

Consider how the individual can be supported to:

- Host the meeting – sending out invitations, preparing refreshments, making the introductions etc.
- Decide who should be there – Who will have positive things to say? Which people are central in the person's life?
- Think about what needs to be discussed (and perhaps there are things that the person doesn't want discussed)
- Decide where to have the meeting – Where does the person feel comfortable and relaxed?

- Think about the best time for the meeting – What time of day works best for the person? What day of the week? How long will you need for the meeting?
- Consider how the meeting is going to be run - Is there a chair or facilitator? How is the meeting going to be recorded?
- Decide how the action plan will be communicated to others – Does the Support Plan need to be updated? Who needs feedback from the meeting?

All of this will take some time and may need some careful negotiation to ensure that the meeting is an empowering experience for the individual as well as an efficient process for review.

Using the information from outcomes focused reviews to improve the service.

As well as using the information from each person's review to help them change their life, and to improve the individual service they receive, provider agencies can also aggregate the information received from all the review meetings they have with the people supported by the agency to determine in a more general way what is and isn't working across the service, how well the agency is doing and what needs to be improved. Thought can be given to the underlying reasons for what is not working for people, and what the outcome would be if each of these were addressed by the agency. Plans can then be put into place to improve the service.

Aggregating information about common 'hoped for' outcomes can also assist agencies to determine the steps they can take to help achieve these common outcomes. This will often involve working with groups and agencies outwith the service, as much of what people want to achieve will not be within the control of the service but will lie within the scope of universal services within the wider community.

Useful links and websites:



Keys to life

<http://keystolife.info/>



Scottish Human Rights

scottishhumanrights.com



‘Being Human’: A Human Rights Based Approach to Health and Social Care in Scotland

<https://goo.gl/zT1Xxi>



Scottish Government

gov.scot/Topics/Health/Support-Social-Care/Regulate/Standards



National Care Standards

<http://www.gov.scot/Topics/Health/Support-Social-Care/Regulate/>



Scottish Government

gov.scot/Publications/2014/04/3249



One page profiles

<http://www.helensandersonassociates.co.uk/person-centred-practice/one-page-profiles/>



Mental Welfare Commission – Guide to Supported Decision making

http://www.mwscot.org.uk/media/348023/mwc_sdm_draft_gp_guide_10__post_board__jw_final.pdf



Centre for Welfare Reform – ‘Whose Risk is it Anyway?’

<https://goo.gl/8QZrtr>



NHS Borders/Scottish Borders Council’s ‘Positive Risk Management Good Practice Guidelines’

<https://goo.gl/6d98sp>



Charter for Involvement

<http://arcuk.org.uk/scotland/charter-for-involvement/>



Leading for Outcomes – A guide – IRISS

<http://www.iriss.org.uk/resources/leading-outcomes-guide>



Good Conversations

<http://arcuk.org.uk/scotland/files/2011/08/JIT-Good-conversations.pdf>



Doing Things Together - Co-Production

<http://www.coproductionsotland.org.uk/about/what-is-co-production/>



Report of the Care Inspectorate’s Inspection Focus Area

<https://goo.gl/eCFDfP>