Shaping Together the Future

Together

A strategic planning tool for services supporting people with learning disabilities
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PLUS  A CD containing a pdf of *Shaping the Future Together* and a database can be found in the front pocket of this folder.
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CHANGING the way in which services are planned and developed is central to Valuing People. In the past we have often done ‘individual planning’ with people and then looked around for a service to fit the plan. Often the fit has not been a very good one. The future has to be different. People with learning disabilities, supported by their friends and families, need to have much more power and choice over the opportunities, services and supports they receive. Central to this will be supporting people to develop their own person-centred plans. It then becomes the job of managers and professionals to help turn these plans into a reality.

This change will not be easy – but we know from those places that have begun to make progress that it is possible. One particular difficulty in being more person-centred is the tension between taking time to listen to people, and the pressure to get a move on and change services that we know people are unhappy with. Whether it is around long-stay hospital and NHS campus closure, day service change or large residential care re-provision programmes, I often hear the same two statements:

‘We can’t do anything until we have finished person-centred planning.’

‘Lots of people say they want something different, but it doesn’t add up to major service change.’

Person-centred planning cannot be used as an excuse for things not changing. At its worst, these are excuses for slowing things down – but they can also be genuine pleas for help from people needing to make sense of the complexity of large-scale change.

This publication, Shaping the Future Together, can help with this challenge. It shows how service planners and managers can take emerging information from person-centred plans and from people’s individual reviews and use it to kick-start service change in a way that does not prejudge what people say they want. Instead, it can be used to offer people some real, new options which help expand and develop their lives – which is what Valuing People is all about.
Finally, there are two really important things to always remember. Firstly, person-centred planning should not be a time-limited process done by professionals to inform service decisions. Planning is owned by the person themselves and their friends and family, and is a continual, evolving statement of what people want from their lives. Secondly, the information from people’s person-centred plans should be the starting point for all service planning and commissioning decisions.

With these things in mind – and using approaches such as those suggested in *Shaping the Future Together* – the future really can be different.

Rob Greig
National Director
Valuing People
Summary

*Shaping the Future Together* is about developing opportunities, services and support that reflect what people with learning disabilities want and need, now and into the future. It:

- helps you pull information together from people’s individual plans to shape your strategic commissioning and service developments
- will help you achieve *person-centred* commissioning and service development
- is about people *at all levels* taking action to help people achieve the lifestyles they want and the support they need
- gives an easy format for summarising from person-centred plans and from individual reviews
- can be used flexibly to suit your local situation and requirements
- gives people with learning disabilities and their supporters a voice directly through to planners
- can be used in conjunction with other ways of ‘listening’ to people so that you get a more complete picture of the developments that are needed
- can be used wherever individual planning is taking place.

Although *Shaping the Future Together* was developed in England, policy directives in all parts of the UK stress that developments should be based on information from and about people using services. “If those who make policies and planners are to provide the services people need, they have to gather better information about the numbers and needs of those with learning disabilities (and their carers) locally...” (The Scottish Executive 2000). *Shaping the Future Together* can be used *anywhere* in the UK.

The pack has four parts. You need to read **Part 1** to understand how to use all the other parts.
An overview

Welcome to Shaping the Future Together. This resource has been produced to help organisations develop support services and approaches that respond to what people with learning disabilities want and need. It is about person-centred development. The pack is aimed at service planners, developers, commissioners and managers – the term planners and managers is used to cover them all.

Shaping the Future Together will help organisations gather information from people’s individual plans so that it can be looked at as a whole to get an overall picture of the opportunities and support that people want and need. It enables planners and managers to make sense of lots of information; it produces information for planning purposes. Planners and managers can then make sure that the right opportunities, services and support are developed locally to meet people’s wishes and needs into the future. Shaping the Future Together will help organisations to plan for, and deliver, the changes that people want.

What do you mean by ‘individual plans’?

Most people who use services have some form of individual plan. It may be discussed and agreed through:

- person-centred planning
- annual reviews organised by a person’s support provider
- reviews organised by a person’s care manager.
Shaping the Future Together is not a system for planning with individuals, but it does ensure there is a route from individual planning to planners and managers who can influence how resources are used. It’s another way of ensuring that people’s voices are heard. It helps achieve person-centred approaches.

Person-centred approaches are ways of commissioning, providing and organising services rooted in listening to what people want, to help them live in their communities as they choose. These approaches work to use resources flexibly, designed around what is important to a person from their own perspective and work to remove any cultural and organisational barriers to this…. Person-centred approaches look to mainstream services and community resources for assistance and do not limit themselves to what is available within specialist learning disability services.

Routledge and Sanderson, 2001

We hope that the pack will help you to develop the opportunities, services and support that people want and need in your local area.
What’s in the pack?

The pack contains all the forms and detailed guidance needed to produce an overview from people’s individual plans. It is organised so that you have options about how much information you gather – either from person-centred planning or from reviews or from both. When feedback is gathered from both person-centred planning and individual reviews, more people are included and it gives a bigger picture of developments that are needed in a locality. All the forms and guidance for gathering information are in Part 2. Why not stop and take a brief look at them now – it will help you understand the rest of Part 1.

In Part 2 you will find:

- clear instructions and guidance for the different people who need to be involved, including local operational managers who play a key role in the process
- a leaflet, designed by a People First group, which can be used to inform people with learning disabilities about the process and help them understand it
- a format for person-centred planning facilitators to summarise information from people’s person-centred planning (the PCP Summary Feedback Form)
- a format for care managers to summarise information from people’s normal service reviews (the Review Summary Feedback Form)
- templates for planners to help with aggregating and analysing the information both by hand and using a database, supported by detailed guidance. There are also pro-forma sheets to summarise key findings for feeding back to others.

The pack also includes:

- guidance on how to gather more detailed information to help design and fine-tune new service developments (Part 3)
- guidance on how to use the information so that it helps deliver the opportunities, services and support that people want and need (given throughout)
- some stories from services that illustrate creative and person-centred approaches to strategic development (Part 4)
- pointers to other helpful resources and a pdf of the pack on CD.
Why is it worth doing?

“...even if the number of people experiencing real person-centred planning in each locality is fairly small in the early years, both mainstream and specialist (intellectual disability) services can learn a great deal from the choices these people make for reshaping what is offered more widely.”

Towell and Sanderson, 2004

Good individual planning is about achieving positive changes in people’s lives. For many people with learning disabilities their opportunities are limited by the support and services that are available to them. Resources are often tied into buildings; staff may have inflexible work patterns; people are slotted into what is available though it may not give them the opportunities they really want. Individual planning, especially person-centred planning, helps us to really focus on what someone wants in their life, what a good life would be like for them, and what help they may need to achieve those things.

If this can be captured it means that planners can focus their strategies, commissioning and allocation of resources in ways that are more likely to meet the aspirations of individuals.

Guidance on person-centred planning to support the implementation of Valuing People suggests that organisations need clear ways of responding to what they learn from person-centred plans (Routledge & Sanderson 2001).

What the person-centred planning guidance says

- Service managers should base the running and improvement of services on careful listening to people with learning disabilities and those who know them best.
- Commissioners should invest strategically in developing systems and services that offer assistance which upholds people’s rights and supports independence, choice and inclusion.
- Person-centred approaches design and deliver services and supports based on what is important to a person.
- One of the aims of a person-centred planning framework should be ‘to provide a way that commissioners and providers can learn how their services and systems need to change in order to respond positively to the aspirations of people with learning disabilities and their families’.
Local Partnership Boards have developed person-centred planning frameworks to steer the introduction and development of person-centred planning. The Department of Health publication *How good is our person-centred planning framework?* (2002) clarifies what brilliant frameworks will have in them.

### Brilliant person-centred planning frameworks will have:

- a way for commissioners and providers (specialist and non-specialist) to learn how their services and systems need to change in order to respond to what people with learning disabilities and their families want
- ways of showing how the learning from person-centred planning will be turned into action
- ways of recording where services cannot respond to individuals’ informed choices, ways of looking at this and of the Partnership Board agreeing what will be done about it
- feedback loops so that people (staff, families, people with learning disabilities, other stakeholders) get information about what has been learned and what action is being taken.

_Geared to plan? A checklist of organisational capacity for person-centred planning and person-centred approaches_ (Red House Partnership, 2001) also lists a number of important service features that help make the link between person-centred planning and service development. One of the targets is strategic planning that is ‘driven by person-centred planning’, supported by the development of ‘a range of more individualised support options (such as supported living, supported employment, building individuals’ links with their communities) in response to people’s plans’.

_Making Valuing People Work_ (2004) highlights that care managers have an important role to play, and that an effective link between care management and service commissioning is crucial (see page 6). _Shaping the Future Together_ will help organisations to meet Valuing People targets and to achieve person-centred approaches. It also helps make the link between care management and commissioning. Ultimately it will give you a ‘rich picture’ to use for developing and improving local opportunities, services and support.
Care management and service commissioning: good practice

- Assessment should take place not only in response to a crisis but as part of a rolling programme.
- Assessments should detail both current and future needs and wishes. Future needs might include predictable changes in circumstances due to – for example – family carers getting older.
- Information about assessed need should be recorded in such a way that it can be used to help plan future services...a system from which data can be easily extracted.
- Care managers need to regularly update commissioners about what new services they believe are needed.
- Care managers should be encouraged to identify service shortfalls and to systematically record them.


Can we be flexible in how we use the pack?

Yes, yes, yes! If you can use the *Shaping the Future Together* system in it’s entirety that’s great – it will produce a wealth of information for you to use to develop and improve services and support for people. But we recognise that it will not be possible for every organisation to do that. So use it flexibly. Pick out bits that you think will help you and use them (modify them if you need to), or use the system in bite-sized chunks. For example:

- you could just use it with a targeted population, such as young people aged 14 to 16, so that you can ensure the right resources and support are available when they reach adulthood; or with people living with older carers so that you can ensure the right accommodation and support is available when it’s needed
- you could just target a specific geographic locality to see what’s needed, encouraging people to concentrate their development efforts in a very community-focused, local way. This could help you to link with regeneration initiatives which are targeted to local areas
- you could just use the front sheet of the person-centred planning (PCP) or Review Summary Feedback Forms (the front sheets are the same) so that people can send planners and service staff a direct message about their greatest priority
you could use the person-centred planning (PCP) and Review Feedback Forms as part of a survey, for example using them with a sample of people and then combining the individualised information with information from group consultation to give you development themes. Using the system with a sample of people can help you to project development needs, and can prompt deeper investigation.

you could get person-centred planning facilitators and their managers to complete the feedback forms and then bring everyone together with planners to share the learning and problem-solve together, generating developments as a group. Using *Shaping the Future Together* in this way can give a helpful focus for interactive learning.

In Salford the PCP Summary Feedback Form from *Shaping the Future Together* was used during a support and problem solving session for PCP facilitators and their managers. Each facilitator filled out a form with their manager and then the group as a whole looked at how the blocks identified could be overcome. It generated helpful ideas and examples that facilitators and managers could take away and try out, as well as producing information about service development needs and gaps that local planners required.

you could bring people, their families and PCP facilitators together to present their summary feedback and their key messages to planners and managers, animating the process and creating a team feeling.

The key message is, use this pack in a way that makes sense for your local area.

**Who will the pack help?**

*Shaping the Future Together* produces information and uses approaches that can help:

**Partnership Boards**

to make sure the strategic plans they approve are focused on what people with learning disabilities actually want to achieve in their lives, and on the support they need to realise those things. It helps with action planning by highlighting the main barriers and the ways that services need to change and develop.
**PCP implementation groups**
to develop, refine and target the training and support they arrange, especially for person-centred planning facilitators, managers and support circles. It can help identify where problem-solving support is needed to realise people’s plans.

**Joint commissioners**
to achieve person-centred commissioning, ie securing resources, services and opportunities that respond to the actual aspirations of people on the receiving end of services. It can provide evidence for use in negotiating developments with providers of mainstream community facilities and services, and for assessing achievements against performance indicators.

**Provider organisations**
to shape their own service developments and ensure they are person-centred, and negotiate their contracts with purchasers on the basis of person-centred evidence. It gives provider organisations a mechanism for engaging with care managers (both locally and at a distance) by feeding summary information back to them after people’s reviews or person-centred planning.

**Care managers**
to facilitate people’s reviews so that key areas of life are covered and people are helped to think about the future as well as the present. It can help identify and plan for future changes, and make it more likely that resources will be available when they are needed. It provides an easy way of summarising reviews and feeding back to others so that they too can help to make things happen for people.

**PCP facilitators and support circles**
to summarise plans and let others know about them so that they too can help to make things happen for people. It also summarises things that are stopping plans being achieved and feeds them back to managers, making it more likely that the blocks will be addressed.

**People with learning disabilities and their families**
to let everyone know what they are wanting to achieve and the blocks they are encountering. It gives people an opportunity to send a message directly to staff, managers and planners in services about their personal priorities. It can help to mobilise people and focus their energies on achieving those things.
Another string to the bow

If you really want to ensure that you are getting the fullest, richest picture to base service change and development on, it can help to get information in more than one way and then see what it tells you overall. Gathering information from person-centred planning and from people’s individual reviews can be strengthened by learning from other sources as well. The diagram below shows some of the many ways that you can learn about changes that are needed. You certainly don’t need to do all of these – it would probably be impossible to manage – but bringing together and studying the findings from more than one will help you to get developments right in your local area.

Keeping in touch

*Shaping the Future Together* has been distributed to all the learning disability Partnership Boards in England. The Foundation for People with Learning Disabilities is keen to hear from organisations that are using it, whether in full or in part, with a view to setting up a network so that lessons and examples of person-centred strategic development can be shared more widely. If you are using the pack we’d like to hear from you. Contact the Foundation on 020 7803 1100 or email fpld@fpld.org.uk.
Further reading on the link between person-centred approaches, strategic planning and change


The system

Principles

The system to gather and aggregate information is shaped by a set of principles:

- it should be a person-centred process, whilst recognising that it is an organisational planning tool and not about planning with individuals
- it has to be easy to do so that it is usable and sustainable by busy people in busy organisations
- it should include verbal reporting and not just be based on forms
- it must be linked into management roles and into quality systems, and not centre around a ‘special’ person
- it should be able to capture information from any person-centred planning or individual planning format (Essential Lifestyle Planning, Personal Futures Planning, PATH etc)
- it needs to have added value – not just collecting information but also supporting the achievement of people’s goals
- it must show the support that people need as well as the opportunities that people want
- it should encourage and support action planning to address and achieve the service changes that are indicated
- it should be possible to link it into other data management systems such as registers
- it should encourage developments that are not constrained by service options, but that utilise the full potential and capacity of the community and local neighbourhoods.
How it works

Gathering and aggregating information from person-centred plans and individual reviews is the start of a process of service improvement and development. Figure 1 and Figure 2 show how the Shaping the Future Together system works, in its simplest form, either developing an overview from person-centred plans (Figure 1) or from individual service reviews (Figure 2). Figure 3 shows how the two can be merged together to get the ‘big picture’ in your local area. Figure 4 shows how the overview may lead to gathering more detailed information in order to fine-tune service developments.
Figure 1: Getting an overview from person-centred plans

A planner starts the process and sends forms and guidance out.

Managers of local services ask person-centred planning facilitators to complete PCP Summary Feedback Forms.

Facilitators complete form using the information that has come from a person's planning.

Then they carry on working to achieve the person's goals.

Development needs emerge.

The facilitator meets with their manager to go through the form and identify service or support gaps.

The completed form is returned to the planner.

The information on all the forms is aggregated.

...about changes needed to services and support to realise people's goals.

...about support needed for person-centred planning locally.

New services are developed and existing services are helped to change.

The local PCP implementation group is informed and responds.
**Figure 2: Getting an overview from individual service reviews**

The ‘review feedback system’ is introduced to care managers.

Care managers ask about seven key areas at people’s individual review.

Actions are agreed.

The care manager completes a Review Summary Feedback Form following the review.

...then works on achieving the person’s goals.

The completed form is copied to the planner.

The care manager meets with their manager to discuss the form and the actions planned.

Development needs emerge.

...about changes needed to services and support.

...about support needed for care management locally.

Training and development input is organised.

New services are developed and existing services are helped to change.

The information on all the forms is aggregated at set intervals.

The completed form is copied to the planner.

...and works on achieving the person’s goals.
People with person-centred plans

PCP facilitators

PCP Summary Feedback Form

Completed forms aggregated and analysed at set intervals

An individual’s service review

Review Summary Feedback Form

Care managers

People who don’t have person-centred plans

Development and planning priorities emerge

Figure 3: Getting the big picture
Figure 4: Getting more detail for fine-tuning: an example

Completed forms are returned to the planner

The information on all the forms is analysed

It shows that several people want to move, but there’s not enough detail about the type of accommodation or the support that needs to be available

The planner asks care managers to gather more detailed information about what’s wanted and needed and to help each person who wants to move to develop an action plan

Care managers link up with PCP facilitators and others to gather the details that are needed.

A detailed service and support specification is drawn up

Detailed information is returned to the planner

The planner uses the information to talk to developers and providers, fine-tuning housing and support developments so that they really do meet people’s needs
Once the information gathered has been aggregated and analysed it will give you an overview in relation to seven areas of life, as well as some clues about the quality of the person-centred planning and/or individual reviews that are happening. The seven areas are:

work
learning
leisure and fun
my choices, control and rights
feeling well and good about myself
my friends, family and relationships
where and how I live

The analysis identifies development themes. It can never be 100% accurate, but it should be reasonably reliable as an indicator of the developments that are needed in your locality. The challenge is then to feed the results into strategic planning and use them to guide service development activity. Two examples are given below.

Example 1

The analysis
This shows that at least 14 people in one locality are living with carers who are over 70 but no plans appear to have been made about where they will live in the future.

Service development activity
A ‘virtual team’* is created in the locality, with input from learning disability care management, housing, older people’s care management, and local voluntary organisations (as relevant). The team is given the task of gathering more detailed information about what’s wanted and needed in the future for the 14 people, and drawing up plans with people and their families.

Strategic planning
The information is fed into strategic planning with the housing department, local housing providers and the Supporting People team. Information about the level of support people will need is fed into forward planning for the learning disability community care budget.

*In a virtual team staff may not be based together and do not necessarily come from the same organisation, service or profession, but they work together on a shared agenda (or around an individual). Team members come together at specified times and share accountability for the outcomes of their work. They are similar to the ‘practitioner partnerships’ described in the Valuing People Support Team guidance on community team reviews (2002).
Example 2

The analysis
This shows that at least 22 people in one locality want to find work, but the Supported Employment Scheme already has a waiting list.

Service development activity
There is no new money available, but most of the 22 people use local day services so developments focus around that service. Some day service staff are supported to develop knowledge and skills in supported employment and to work specifically with the 22 people on their employment goals.

Strategic planning
The information is fed into strategic planning with the local Learning and Skills Council, Jobcentre Plus, and the Economic Development Unit. It influences the learning disability day service modernisation plan and the employment strategy, as well as the workforce development plan.

Getting the best from the tool

- A named individual (usually a planner, commissioner or development manager) should lead and oversee the Shaping the Future Together process. Make it someone with enough authority or backing to ensure that people respond to requests for information. There needs to be a contact number if people have queries.

- People involved in the process need to understand what is happening and why. The process is more likely to run smoothly if local operational managers, person-centred planning co-ordinators and care managers are clear about what they need to do. It’s important to raise awareness about the process through managers’ briefings, team meetings, workshops, training, newsletters, events, or whatever will work in your area. Tell people about it during initial training on person-centred planning and during training for care managers, so that people know that they will be expected to provide feedback from planning.

- The information that reaches planners will only be as good and reliable as the person-centred planning underpinning it, or the quality of reviews that are taking place. This will depend to a large extent on the approach and skills of the person who is facilitating. Things don’t have to be working perfectly but it helps if the Shaping the Future Together process is used in the context of:
– an overall person-centred planning framework where there is:
  a clear way of identifying facilitators
  a sound programme of training and support for facilitators
  depth and breadth training for those involved
  a process that is increasingly owned by the person and those important to them, rather than just by an organisation
  a commitment to action to achieve people’s plans
  a clear way of feeding information into strategic planning
– a review system where care managers or care co-ordinators have:
  attended training and information sessions about person-centred approaches
  been introduced to the review feedback system in this pack, and the expectations on them, and had a chance to discuss the best ways of putting it into practice.

• Person-centred planning is action-focused: it's about people helping someone achieve the changes they want in their life. Individual service reviews are also about taking action to improve a person’s situation. It is important that action to make things happen for people should not stop while planners consider the information gathered through *Shaping the Future Together*.

• Try to use *Shaping the Future Together* systematically so that information is being continuously gathered, and then aggregated and analysed at set intervals. Service developments can then be continually shaped by information about what people want and need. To gather feedback from people’s regular reviews using the review feedback pack, we recommend introducing a system where care managers automatically complete and submit a feedback form after each review. With person-centred planning it makes more sense to gather feedback at set intervals, perhaps once or twice a year. Allow enough time – up to 12 weeks. It is easy to underestimate how long it will take to get information back from people. Map out anticipated times and avoid periods when people are likely to be very busy (e.g. end of financial year) or lots of staff away, and ensure there are prompts and follow-up so that forms do come in.

• Be clear about time-scales. If you want to feed information into other key strategy developments and action plans you need to take those timeframes into account.
Aggregate and analyse the information carefully, don’t try to rush it. A systematic way of doing it is suggested in Part 2. It may be tempting not to bother with such a systematic approach, but we would caution against shortcuts if you want anything more than impressions to underpin strategic developments.

Think about gathering information to give you an ‘indication’ of what’s needed. Go for ‘good enough’ information not ‘perfect’. Seek indicators of what is needed at a point in time, but recognise that what people say they want and need will change.

Modify the process to suit your situation. For example, in one development site the local manager met with each PCP facilitator so that they could discuss and complete the feedback form together, rather than the manager sending the form out to facilitators and then meeting later. In another site managers and PCP facilitators were brought together as a group to discuss progress on person-centred planning and were asked to complete some parts of the feedback form together in that forum.

Help people with learning disabilities to understand how things happen, how decisions are made about resources and development of services, and who makes the decisions. Information and empowerment go hand in hand. Supporting people to take part in courses like Partners in Policymaking helps them see how they can influence decision-makers, which is fundamental to Shaping the Future Together. People will need help to understand how feeding information from their planning through to planners may help to improve things and help them get what they want. There is a leaflet to use or adapt in Section 2.5.

Be flexible about how to involve people with learning disabilities. During the development of Shaping the Future Together people were especially excited about filling in the first page of the feedback form and sending a ‘message’ to the planners. Wherever possible try to involve people in completing that page. But remember, this is about providing information for strategic planning purposes, it is not person-centred planning, so simply summarising (accurately) what’s already been discussed and agreed during person-centred planning or at someone’s review is perfectly okay.

Take a developmental approach, not a criticising and blaming one. The process will produce information about the quality of what is going on – good and not so good. Use it as an opportunity to give people praise, support, direction and developmental assistance.
Recognise when more detail is needed. The process will indicate gaps in services and support networks and help you to target your developments to respond to what people want. If you want those new service developments to be really person-centred and right for the people who are going to be using them you will need to go further. You will need more information. This is explored in Part 3.

An integrated approach

Getting individual voices into planning

People gradually began to ‘think outside the box’ for the 26 people involved in person-centred planning in Kensington and Chelsea. A need for new types of support began to emerge. It became apparent that a mechanism was needed to link the individual voices from person-centred planning to the bigger picture of planning services, commissioning, and progression of inclusion agendas. We wanted a mechanism that would not lose the individual story, the essence of person-centred planning. We also wanted people with learning disabilities and those supporting them to see how their personal requests for change were being actioned and listened to, not just by people directly supporting them, but also by care management and commissioning.

H. Medora & S. Ledger, Royal Borough of Kensington & Chelsea

You can use *Shaping the Future Together* to analyse information solely from person-centred planning. But not everyone has a personal plan. For *Shaping the Future Together* to be most effective as a tool for strategic planning purposes, the information gathered and analysed from person-centred planning really needs to be ‘joined up’ with information about the wishes and needs of those people who have not developed plans through person-centred planning. Unless this happens strategic plans won’t reflect the full picture of what’s needed in the locality, and there may be equity issues.

This pack provides a way of doing that through the reviews that most people participate in annually. A review is not the same as person-centred planning, but it is a forum where someone’s desire or need for major change in their life may be raised (changes likely to require significant planning input to achieve). To this end, the review feedback papers (Section 2.3) will help organisations gather specific information from individual reviews to feed into the strategic planning process.
The quality framework

Organisations monitor or review the quality of service provision for people with learning disabilities in a range of ways. Most have a quality framework that pulls it all together. *Shaping the Future Together* is not about the quality of person-centred planning or reviews, but it does produce clues about how well person-centred planning and reviews are being facilitated and what they are achieving. It will also generate information about the range and level of opportunities, services and support that people can actually access, particularly about unmet and latent needs. It is important that there are clear links between *Shaping the Future Together* and local quality systems, including systems for monitoring the quality of person-centred planning itself.

Existing strategies and plans

In recent years statutory organisations have been required to develop a multitude of strategic action plans – Joint Investment Plans, Best Value review plans, day service modernisation plans, housing and employment strategies, to name but a few. Making them all fit together and feel coherent has been a challenge. *Shaping the Future Together* may produce information that is relevant to all of these, but producing another separate action plan would muddy the waters even further. Finding a way to feed the findings through into these other planning processes is key.

Figure 5 on page 24 illustrates how, in the Royal Borough of Kensington and Chelsea, information gained from using *Shaping the Future Together* will link into, and fit with, their existing care management, quality and planning systems.

The health improvement agenda

With Health Action Plans as an integrated part of a person’s individual plan, *Shaping the Future Together* will capture information about how mainstream health services need to develop to better serve local people with learning disabilities. Separating out and analysing the health information and then feeding it into the local PCT planning system and health user forums may help to influence local developments in a positive way. Similarly, there may be specialised health services that could improve how they include and serve people with learning disabilities, like the local mental health Trust, ophthalmology or dental services, so feed relevant information through into their planning systems too.
Mainstreaming: a community focus

Joint and lead commissioning, with pooled social services and health budgets to pay for services for people with learning disabilities, enable more joined up and coherent development of specialised services. For Valuing People objectives to be achieved, though, and for more people to experience ordinary lives, there remains a need to influence how mainstream services are developed to ensure that they appropriately meet the needs of people with learning disabilities. Those mainstream services have their own planning systems and timetables. They will not work to yours. Familiarity with their systems is essential if you really want to make them work for you and, ultimately, for people with learning disabilities.
Figure 5: Linking systems – the Kensington & Chelsea way

People with person-centred plans

PCP Summary Feedback Form

Feeds into

Individual Service Review

People who don’t have person-centred plans

Feedback Form

Completed forms analysed

Annual summary

Review Summary Feedback Form

Quality Network checkers look at form

Feeds into

Quality Action Planning for a service

Feeds into

Quality Network Action Plan for borough

Joint Investment Plan

Best Value reviews

Housing strategy

Employment strategy

Health commissioning

PCP Implementation group

Partnership Board

User forum

Informs

Informs
So, who does what?

More detailed information is contained in the guidance sheets in Part 2, but here is a brief summary of who would do what.

Getting an overview from person-centred planning

The planner (eg a joint commissioner, or a service development manager in a provider organisation):

- sets the process in motion, prepares and lets people know about it
- sends out *Shaping the Future Together* packs to local managers and people supporting PCP facilitators, with return instructions
- receives PCP Summary Feedback Forms back from local managers/co-ordinators
- aggregates the information from the forms
- studies the findings and identifies service development needs
- gives people feedback on the findings
- co-ordinates an action plan and negotiates/contracts with providers so that opportunities, services and support are developed to meet needs.

Local managers and people who support PCP facilitators:

- distribute PCP Summary Feedback Forms and guidance to PCP facilitators, with return instructions
- meet with PCP facilitators to go through the information on the form
- fill in a section on the form themselves
- gather all the forms back in and study them for themes and development needs (a local analysis)
- identify and plan local action to address local development needs
- return copies of the forms to the planner.

PCP facilitators

- complete PCP Summary Feedback Forms (with the person and/or their circle as appropriate)
- meet with their manager or PCP co-ordinator to go through the information on the form
- support the person to use the information on the form at their next review meeting
- carry on working to ensure that the person’s hopes and dreams are achieved.
Gathering information from individual service reviews

The planner
- sets up a system to ensure that Review Summary Feedback Forms are completed following people’s annual reviews
- ensures that care managers are well-briefed and well-prepared for the task
- receives Review Summary Feedback Forms back from the care management service
- adds the information to the PCP feedback, and analyses it at set intervals
- studies the findings and identifies overall service development needs.

Local team managers (care management and review teams)
- ensure that care managers are well-briefed and well-prepared to complete Review Summary Feedback Forms
- receive and study forms after reviews, identifying themes and agreeing action
- discuss the completed form and the planned action with the care manager
- fill in a section on the form themselves
- copy and send forms to the planner
- support care managers through supervision and training to achieve people’s goals.

Care managers
- complete Review Summary Feedback Forms after people’s annual reviews
- copy the form to their manager
- discuss the completed form and action to take in supervision with their manager
- send a copy to the person and/or their representative
- work to ensure that the person’s hopes and dreams are achieved.
Embedding the process for future years

You can use *Shaping the Future Together* as a one-off information-gathering tool, but it will be more helpful (and cost-effective) as an ongoing process that is integrated into the day-to-day work of organisations and staff. You can do this by:

**Getting feedback and adapting the process**
After using it the first time review how it worked, and talk to people locally about how it can be made even more effective and helpful. Adapt the process to fit local circumstances.

**Taking a planned, structured approach**
Decide how often you want to gather information from person-centred planning, and at what intervals you want to aggregate and analyse all the forms gathered back. Work out when you need information for strategic planning purposes, and build your approach around those dates so that you can quickly make use of the findings.

**Building it into contracts with providers**
Make it clear that organisations will be expected to participate in the *Shaping the Future Together* information-gathering process, and to act on the findings.

**Linking it with your existing database or register**
Doing this at the outset will help to ensure that the process lasts, and that the information available locally is coherent and joined up.

**Adding the forms to your computerised recording system**
Make it easy for staff to access the forms by putting them onto the computerised system with prompts to use them (eg on Lotus notes). This may be especially helpful in relation to Review Summary Feedback Forms where forms need to be returned after each person’s review.
Using the findings

What to consider

It is essential that service development and systems change takes place alongside initiatives to embed person-centred approaches within organisations. *Shaping the Future Together* aims to help you achieve that. There are several things to consider about using the findings as part of the service development and change process.

A bias towards action

Organisations should not wait for lots of plans to be developed and for information to be analysed before they take action to increase employment opportunities, broaden choice and control in housing, promote direct payments, and so on. Most planners have a good idea of what’s broadly needed – for example more wheelchair-accessible accommodation options – but it’s the detail about how many, when, and specific design features needed by individuals that’s often missing. Getting local housing developers to agree to build some two or three bedroom fully wheelchair-accessible dwellings in good locations is going to be a fairly safe step. If people with learning disabilities don’t want or need them all, people with physical impairments in the local community probably will! The message is don’t wait – get some general developments underway and fine-tune them as more detailed information is gathered through *Shaping the Future Together*. Developments don’t have to be set in stone from the outset, and really can be shaped as they proceed.

Developing plans

*Shaping the Future Together* should produce information that is relevant to a wide range of different plans that are already in place or being developed – see *An integrated approach* on page 21. Feeding the results through into these other planning processes is key. There are some summary and action
planning sheets in Section 2.4 to help you. In developing plans it is important to ensure that people with learning disabilities are involved in looking at the findings and thinking about the actions that are needed to address them. The information is about the lives of people with learning disabilities – they and their representatives should have the opportunity to contribute to the action planning.

**Influencing mainstream community planning**

Wider strategic change is critical to ensure that person-centred planning has a significant impact on people’s lives. Generic housing, leisure, education and employment services, for example, need to be creating services that are capable of responding to the individual wishes and needs of people with a learning disability. Community development is needed to create inclusive opportunities for people. The findings from *Shaping the Future Together* can inform and add weight to negotiations with mainstream agencies. Information can help you to influence how those agencies meet the needs of people with learning disabilities as members of the local community they serve.

**Informing resource allocation**

There need to be routes so that the findings can actually influence and shape resource allocation. Senior managers, trustees or accountants within organisations need to be involved in the *Shaping the Future Together* process, and be prepared to change things in light of the findings. Ensuring that they are well-informed about the process and involved in discussing the findings and their implications for services and resource allocation is essential.

**Informing strategic planners**

The findings need to be fed through to groups and strategic bodies that are responsible for drawing up plans that shape future services. The local learning disability Commissioning Board and the Partnership Board are key examples, but higher strategic bodies such as Local Strategic Partnerships have a central role to play in wider community developments and should not be overlooked. And don’t forget to feed information through to planners in provider organisations too so that you are ‘managing the market’ and shaping their developments to fit what’s wanted and needed. Learn from the experience of one London borough, honestly reflected on below.
A lesson learnt

It was known through demographic information that Asian people, particularly Asian women with learning disabilities, were not making proportionate use of local supported housing or residential care. The feeling was that a specific provision would be more attractive to people. A local housing association linked up with an Asian-run organisation to develop a sheltered housing scheme catering for Asian elders and Asian people with learning disabilities of all ages. When the scheme opened, there just wasn’t the demand from local Asian people with learning disabilities and the housing association understandably became concerned about vacancies. A decision was taken to open the units to people with learning disabilities from any background and the flats were soon snapped up. We’ve ended up with a housing scheme that people are very positive about - but Asian people are still under-catered for.

We made the mistake of leaping from general trends information to service development without the bit in between – ie how does this match with what individuals actually want? We needed a more systematic way of gathering individualised information about where people would like to live, and with whom, what sort of support people would need and what sort of lead-in reassurances – basically what people’s long term hopes and plans were in relation to their housing. We needed to be more person-centred.

Opportunistic and enforced developments

The reality of commissioning and developing services is that, in addition to planned strategic developments, there are others that are opportunistic or enforced. Using Shaping the Future Together means that there will be person-centred information at hand to help shape those developments that need to take place quickly. The findings can help planners to grasp an unexpected opportunity that is right for a particular person or, for example, to provide an outline specification when having to commission new provision at short notice for people.

Empowering people with learning disabilities...

Information gives power. It is important that local advocacy groups and organisations of people with learning disabilities are given the findings so that they can, in their own right, take action to secure service developments and change.
...and carers too
Securing service developments and change does not need to be the sole responsibility of planners. Feeding the findings back to carers groups and organisations gives them an opportunity to bring their weight to bear too. You may not be in a position to lobby, but others are.

Making comparisons
The findings about the issues faced by people with learning disabilities can be compared with local population information to assess if there is any latent discrimination or bias in mainstream systems. For example, does the level of housing demand indicated through using *Shaping the Future Together* equate with the figures held by the housing department?

Operational management
Managers of services will want to know if planners think they could be doing things differently, and will want to have a dialogue with them about why and how. They will want a chance to talk about the constraints on their service and staff, and may appreciate help and support to think about how they can best use their existing resources to make changes happen for people.

Improving the quality of person-centred planning and individual reviews
Facilitators and care managers will want to know what’s been found out. They are, after all, working hard to make person-centred planning and more general individual planning a success for people.

Achieving person-centred commissioning
Using the findings from *Shaping the Future Together* can help achieve more person-centred commissioning. In the description of the commissioning role that follows, several of the core elements reflect information and approaches that are central to *Shaping the Future Together*. 
What is commissioning?
Commissioning is at the very heart of providing effective social care for both children and adults. It is the process by which local authorities decide how to spend their money to get the best possible services for local people. Councillors, managers and staff at all levels, service users and carers, statutory agencies and service providers in the independent sector need to contribute to this.

Commissioning is about enhancing the quality of life of service users and their carers by:
- having the vision and commitment to improve services
- connecting with the needs and aspirations of users and carers
- making the best use of all available resources
- understanding demand and supply
- linking financial planning and service planning
- making relationships and working in partnership.

It is about getting ahead of the game and anticipating future needs and expectations rather than just reacting to present demand.

Core elements of commissioning
Commissioning has to be based on:
- a common set of values that respect and encompass the full diversity of individuals’ differences
- an understanding of the needs and preferences of present and potential future service users and their carers
- a comprehensive mapping of existing services
- a vision of how local needs may be better met
- a strategic framework for procuring all services within politically determined guidelines
- a bringing together of all relevant data on finance, activity and outcomes
- an ongoing dialogue with service users and carers and service providers in all sectors
- effective systems for implementing service changes, whether of in-house or of independent sector services
- an evidence-based approach which continuously evaluates services with a view to achieving measurably better outcomes for service users and their carers
- an improving alignment with the way that other health and social care services are commissioned.

From the Audit Commission/SSI/National Assembly for Wales Making Ends Meet website (about managing the money in social services). See www.joint-reviews.gov.uk/money/homepage.html
Seizing opportunities: every cloud has a silver lining!

Analysis of the information gathered through using *Shaping the Future Together* can produce any number of possible findings. Each one could present an opportunity, as illustrated below.

**Possible finding:**
that people need clearer explanation of the *Shaping the Future Together* process and its importance.

**An opportunity to:**
reinforce the need to link person-centred planning and individual planning with service development and change, and ensure people understand that change is necessary to make it more possible to achieve people’s goals and aspirations.

**Possible finding:**
that some services are struggling to support people with fairly basic quality of life activities, and need specific support.

**An opportunity to:**
encourage and support those services to change the way they operate, and to help them develop. Sanderson (2002) talks about developing person-centred teams as an effective way of making things happen for people – this could be a good opportunity to support local managers to do just that.

**Possible finding:**
that services find it difficult to sustain support for people to undertake regular, planned activities.

**An opportunity to:**
courage services to organise and use their staff differently so that time and energy is focused more on supporting people to achieve their goals and dreams. One way of doing this is called ‘active support’ (Mansell *et al.*, 2004). Giving services information about this method of focusing staff time could help. It is also an opportunity to organise training for services about how to develop people’s community networks and connections, and develop natural support.
**Possible finding:**
a need for more in-depth training and support to improve the quality of person-centred planning and individual reviews.

**An opportunity to:**
reinforce the importance of moving from goals that are framed in terms of service solutions, or that do little to improve people’s overall quality of life, to goals that are about community connections and inclusion, and valued lives.

**Possible finding:**
a need for more in-depth training and support to improve the quality of person-centred planning and individual reviews.

**An opportunity to:**
consider how staff time might be re-worked to provide allocated time for individuals, or to consider whether a Direct Payment might enable the person to organise their own support.

**Possible finding:**
that some things with costs attached are blocking the achievement of people’s goals.

**An opportunity to:**
do some unblocking. For example, by creating a small pot of money that can be used to free things up and make things happen for individuals whilst longer-term solutions are being developed. It’s also an opportunity to consider whether people may be eligible for funding through other external channels, such as the benefits system or the Independent Living Fund, or through one-off grants or concessionary schemes.
Above all, it’s important for planners and managers to seize opportunities to ask people how the planning is going and what they can do to help; to listen … and then find a way, with others, to help make things happen for people.

**Non-stop learning**

To get services and support right means recognising that learning never stops. As Rob Greig points out in the foreword, good person-centred planning ‘is a continual, evolving statement of what people want from their lives’. Keeping abreast of people’s growing and changing aspirations is a challenge that *Shaping the Future Together* can help planners to meet.
Guidance for commissioners and service planners

Introduction

*Shaping the Future Together* is a system for gathering information from person-centred planning and from people’s regular service reviews so that managers and planners can make sure the right opportunities, services and support are developed to meet people’s wishes and needs into the future. It will help managers within services to plan for and deliver the changes that people want. It will help service commissioners and planners develop the right opportunities and support services for people.

This guidance covers:

- preparation
- gathering overview information from person-centred planning
- adding information from people’s service reviews
- seeing what the information tells you.

It’s only worth gathering information if it’s going to be used! **Part 1** of the pack includes pointers and ideas about different ways that planners might use the information that comes from the *Shaping the Future Together* process.
What you need to do

Prepare

- Decide *when* you are going to start gathering information from person-centred planning to inform your commissioning and service planning. There’s no set time, it really depends on local circumstances. To get the most out of it people need to have been involved in person-centred planning for long enough to have identified some changes they want to achieve in their lives. The number of people who have person-centred plans is less important. Getting information back about even a few people’s goals means that you can make a difference and help them achieve the life changes they want.

- Decide whether you are going to gather information from people’s ordinary reviews *as well as* from person-centred planning to better inform your commissioning and service planning. To some extent this decision needs to take into account the current state of your local review system. If reviews aren’t actually happening for most people it may be more profitable to concentrate on getting a reliable system up and running first and build feedback in as an integral part of that system.

- Discuss and agree the information-gathering plan with your person-centred planning implementation team and/or the Partnership Board in your local area. Agree a date when you will present the findings to them. If you are just concentrating on information from person-centred planning we would suggest allowing three months from when forms are distributed so that you can gather the information in, analyse it and prepare a report.

- Clearly, the more forms you get back the more time it will take to analyse the information. As person-centred planning grows you will need to allow more time for the analysis – ask yourself whether you have the time to do it yourself or whether you need someone else to do it and give you the results.

- Think about who else you want the findings to go to. The findings may indicate that new developments or changes are needed in a whole range of local services – further education, leisure services, employment services, transport, community safety, to name but a few. We suggest you discuss *Shaping the Future Together* with them in advance to find out how they would want to use the information and how it might fit into their own planning cycles.
● Let people know what’s happening! Let services know what *Shaping the Future Together* is about and why you are using it. Let people with learning disabilities and carers know (there is a sample leaflet designed by and for people with learning disabilities in Section 2.5. You could adapt it for use in your own area). Ask managers to let people involved in person-centred planning in their service know that *Shaping the Future Together* is going to be used, why, and when.

● Create a positive climate so that people welcome the chance to let managers and commissioners know what’s wanted and needed. You really want people to know that it is about gathering information so that the right opportunities, support and services can be developed for people. You certainly don’t want people to feel they are being checked up on, otherwise you may not get quality information.

● Some people with learning disabilities may be facilitating their own person-centred planning. It will be important to find out from local managers and advocacy organisations who those people are, and to identify who will support them to complete a feedback form.

● If you have the necessary IT resources to use a database to manage the information, get it ready before the forms come back to you. There is a basic database framework you could use on the CD included in this resource. Further details about the database can be found in Section 2.4. Remember, though, that if you are intending to use the *Shaping the Future Together* system as a long-term planning aid the database will need to be kept up-to-date and the information maintained. Someone needs to have allocated time to do that.

**Gather the information**

**From person-centred planning**
Distribute the person-centred planning feedback papers, with a covering letter, to local managers so that they can pass the forms through to staff who are acting as person-centred planning facilitators, receive completed forms back and then return them to you. Your covering letter needs to include the date when you want managers to have returned the completed forms to you.

**From people’s ordinary reviews**
Introduce the review feedback system to the care management service and distribute the review feedback papers to the manager. It includes guidance for the manager as well as guidance for care managers. Reviews happen
throughout the year so feedback forms will come in steadily rather than en masse. You will need to decide how often you are going to aggregate the feedback with the information from person-centred planning and analyse it as a whole.

You may want to give people a gentle reminder about the return date for forms a week or so before they are due back. Try a simple postcard or email, signed by you, that says ‘I’m really looking forward to receiving your Shaping the Future Together forms back on (date). Thanks for your help’.

See what the information tells you

- First, organise the information. A way of doing this without using a computer database is shown in Section 2.4. Organising the information will take time, but it needs to be done to achieve a proper analysis and to reap the full benefits of the information gathering.

- If you are using a computer database, information from the forms will need to be entered onto it. There is guidance for the person inputting actually within the database on the CD in this pack.

- Even if you are using a database and someone else is going to enter the information onto it for you, we still recommend that you read through all the forms yourself. Doing so will give you some really strong messages directly from individuals and the people supporting them to achieve changes. It will also give you a picture of the quality of person-centred planning and reviews. It may indicate that some staff need more guidance and support, which is useful information for your local person-centred planning implementation group and training team. Jot down some notes as you read through the forms. Here are just a few questions to consider as you read them.

  - Are people being helped to dream or think about ordinary, not segregated or ‘special’ opportunities?

  - Are people being helped to achieve changes that will make a long-term difference to their lives, rather than just one-off experiences?

  - Does the planning seem to be coherent, ie if someone wants to achieve something is there a goal being worked on that will take them towards it?

  - Do some facilitators seem to be achieving better quality planning than others? Are any development or training needs highlighted?
Shaping the Future Together is not a tool for evaluating person-centred planning or reviews, but it will provide some clues about the quality of planning that can be fed into an evaluation.

- Think about what you want to know – things that will help you to develop the right opportunities, support and services for people. Then study and analyse the information to see what it tells you. There is more about this in Section 2.4.

- Do some counting. How many people want to achieve changes in each of the seven areas on the form? What kind of changes? How many people need what resources or support for it to happen? Weight of numbers can help to persuade people that there really is a need for something to change or for something to be developed. Use them to argue for increased resources and opportunities – but make sure that those resources and opportunities are right for the individuals who will use them.

- Look for any themes that emerge, such as people who live near each other wanting or needing the same things. Development of opportunities, support or services may need to be specific to a local area; or, people with particular needs may be missing, for instance people who use wheelchairs may not be appearing in the work section because people may not be seeing it as a viable option for them; or there may be gaps in support or services that indicate a new development may be needed.

Use the findings!

Have another look at the suggestions in Part 1, Using the findings.
Person-centred planning feedback papers:

Guidance for local managers
Introduction

*Shaping the Future Together* is a system that gathers information from person-centred planning so that managers and planners can make sure the right opportunities, services and support are developed to meet people’s wishes and needs into the future. It will help you and other managers to plan for and deliver the changes that people want. It will help service commissioners and planners to develop the right opportunities and support services for people.

These person-centred planning feedback papers consist of a form and guidance on how to fill it in. The form and the guidance is for your person-centred planning facilitators – they need to fill the form in and return it to you. There is also a comments sheet for you to fill in. Ultimately the form has to go back to the commissioner/planner.

It will help if you familiarise yourself with the forms before reading the rest of this guidance.

**This guidance covers:**

- what you need to do (as the local manager)
- seeing what the information tells you
- how you might use the findings.

It’s only worth gathering information if it’s going to be used!
What you need to do

- Decide when you want PCP facilitators to get completed forms back to you and put the date on the front of the PCP Summary Feedback Form with your name, or the name of the person the form should be returned to. You need to allow time so you can meet with each PCP facilitator between getting the forms back and the date when you have to forward them on to your commissioner or service planner.

- Get the forms filled in and returned to you, then meet with each facilitator and go through the information on the form. Ask them to bring along the person’s planning materials (papers, posters, videos etc). This is a crucial part of the process. It’s so that you can make sure the information written on the form is accurate and clear, but it will also give you a sense of how person-centred the planning really is and what the quality is like. It will help you identify anyone who might need extra support.

- In particular, look at the last columns of the form on pages 3 and 4 with the facilitator. They are about service and support issues that might be getting in the way of achieving the person’s goals. Talk them through: you may be able to find another way forward to ‘unblock’ things.

- Complete the manager’s comments and sign and date the form.

- Copy the completed forms so that you can take time later to study the information and use it, and then return the completed forms to the planner/commissioner who sent you this pack, by the date required.

Seeing what the information tells you

- We strongly recommend that you read through all the forms. Doing so will give you some really strong messages directly from individuals and the people supporting them to achieve changes. It will also give you a picture of the quality of person-centred planning and reviews. It may indicate that some staff need more guidance and support. Study the forms you have received and look for any themes that are emerging. See Section 2.4 of the Shaping the Future Together pack.

- Use the information to make sure your day-to-day management of staff and resources is helping people to achieve their goals and dreams. There are some ideas about this opposite.
Using the information

When you have met with each facilitator and studied the information on all the completed forms you will have a picture of:

– what people who use your service want, what support or resources they will need to achieve it (that they don’t have at the moment), and any individual factors that must be taken into account.

– the quality of planning that’s taking place locally. It may indicate that some of your facilitators need more guidance and support

Here are some ideas about what you could do next.

To improve the quality of person-centred planning

● Pair up facilitators who need some support with other facilitators who are particularly creative and person-centred. Ask them to work together on planning.

● Make sure there are regular ‘ideas and problem-solving’ sessions for your facilitators to meet up and learn from each other.

● Regularly use team meetings to discuss person-centred planning and person-centred approaches. Keep asking ‘how can we do this in a more person-centred way?’

● Have ‘person-centred planning’ on the supervision agenda of all facilitators and discuss it each time. Ask people how they are making the planning ‘right’ for the person, and how they are helping people to achieve opportunities that are inclusive and integrated.

● Think about your own development needs too. Do you feel you know enough about person-centred planning? Do you feel confident about your role in making it work for people? If you don’t, then seek out some support and development opportunities that are right for you as a manager.

● Read the papers below for helpful advice and guidance. All are available on the Valuing People website at www.valuingpeople.gov.uk

  Implementing person-centred plans. H. Sanderson.
  Training and support in person-centred approaches. M. Routledge and H. Sanderson
  After the plan. M. Smull.
To create local opportunities and support which help people achieve their personal goals and dreams

- Change the way you organise and use staff so that their time and energy is focused on supporting people to achieve their goals and dreams. Create as much flexibility as you can. One way of focusing staff is called ‘active support’. You can find out about it by reading Active support and person-centred planning (H Sanderson et al 2002).

- Organise training for your staff about how to develop people’s community networks and connections, and developing natural support. Make sure you know about these things too.

- Talk to your local agencies – like employment or adult education services or your local leisure centre – about the opportunities people want and the support they need. Tell them about the information gathered, and negotiate with them to develop those opportunities.

- Try to create a small pot of money from within your budget that can be used to free things up and make things happen for individuals whilst longer-term solutions are being developed.

- Think about whether a personal assistant might be the answer for the person – explore Independent Living Fund monies and Direct Payments.

- Set up a meeting with your local commissioner to discuss the findings and talk through what you and your staff will be doing, and what help you would like to achieve the changes.

- Keep asking people how the planning is going and what you can do to help. Listen – and then find a way to make things happen for people!

- And – remember to think about your own networks and contacts and how you might be able to use them to make things happen directly for some people, as Peter did below.

Peter, a manager of a local authority service, took a couple of hours to read through all the feedback forms that were returned. One of Helen’s goals jumped out at him, because it was something that he could help her with very quickly. Helen wanted to go to watch the local football team play – and Peter had good links with the club. He helped to make it happen.
Person-centred planning feedback papers:

Guidance for person-centred planning facilitators
Introduction

*Shaping the Future Together* is a system that gathers information from person-centred planning so that managers and planners can make sure the right opportunities, services and support are developed to meet people’s wishes and needs into the future. It will assist you in your work as a person-centred planning facilitator because it will help to make sure that the right opportunities and support services are developed for people. It should help people to get the things they want in their lives.

The form at the end of this section will feed information through to managers and planners so that they can make sure the right opportunities, services and support are developed to meet people’s wishes and needs into the future. The information you put on this form will help with forward planning.

It will help if you familiarise yourself with the form before reading the rest of this guidance.

**This guidance covers:**

- what you need to do (as a person-centred planning facilitator)
- how you could help the person you are planning with to use the form to help make things happen for themselves.

**Remember**

Person-centred planning is about people taking action so that someone achieves the opportunities and lifestyle that are right for them. It’s about lots of different people playing a part. *Shaping the Future Together* is not about feeding information on what people want and need up to planners and managers and then waiting for them to make things happen. Their role is about managing resources and planning for the future – your role is about the here and now. What you are doing is important. You can make things happen. Don’t wait!
What you need to do

Look at the front page of the PCP Summary Feedback Form

You should fill this page out with the person and/or their planning circle. It’s about the person’s message to planners and managers.

Help the person paste a photo of themselves into the box on the form.

Put the person’s first and last names and their address into the first speech bubble. Use the name that the person likes to be known by.

The next bubble is for a message to managers and planners from the person (and those helping them to plan).

It may be something like ‘please make sure I get a new home this year’, or ‘I really want to go swimming every week, not once a month’.

It’s a chance to give managers and planners a sense of what the person most wants action on. It can be any message at all.

Now look at page 2

It is not necessary to fill out pages 2, 3 and 4 with the person. Remember, this is not person-centred planning, it is a tool for gathering information from the planning. But, if you think the person would really enjoy doing it then there’s nothing to stop you filling it out with them. Your responsibility is to make sure that the information put on the form is accurate and clear, and really does reflect what has come from the person-centred planning.
Fill in page 2. It is really important. It lists all the things that need to be taken into account when planning services and support for the person. Knowing these things means that planners are more likely to get developments right for people.

Please give all the information about the person that’s asked for. Most information simply requires a tick if the answer is ‘yes’.

Don’t forget to state the obvious – the person reading the information will not know the person like you do.

And now page 3

Pages 56 and 57 show how pages 3 and 4 of the form might look when filled out. Have a careful look at it – it will help you to fill the form out well.

You need to think about what you’ve been working on in the person-centred planning. What does the person want to change about their life? What do they want something done about?

In the first column, with a ✩ above it, write in what the person wants to achieve or what their circle has agreed should be achieved to improve their life in some way. Write these things into whichever of the rows seem appropriate.

Write things in that the person has said they want to achieve even if they seem unachievable. Some things that people say they want to do might seem a bit ‘pie in the sky’ – but there is nearly always something lying behind it, as the story below about Michael demonstrates.

Michael said he wanted to play football for England. What he was really saying was that he loved football and had a real interest in the game. His planning circle agreed that helping him to join the fan club of the local league team, go to matches regularly and do some training with the village team would really give him joy, open up new friendships and improve his life. That’s what they worked on.
You don’t have to put something in all seven rows, only what’s emerged during the person’s planning so far. Do not put what you think the person should be trying to achieve, only what the person has actually said or their circle has agreed.

**In the second column**, with a ⚖ above it, write in what things are like now for the person in relation to each of the things they are wanting to achieve. This is so that people can see how big the changes are that you are working on.

**In the third column**, with a ← above it, write in the action you and others are taking to help the person achieve the things that are written in the first column. For example, if the person wants to move to their own flat you may have agreed that someone will try to get them registered with the housing department or to go around estate agents. You may not have agreed to take any action yet. That’s okay – just don’t write anything in.

**In the fourth column**, with a ⚡ above it, write in any service or support issues that are getting in the way of achieving the goal written in the first column. This is about service or support issues, not about issues to do with the person.

**Now page 4**

This is for you to feed back about anything that the person really wants to carry on doing but which it is proving difficult to achieve because of service or support issues. Again, this is about service or support issues not about issues to do with the person.

**And finally**

When you feel you have given enough information for managers and planners to be developing the right kind of opportunities, services and support, return the form by the required date to the person named on page 1. Don’t forget to put the person’s name at the top of page 3, and you need to sign and date the form on page 5.
Going through the form with your manager or PCP co-ordinator

Your manager or PCP co-ordinator will want to go through the information on the form with you. This is because they have to give their comments about service and support issues (on page 5). It is also so they get to know what people are trying to achieve and can hear about any difficulties you are facing. They may be able to help.

When you meet with your manager take along the person-centred planning materials that you have developed with the person and/or their planning circle. This will help you to explain things.

Using the PCP Summary Feedback Form to help make things happen

One of the good things about filling in the form is that you can then use it to help the person you are planning with let other people know what they are trying to change in their life. You could help the person to:

- show it to their care manager
- go through it with people at their review
- show it to relatives, friends and professionals who haven’t been involved in the planning
- show it to anyone who may be able to help.

Letting people know is all about getting more help and ideas to achieve the goals. Everyone has friends and contacts; many people are members of clubs, associations, churches, groups. Who knows what opportunities might open up once people know what the person wants to achieve. Letting people know is the key.
**PCP Summary Feedback Form: EXAMPLE**

<table>
<thead>
<tr>
<th>My name is: Jane Jones</th>
<th>What I really want to change is…</th>
<th>What things are like for me now</th>
<th>Action we’re taking through person-centred planning</th>
<th>What service or support issues are getting in the way of achieving the change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work</td>
<td>I want a job working with animals</td>
<td>I don’t work. I go to a day centre</td>
<td>Referred to the supported employment service</td>
<td>There’s a waiting list for the supported employment service</td>
</tr>
<tr>
<td>Learning</td>
<td>I want to learn how to use a computer</td>
<td>I do a cookery class at college and am learning about using money at my day centre</td>
<td>We’re looking to see if there’s a computer course at college</td>
<td></td>
</tr>
<tr>
<td>Leisure and fun</td>
<td>I want to go to watch Chelsea every week</td>
<td>I don’t go to football. I don’t go out much at weekends</td>
<td></td>
<td>We can’t find anyone to support Jane to go out at weekends</td>
</tr>
<tr>
<td>Choices, control and rights</td>
<td>I want to be able to pay for things using my own money</td>
<td>The day centre is teaching me how to pay for things</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling well and good about myself</td>
<td></td>
<td>Fine – I’m well and happy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends, family and relationships</td>
<td>I want to make more friends</td>
<td>I don’t see anyone apart from mum at weekends</td>
<td></td>
<td>There’s no-one to support Jane to go out at weekends</td>
</tr>
<tr>
<td>Where and how I live</td>
<td>With mum. It’s fine. I like the house. I want to stay in it, and mum wants that too</td>
<td>Exploring getting a ground floor bathroom because the stairs are getting harder</td>
<td></td>
<td>Don’t know where to get information about how to do it</td>
</tr>
</tbody>
</table>
**Things I want to continue but it’s proving difficult**

My name is:  
_Jane Jones_

<table>
<thead>
<tr>
<th>What I want to continue doing</th>
<th>Service or support issues that are stopping it or getting in the way</th>
<th>Action we’re taking through person-centred planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leisure and fun</td>
<td>Horse riding at the local stables</td>
<td>The stables have problems about insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>We don’t know what to do about it</td>
</tr>
<tr>
<td>Choices, control and rights</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling well and good about myself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends, family and relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where and how I live</td>
<td>Living in the house I live in now</td>
<td>I need a ground floor bathroom but people don’t know how to get one</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Looking into it — but we need some help!</td>
</tr>
</tbody>
</table>
Person-centred planning feedback papers:

PCP Summary
Feedback Form
Dear Managers and Planners,
Here is some information that will help you to plan and develop the right opportunities, services and support for me in the future.

Hello, I am ........................................
and I live at ........................................
My message to you is
........................................
........................................
........................................
........................................

Return this form to........................................by........................................
You need to take into account that:

<table>
<thead>
<tr>
<th>Information</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am …… years old</td>
<td></td>
</tr>
<tr>
<td>I am female</td>
<td>□ female □ male</td>
</tr>
<tr>
<td>I am white UK/Irish</td>
<td>□ white UK/Irish □ African Caribbean</td>
</tr>
<tr>
<td>I am black UK</td>
<td>□ black UK □ black African</td>
</tr>
<tr>
<td>I am Asian UK</td>
<td>□ Asian</td>
</tr>
<tr>
<td>I am Asian</td>
<td>□ Asian</td>
</tr>
<tr>
<td>My faith is</td>
<td>□ I have none □ Roman Catholic</td>
</tr>
<tr>
<td>My faith is</td>
<td>□ Muslim □ Jewish</td>
</tr>
<tr>
<td>I use a wheelchair inside</td>
<td>□ inside □ outside</td>
</tr>
<tr>
<td>I use a wheelchair outside</td>
<td></td>
</tr>
<tr>
<td>I can propel my wheelchair myself (I don’t need help)</td>
<td>□</td>
</tr>
<tr>
<td>I find it very difficult or impossible to manage steps and stairs</td>
<td>□</td>
</tr>
<tr>
<td>I am partially sighted or blind</td>
<td>□</td>
</tr>
<tr>
<td>I have a hearing impairment</td>
<td>□</td>
</tr>
<tr>
<td>Speech is very difficult or impossible for me</td>
<td>□</td>
</tr>
<tr>
<td>Speech is very difficult or impossible for me</td>
<td></td>
</tr>
<tr>
<td>I use communication equipment</td>
<td>□</td>
</tr>
<tr>
<td>I use sign language</td>
<td>□</td>
</tr>
<tr>
<td>I need someone with me when I go out</td>
<td>□</td>
</tr>
<tr>
<td>I need someone with me when I go out</td>
<td></td>
</tr>
<tr>
<td>The person has to be just for me (one-to-one)</td>
<td>□</td>
</tr>
<tr>
<td>The person has to be just for me (one-to-one)</td>
<td></td>
</tr>
<tr>
<td>I have long-term health problems</td>
<td>□</td>
</tr>
<tr>
<td>I have long-term health problems</td>
<td></td>
</tr>
<tr>
<td>What? (eg epilepsy, heart condition, thyroid condition, arthritis etc)</td>
<td></td>
</tr>
<tr>
<td>What? (eg epilepsy, heart condition, thyroid condition, arthritis etc)</td>
<td></td>
</tr>
<tr>
<td>I live with family carers</td>
<td>□</td>
</tr>
<tr>
<td>I live with family carers</td>
<td></td>
</tr>
<tr>
<td>My main carer is my (relationship)</td>
<td>□</td>
</tr>
<tr>
<td>My main carer is my (relationship)</td>
<td></td>
</tr>
<tr>
<td>S/he is aged …… yrs</td>
<td>□ under 40 □ 40–49 □ 50–59 □</td>
</tr>
<tr>
<td>S/he is aged …… yrs</td>
<td></td>
</tr>
<tr>
<td>S/he is aged …… yrs</td>
<td></td>
</tr>
<tr>
<td>(If you aren’t sure please estimate):</td>
<td>□ 60–69 □ 70–79 □ 80+ □</td>
</tr>
<tr>
<td>(If you aren’t sure please estimate):</td>
<td></td>
</tr>
</tbody>
</table>
### PCP Summary Feedback Form

<table>
<thead>
<tr>
<th>My name is:</th>
<th>☄ What I really want to change is…</th>
<th>☇ What things are like for me now</th>
<th>➡ Action we’re taking through person-centred planning</th>
<th>✨ What service or support issues are getting in the way of achieving the change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leisure and fun</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choices, control and rights</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling well and good about myself</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends, family and relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where and how I live</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What I want to continue doing</td>
<td>Service or support issues that are stopping it or getting in the way</td>
<td>Action we’re taking through person-centred planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leisure and fun</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choices, control and rights</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling well and good about myself</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends, family and relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where and how I live</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Information about you, the person-centred planning facilitator:

Your name.................................................................................................................................................. 
Contact address........................................................................................................................................ 
.................................................................................................................................................. 
Tel.................................................................................................................................................. Email .............................................................................................................................. 
Signed.................................................................................................................................................. Date .............................................................................................................................. 

Thank you

THIS SECTION SHOULD BE COMPLETED BY YOUR MANAGER

Your person-centred planning facilitator has identified some service and support issues in the right-hand column of page 3.

➡ Have you suggested any other action that the facilitator could take to address these blocks? ☐ Yes ☐ No
If so, what have you suggested?
..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................

➡ Are YOU personally taking any action to try to address the blocks? ☐ Yes ☐ No
If so, what are you doing?
..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................

➡ Do you think there is anything planners/commissioners could do that would really help? ☐ Yes ☐ No
If so, what should they do?
..................................................................................................................................................
..................................................................................................................................................
..................................................................................................................................................

Signed..................................................................................................................................................
Date ..................................................................................................................................................
Review feedback papers:

Guidance for managers of the care management service
Introduction

*Shaping the Future Together* helps organisations to gather information from people’s regular service reviews as well as from person-centred planning. The purpose is the same – so that managers and planners can make sure the right opportunities, services and support are developed to meet people’s wishes and needs into the future. It will help you and other managers to plan for, and deliver the changes that people want. It will help service commissioners and planners to develop the right opportunities and support services for people.

These review feedback papers consist of a form and guidance on how to fill it in. The form and the guidance is for care managers/care co-ordinators and review facilitators – they need to fill the form in and return it to you. There is also a section for you to fill in.

It will help if you familiarise yourself with the form before reading the rest of this guidance.

**This guidance covers:**

- What you need to do (as manager of the care management service)
- Seeing what the information tells you
- How you might use the findings

It’s only worth gathering information if it’s going to be used!
What you need to do

Prepare

- Discuss the current review system with your local commissioner/planner, particularly the proportion of people whose services are reviewed by care managers each year. If, for most people, reviews aren't actually happening it may be more profitable to concentrate on getting a reliable system up and running first – and then introduce the Review Summary Feedback Form in this pack as an integral part of that system.

- Agree with the commissioner how often the Review Summary Feedback Forms will be analysed. They will come in throughout the year, following people’s reviews, so will need to be carefully stored until the analysis. **But do read them first**, so that you can support your care managers to achieve people’s goals and you can pick up early on emerging development issues.

- Introduce the review feedback system to your care managers/co-ordinators and, if you have them locally, your review facilitators. Circulate the forms and guidance. Go through the Review Summary Feedback Form with them and, especially, the seven areas that they will need to ask questions about at reviews. Practise the kind of questions they could ask. You may feel that team members need further training before implementing the system. If so, people delivering person-centred planning training would be a useful source of help and support.

- When a completed form has been copied to you, meet with the care manager/co-ordinator and go through the information on the form (in your normal supervision session if it is regular).

- In particular, look at the **last columns** on pages 3 and 4 of the form with the care manager. They are about service and support issues that might be getting in the way of achieving the person's goals. Talk them through – you may be able to find ways to ‘unblock’ things.

- Complete the manager’s comments (on page 5) and sign and date the form.

- Copy the completed forms so that you can take time later to study the information and use it, and then return the completed forms to the planner/commissioner who sent you this pack.
Seeing what the information tells you

- Study the forms you have copied and look for any themes that are emerging, such as people who live near each other wanting or needing the same things. Development of opportunities, support or services may need to be specific to a local area; or, people with particular needs may be missing, for example people who use wheelchairs may not be appearing in the work section because people may not be seeing it as a viable option for them; or, there may be gaps in support or services that indicate a new development may be needed. There is a suggested way of identifying themes in Section 2.4 of the Shaping the Future Together pack.

- Use the information to make sure your day-to-day management of staff and resources is helping people to achieve their goals and dreams. There are some ideas about this below.

Using the information

Jot down some notes as you read through the forms. Here are just a few questions to consider as you read them.

- Are people being helped to dream or think about ordinary, not segregated or ‘special’ opportunities?

- Are people being helped to achieve changes that will make a long-term difference to their lives, rather than just one-off experiences?

- Does the planning seem to be coherent, ie if someone wants to achieve something is there a goal being worked on that will take them towards it?

- Do some care managers/care co-ordinators seem to be achieving better quality planning than others? Are any development or training needs highlighted?

When you have met with each care manager/care co-ordinator and studied the information on all the completed forms you will have a picture of:

- what people with learning disabilities want, what support or resources they will need to achieve it (that they don’t have at the moment), and any individual factors that must be taken into account
the quality of planning and reviewing that’s taking place. It may indicate that some of your care managers/care co-ordinators need more guidance and support.

Some ideas about what you could do next

To improve the quality of reviews

- Pair up care managers who need some support with care managers who are particularly creative and person-centred. Ask them to work together on some reviews and related action plans.
- Make sure that all team members have training about person-centred planning and person-centred approaches.
- Use team meetings for regular ‘ideas and problem-solving’ sessions that focus on how to make something happen for an individual.
- Regularly use team meetings to discuss person-centred approaches. Keep asking ‘how can we do things in a more person-centred way?’ and ‘how can we make reviews more person-centred?’
- Have person-centred planning and person-centred approaches on the supervision agenda of all care managers, and discuss it each time. Ask people how they are making sure that service and support plans (care plans) are ‘right’ for the person, and how they are helping people to achieve opportunities that are inclusive and integrated.
- Create a ‘consumer panel’ of people who have regular reviews, and seek their feedback on how the review process could be made even better.
- Think about your own development needs too. Do you feel confident about helping team members to achieve person-centred solutions for people? If you don’t, then seek out some support and development opportunities that are right for you as a manager.
- Circulate papers about care management and person-centred planning for members of the team to read. A paper to stimulate discussion would be Care Management and PCP (Duffy 2002). There are other references and resources in the full Shaping the Future Together pack and the Valuing People website is a useful source of information at www.valuingpeople.gov.uk.
To create opportunities and support which help people achieve their personal goals and dreams

- Help team members to focus their time and energy on people’s goals and dreams, and develop skills in drawing up person-centred service and support specifications for individuals.

- Encourage staff to consider whether a personal assistant might be a good solution for a person, made possible through Independent Living Fund monies or a Direct Payment.

- Feed back the aggregation findings to team members and consider creating some shared solutions for people with the same goals.

- Give team members a lot of creative examples of things done elsewhere to achieve people’s goals. Provide details so they can see the ‘how’ as well as the ‘what’.

- Talk to your local agencies – like housing and support providers, employment or adult education services or your local leisure centre – about the opportunities people want and the support they need. Tell them about the information gathered, and encourage them to develop those opportunities.

- Set up a meeting with your local commissioner to discuss the findings and talk through what you and your staff will be doing, and what help you would like to achieve the changes.

- Keep asking team members about progress towards goals and what you can do to help. Listen – and then find a way to make things happen for people!

- And… remember to think about your own networks and contacts and how you might be able to use them to make things happen directly for some people, as Peter did below.

Peter, a manager of a local authority service, took a couple of hours to read through all the PCP feedback forms that were returned. One of Helen’s goals jumped out at him, because it was something that he could help her with very quickly. Helen wanted to go to watch the local football team play – and Peter had good links with the club. He helped to make it happen.
Review feedback papers:

Guidance for care managers and review facilitators
Introduction

*Shaping the Future Together* is a system that gathers information from person-centred planning and from people’s service reviews so that managers and planners can make sure the right opportunities, services and support are developed to meet people’s wishes and needs into the future. It will assist you in your work as a care manager/care co-ordinator because it will help to make sure that the right opportunities and support services are developed for people. It should help people to get the things they want in their lives.

The form at the end of this guidance is for you to feed information through to managers and planners so that they can make sure the right opportunities, services and support are developed to meet people’s wishes and needs into the future. The information you put on this form will help with forward planning.

It will help if you familiarise yourself with the form before reading the rest of this guidance.

**This guidance covers:**

- what you need to do (as a care manager/care co-ordinator)
- how you can shape reviews so that they focus on the whole of a person’s life.

**Remember**

Reviews are about people taking action so that someone achieves the opportunities and lifestyle that are right for them. It’s about lots of different people playing a part. *Shaping the Future Together* is not about feeding information on what people want and need up to planners and managers and then waiting for them to make things happen. Their role is about managing resources and planning for the future – your role is about the here and now. What you are doing is important. You can make things happen. Don’t wait!
What you need to do

The attached form focuses on seven aspects of a person’s life:

work
learning
leisure and fun
choices, control and rights
feeling well and good about themselves
friends, family and relationships
where and how they live

You need to ensure that you find out about the person’s views and ambitions in relation to each of these areas during their service review. Someone’s service review is not person-centred planning, but it is just as important to take a person-centred approach.

Why not read Person-centred planning and care management by Simon Duffy and Helen Sanderson (2004), available at www.helensandersonassociates.co.uk.

For each of the seven areas, you are trying to identify how the person and their close support network might want things to change in terms of:

● the opportunities the person gets
● the person’s actual experience (ie what things are like now)
● and the support the person receives.

You are also trying to make sure that:

● the person is getting help and support that is uniquely right for them.

Good reviews feel comfortable and ‘person-centred’, enabling the person to take as much of a lead as possible. This means that you need to be very familiar with the seven areas and weave them in naturally, rather than taking a rigid approach. It is about asking the right questions at the right time, and creating openings for people to talk about the seven areas. So:
Prepare yourself

This is especially important if you are facilitating a person’s review but don’t really know them well. Study the form and think about the kind of questions you could ask to get the information you want.

Look at the front page of the form

You should fill this page out with the person and the people at the review – but not until near the end. It’s about the person’s message to planners and managers.

Ask the person for a photo to put into the box on the form.

Put the person’s first and last names and their address into the first speech bubble. Use the name that the person likes to be known by.

The next bubble is for a message to managers and planners from the person (and those supporting him/her at the review).

It may be something like ‘please make sure I get a new home this year’, or ‘I really want to go swimming every week, not once a month’.

It’s a chance to give managers and planners a sense of what the person most wants action on. It can be any message at all.

Finally, don’t forget to write in the date that the person’s review took place.
Now look at page 2

You do not have to fill out pages 2, 3 and 4 with the person. Remember, this is a process that gathers information for planning purposes. The form is for you to summarise what’s been talked about at the review and the action that is being taken to improve the person’s life. You should fill in pages 2, 3 and 4 as soon as possible after the review, but if you think the person would really enjoy being involved then there’s nothing to stop you doing it during the review, ideally as a way of summing up at the end.

Your responsibility is to make sure that the information put on the form is accurate and clear, and really does reflect what’s come from the person’s review.

Fill in page 2 of the form. It is really important – these are all things that need to be taken into account when planning services and support for the person. Knowing these things means that planners are more likely to get developments right for people.

Please give all the information about the person that’s asked for. Most information simply requires a tick if the answer is ‘yes’.

Don’t forget to state the obvious – the person reading the information may not know the person like you do.

Now page 3

Pages 77 and 78 show how pages 3 and 4 of the form might look when filled out. Have a careful look at it – it will help you to fill the form out well.

You need to focus on what’s been said and agreed during the review. What does the person want changed about their life? What does something need to be done about?

In the first column, with a ✩ above it, write in what the person wants to achieve or what the review has agreed should be achieved to improve their life in some way. Write these things into whichever of the rows seem appropriate.
Write things in that the person has said they want to achieve even if they seem unachievable. Some things that people say they want to do might seem a bit ‘pie in the sky’, but there is nearly always something lying behind it, as the story below about Michael demonstrates.

Michael said he wanted to play football for England. He was really saying that he loved football and had a real interest in the game. It was agreed that helping him to join the fan club of the local league team, go to matches regularly and do some training with the village team would really give him joy, open up new friendships and improve his life. That’s what was worked on.

You don’t have to put something in all seven rows, only what’s emerged during the review. Do not put what you think the person should be trying to achieve, only what the person has actually said or the review agreed.

In the second column, with a ☐ above it, write in what things are like now for the person in relation to each of the things they are wanting to achieve. This is so that people can see how big the changes are that you are working on.

In the third column, with a ➡ above it, write in the action you and others are taking to help the person achieve the things that are written in the first column. For example, if the person wants to move to their own flat you may have agreed that someone will help get them registered with the housing department or to go around estate agents. You may not have agreed to take any action yet. That’s okay – don’t write anything in.

In the fourth column, with a ⚡ above it, write in any service or support issues that are getting in the way of achieving the goal written in the first column. This is about service or support issues, not about issues to do with the person.

Now page 4

This is for you to feed back about anything that the person really wants to carry on doing but where it is proving difficult to achieve because of service or support issues. Again, this is about service or support issues, not about issues to do with the person.
And finally

When you feel you have given enough information for managers and planners to be developing the right kind of opportunities, services and support, return the form to the person named on page 1 by the required date. Don’t forget to put the person’s name at the top of page 3, and you need to sign and date the form on page 5.

Going through the form with your manager

Your manager will want to go through the information on the form with you. This is because they have to give their comments about service and support issues (on page 5). It is also so they get to know what people are trying to achieve and can hear about any difficulties you are facing. They may be able to help.

Using the Review Summary Feedback Form to help make things happen

One of the good things about filling in the form is that you can then use it to help the person let other people know what they are trying to change in their life. You could help the person by:

- making sure they get a copy of it
- supporting them to show it to people who couldn’t attend the review
- supporting them to show it to anyone who may be able to help.

Letting people know is the key to getting more help and ideas to achieve the goals. Everyone has friends and contacts; many people are members of clubs, associations, churches and groups. Who knows what opportunities might open up once people know what the person wants to achieve. Letting people know is the key.
### Review Summary Feedback Form: EXAMPLE

<table>
<thead>
<tr>
<th>My name is:</th>
<th>What I really want to change is…</th>
<th>What things are like for me now</th>
<th>Action people agreed to take at my review</th>
<th>What service or support issues are getting in the way of achieving the change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Jones</td>
<td><img src="image1.png" alt="Image" /> Work</td>
<td><img src="image2.png" alt="Image" /> I want a job working with animals</td>
<td><img src="image3.png" alt="Image" /> I don’t work. I go to a day centre</td>
<td><img src="image4.png" alt="Image" /> Referred to the supported employment service</td>
</tr>
<tr>
<td></td>
<td><img src="image6.png" alt="Image" /> Learning</td>
<td><img src="image7.png" alt="Image" /> I want to learn how to use a computer</td>
<td><img src="image8.png" alt="Image" /> I do a cookery class at college and am learning about using money at my day centre</td>
<td><img src="image9.png" alt="Image" /> We’re looking to see if there’s a computer course at college</td>
</tr>
<tr>
<td></td>
<td><img src="image10.png" alt="Image" /> Leisure and fun</td>
<td><img src="image11.png" alt="Image" /> I want to go to watch Chelsea every week</td>
<td><img src="image12.png" alt="Image" /> I don’t go to football. I don’t go out much at weekends</td>
<td><img src="image13.png" alt="Image" /> We can’t find anyone to support Jane to go out at weekends</td>
</tr>
<tr>
<td></td>
<td><img src="image14.png" alt="Image" /> Choices, control and rights</td>
<td><img src="image15.png" alt="Image" /> I want to be able to pay for things using my own money</td>
<td><img src="image16.png" alt="Image" /> The day centre is teaching me how to pay for things</td>
<td></td>
</tr>
<tr>
<td></td>
<td><img src="image17.png" alt="Image" /> Feeling well and good about myself</td>
<td><img src="image18.png" alt="Image" /> Fine – I’m well and happy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><img src="image19.png" alt="Image" /> Friends, family and relationships</td>
<td><img src="image20.png" alt="Image" /> I want to make more friends</td>
<td><img src="image21.png" alt="Image" /> I don’t see anyone apart from mum at weekends</td>
<td><img src="image22.png" alt="Image" /> There’s no-one to support Jane to go out at weekends</td>
</tr>
<tr>
<td></td>
<td><img src="image23.png" alt="Image" /> Where and how I live</td>
<td><img src="image24.png" alt="Image" /> With mum. It’s fine. I like the house. I want to stay in it, and mum wants that too</td>
<td><img src="image25.png" alt="Image" /> Exploring getting a ground floor bathroom because the stairs are getting harder</td>
<td><img src="image26.png" alt="Image" /> Don’t know where to get information about how to do it</td>
</tr>
</tbody>
</table>
### Things I want to continue but it’s proving difficult

<table>
<thead>
<tr>
<th>My name is:</th>
<th>What I want to continue doing</th>
<th>Service or support issues that are stopping it or getting in the way</th>
<th>Action we agreed to take at my review</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Jane Jones</strong></td>
<td><strong>Work</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Horse riding at the local stables</td>
<td>The stables have problems about insurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Living in the house I live in now</td>
<td>I need a ground floor bathroom but people don’t know how to get one</td>
<td>Looking into it — but we need some help!</td>
</tr>
<tr>
<td><strong>Learning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Leisure and fun</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Choices, control and rights</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Feeling well and good about myself</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Friends, family and relationships</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Where and how I live</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Review feedback papers:

Review Summary
Feedback Form
Review Summary Feedback Form

Please read the guidance before filling out this form

Dear Managers and Planners,

Here is some information that will help you to plan and develop the right opportunities, services and support for me in the future.

My message to you is:

Hello, I am ........................................
and I live at ........................................

My review took place on:

When completed return this form to your manager.
### You need to take into account that:

I am …… years old

<table>
<thead>
<tr>
<th>I am</th>
<th>female</th>
<th>male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

My date of birth is……………………………..

<table>
<thead>
<tr>
<th>I am</th>
<th>white UK/Irish</th>
<th>African Caribbean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I am</th>
<th>black UK</th>
<th>black African</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I am</th>
<th>Asian UK</th>
<th>Asian</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My faith is</th>
<th>I have none</th>
<th>Roman Catholic</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My faith is</th>
<th>Muslim</th>
<th>Jewish</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My faith is</th>
<th>Church of England</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I use a wheelchair</th>
<th>inside</th>
<th>outside</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I can propel my wheelchair myself (I don’t need help)</th>
<th>☐</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>I find it very difficult or impossible to manage steps and stairs</th>
<th>☐</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>I am partially sighted or blind</th>
<th>I have a hearing impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Speech is very difficult or impossible for me

<table>
<thead>
<tr>
<th>I use communication equipment</th>
<th>I use sign language</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I need someone with me when I go out</th>
<th>The person has to be just for me (one-to-one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I have long-term health problems</th>
<th>What? (eg epilepsy, heart condition, thyroid condition, arthritis etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I live with family carers</th>
<th>My main carer is my…………………………………………………………….. (relationship)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S/he is aged …… yrs</th>
<th>His/her date of birth is ………………</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(If you aren’t sure please estimate):</th>
<th>under 40</th>
<th>40–49</th>
<th>50–59</th>
<th>60–69</th>
<th>70–79</th>
<th>80+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work</td>
<td>What I really want to change is...</td>
<td>What things are like for me now</td>
<td>Action people agreed to take at my review</td>
<td>What service or support issues are getting in the way of achieving the change?</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>----------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leisure and fun</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choices, control and rights</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling well and good about myself</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends, family and relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where and how I live</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Things I want to continue <em>but it’s proving difficult</em></td>
<td>Service or support issues that are stopping it or getting in the way</td>
<td>Action we agreed to take at my review</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>-------------------------------------------------------------------</td>
<td>--------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What I want to continue doing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Learning</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leisure and fun</td>
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<td>Choices, control and rights</td>
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<td>Feeling well and good about myself</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Friends, family and relationships</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Where and how I live</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Information about you, the care manager/care co-ordinator:

Your name..........................................................................................................................................................................

Contact address........................................................................................................................................................................

.........................................................................................................................................................................................

Tel........................................................................................................ Email ..............................................................................................

Signed........................................................................................................ Date .............................................................................................

Thank you

THIS SECTION SHOULD BE COMPLETED BY THE TEAM MANAGER

The care manager has identified some service and support issues in the right-hand column of page 3.

➡ Have you suggested any other action that the care manager could take to address these blocks? ☐ Yes ☐ No

If so, what have you suggested?
..........................................................................................................................................................................................
..........................................................................................................................................................................................
..........................................................................................................................................................................................

➡ Are YOU personally taking any action to try to address the blocks? ☐ Yes ☐ No

If so, what are you doing?
..........................................................................................................................................................................................
..........................................................................................................................................................................................
..........................................................................................................................................................................................

➡ Do you think there is anything planners/commissioners could do that would really help? ☐ Yes ☐ No

If so, what should they do?
..........................................................................................................................................................................................
..........................................................................................................................................................................................
..........................................................................................................................................................................................

Signed .......................................................................................................................... Date ..........................................................................................
Guidance on analysing the information

Analysis: why bother?

It’s only worth gathering information if it’s going to be used. That phrase can be found several times in this pack. People are disappointed and irritated when they make the effort to provide information and then find that it has not been used to any benefit. Studying the information to see what it tells you – analysing it – is the first step towards using it to achieve positive benefits for people.

Analysing the information will help your organisation learn more about the following.

- **What needs to happen to improve the life of each individual?**
  Managers are encouraged to read all the individual feedback forms and to discuss them with PCP facilitators and care managers. In doing so the organisation becomes more focused on each person’s goals and can manage its resources more purposefully to help achieve them.

- **What needs to change to make existing services and support more person-centred?**
  Analysing feedback forms en masse (ie aggregating the information) will help you to identify the main service and support issues that are getting in the way of people achieving desired changes to their lives – organisational blocks. It should help you to see where and what the blocks are, and help you to prioritise action.
What new opportunities, services and support need to be developed?

Analysing feedback forms en masse will also indicate where there are gaps in local opportunities and service provision. It will help you to identify developments in community provision that are needed, and will give evidence to support your negotiations. It will help you commission services that fit with what people want and the support they need.

Important considerations

How often?

How often you analyse the information will depend on whether you are just gathering feedback periodically from person-centred planning, or on an ongoing basis from reviews, or are doing both. We suggest:

- that individual feedback forms are looked at and analysed by local managers as they come in so they can do whatever they can to support the achievement of individual goals
- that analysis of aggregated information from large numbers of people takes place no more than twice a year.

Who will do the analysis?

*Shaping the Future Together* encourages local managers to undertake a local (micro) analysis separate from the overall (macro) analysis at commissioner or planner level. This is important to promote local solutions and developments, and to empower local teams.

The overall analysis, which may be based upon information from quite large numbers of people, can be broken down into two main tasks – organising the information, and then asking questions of it. The two can be done by different people, but it is important that commissioners and planners take responsibility for setting the questions, ideally after thinking with others about what they should be. There is more on this below.

We would strongly recommend that all parts of the analysis be undertaken by people who are very familiar with services for people with learning disabilities, the terminology and the issues.
**Will the analysis be done by hand or on a computer database?**

Whichever way you do it, someone will need to have allotted time to organise the data by sorting it and writing it down, or by inputting onto the database. We recommend that one person has ongoing responsibility for organising/inputting information because it involves an element of interpretation and judgement – if the same person does it each time it will mean a consistent approach. Make sure the person is briefed and prepared well.

**What scale do you want the analysis to take?**

Think about whether you want a picture of what’s happening for people using particular services or living in particular areas. This can be helpful in large counties, or where changes to particular services or developments in particular localities are being considered for the future. If so, you may want information from those people to be aggregated and analysed separately.

**What do you want to know, and when?**

There is a database on the CD in this pack and there are suggested column headings for analysis by hand and a sample sheet you can photocopy, in the pocket of the ringbinder. They will help you to organise information but you will first need to decide what you want to learn from it. There will be umpteen possibilities, so it is important to think about what you most want to know and establish some priorities. This will probably be governed by strategic planning timeframes, such as when particular action plans have to be produced or updated. You can always revisit the information later to get answers to other questions.

A few basic questions are suggested below.

- **How many people using day services/centres are wanting to work?**
  - Which services/centres are they currently using? What’s getting in the way of them working?

- **How many people are wanting to change their accommodation?**
  - How many of them are living with carers over 60? How many need wheelchair accessible or level-access accommodation?

- **What are the most popular things that people want to learn?**
What are the most popular leisure pursuits that people are trying to take up? Where do the people live – are there any groupings?

What are the main issues that are stopping people from doing things in each of the seven areas of life. Is there any difference for people living in different localities?

How many people are experiencing travelling difficulties? Where do they live and what do they want the transport for? How many have mobility difficulties that suggest adapted transport is needed?

How many people are experiencing difficulties continuing things they already enjoy doing? What are the key issues?

Are there any particular themes for people from ethnic minorities?

Are there any particular issues about the support people get with their health?

What are the main issues identified for people who need one-to-one support when they go out, or those who find speech very difficult or impossible? Is there any pattern linked to localities?

What are the things that local managers most want commissioners and planners to do?

How will you feed back the findings?

Think about who needs to see the findings and, therefore, how they should be presented. Make sure they are easy to understand for everyone. Rows of figures can turn people off. Use pictures wherever you can, and illustrate findings with some real stories about what’s happening to people – they make it more interesting.
Are you well prepared for the analysis?
A checklist to help you. See if you can tick these off.

We’re only gathering feedback from person-centred planning. We’ve decided how often and when – so we know when the feedback forms will be in and analysis will need to take place.

OR

We’re gathering feedback from person-centred planning and individual reviews. We’ve decided how often and when we will analyse the feedback forms from individual reviews, and we’ve organised PCP feedback forms to be gathered to fit with this.

We know when significant strategies and plans have to be submitted by learning disability services and by community partners, and our analysis will fit with those timescales so we have information ready.

Local managers have been briefed about doing a local analysis, and have been given the database or example hand analysis sheets from the Shaping the Future Together pack.

We have identified a permanent member of staff who will take responsibility for inputting data onto the database or organising it by hand. The person has been briefed and prepared.

The person doing the manual analysis or managing the database has time set aside in their diary to do it.

The people involved in the analysis are very familiar with services for people with learning disabilities, the terminology and the issues.

We have decided what scale we want the analysis to take, ie whether the analysis will focus around people living in local areas or whether it will be more global.

People have been consulted about the key questions we want answers to. We have thought about what we most want to know, and have a list.

We have thought about who we need to report the findings to, and how the findings should be presented.
Analysing the information by hand

One way of doing it

Copy and enlarge the seven pairs of blank pro forma sheets that are in the pocket of the ringbinder. The larger you can make them the better. They focus on the seven areas that *Shaping the Future Together* covers: work; learning; leisure and fun; choices, control and rights; feeling well and good about self; friends, family and relationships; where and how people live.

Give each of the Summary Feedback Forms you have received a unique reference number (eg 2005/01; 2005/02), and then insert the information from each form into the relevant columns on the sheets, mostly by simply inserting a tick for ‘yes’ or a cross for ‘no’. It may help to use a different colour for the ticks so that they stand out from the crosses. You do not need to include every person on every sheet – only enter a person’s name on a sheet if they have indicated that they want to achieve something in that area. For example, if someone’s form has entries in the rows to do with work, leisure and relationships then their information should be entered only onto those analysis sheets.

Some of the column headings require you to enter basic details, like the person’s name or age or a date. Those in italics need you to enter more detail – a brief summary of whatever is on the Summary Feedback Form.

Once all the information from the forms has been entered onto the sheets add up the ticks in each column to give you total numbers. Then really study the information and pull out the answers to your prepared questions.
Using a database

There is a basic database framework on the CD in this pack. You can use this to organise the information you get back. It has a pre-set data inputting form and a table with headings that relate to all the information on the feedback forms. The advantage of using a database is that once all the information has been fed in you can run numerous queries and produce reports quite easily. It also gives you ready access to the information, and the possibility of comparing findings over time. But the person using the database needs to be knowledgeable and skilled in their use otherwise it may not produce the benefits you seek.

Factors to consider:

- a database needs someone with the time and skills to use it
- you need to be clear about what you want to know and have someone who can write database queries to get the answers
- it takes time to input data onto, and produce analysed information out of, a database
- a lot of databases get set up and then drift into oblivion
- to get best value from a database it needs to be resourced adequately and those resources be sustained over time! Think carefully. Can you resource it and sustain it?

The database in this pack

The database is on the CD that accompanies this pack. It is an Access 2000 database that can be used on standalone computers. We have deliberately kept it basic. However some Access 2000 experience is necessary.

- It is not protected – you can change it to suit your local needs.
- Because it is not protected you need to be careful that you don’t change anything without actually meaning to. The simplest way to avoid doing so is not to change anything in design view.
- There are guidance notes actually on the database for the person inputting data. It’s important that the person reads these before they start putting information onto the input form.
As well as a blank database ready to receive your data we have also included an example database which has some fake data already on it, plus a few example queries and an example of how a report might look. This is just so that you can see how things might look if you decide to use the database.

There are some mini-tables as well as a main data table. All of the data that is inputted will show up on the main data table. The mini tables are there simply so that you can add new items to the dropdown menus for those fields without having to go into design view. This means, for example, that you can insert the specific ethnicity headings that your organisation uses rather than sticking with the ones that are already there.

Some organisations will already be using a database to store and analyse information about people who use their services, perhaps as a register of people and their needs. We would encourage those organisations to merge the Shaping the Future Together database with their existing one to provide even richer information to inform planning.
Findings summary sheets

Using the summary sheets

Sheets to summarise your findings and plan associated action are on pages 91–97. There is a separate summary sheet for each of the seven areas of life covered by Shaping the Future Together. This makes it easier to pass specific findings through to the relevant planning groups, particularly Partnership Board working groups. It means that you can target how you use the findings.

Step 1  Summarise the key findings from Shaping the Future Together in the first column – What we found. Use plain language and make it easy to understand.

Step 2  Ask the relevant planning group to liaise with partner organisations and agree what action will be taken. For example, give the work summary sheet to the employment strategy sub-group of the Partnership Board, or the where people live sheet to the housing strategy group. If the planning group does not already include representatives of people with learning disabilities and carers, ask the group to ensure that they consult people about what action should be taken.

Step 3  Once an action plan has been agreed by all the partners you may want to report the plan to the local Partnership Board, and then monitor it through that body. Incorporate the plans into your wider strategies. For example, incorporate the plans about work into your employment strategy, the Joint Investment Plan, the workforce plan etc.

Step 4  Give individuals, departments and organisations copies of the plans so that they can see what action is going to be taken. Make sure that partner agencies have copies to remind them of any action they have agreed to take.

On the next page is an example summary sheet focusing on work, with some of the columns completed. This is followed by the seven blank proforma sheets for you to use, one for each of the seven areas covered by Shaping the Future Together.
**Shaping the Future Together**

### Findings and actions

<table>
<thead>
<tr>
<th>What we found</th>
<th>Action that learning disability services are going to take</th>
<th>Action other services/agencies are going to take</th>
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</thead>
<tbody>
<tr>
<td>6 people who use Bridgepoint day service want to get work.</td>
<td>A member of the day service staff team will be seconded to the supported employment team, but based at Bridgepoint to work with the 6 people on work-related activities.</td>
<td>The college has agreed to run a short course for the 6 people to introduce them to the world of work.</td>
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<tr>
<td>Another 8 adults want to find work but can’t get any support to get started. The supported employment scheme has a waiting list.</td>
<td>We are going to talk to Jobcentre Plus about how, between us, we can expand the Supported Employment Scheme.</td>
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<tr>
<td>Another 6 young people who are still at school want to get jobs for next September but aren’t getting support around work at the moment.</td>
<td>We will make a member of the supported employment team available to mentor/supervise school staff and families to do vocational profiles for the 6 people. We will agree with the school, Jobcentre Plus and families how people will then be supported into the jobs they want.</td>
<td>The regeneration unit will work with us to accommodate any of the 6 people who want to be included in existing work projects for young people in the construction industry.</td>
</tr>
<tr>
<td>No-one who uses a wheelchair is working or thinking about getting work. Why is this?</td>
<td>We will look at what kind of information and encouragement we are giving to people, and try to identify if there is something amiss.</td>
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Co-ordinating officer..........................................................................................................................
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Date of findings............................... Date form completed in full....................
## Findings and actions

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<th>Work</th>
<th>What we found</th>
<th>Action the learning disability services are going to take</th>
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<table>
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<tr>
<th>Learning</th>
<th>What we found</th>
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<th>Action other services/ agencies are going to take</th>
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<table>
<thead>
<tr>
<th>Leisure and fun</th>
<th>Findings and actions</th>
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<tr>
<td>What we found</td>
<td>Action the learning disability services are going to take</td>
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#### Findings and actions

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<tr>
<th>Feeling well and good about self</th>
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Date of findings

Date form completed in full
# Shaping the Future Together

## Findings and actions

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Date form completed in full
## Where and how people live

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Date of findings........................................ Date form completed in full.........................
SHAPING THE FUTURE TOGETHER

The Learning Disabilities Partnership Board would like information from you to help us plan for the things that YOU

With many thanks from
The Learning Disabilities Partnership Board

If you want to find out more or for information in other languages contact:
After Circles, Person-Centred Planning meetings and reviews, people who know you this is your chance to tell us about the things you'd like to do in the future… next year… and the year after…

2005 2006 2007 2008

2005 2006 2007 2008

The Partnership Board and managers will look at all the things that people have said they want to do. We will use the information to help people with other organisations to plan better. Lots of other people are giving this information too.

What will happen next?

Planning meetings and reviews, people who know you will be filling in a form.

After Circles, Person-Centred
Fine-tuning developments to meet needs

Why further work?

Using the *Shaping the Future Together* process will give you an overview of the changes that people want to achieve. Some of these will be everyday things that will be achieved by services working differently or using the resources they have at hand differently. Some of the changes will require new opportunities and resources to be developed for people. Getting the detailed information needed to shape those new opportunities and resources so that they are really right for people is what this further work is all about. It gives care managers a central role in co-ordinating individualised service and support profiles – detailed specifications – which then inform negotiations and detailed planning with providers and developers. It is essentially about good care management.

What kind of new opportunities and resources?

It is particularly useful to have detailed service and support specifications for individuals when you want to:

- *design or adapt buildings* so that they are right for the people who are going to live in them or use them.

  For example, some people may benefit from specific equipment or technology to increase their independence, or will require additional space to accommodate live-in support staff, or their motorised buggy, or will need particular safety features.
- *commission support services* so that they are right for the people they are going to be supporting.

For example, you may want to ensure that staff have the right skills and training to respond to the needs of the people they are going to support; or you may want to make sure that staffing meets people’s ethnic and cultural needs. You may want to make sure that support is going to be available at the times of day it is most needed, and in the right places.

- *negotiate with other community services* to ensure that they have the right facilities and support available for people.

For example, you may want to work with the local college to make sure that a computing class has the right facilities and support for the people with learning disabilities who want to take part; or you may be negotiating with the local bus operator to develop a new bus route and need to ensure that the vehicles have the right design features and that support is available for people who need it.

The more detail you have about people the easier it is to shape new services or facilities that meet their requirements.

---

*But shouldn’t we be concentrating on making things happen for each individual rather than developing block provision?*

*Yes, absolutely! We’re not talking about developing block, one-size-fits-all provision, but we are talking about planning so that, for example:*

- there are support services available when and where they are needed, with staff who have knowledge and skills that match people’s needs
- there is housing available in areas where people want to live, designed to match people’s needs
- there are college classes available covering the things people want to learn, and ongoing support so that people can participate in them
- there are enough specialist health staff available in a locality to provide the actual support that people who live there need*
existing services and staff are used in a focused and purposeful way to support people to achieve their goals, or are reorganised to provide better coverage or different opportunities.

Working with individuals to make things happen, using all the resources of the community and services to do it, goes hand in hand with strategic development. With the efforts of staff, family and friends many people achieve their goals, but there are often huge frustrations along the way because of the lack of something basic like level-access housing, or a support service with appropriate skills. Strategic planning is about reducing the chances of there being a ‘lack’ of something for people in the future.

**Fine-tuning in practice**

In one London borough individual planning highlighted that several people living in residential homes wanted to move into different accommodation and many people living with family carers were ready and waiting to leave home. There was basic information about their mobility, sensory impairments and health conditions, and about the level of support they might need. Joint planning with the local authority housing department and local housing providers led to agreement and funding to develop around 30 one-, two- and three-bedroom properties over a five-year period. As the properties began to be developed care managers were asked to draw up detailed service specifications for individuals so that the properties could be fine-tuned to fit and so that support providers could be asked to show how they would meet people’s needs – part of the process of commissioning individual support packages. A new support provider was commissioned to widen the provider base and give more choice.

**A central role for care managers**

This fine-tuning work relies upon the active involvement of care managers. It serves a number of purposes.

*Promoting person-centred care management*

Person-centred care management is promoted by care managers drawing up and agreeing detailed service and support profiles for individuals. This is at the heart of good care management, but is sadly underdeveloped and patchy across the UK.
If people are engaged in person-centred planning they may already have a detailed service and support profile as part of their person-centred plan, for example if Essential Lifestyle Planning has been used as the format. In such a situation the care manager may simply need to liaise with the PCP facilitator, talk through and agree the profile, and then act on it – as well as feeding some information through to planners. It is more likely, though, that the care manager will want to do some work with the person and their planning team to make sure that there is a comprehensive profile and that a number of options have been explored.


If, during a review, it has been identified that someone is aiming to achieve a change to their life that will require significant planning and resource input – such as moving home or changing from support provided by the family to paid support – the care manager will need to instigate person-centred planning in order to develop a detailed service and support profile. To organise and purchase a new service that is just right for someone, there needs to be a clear picture of the person’s likes, dislikes, aspirations, support needs and so on, to underpin it.

Some of these details are also needed by planners and managers to help them design, commission and negotiate new community resources and services which the care manager, the person and their team can ultimately draw on. It is important that planners and commissioners ask care managers for those details and demonstrate that developing service specifications for individuals is important and valued work.

If care managers are not themselves able to give the time needed to facilitate a plan, Valuing People guidance approves the use of paid facilitators from outside services.

Helpful person-centred planning formats for information to underpin detailed service and support profiles are:

Getting care managers engaged early on in pursuing significant life changes for individuals, with funding considered as part and parcel of planning the change

Care managers have an important role in relation to the allocation of community care funding and access to Direct Payments. Too often people have been supported by family and friends to plan for a significant life change and then had a long wait for care management involvement to see if funding will be agreed. Because the care manager has not been involved in the discussion, disputes are more likely to arise.

When someone indicates that they are anticipating a big change in their life there needs to be active planning and support to help them achieve it. Getting care managers actively engaged early on means that things won’t get left until it’s too late to plan well.

A case in point

Many older carers have struggled, and often failed, to get care management involvement so they can get help to make a plan with their son or daughter for the future. Because the person is safe and well cared for they do not get any priority for care management support. People in services know that the carer is ageing, but the system works against forward planning. Often the result is that the carer becomes incapacitated or dies and a crisis response follows.

The Shaping the Future Together system would flag up at the person’s review that a change of home or support will be required. The care manager can then be asked to develop a service and support profile with the person and their carer(s). The profile would provide essential information for the planning of housing and support in the locality, and for planning anticipated demand on the community care budget. The care manager will be engaged with the person and their carer(s) in securing the services and support they have agreed on. It’s a proactive rather than reactive approach.

Figure 6 gives an overview of how the work on individual service and support specifications by care managers fits with the work of strategic planners to make it more likely that major changes will be achieved more quickly and easily for people. Figure 7 illustrates how planning and action at different levels can work together to achieve person-centred housing and support options for people moving home.
The commissioner and Partnership Board negotiate and agree general developments with planners from –

housing  education  transport  leisure  support agencies

The commissioner ensures that the general plans are fine-tuned to better match individual service and support profiles

The care manager agrees a detailed service and support profile with a person and their family/friends

The care manager explores options to see if any match the person’s service and support profile

CHOICES

New developments coming on stream
Existing community and service options
FIGURE 7 Moving home: fine-tuning housing developments and support

**PLANNING**

Commissioners and planners from housing and learning disability services agree to develop some housing which will be made available to people with learning disabilities.

Development funding, building land (or properties for adaptation) and general plans are agreed.

The learning disability commissioner ensures local support providers and funding will be available when the housing is ready.

**DELIVERY**

Care manager agrees detailed service and support profile with person and their supporters.

The care manager explores the available options to see which best match the person’s housing and support requirements.

Care managers, or people themselves, secure housing and purchase support from a provider.
What you need to do

Prepare care managers

This work rests on the skills of care managers, and provision of adequate training and support for them cannot be emphasised enough. They need to have a very person-centred focus so that the detailed information they gather helps shape developments to be right for people. It is therefore important to ensure that care managers:

- have taken part in introductory training about person-centred planning and person-centred approaches
- have received training in how to develop a service and support profile – a detailed specification – for an individual
- know why they need to develop individual service and support specifications, and how important their role is in making the bigger things (like moving home, or getting good quality breaks away from home) happen for people
- get ongoing support to explore different options and avenues to make things happen for people, without needing to wait for big strategic developments that may need extra resources and time to materialise.

Consider how well equipped your local care managers are, and how fit your care management service is to do the task you want and need them to do, and to do it well. Invest in them so that they are prepared, equipped and able.

Some helpful papers to read about person-centred care management


Creativity in service design. S. Duffy, 2002.

All available on the Paradigm website: www.paradigm-uk.org
Finally, remember that if you want care managers to give you funding estimates based on people’s service and support specifications – so that you can negotiate resources and plan for future budget demand – they will need some information to base those estimates on: for example, average hourly rates for support which show different prices for people requiring differing levels of knowledge and skill.

**Give a lead**

Be proactive and don’t leave it to chance – *ask* care managers to draw up detailed service and support profiles for people (a ‘specification’). Ask individual workers for specific information, but give a realistic timescale for people to get the work done and the information to you. It helps if you can follow-up and give whatever support you can. Making the request in writing can help to stress the importance of the work and give it weight.

There is a sample letter on page 110, followed by a feedback form that you may wish to use to get finer details back from care managers. *We urge caution* in using the form though. Do not add to people’s administrative workloads unnecessarily. The form may help when you need specific details for a particular development, but use it with care. If you do use it, stress to care managers that the form should only be completed *after* a detailed service and support specification has been drawn up.

**Reinforce good practice**

Praise and recognition goes a long way!
Sample letter

Dear care manager

Summary feedback from person-centred planning and reviews has indicated that

Name ........................................................................................................
of (address) .........................................................................................
is aiming to ............................................................................................

You and I both need to know more about the support that s/he will need. We need to know what features are required in any buildings or venues or vehicles s/he will use (eg level access, shower facilities, loop system, lifting equipment etc), and about funding requirements.

The information is needed so that:

● **you** can specify to service providers exactly what is needed when you negotiate with them about purchasing their services for the individual

● **I** can negotiate with developers, service providers and funders to make sure that the right buildings, support and funding are likely to be available.

I would be grateful if you would:

● **draw up** a detailed profile showing what services and support the person will need in relation to their aim above, ie design their individual service with them and the people who know them well. Liaise with their PCP facilitator if they have one.

● **agree** the service and support profile and the individualised service design with the person and their planning team, and **create an action plan** with them

● **discuss** the service and support profile, the individualised service design and the action plan with your team manager

● **complete the attached form** – information for strategic planning – after discussion with your team manager. S/he needs to sign it and return it to me.

● **work with others to make the plan happen.**

Please return the attached form to me by ..............................................
Thank you ...........................................................................................

(date)

Commissioner/Planner
Information for strategic planning
based on a detailed service and support profile

Important note to care managers

1) This form should be completed after you have drawn up a detailed service and support profile for the person (a detailed ‘specification’). It asks for specific information for planning purposes – but it does not add up to a comprehensive profile, so should not be used to shape the service and support profile you compile.

For more guidance on drawing up detailed service and support specifications, you could take a look at:


2) Simply fill in the sections on the form that apply. There may be more than one section that’s relevant – for example if someone wants a new place to live they will most likely need support too, so you should complete both the *place to live* and the *support* sections.

3) There are four main questions. If you tick yes to any of these you then need to complete that section. If you tick no then go on to the next section.

4) The more accurate you are, the better we can plan so that the right resources will be available when they are needed.

Many thanks.
Information for strategic planning

based on a detailed service and support profile

For
Person’s name..................................................  Drawn up by
Address ..........................................................  Care managers’ name .....................................

Contact details................................................. .................................................................

1. Will s/he need a new place to live? □ Yes □ No

1st choice ..............................................  2nd .............................................  3rd ..............................................

When do they want to move? ..........................................................

Yes □ No

If yes, who? ........................................................................................................

How many people? ..........................................................................................

Will s/he need a bedroom for a support worker? □ Yes □ No

Does s/he want a garden? □ Yes □ No

Does s/he need a parking space right next to the property for mobility reasons? □ Yes □ No

Is s/he registered on the housing waiting list? □ Yes □ No

What particular features will s/he need the property to have (give as much detail as possible)?

.......................................................................................................................

.......................................................................................................................

.......................................................................................................................

Is any lifting or handling or sensory equipment needed? □ Yes □ No

If so, what? ........................................................................................................

.......................................................................................................................

Are any particular safety features needed? □ Yes □ No

If so, what? ........................................................................................................

.......................................................................................................................

Any there particular storage requirements? □ Yes □ No

If so, what? ........................................................................................................

.......................................................................................................................

Have you explored
– shared ownership? □ Yes □ No
– private renting? □ Yes □ No
– purchase? □ Yes □ No

Details of what happened/why: ..................................................................................

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Will funding be needed?  
☐ Yes  ☐ No
If yes, please fill in details below.

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Anything else planners should take account of?

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2. Will the buildings s/he uses (when not at home) need to have particular features?  
☐ Yes  ☐ No
What particular features will s/he need buildings to have (give as much detail as possible)?
......................................................................................................................
......................................................................................................................
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Does any lifting or handling or sensory equipment need to be available?  
☐ Yes  ☐ No
If so, what?
......................................................................................................................
......................................................................................................................

Are any particular safety features needed?  
☐ Yes  ☐ No
If so, what?
......................................................................................................................
......................................................................................................................

Any particular parking requirements?  
☐ Yes  ☐ No
If so, what?
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Will funding be needed?  
☐ Yes  ☐ No
If yes, please fill in details below.

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Anything else planners should take account of?
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3. Will s/he need support?  □ Yes □ No

**DURING THE DAY**

When will s/he need a paid supporter with them? Use arrows to indicate

<table>
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<tr>
<th>Day</th>
<th>7am</th>
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**How many hours** of support will need to be purchased each day, 7am–11pm?

- Mon ............
- Tues............
- Wed ............
- Thur............
- Fri...............  
- Sat.............
- Sun ..........

**Where** is the support needed? What locality?

.................................................................................................................................
.................................................................................................................................
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**AT NIGHT**

Will s/he need support available at night?  □ Yes □ No

Will the night supporter need to be awake all the time?  □ Yes □ No

Could the night supporter be in a nearby property (eg a flat in the same block) with a communication/sound link?  □ Yes □ No

**GENERAL**

Do the support workers need to have particular knowledge or skills?  □ Yes □ No

- What knowledge?
  .................................................................................................................................
  .................................................................................................................................

- What skills?
  .................................................................................................................................
  .................................................................................................................................

Do the support workers need particular cultural knowledge or language skills?  

- If so, what?
  .................................................................................................................................
  .................................................................................................................................
Does s/he ever need the help of 2 people?
   If so, to do what, and at what time of the day?
   ......................................................................................................................
   ......................................................................................................................
   ......................................................................................................................

Will s/he be having a Direct Payment?
Will s/he require support to manage their Direct Payment?

Will funding be needed?
If yes, please fill in details below.

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Anything else planners should take account of?

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4. Will the transport s/he uses need to have particular features?

Does it need to be able to accommodate the person sitting in a wheelchair?

Does it need to have room to store a wheelchair (ie s/he can transfer from their wheelchair to a seat)?

Does it need to have easy access because of mobility difficulties?

What other particular features will s/he need vehicles to have (give as much detail as possible)?

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Will funding be needed?
If yes, please fill in details below.

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Stories of service development in practice

Introduction

This section gives seven examples of how information from individual plans has been used to shape strategic developments around the country. We hope they will give you some ideas about how you might take things forward in your local area.

Summary

This piece, from a joint commissioner, describes how *Shaping the Future Together* has been used to inform local strategic planning and development. It gives some examples of how the pack can benefit a local area.

Using *Shaping the Future Together*

Introduction

The pack was introduced and discussed at our local person-centred planning implementation group. The approach was welcomed by the group as it supported one of the targets in our local PCP framework – to have a way of ensuring that information from individual PCPs informs strategic planning. We decided to use the approach to gather information from those people who had person-centred plans.

As commissioning manager I circulated the pack to local managers of services where it was known that people had PCPs. This was accompanied by a letter outlining the process and setting a 10-week deadline for return of the forms. A reminder letter was circulated prior to the deadline and people were also reminded through the PCP group. In all, 35 forms were returned, 10 of which were after the deadline.
During the process I agreed that one service could include information from people who did not have recognised PCPs but were known very well and there was confidence about what they wanted in their lives.

The analysis

I read through the forms to get a sense of key messages and themes and then went back through each form more thoroughly making a note of the name of the person, the key message, where they lived and the areas that people are struggling to change.

From this emerged:

- particular issues for people living at the same house. The issues are hard to resolve but are being addressed by the service provider and are being incorporated into our action plan following a recent review of Homes for Life placements in our area
- themes about the key things that people want to do. In particular, getting work, improving their leisure time (especially seeing friends at weekends, and going to the pub) and getting help with their health issues.

In the future I’d like to organise and record the information in a more systematic way so that it can be updated and expanded. We will be using a database to do this.

Using the information

The information was used to inform the employment strategy, both in terms of the quantity and quality of provision needed, and there has been follow-up with services to ensure individuals have been referred through for employment support. The information has also been used as part of a European Social Fund bid to show demand for employment services locally.

Issues around leisure have been fed through to the leisure forum that meets every two months. It has also been a workshop item at the transition liaison group and the service group so that people can share ideas of good practice and problem-solve.

How else have the findings been used?

- There has been feedback to the Partnership Board which will be followed up with a report about what has happened as a result of gathering the information.
The findings are being incorporated into contract monitoring.

Discussions have taken place with day service managers about the implications of the findings. We will use the findings when we update the Day Service Modernisation Plan.

We are using the information to back up bids for external funding, eg for employment, and to secure resources for voluntary sector organisations.

Information has been shared with the PCP co-ordinator and the PCP implementation group, particularly drawing out the findings and implications for PCP support, training and facilitation. The findings will inform our PCP framework.

We have drawn out the housing and support findings so that development implications can be addressed when we update the Learning Disability Housing Strategy.

What people said about the process

Some managers reflected that it highlighted how much they were not doing and prompted them to take action as providers. It acted as a jog.

Going through the forms with individuals made it clear what people really wanted, prompted new ideas and clarified the issues getting in the way.

It made people think about why certain things aren’t already happening, for example Direct Payments, or about why they haven’t been sorted.

It gave people an opportunity to look at why some people aren’t getting certain opportunities.

It prompted thinking about what the service could be doing better or differently.

It made people think about how we are linking with other services or opportunities, for example college.

It prompted thinking and questions about people who are not linked to services.

Using the pack in our area has given us really helpful information. It’s just a start that we now aim to build on.
**Summary**

Information is power, or so the saying goes. In the London borough of Newham detailed information about individuals and their housing requirements has helped to shape the local housing strategy. It has been an important factor in developing a stronger partnership with the local housing department and housing providers.

**Newham housing survey and strategy**

Newham undertook a housing survey to inform the development of its joint housing strategy for people with learning disabilities. The survey collected information about the housing needs of individuals by asking workers who knew people well to fill out a form about their specific needs, wishes and changing needs in the future.

Whilst we already had useful demographic information, getting information directly about individuals helped in a number of ways:

- it gave qualitative as well as quantitative information to inform our housing strategy
- it added weight to our discussions with the housing department and Supporting People team and we were able to secure a greater priority for the development of housing and support for people with learning disabilities
- it dispelled our hunch that large numbers of people living outside the borough wished to return to the area
- it gave local housing providers the confidence to pursue developments for people with learning disabilities and they linked with commissioners, occupational therapy and care management to develop specifications for housing that would meet local need.

The survey highlighted a shortfall of around 100 units of accommodation over the next 10 years, and at least 250 individuals who are likely to need a change in housing, support or adaptations. The majority of these developments and changes were likely to be needed in the first few years because of a backlog of unmet need.
We were able to secure details about the number of people who:

- require accessible accommodation
- have parents who are elderly or frail
- want to move out of the family home
- are in property no longer suited to their physical needs
- want to live in a different type of set up, eg their own flat rather than residential care
- need additional support to maintain their tenancies
- may need particularly skilled support, eg people with autism or challenging needs
- want to live alone or with others
- are approaching adulthood and may not wish to continue living with their families
- are experiencing particular pressures due to an inappropriate physical environment
- are likely to need additional support or to move into more suitable or adapted properties in the very near future.

Some of the feedback forms raised issues of concern which needed dealing with urgently. These forms were immediately pulled out and passed on to the social work team.

The survey revealed that lots of families did not know where to start in terms of planning for the future or getting help in their current situation. This prompted us to co-ordinate training and awareness sessions for family carers covering:

- how to access Disability Facilities Grants for adaptations to people’s own properties
- channels for getting help for people in local authority or housing association accommodation
- leaving a house to a family member with a learning disability
- planning for the future in terms of registering as joint tenants to avoid losing the property if the parent dies
- person-centred planning.
It also prompted discussions with the housing department about their own practices and awareness about the needs of people with learning disabilities. It had emerged that some families with a son or daughter with learning disabilities and additional physical disabilities had been offered inaccessible accommodation, or little understanding had been shown about these needs. The housing department incorporated these issues into their staff training programme. We were also able to get messages out to families about being very clear about their housing needs – a more efficient use of everyone’s time.

The findings were fed into the Joint Learning Disability Housing Strategy and the Supporting People Strategy. Housing providers responded really positively to the strategy and themselves came forward with numerous proposals for new developments and accessing new accommodation. Housing providers have accessed properties from their general needs stock and support packages have been set up to enable supported living arrangements. Other providers have registered new properties for residential care. One provider is developing a shared ownership scheme and there are developments awaiting planning permission for new flats. A KeyRing scheme has also been established in line with the numbers identified wanting community living support.

Many people seemed to be interested in a KeyRing type model and we are delighted that this is progressing. However, the original siting of the scheme was in an area where some people with learning disabilities did not want to live and where one-bed flats were not becoming available. Our close links with the housing department and our knowledge of people’s needs and wishes enabled us to quickly identify another area, which was more attractive to people with learning disabilities and where the housing department could offer us greater priority for allocation.

Providers are now clearer who to link with and we have a team that is brought together to link with providers when any new opportunities become available. The team includes the commissioning manager, an occupational therapist, a member of the social work team, the supported housing development manager and the Supporting People team (as needed).

A subsequent survey looking at the housing needs of people with physical impairments added weight to our argument that one of the bottlenecks in getting appropriate accommodation and adaptations was the lack of occupational therapists in the area. Neighbourhood Renewal Fund monies were accessed to employ an occupational therapist to assess people on the waiting list and deal with the backlog.
Housing issues are fed back regularly to the Partnership Board and sub-groups. As in most areas, the commissioner and social work team receive regular approaches from providers wanting to set up new services in the borough. The housing survey gives us a clear starting point in terms of the types of properties we need.

The main message is still to increase the choice but not to progress developments without the fine-tuning information that is needed to appropriately shape the accommodation and support that people need. We need to keep checking back to individuals. Information and specifications from care managers are vital. It’s never perfect. Providers have been responsive but people may not be ready to move when properties become available. A vacancy may arise in a place people do not want to move to. Planning permission may be delayed. But the closer the big picture of need can be linked with the individual needs the better it will be for everyone – people with learning disabilities, carers, care managers, providers, housing colleagues and commissioners.

For more information contact:

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Summary

Often organisations do not have a clean sheet for their developments and have to consider how to make best use of a unique set of existing resources, location, planning constraints, and local opportunities to better meet the wishes and needs of the equally unique people they are serving. This story illustrates how HFT (Home Farm Trust) has been making progress in re-developing two large rural residential services to fit with the aspirations people have expressed through person-centred planning.

Pursuing change

Tom and Jane moved into an HFT residential home in the south Cotswolds within a month of each other in 2001. They had both left college a short time before and came to live in a newly refurbished flat with two other people. Their friendship developed very quickly and, after a flatmate moved on in March 2002, Jane asked staff if she could move into the vacant room next to Tom’s. Their relationship flourished.

In January 2004 the staff team facilitated a PATH (a person-centred planning technique) to help Tom and Jane plan a way forward. The couple invited the most important people in their lives to help them with their planning. Jane and Tom were helped to map out what they wanted and to make a plan covering what needed to happen over the next two years. The plan included:

- finding suitable employment
- going on holiday together
- finding a house together
- getting engaged and then married.

Tom and Jane want to stay living near their current residential home which is in a village they like, and they want to be supported by staff they know. The challenge for HFT is to find a way of making that happen.

When HFT was originally set up a number of large residential homes were established on rural sites. In recent years the organisation has been concerned that this model of provision no longer matches what people want and is no longer a good fit with national policy. We have been working towards major service re-development and have found the introduction of person-centred planning to be a great help. It is not a one-size-fits-all approach – each residential service is developing differently. We have had to progress with care and respect the fact that many of the people living in
the residential homes have been there for a number of years, and many are now old age pensioners. A lot of their families had believed their relative to be settled for life in their current home. We have also had to think carefully about how best to use our resources – the buildings and land we own, and the staff we employ – to secure the lives that people want and the support they need. Developments at two of our services in the Cotswolds show the type of changes that we are implementing in our efforts to create more person-centred provision.

Old Quarries is in a village with a thriving community where a lot of the people we support are well-known and quite well-integrated. There are a lot of local amenities, and people have very comfortable lives. We also support people in a number of bedsits in the local town and, as vacancies have arisen, people at Old Quarries have had the opportunity to move on, but not many have actually done it. In the mid 1990s, before person-centred planning, a decision was made to redevelop the large country house into 6 flats and a bedsit, and to develop three other properties on the site. This was achieved in 1999. In all 31 people are supported by the service. Alongside the re-development of the accommodation we also reorganised staffing so that each flat has its own separate staff team, rather than staff working across the service as a whole. We were starting to become more person-centred, but it’s only really since the introduction of person-centred planning that we have heard more about what each individual wants and about the support they need. As a result we have since redeveloped one man’s flat to create a new, separate front door because he wanted to be more independent, and we have de-registered the accommodation. We have also de-registered a flat that two women share because they, too, wanted to be in charge of their own home. Tom and Jane, whose story is shared on the previous page, want to stay in the village, but there are tight planning controls because it’s in the Cotswolds, and Tom needs purpose-designed accessible accommodation. Because HFT owns property and land we are trying to make best use of it to meet Tom and Jane’s requirements. The downstairs of one of the separate properties will be converted and re-designed specifically for them, pending planning permission. If planning permission is not granted we will actively seek suitable housing elsewhere in the local area.

If person-centred planning had been up and running before the major re-developments at Old Quarries in 1999 we may well have done things differently, but we can only start from where we are and try to ensure that developments from now on are rooted in the lives that people really want.
Development of HFT services in Frocester – again a large country house and grounds but in a small village with few amenities – has been shaped more centrally by what people have said through person-centred planning. The main building is in a poor state of repair and we have had to take that into account. A key question was whether we should invest large amounts of money in refurbishing the building. Would it provide accommodation that people wanted? Person-centred plans were telling us that several people wanted to live nearer shops and other facilities rather than in a small village. The plan that we are now pursuing is to sell the manor house but to keep part of the land and build some new accommodation for the people who want to stay living in the village. We will work with other housing associations and/or purchase property to secure accommodation for the people who want to move away from the village. Person-centred planning means we can be much more certain about what people want and the support they need, and design our services with that at the forefront.

For more information contact:

Lynn Kellerman, HFT
Tel: 01452 526054
Email: lynn.kellerman@hft.org.uk
Summary

You do not always have to go it alone. This story demonstrates that local areas often face the same service shortfalls and development issues, and how, by joining forces, real progress can be made.

Working partnerships

The neighbouring London boroughs of Westminster and Kensington & Chelsea had each received considerable feedback from people with learning disabilities who wanted to get a paid job, try a work placement or volunteering, or learn more about the world of work so that they could make informed choices. People’s individual reviews and person-centred plans, as well as whole service reviews, were flagging up that a shortage of employment opportunities and related services was especially an issue for people with higher support needs. As a result the employment strategies in both boroughs had identified people with higher support needs as a priority area for service development.

There was already a network of supported employment services, day services and adult education classes in each borough supporting people around employment. People with higher support needs were, however, finding that these did not meet their needs. A significant issue was that services were not providing the levels of support that people needed to participate in work-related activities.

A joint funding bid was made to the Learning and Skills Council (LSC) for a project across the two boroughs. £48,000 was awarded for one year initially, to fund support and transport costs for 10 people. The project involves six partners – from day and employment services, and adult and further education – all committed to increasing access to employment for people with learning disabilities who have higher support needs. The LSC funding enables these services to stretch their own delivery and to find ways of ensuring support follows people across different organisations. This has been one of the key benefits of the project – we can pay for the support that people need, wherever that may be.

The two supported employment services involved have a key role in working with individuals to identify their preferences and to try to match these to a work placement. They also identify learning needs and feed them through to the colleges involved, who then design individual and group
learning to support people. The day services contribute staff with the skills to meet the complex support needs of the people using the project’s services.

The project is steered by a group which has representatives from both boroughs, ensuring that benefits are shared by people with learning disabilities from across the boroughs. The project does not have a specific, paid co-ordinator and, on reflection, it would probably benefit from one – particularly given the amount of monitoring and reporting back that is required in relation to the funding streams.

Most people have been referred through local day services. The introduction of person-centred planning in each borough has helped to identify people who may be interested in employment, and to detail the support that each would need. Each person is then helped, through the project, to develop an individual employment plan based on person-centred approaches. The result so far is that people have had more adult education opportunities and have been supported to try out some work placements, for example in catering and office environments. Everyone is learning through the experience. We have high hopes that people can be supported into an even wider range of employment settings in the future.

For more information contact:

Pru Neilson, Day Services Manager, Westminster
Tel: 020 7641 1501
Email: pneilson@westminster.gov.uk

Or

Simon Groves, Joint Provisions Manager,
Royal Borough of Kensington & Chelsea
Tel: 020 7361 2677
Email: simon.groves@rbkc.gov.uk
Summary

A small number of people can be identified in most local areas who really do need ‘something different’: there is a general feeling that they urgently need a better life. This story shows how it can help to focus developments around those people and then, having learnt from that experience, widen the opportunities and new approaches out to others. A version of this story first appeared on the Valuing People website.

Housing developments at IAS in Salford and Wigan

Introduction

IAS (Independent Advocacy and Support) is an independent service providing supported accommodation for adults with learning disabilities in Greater Manchester. Some people in IAS group homes were showing that they weren’t happy about who they lived with and how they were supported, and some wanted to live more independently, alone or with friends. Some could only tell people they were unhappy by upsetting themselves or those around them. The homes were registered residential care homes, so people had very limited choice or control over their lives and only £17 a week to spend as they chose. Local care managers were often stretched and busy dealing with crises; when they did plan with people for moving on there wasn’t enough alternative housing to make it happen.

Valuing People says people should have more choice and control. IAS and social services locally believe that people use extreme ways to say what they want if they’re not being listened to, so we set out to listen to how people in the group homes wanted to live and then to work together to help them achieve it. By working with the money that was already being spent and using it differently it’s been possible to help people move from residential care and group homes to supported living.

What happened

A steering group began to meet regularly and agreed that people needed more choice of accommodation and support and that tenancies would give people more control. The group identified five or six people where things really weren’t right and decided to start with them. Having learnt from that experience they would then move on to help more people.
Person-centred planning groups started meeting for each of these individuals. They spent time listening to what the person wanted and then working out possible ways of making it happen. It became clear that person-centred planning needs passion, creativity and perseverance! Having heard back from the person-centred planning groups about the kind of living arrangements each person wanted, the steering group made plans and strategic changes to secure the housing and support they needed. Each person with a learning disability had their own action plan so that everyone was clear about who would do what and how.

IAS owned all the group homes, but to move from residential care to supported living meant finding housing partners so that housing and support could be separate. IAS wanted to work with other housing associations and met with several to discuss possibilities. New partnerships were forged.

Money to pay for people’s support was reorganised and staffing hours were reallocated between more houses. Staff management, support and development was changed to focus around supporting individuals in their own homes. Staff have been helped to work out how best to support each person, and how they can measure success.

Eventually, the IAS group homes in the Salford area were de-registered (people in Wigan already had supported tenancies) which gave people more control over their money. Some of the houses were left with no tenants as people moved on to other properties that better matched their personal wishes. Wigan needed more housing for people still living in hospital so two of the houses are now being refurbished for people leaving hospital who need a lot of support.

What helped?

An overall implementation strategy was important and project management helped to make sure that all the pieces of the jigsaw fitted together and progress was monitored and celebrated. We found that some people had low expectations of people with learning disabilities and were anxious about moves to more independent living. But people have shown that they can do it. As people have watched their friends’ lives changing they have seen that their lives can also change, and staff have become enthusiastic advocates for change too. People with learning disabilities have challenged people’s ‘we know best’ attitudes. It’s important to have an open mind.
Possible partners and allies often need lots of reassurance which tests your own beliefs and ability. We were committed to a partnership approach and to giving the time needed to convince organisations to come on board. The local commissioners helped to shape developments by decommissioning and recommissioning services.

Setbacks in the early stages were frustrating and difficult but a determination to carry on and look creatively and imaginatively for solutions meant everyone became more competent and confident. We had to stay strong and focused. Reorganising people’s time and resources is much harder work than simply making wish lists. And arranging housing and support for people is a job that never finishes because people change and grow and want new and different things.

The result of changing people’s living and support arrangements can be measured by looking at how this has affected them. Performance targets or indicators don’t always see that people can be happier and healthier living where and how they want. Our local changes have shown how important it is to listen to people with learning disabilities when they say they want ordinary things like a home that’s really home and a choice of who supports them.

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Summary

Direct Payments can influence service development through people’s combined purchasing power and the choices they make. High take-up of Direct Payments presents an opportunity to see which services people choose to purchase: it can help to shape commissioning decisions. In Essex, as this account shows, a great deal of work has gone into developing the Direct Payments scheme in ways which promote and support high take-up. A version of this story first appeared on the Valuing People website.

Direct Payments in Essex

In 1997, 60 people in Essex were getting ‘indirect’ payments from the council to buy their own care services, but this included only one person with a learning disability and that person did not actually control the money. Essex County Council wanted more people with learning disabilities to use Direct Payments, including people who need a lot of help and support. It set about changing the way that people could get support to take-up and use Direct Payments in partnership with groups, managed by disabled people, who were already planning how to develop independent advice, support and advocacy so that people could have more choice and control.

How it works now

Independent Living Advocacy Essex (ILAE) and the Personal Assistant Support Service (PASS) help people to apply for and use Direct Payments. Both organisations work in partnership with Essex Council which gives them funding. If someone is interested in Direct Payments ILAE gives them information about how the payments work. They help the person think about what it might be like to buy their own services and about who could support them to apply for a Direct Payment and to employ their own personal assistants. The person may already have a circle of support or they might want to start a circle or network of friends and family. ILAE also advises about job descriptions and recruitment of personal assistants.

Following a Community Care Assessment and the setting up of a Direct Payment, PASS gives people ongoing support to manage it. PASS can hold the money on someone’s behalf and also has a payroll scheme to organise payment to people’s personal assistants. The Council needs a quarterly report from each person showing how they have been using their Direct Payment and PASS will either write this for them or will show them how
to do it. PASS provides training for personal assistants and Direct Payment users that focuses on empowering disabled people, independent living and the social model of disability. The training highlights the difference between a ‘carer’ and a ‘personal assistant’, helping people to have more control over how they are supported. People with learning disabilities can find it hard to direct their own support if they’ve been used to being told what to do by other people who have made choices for them. The personal assistant training helps workers learn how to encourage people to make their own decisions and choices.

People with learning disabilities may initially find it hard to understand what it’s really like to use Direct Payments. Essex uses lots of different ways to help them, for example role plays. Someone can also have an individual support worker for a short time to see what it might be like to have their own personal assistant.

A circle or network of friends and family who really know the person and can communicate well with them helps the Direct Payment user tell other people what they want. The person must be in control and central to all decision-making with as much support as they require. In the past people with learning disabilities were refused Direct Payments because other people said they could not really choose whether they wanted them, particularly if they did not speak. Now it is agreed that someone’s facial expression or behaviour can be taken as a real sign of what they want. Circles of support or informal networks can make a very big difference to how successfully someone uses Direct Payments.

Use of Direct Payments can be more limiting than using services if no-one monitors their impact. Essex has found that it’s important to get regular feedback about the relationship between the person and their personal assistant to see how it’s going. People’s circles or networks also need to keep an eye on how things are working out. There is a Direct Payments Users Network where people meet to talk about their experiences. The network helps the council improve the scheme by telling them what works well and what needs to improve. People wanting to find out about Direct Payments also contact this group.

What have we learnt?

Here are just three of the many things we have learnt.

Support for people using Direct Payments will work well if it’s flexible and responsive, and if it keeps the person with learning disabilities at the centre,
particularly when they are being supported to make decisions about their care. People using Direct Payments need to be able to choose to organise support in ways which personally suit them, and it’s important to recruit personal assistants who are willing to learn new ways of working and have signed up to empowering the person they are assisting.

Because Direct Payments are linked to a person’s Community Care Assessment it is crucial to train care managers so that they understand how to help people access and manage a Direct Payment. Care managers need information about Direct Payments which is easy to understand, not too long, and can be used on a regular basis. Essex now offers training to care managers to help them understand more about Direct Payments.

A lot of people who could benefit from Direct Payments still don’t know about them, so it’s important to spread the word around and keep doing it. In Essex the Direct Payment Users Network helps new users learn from people who already have experience of the scheme. People find they often share the same problems and can solve them together. Having such a network can really help to empower people.

The proof of the pudding...

About 100 people with learning disabilities now get money from Essex County Council to buy their own services. The key to successful Direct Payments is good planning and robust support. Developing this can take time: it’s better to be patient and succeed than rush and fail. Staff sometimes worry that Direct Payments are too risky and difficult, but as more people have successfully used them in Essex staff have seen the positive difference it makes to people’s lives. We hope Direct Payments will make a positive difference to even more people’s lives in the future.

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Summary

New Avenues currently offers a day opportunities service to a number of adults with learning disabilities living in east London. It is run by Heritage Care, a not-for-profit organisation. People using New Avenues live in properties that are also supported by Heritage Care staff. This story of day service modernisation shows how information about people’s preferences and aspirations shaped an initial reorganisation, but person-centred planning has since fed into more re-shaping and fine-tuning of the service. New Avenues has entered a period of ‘ongoing’ improvement and development in pursuit of person-centredness. They are actively working at it.

Modernising day opportunities in east London

Summary

New Avenues has been running for 15 years and was originally set up as part of the resettlement of people from long stay institutions. In the past New Avenues has had changes of name, staffing structure and location but in light of the changes in social policy and practice, culminating in Valuing People, we felt that we needed to systematically review the service that we offered.

A steering group was set up and met monthly. The make-up of this group has been fundamental to the process – having some senior people in the organisation involved has meant that things have happened and not just been talked about, and also that staff and users felt listened to and that the service was important and valued.

The initial review looked at how the service operated and what people were getting from it. A single tool was used – an individual activity assessment – to find out what people were doing when using the service, what they were interested in doing, when and how often they wanted to do things, and where and how. People were given a lot of different options to consider: we judged that if we simply asked people what they would like to do they would be likely to tell us the things they are already doing. We wanted to open up more choices. Where people had difficulties speaking up we involved their keyworker from home to try to get a bigger picture.

These activity assessments gave us a snapshot, but we backed them up by bringing in an independent consultant to undertake a user consultation. This took a broader approach, and used a lot of pictures, symbols and photos to
help with communication and understanding. One of the most important messages that came from the consultation was that people liked coming to the New Avenues service because they had friends there.

We also looked at the staffing structure, funding streams, what we offered, how and why, as well as national and local policy. We consulted with all key internal and external people, and we carried out literature reviews.

All of the information gathered fed into and shaped our initial redesign of the service. We decided to continue offering group sessions because there were some activities that several people wanted to do, but we also developed a new service offering support to individuals on a one-to-one basis to build interests, links and social networks within their local community.

Once we had a clear idea of what we needed to offer we looked at how to make it happen. We changed the staffing structure to make it more team focused. We created two new team leader posts, one for group workers and one for community builders. This has enabled me, as co-ordinator, to focus more on the overall direction of the service rather than needing to be involved in every decision.

We launched the new service but very soon the ‘change’ became a ‘process’ of continual development. People tried doing things and then changed their minds, people saw others doing things and then wanted to do them. We also had to adapt plans and ideas as we tried things that we thought would work but in reality didn’t. The costings and budget had to be reset many times.

New Avenues has traditionally been focused around a building – the centre. This started to change. One of our successes has been that groups we offer have become more focused: they were designed on the basis of the activity assessments and therefore people are doing what they are interested in rather than simply ‘going to the centre’. Staff also found this more rewarding as they found that they were achieving things and enabling people to do what they wanted rather than running sessions because they had always been run.

Community building has also been a great success. Individuals are getting to know their local communities and becoming part of them. The staff were ‘zoned’ to areas so that they only work with individuals in one locality. This has meant that they have got to know the local community and the facilities it offers. People have got to know the users and staff as they walk around or go to the local pub or club.
We now have a principle that we don’t offer anything at the New Avenues building that people could get elsewhere. We are using the building less and less and are aiming to stop using it completely. Staff now have to hire rooms in the building if they want to use them. We are aiming to maximise resources for each individual by using the money currently spent on the building on direct support so that people can do what they want, when they want to. We have also drawn the staff who support people in their homes into the developments. House managers are now developing person-centred plans (‘my life’ plans) with each person which include details about what they want to do, when, and what support they need to achieve it. Every plan has to include activities that help people to develop and strengthen their friendships – they have to show what the person will be doing to maintain their friendships. The service is becoming more based from home, with people going out directly from home to do things. Each home is getting its own worker to help achieve this.

I am often asked why we didn’t get it right initially. Why are we changing things again? I answer that we did get it right, we listened to people who use the service and we are still listening. Change is a process. It was hard adjusting to new roles and responsibilities and adapting how we worked. It is just as hard to keep making improvements. However, we are working to support individuals to achieve what they want, not what we want, and that’s never easy – but it is our job.

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References


Resources

Websites for general information related to service development, commissioning and management

CareData – more than 70,000 summaries of books, central and local government reports, research papers, publications by voluntary organisations, and articles from a wide range of journals: www.elsc.org.uk/caredata/caredata.htm

eLSC (electronic Library for Social Care), a free online resource owned and managed by the Social Care Institute for Excellence (SCIE) www.elsc.org.uk

Improvement & Development Agency: www.idea-knowledge.gov.uk

Joseph Rowntree Foundation (JRF): www.jrf.org.uk

JRF Findings Reports from research and innovative projects: www.jrf.org.uk/knowledge/findings/


Social Care Institute for Excellence: www.scie.org.uk

Websites for specific information about developing better opportunities and support for people with learning disabilities

British Institute of Learning Disabilities (BILD): www.bild.org.uk

Foundation for People with Learning Disabilities (FPLD): www.fpld.org.uk

Inclusion Press publications: www.inclusiononline.co.uk

Institute for Health Research at Lancaster University – learning disability stream: www.lancs.ac.uk/fss/hr/research/learning/research.htm

National Development Team (NDT): www.ndt.org.uk

National Electronic Library for Learning Disabilities (neLLD), part of the National Electronic Library for Health: http://libraries.nelh.nhs.uk/learningdisabilities/

Norah Fry Research Centre: www.brис.ac.uk/Depts/NorahFry

North West Training & Development Team (NWTD): www.nwtdt.com
Paradigm consultancy – very extensive range of information and links into other useful websites: www.paradigm-uk.org
Partners in Policymaking: www.circlesnetwork.org.uk/partners_in_policymaking.htm and www.shstrust.org.uk
Valuing People Support Team (VPST): www.valuingpeople.gov.uk

Tools and guides to aid commissioning


Developing new capital provision (about PFI). Factsheet available on www.valuingpeople.gov.uk


Take into account. John Belcher, Claire Smart and Martin Willis. In Community Care 2003, March 6, pp44–45. (Looks at the skills involved in commissioning, and provides tips).


Guidance and tools for developing specific services


The Quality Network. Information from www.bild.org.uk/tqm


Information on person-centred planning

See websites for:

Helen Sanderson Associates: www.helensandersonassociates.co.uk

Inclusion Press: www.inclusiononline.co.uk

Paradigm: www.paradigm-uk.org


Publications by Beth Mount: www.capacityworks.com/

The Learning community for Essential Lifestyle Planning: www.elpnet.net/

Valuing People Support Team (VPST): www.valuingpeople.gov.uk


To stimulate thought and ideas


*REAL organisational support for evidence based practice action pack.* (Guidance on how to develop an evidence-informed approach to practice at all levels of an organisation, whilst recognising the practical difficulties that may stand in the way). Available at [www.rip.org.uk](http://www.rip.org.uk)


Stories of service development in practice

Introduction

This section gives seven examples of how information from individual plans has been used to shape strategic developments around the country. We hope they will give you some ideas about how you might take things forward in your local area.

Summary

This piece, from a joint commissioner, describes how *Shaping the Future Together* has been used to inform local strategic planning and development. It gives some examples of how the pack can benefit a local area.

Using *Shaping the Future Together*

Introduction

The pack was introduced and discussed at our local person-centred planning implementation group. The approach was welcomed by the group as it supported one of the targets in our local PCP framework – to have a way of ensuring that information from individual PCPs informs strategic planning. We decided to use the approach to gather information from those people who had person-centred plans.

As commissioning manager I circulated the pack to local managers of services where it was known that people had PCPs. This was accompanied by a letter outlining the process and setting a 10-week deadline for return of the forms. A reminder letter was circulated prior to the deadline and people were also reminded through the PCP group. In all, 35 forms were returned, 10 of which were after the deadline.
During the process I agreed that one service could include information from people who did not have recognised PCPs but were known very well and there was confidence about what they wanted in their lives.

The analysis

I read through the forms to get a sense of key messages and themes and then went back through each form more thoroughly making a note of the name of the person, the key message, where they lived and the areas that people are struggling to change.

From this emerged:

- particular issues for people living at the same house. The issues are hard to resolve but are being addressed by the service provider and are being incorporated into our action plan following a recent review of Homes for Life placements in our area

- themes about the key things that people want to do. In particular, getting work, improving their leisure time (especially seeing friends at weekends, and going to the pub) and getting help with their health issues.

In the future I’d like to organise and record the information in a more systematic way so that it can be updated and expanded. We will be using a database to do this.

Using the information

The information was used to inform the employment strategy, both in terms of the quantity and quality of provision needed, and there has been follow-up with services to ensure individuals have been referred through for employment support. The information has also been used as part of a European Social Fund bid to show demand for employment services locally.

Issues around leisure have been fed through to the leisure forum that meets every two months. It has also been a workshop item at the transition liaison group and the service group so that people can share ideas of good practice and problem-solve.

How else have the findings been used?

- There has been feedback to the Partnership Board which will be followed up with a report about what has happened as a result of gathering the information.
- The findings are being incorporated into contract monitoring.
- Discussions have taken place with day service managers about the implications of the findings. We will use the findings when we update the Day Service Modernisation Plan.
- We are using the information to back up bids for external funding, eg for employment, and to secure resources for voluntary sector organisations.
- Information has been shared with the PCP co-ordinator and the PCP implementation group, particularly drawing out the findings and implications for PCP support, training and facilitation. The findings will inform our PCP framework.
- We have drawn out the housing and support findings so that development implications can be addressed when we update the Learning Disability Housing Strategy.

**What people said about the process**

- Some managers reflected that it highlighted how much they were not doing and prompted them to take action as providers. It acted as a jog.
- Going through the forms with individuals made it clear what people really wanted, prompted new ideas and clarified the issues getting in the way.
- It made people think about why certain things aren’t already happening, for example Direct Payments, or about why they haven’t been sorted.
- It gave people an opportunity to look at why some people aren’t getting certain opportunities.
- It prompted thinking about what the service could be doing better or differently.
- It made people think about how we are linking with other services or opportunities, for example college.
- It prompted thinking and questions about people who are not linked to services.

*Using the pack in our area has given us really helpful information. It’s just a start that we now aim to build on.*
**Summary**

Information is power, or so the saying goes. In the London borough of Newham detailed information about individuals and their housing requirements has helped to shape the local housing strategy. It has been an important factor in developing a stronger partnership with the local housing department and housing providers.

**Newham housing survey and strategy**

Newham undertook a housing survey to inform the development of its joint housing strategy for people with learning disabilities. The survey collected information about the housing needs of individuals by asking workers who knew people well to fill out a form about their specific needs, wishes and changing needs in the future.

Whilst we already had useful demographic information, getting information directly about individuals helped in a number of ways:

- it gave qualitative as well as quantitative information to inform our housing strategy
- it added weight to our discussions with the housing department and Supporting People team and we were able to secure a greater priority for the development of housing and support for people with learning disabilities
- it dispelled our hunch that large numbers of people living outside the borough wished to return to the area
- it gave local housing providers the confidence to pursue developments for people with learning disabilities and they linked with commissioners, occupational therapy and care management to develop specifications for housing that would meet local need.

The survey highlighted a shortfall of around 100 units of accommodation over the next 10 years, and at least 250 individuals who are likely to need a change in housing, support or adaptations. The majority of these developments and changes were likely to be needed in the first few years because of a backlog of unmet need.
We were able to secure details about the number of people who:

- require accessible accommodation
- have parents who are elderly or frail
- want to move out of the family home
- are in property no longer suited to their physical needs
- want to live in a different type of set up, eg their own flat rather than residential care
- need additional support to maintain their tenancies
- may need particularly skilled support, eg people with autism or challenging needs
- want to live alone or with others
- are approaching adulthood and may not wish to continue living with their families
- are experiencing particular pressures due to an inappropriate physical environment
- are likely to need additional support or to move into more suitable or adapted properties in the very near future.

Some of the feedback forms raised issues of concern which needed dealing with urgently. These forms were immediately pulled out and passed on to the social work team.

The survey revealed that lots of families did not know where to start in terms of planning for the future or getting help in their current situation. This prompted us to co-ordinate training and awareness sessions for family carers covering:

- how to access Disability Facilities Grants for adaptations to people’s own properties
- channels for getting help for people in local authority or housing association accommodation
- leaving a house to a family member with a learning disability
- planning for the future in terms of registering as joint tenants to avoid losing the property if the parent dies
- person-centred planning.
It also prompted discussions with the housing department about their own practices and awareness about the needs of people with learning disabilities. It had emerged that some families with a son or daughter with learning disabilities and additional physical disabilities had been offered inaccessible accommodation, or little understanding had been shown about these needs. The housing department incorporated these issues into their staff training programme. We were also able to get messages out to families about being very clear about their housing needs – a more efficient use of everyone’s time.

The findings were fed into the Joint Learning Disability Housing Strategy and the Supporting People Strategy. Housing providers responded really positively to the strategy and themselves came forward with numerous proposals for new developments and accessing new accommodation. Housing providers have accessed properties from their general needs stock and support packages have been set up to enable supported living arrangements. Other providers have registered new properties for residential care. One provider is developing a shared ownership scheme and there are developments awaiting planning permission for new flats. A KeyRing scheme has also been established in line with the numbers identified wanting community living support.

Many people seemed to be interested in a KeyRing type model and we are delighted that this is progressing. However, the original siting of the scheme was in an area where some people with learning disabilities did not want to live and where one-bed flats were not becoming available. Our close links with the housing department and our knowledge of people’s needs and wishes enabled us to quickly identify another area, which was more attractive to people with learning disabilities and where the housing department could offer us greater priority for allocation.

Providers are now clearer who to link with and we have a team that is brought together to link with providers when any new opportunities become available. The team includes the commissioning manager, an occupational therapist, a member of the social work team, the supported housing development manager and the Supporting People team (as needed).

A subsequent survey looking at the housing needs of people with physical impairments added weight to our argument that one of the bottlenecks in getting appropriate accommodation and adaptations was the lack of occupational therapists in the area. Neighbourhood Renewal Fund monies were accessed to employ an occupational therapist to assess people on the waiting list and deal with the backlog.
Housing issues are fed back regularly to the Partnership Board and sub-groups. As in most areas, the commissioner and social work team receive regular approaches from providers wanting to set up new services in the borough. The housing survey gives us a clear starting point in terms of the types of properties we need.

The main message is still to increase the choice but not to progress developments without the fine-tuning information that is needed to appropriately shape the accommodation and support that people need. We need to keep checking back to individuals. Information and specifications from care managers are vital. It’s never perfect. Providers have been responsive but people may not be ready to move when properties become available. A vacancy may arise in a place people do not want to move to. Planning permission may be delayed. But the closer the big picture of need can be linked with the individual needs the better it will be for everyone – people with learning disabilities, carers, care managers, providers, housing colleagues and commissioners.

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Summary

Often organisations do not have a clean sheet for their developments and have to consider how to make best use of a unique set of existing resources, location, planning constraints, and local opportunities to better meet the wishes and needs of the equally unique people they are serving. This story illustrates how HFT (Home Farm Trust) has been making progress in re-developing two large rural residential services to fit with the aspirations people have expressed through person-centred planning.

Pursuing change

Tom and Jane moved into an HFT residential home in the south Cotswolds within a month of each other in 2001. They had both left college a short time before and came to live in a newly refurbished flat with two other people. Their friendship developed very quickly and, after a flatmate moved on in March 2002, Jane asked staff if she could move into the vacant room next to Tom’s. Their relationship flourished.

In January 2004 the staff team facilitated a PATH (a person-centred planning technique) to help Tom and Jane plan a way forward. The couple invited the most important people in their lives to help them with their planning. Jane and Tom were helped to map out what they wanted and to make a plan covering what needed to happen over the next two years. The plan included:

- finding suitable employment
- going on holiday together
- finding a house together
- getting engaged and then married.

Tom and Jane want to stay living near their current residential home which is in a village they like, and they want to be supported by staff they know. The challenge for HFT is to find a way of making that happen.

When HFT was originally set up a number of large residential homes were established on rural sites. In recent years the organisation has been concerned that this model of provision no longer matches what people want and is no longer a good fit with national policy. We have been working towards major service re-development and have found the introduction of person-centred planning to be a great help. It is not a one-size-fits-all approach – each residential service is developing differently. We have had to progress with care and respect the fact that many of the people living in
the residential homes have been there for a number of years, and many are now old age pensioners. A lot of their families had believed their relative to be settled for life in their current home. We have also had to think carefully about how best to use our resources – the buildings and land we own, and the staff we employ – to secure the lives that people want and the support they need. Developments at two of our services in the Cotswolds show the type of changes that we are implementing in our efforts to create more person-centred provision.

Old Quarries is in a village with a thriving community where a lot of the people we support are well-known and quite well-integrated. There are a lot of local amenities, and people have very comfortable lives. We also support people in a number of bedsits in the local town and, as vacancies have arisen, people at Old Quarries have had the opportunity to move on, but not many have actually done it. In the mid 1990s, before person-centred planning, a decision was made to redevelop the large country house into 6 flats and a bedsit, and to develop three other properties on the site. This was achieved in 1999. In all 31 people are supported by the service. Alongside the re-development of the accommodation we also reorganised staffing so that each flat has its own separate staff team, rather than staff working across the service as a whole. We were starting to become more person-centred, but it’s only really since the introduction of person-centred planning that we have heard more about what each individual wants and about the support they need. As a result we have since redeveloped one man’s flat to create a new, separate front door because he wanted to be more independent, and we have de-registered the accommodation. We have also de-registered a flat that two women share because they, too, wanted to be in charge of their own home. Tom and Jane, whose story is shared on the previous page, want to stay in the village, but there are tight planning controls because it’s in the Cotswolds, and Tom needs purpose-designed accessible accommodation. Because HFT owns property and land we are trying to make best use of it to meet Tom and Jane’s requirements. The downstairs of one of the separate properties will be converted and re-designed specifically for them, pending planning permission. If planning permission is not granted we will actively seek suitable housing elsewhere in the local area.

If person-centred planning had been up and running before the major re-developments at Old Quarries in 1999 we may well have done things differently, but we can only start from where we are and try to ensure that developments from now on are rooted in the lives that people really want.
Development of HFT services in Frocester – again a large country house and grounds but in a small village with few amenities – has been shaped more centrally by what people have said through person-centred planning. The main building is in a poor state of repair and we have had to take that into account. A key question was whether we should invest large amounts of money in refurbishing the building. Would it provide accommodation that people wanted? Person-centred plans were telling us that several people wanted to live nearer shops and other facilities rather than in a small village. The plan that we are now pursuing is to sell the manor house but to keep part of the land and build some new accommodation for the people who want to stay living in the village. We will work with other housing associations and/or purchase property to secure accommodation for the people who want to move away from the village. Person-centred planning means we can be much more certain about what people want and the support they need, and design our services with that at the forefront.

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Summary
You do not always have to go it alone. This story demonstrates that local areas often face the same service shortfalls and development issues, and how, by joining forces, real progress can be made.

Working partnerships

The neighbouring London boroughs of Westminster and Kensington & Chelsea had each received considerable feedback from people with learning disabilities who wanted to get a paid job, try a work placement or volunteering, or learn more about the world of work so that they could make informed choices. People’s individual reviews and person-centred plans, as well as whole service reviews, were flagging up that a shortage of employment opportunities and related services was especially an issue for people with higher support needs. As a result the employment strategies in both boroughs had identified people with higher support needs as a priority area for service development.

There was already a network of supported employment services, day services and adult education classes in each borough supporting people around employment. People with higher support needs were, however, finding that these did not meet their needs. A significant issue was that services were not providing the levels of support that people needed to participate in work-related activities.

A joint funding bid was made to the Learning and Skills Council (LSC) for a project across the two boroughs. £48,000 was awarded for one year initially, to fund support and transport costs for 10 people. The project involves six partners – from day and employment services, and adult and further education – all committed to increasing access to employment for people with learning disabilities who have higher support needs. The LSC funding enables these services to stretch their own delivery and to find ways of ensuring support follows people across different organisations. This has been one of the key benefits of the project – we can pay for the support that people need, wherever that may be.

The two supported employment services involved have a key role in working with individuals to identify their preferences and to try to match these to a work placement. They also identify learning needs and feed them through to the colleges involved, who then design individual and group
learning to support people. The day services contribute staff with the skills to meet the complex support needs of the people using the project’s services.

The project is steered by a group which has representatives from both boroughs, ensuring that benefits are shared by people with learning disabilities from across the boroughs. The project does not have a specific, paid co-ordinator and, on reflection, it would probably benefit from one – particularly given the amount of monitoring and reporting back that is required in relation to the funding streams.

Most people have been referred through local day services. The introduction of person-centred planning in each borough has helped to identify people who may be interested in employment, and to detail the support that each would need. Each person is then helped, through the project, to develop an individual employment plan based on person-centred approaches. The result so far is that people have had more adult education opportunities and have been supported to try out some work placements, for example in catering and office environments. Everyone is learning through the experience. We have high hopes that people can be supported into an even wider range of employment settings in the future.

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Summary

A small number of people can be identified in most local areas who really do need ‘something different’: there is a general feeling that they urgently need a better life. This story shows how it can help to focus developments around those people and then, having learnt from that experience, widen the opportunities and new approaches out to others. A version of this story first appeared on the Valuing People website.

Housing developments at IAS in Salford and Wigan

Introduction

IAS (Independent Advocacy and Support) is an independent service providing supported accommodation for adults with learning disabilities in Greater Manchester. Some people in IAS group homes were showing that they weren’t happy about who they lived with and how they were supported, and some wanted to live more independently, alone or with friends. Some could only tell people they were unhappy by upsetting themselves or those around them. The homes were registered residential care homes, so people had very limited choice or control over their lives and only £17 a week to spend as they chose. Local care managers were often stretched and busy dealing with crises; when they did plan with people for moving on there wasn’t enough alternative housing to make it happen.

Valuing People says people should have more choice and control. IAS and social services locally believe that people use extreme ways to say what they want if they’re not being listened to, so we set out to listen to how people in the group homes wanted to live and then to work together to help them achieve it. By working with the money that was already being spent and using it differently it’s been possible to help people move from residential care and group homes to supported living.

What happened

A steering group began to meet regularly and agreed that people needed more choice of accommodation and support and that tenancies would give people more control. The group identified five or six people where things really weren’t right and decided to start with them. Having learnt from that experience they would then move on to help more people.
Person-centred planning groups started meeting for each of these individuals. They spent time listening to what the person wanted and then working out possible ways of making it happen. It became clear that person-centred planning needs passion, creativity and perseverance! Having heard back from the person-centred planning groups about the kind of living arrangements each person wanted, the steering group made plans and strategic changes to secure the housing and support they needed. Each person with a learning disability had their own action plan so that everyone was clear about who would do what and how.

IAS owned all the group homes, but to move from residential care to supported living meant finding housing partners so that housing and support could be separate. IAS wanted to work with other housing associations and met with several to discuss possibilities. New partnerships were forged.

Money to pay for people’s support was reorganised and staffing hours were reallocated between more houses. Staff management, support and development was changed to focus around supporting individuals in their own homes. Staff have been helped to work out how best to support each person, and how they can measure success.

Eventually, the IAS group homes in the Salford area were de-registered (people in Wigan already had supported tenancies) which gave people more control over their money. Some of the houses were left with no tenants as people moved on to other properties that better matched their personal wishes. Wigan needed more housing for people still living in hospital so two of the houses are now being refurbished for people leaving hospital who need a lot of support.

What helped?

An overall implementation strategy was important and project management helped to make sure that all the pieces of the jigsaw fitted together and progress was monitored and celebrated. We found that some people had low expectations of people with learning disabilities and were anxious about moves to more independent living. But people have shown that they can do it. As people have watched their friends’ lives changing they have seen that their lives can also change, and staff have become enthusiastic advocates for change too. People with learning disabilities have challenged people’s ‘we know best’ attitudes. It’s important to have an open mind.
Possible partners and allies often need lots of reassurance which tests your own beliefs and ability. We were committed to a partnership approach and to giving the time needed to convince organisations to come on board. The local commissioners helped to shape developments by decommissioning and recommissioning services.

Setbacks in the early stages were frustrating and difficult but a determination to carry on and look creatively and imaginatively for solutions meant everyone became more competent and confident. We had to stay strong and focused. Reorganising people’s time and resources is much harder work than simply making wish lists. And arranging housing and support for people is a job that never finishes because people change and grow and want new and different things.

The result of changing people’s living and support arrangements can be measured by looking at how this has affected them. Performance targets or indicators don’t always see that people can be happier and healthier living where and how they want. Our local changes have shown how important it is to listen to people with learning disabilities when they say they want ordinary things like a home that’s really home and a choice of who supports them.

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Summary

Direct Payments can influence service development through people’s combined purchasing power and the choices they make. High take-up of Direct Payments presents an opportunity to see which services people choose to purchase: it can help to shape commissioning decisions. In Essex, as this account shows, a great deal of work has gone into developing the Direct Payments scheme in ways which promote and support high take-up. A version of this story first appeared on the Valuing People website.

Direct Payments in Essex

In 1997, 60 people in Essex were getting ‘indirect’ payments from the council to buy their own care services, but this included only one person with a learning disability and that person did not actually control the money. Essex County Council wanted more people with learning disabilities to use Direct Payments, including people who need a lot of help and support. It set about changing the way that people could get support to take-up and use Direct Payments in partnership with groups, managed by disabled people, who were already planning how to develop independent advice, support and advocacy so that people could have more choice and control.

How it works now

Independent Living Advocacy Essex (ILAE) and the Personal Assistant Support Service (PASS) help people to apply for and use Direct Payments. Both organisations work in partnership with Essex Council which gives them funding. If someone is interested in Direct Payments ILAE gives them information about how the payments work. They help the person think about what it might be like to buy their own services and about who could support them to apply for a Direct Payment and to employ their own personal assistants. The person may already have a circle of support or they might want to start a circle or network of friends and family. ILAE also advises about job descriptions and recruitment of personal assistants.

Following a Community Care Assessment and the setting up of a Direct Payment, PASS gives people ongoing support to manage it. PASS can hold the money on someone’s behalf and also has a payroll scheme to organise payment to people’s personal assistants. The Council needs a quarterly report from each person showing how they have been using their Direct Payment and PASS will either write this for them or will show them how
to do it. PASS provides training for personal assistants and Direct Payment users that focuses on empowering disabled people, independent living and the social model of disability. The training highlights the difference between a ‘carer’ and a ‘personal assistant’, helping people to have more control over how they are supported. People with learning disabilities can find it hard to direct their own support if they’ve been used to being told what to do by other people who have made choices for them. The personal assistant training helps workers learn how to encourage people to make their own decisions and choices.

People with learning disabilities may initially find it hard to understand what it’s really like to use Direct Payments. Essex uses lots of different ways to help them, for example role plays. Someone can also have an individual support worker for a short time to see what it might be like to have their own personal assistant.

A circle or network of friends and family who really know the person and can communicate well with them helps the Direct Payment user tell other people what they want. The person must be in control and central to all decision-making with as much support as they require. In the past people with learning disabilities were refused Direct Payments because other people said they could not really choose whether they wanted them, particularly if they did not speak. Now it is agreed that someone’s facial expression or behaviour can be taken as a real sign of what they want. Circles of support or informal networks can make a very big difference to how successfully someone uses Direct Payments.

Use of Direct Payments can be more limiting than using services if no-one monitors their impact. Essex has found that it’s important to get regular feedback about the relationship between the person and their personal assistant to see how it’s going. People’s circles or networks also need to keep an eye on how things are working out. There is a Direct Payments Users Network where people meet to talk about their experiences. The network helps the council improve the scheme by telling them what works well and what needs to improve. People wanting to find out about Direct Payments also contact this group.

**What have we learnt?**

Here are just three of the many things we have learnt.

Support for people using Direct Payments will work well if it’s flexible and responsive, and if it keeps the person with learning disabilities at the centre,
particularly when they are being supported to make decisions about their care. People using Direct Payments need to be able to choose to organise support in ways which personally suit them, and it’s important to recruit personal assistants who are willing to learn new ways of working and have signed up to empowering the person they are assisting.

Because Direct Payments are linked to a person’s Community Care Assessment it is crucial to train care managers so that they understand how to help people access and manage a Direct Payment. Care managers need information about Direct Payments which is easy to understand, not too long, and can be used on a regular basis. Essex now offers training to care managers to help them understand more about Direct Payments.

A lot of people who could benefit from Direct Payments still don’t know about them, so it’s important to spread the word around and keep doing it. In Essex the Direct Payment Users Network helps new users learn from people who already have experience of the scheme. People find they often share the same problems and can solve them together. Having such a network can really help to empower people.

The proof of the pudding...

About 100 people with learning disabilities now get money from Essex County Council to buy their own services. The key to successful Direct Payments is good planning and robust support. Developing this can take time: it’s better to be patient and succeed than rush and fail. Staff sometimes worry that Direct Payments are too risky and difficult, but as more people have successfully used them in Essex staff have seen the positive difference it makes to people’s lives. We hope Direct Payments will make a positive difference to even more people’s lives in the future.

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Summary

New Avenues currently offers a day opportunities service to a number of adults with learning disabilities living in east London. It is run by Heritage Care, a not-for-profit organisation. People using New Avenues live in properties that are also supported by Heritage Care staff. This story of day service modernisation shows how information about people’s preferences and aspirations shaped an initial reorganisation, but person-centred planning has since fed into more re-shaping and fine-tuning of the service. New Avenues has entered a period of ‘ongoing’ improvement and development in pursuit of person-centredness. They are actively working at it.

Modernising day opportunities in east London

Summary

New Avenues has been running for 15 years and was originally set up as part of the resettlement of people from long stay institutions. In the past New Avenues has had changes of name, staffing structure and location but in light of the changes in social policy and practice, culminating in Valuing People, we felt that we needed to systematically review the service that we offered.

A steering group was set up and met monthly. The make-up of this group has been fundamental to the process – having some senior people in the organisation involved has meant that things have happened and not just been talked about, and also that staff and users felt listened to and that the service was important and valued.

The initial review looked at how the service operated and what people were getting from it. A single tool was used – an individual activity assessment – to find out what people were doing when using the service, what they were interested in doing, when and how often they wanted to do things, and where and how. People were given a lot of different options to consider: we judged that if we simply asked people what they would like to do they would be likely to tell us the things they are already doing. We wanted to open up more choices. Where people had difficulties speaking up we involved their keyworker from home to try to get a bigger picture.

These activity assessments gave us a snapshot, but we backed them up by bringing in an independent consultant to undertake a user consultation. This took a broader approach, and used a lot of pictures, symbols and photos to
help with communication and understanding. One of the most important messages that came from the consultation was that people liked coming to the New Avenues service because they had friends there.

We also looked at the staffing structure, funding streams, what we offered, how and why, as well as national and local policy. We consulted with all key internal and external people, and we carried out literature reviews.

All of the information gathered fed into and shaped our initial redesign of the service. We decided to continue offering group sessions because there were some activities that several people wanted to do, but we also developed a new service offering support to individuals on a one-to-one basis to build interests, links and social networks within their local community.

Once we had a clear idea of what we needed to offer we looked at how to make it happen. We changed the staffing structure to make it more team focused. We created two new team leader posts, one for group workers and one for community builders. This has enabled me, as co-ordinator, to focus more on the overall direction of the service rather than needing to be involved in every decision.

We launched the new service but very soon the ‘change’ became a ‘process’ of continual development. People tried doing things and then changed their minds, people saw others doing things and then wanted to do them. We also had to adapt plans and ideas as we tried things that we thought would work but in reality didn’t. The costings and budget had to be reset many times.

New Avenues has traditionally been focused around a building – the centre. This started to change. One of our successes has been that groups we offer have become more focused: they were designed on the basis of the activity assessments and therefore people are doing what they are interested in rather than simply ‘going to the centre’. Staff also found this more rewarding as they found that they were achieving things and enabling people to do what they wanted rather than running sessions because they had always been run.

Community building has also been a great success. Individuals are getting to know their local communities and becoming part of them. The staff were ‘zoned’ to areas so that they only work with individuals in one locality. This has meant that they have got to know the local community and the facilities it offers. People have got to know the users and staff as they walk around or go to the local pub or club.
We now have a principle that we don’t offer anything at the New Avenues building that people could get elsewhere. We are using the building less and less and are aiming to stop using it completely. Staff now have to hire rooms in the building if they want to use them. We are aiming to maximise resources for each individual by using the money currently spent on the building on direct support so that people can do what they want, when they want to. We have also drawn the staff who support people in their homes into the developments. House managers are now developing person-centred plans (‘my life’ plans) with each person which include details about what they want to do, when, and what support they need to achieve it. Every plan has to include activities that help people to develop and strengthen their friendships – they have to show what the person will be doing to maintain their friendships. The service is becoming more based from home, with people going out directly from home to do things. Each home is getting its own worker to help achieve this.

I am often asked why we didn’t get it right initially. Why are we changing things again? I answer that we did get it right, we listened to people who use the service and we are still listening. Change is a process. It was hard adjusting to new roles and responsibilities and adapting how we worked. It is just as hard to keep making improvements. However, we are working to support individuals to achieve what they want, not what we want, and that’s never easy – but it is our job.

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References


**Resources**

**Websites for general information related to service development, commissioning and management**

CareData – more than 70,000 summaries of books, central and local government reports, research papers, publications by voluntary organisations, and articles from a wide range of journals: www.elsc.org.uk/caredata/caredata.htm

eLSC (electronic Library for Social Care), a free online resource owned and managed by the Social Care Institute for Excellence (SCIE) www.elsc.org.uk

Improvement & Development Agency: www.idea-knowledge.gov.uk

Joseph Rowntree Foundation (JRF): www.jrf.org.uk

JRF Findings Reports from research and innovative projects: www.jrf.org.uk/knowledge/findings/


Social Care Institute for Excellence: www.scie.org.uk

**Websites for specific information about developing better opportunities and support for people with learning disabilities**

British Institute of Learning Disabilities (BILD): www.bild.org.uk

Foundation for People with Learning Disabilities (FPLD): www.fpld.org.uk

Inclusion Press publications: www.inclusiononline.co.uk

Institute for Health Research at Lancaster University – learning disability stream: www.lancs.ac.uk/fss/hr/research/learning/research.htm

National Development Team (NDT): www.ndt.org.uk

National Electronic Library for Learning Disabilities (neLLD), part of the National Electronic Library for Health: http://libraries.nelh.nhs.uk/learningdisabilities/

Norah Fry Research Centre: www.bris.ac.uk/Depts/NorahFry

North West Training & Development Team (NWTDT): www.nwttdt.com

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Paradigm consultancy – very extensive range of information and links into other useful websites: www.paradigm-uk.org

Partners in Policymaking: www.circlesnetwork.org.uk/partners_in_policymaking.htm and www.shstrust.org.uk

Valuing People Support Team (VPST): www.valuingpeople.gov.uk

**Tools and guides to aid commissioning**


*Developing new capital provision* (about PFI). Factsheet available on www.valuingpeople.gov.uk


*Take into account.* John Belcher, Claire Smart and Martin Willis. In *Community Care* 2003, March 6, pp44–45. (Looks at the skills involved in commissioning, and provides tips).


**Guidance and tools for developing specific services**


*Good practice guidelines produced by the Older Family Carers Initiative.* Available on [www.learningdisabilities.org.uk](http://www.learningdisabilities.org.uk)


*The Quality Network. Information from [www.bild.org.uk/tqm](http://www.bild.org.uk/tqm)*


**Information on person-centred planning**

See websites for:

- Helen Sanderson Associates: [www.helensandersonassociates.co.uk](http://www.helensandersonassociates.co.uk)
- Inclusion Press: [www.inclusiononline.co.uk](http://www.inclusiononline.co.uk)
- Paradigm: [www.paradigm-uk.org](http://www.paradigm-uk.org)
- Publications by Beth Mount: [www.capacityworks.com/](http://www.capacityworks.com/)
- The Learning community for Essential Lifestyle Planning: [www.elpnet.net/](http://www.elpnet.net/)
- Valuing People Support Team (VPST): [www.valuingpeople.gov.uk](http://www.valuingpeople.gov.uk)


To stimulate thought and ideas


REAL organisational support for evidence based practice action pack. (Guidance on how to develop an evidence-informed approach to practice at all levels of an organisation, whilst recognising the practical difficulties that may stand in the way). Available at www.rip.org.uk


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### Analysis Sheet 3: Leisure and fun

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<tr>
<th>GOALS RE</th>
<th>NOW</th>
<th>BLOCKS RE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating/drinking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watching sports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking part in sports</td>
<td></td>
<td></td>
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<tr>
<td>Arts/crafts/hobbies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watching performing arts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking part in outdoor activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Details/notes re: Goals</td>
<td></td>
<td></td>
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<tr>
<td>Details/notes re: Now</td>
<td></td>
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<tr>
<td>Details/Planned Action</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can’t get support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travelling difficulties</td>
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<tr>
<td>Can’t afford it</td>
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<tr>
<td>No-one to do it with (company)</td>
<td></td>
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<tr>
<td>No opportunity locally</td>
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<td></td>
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<tr>
<td>Problem re: continuing existing leisure activity</td>
<td></td>
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<tr>
<td>Details/notes re: Blocks</td>
<td></td>
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<tr>
<td>Details/notes re: blocks to continuing</td>
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<tr>
<td>Details/notes re: what wanting to continue</td>
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<tr>
<td>Date of review (if appropriate)</td>
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<tr>
<td>Planned Action</td>
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<tr>
<td>Form completed by PCP facilitator</td>
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<tr>
<td>Form completed by CM or care co-ordinator</td>
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<tr>
<td>Manager suggested</td>
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<tr>
<td>Manager is doing</td>
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</tbody>
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**Analysis Sheet 3: Leisure and fun**

GOALS RE NOW BLOCKS RE

| Eating/drinking | | |
| Watching sports | | |
| Taking part in sports | | |
| Arts/crafts/hobbies | | |
| Watching performing arts | | |
| Taking part in outdoor activities | | |
| Details/notes re: Goals | | |
| Details/notes re: Now | | |
| Details/Planned Action | | |
| Can’t get support | | |
| Travelling difficulties | | |
| Can’t afford it | | |
| No-one to do it with (company) | | |
| No opportunity locally | | |
| Problem re: continuing existing leisure activity | | |
| Details/notes re: Blocks | | |
| Details/notes re: blocks to continuing | | |
| Details/notes re: what wanting to continue | | |
| Date of review (if appropriate) | | |
| Planned Action | | |
| Form completed by PCP facilitator | | |
| Form completed by CM or care co-ordinator | | |
| Manager suggested | | |
| Manager is doing | | |
## Analysis Sheet 4: Choices/control/rights

| Form reference number | Name of person | Address | Locality | Sex | Age | Ethnicity | Faith | Uses wheelchair inside | Uses wheelchair outside | Self-props wheelchair | Finds steps/stairs difficult | Has visual impairment | Has hearing impairment | Has speech difficulties | Uses communication equipment | Uses sign language | Has to be accompanied when out | Has to have 1:1 when out | Has ongoing health problems | Details of health problems | Lives with family care | Relationship of carer | Age/estimated age of carer |
|-----------------------|----------------|---------|----------|-----|-----|-----------|-------|-------------------------|------------------------|----------------------|---------------------------|-----------------|-------------------|------------------|-----------------------------|-----------------|-----------------------------|----------------------|-----------------------------|----------------------|---------------------|-------------------------|

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## Analysis Sheet 4: Choices/control/rights

### GOALS RE:

<table>
<thead>
<tr>
<th>Control of own money</th>
<th>Making more decisions</th>
<th>Speaking up for self</th>
<th>Doing more for self</th>
<th>Travelling on own</th>
<th>Personal relationships</th>
<th>Organized advocacy</th>
<th>Details/choices re: Goals</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

### NOW:

<table>
<thead>
<tr>
<th>Details/choices re: Goals</th>
<th>Details/choices re: New</th>
<th>Details/choices re: Planned Action</th>
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<tbody>
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</table>

### BLOKCS RE:

<table>
<thead>
<tr>
<th>Problem in continuing existing activity re: choices/control/rights</th>
<th>Details/choices re: Blocks</th>
<th>Details/choices re: blocks to continuing</th>
<th>Details/choices re: Planned Action</th>
</tr>
</thead>
<tbody>
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</table>

### Date of review (if appropriate): Form completed by PCP facilitator or care coordinator: Manager suggested: Manager is doing: Manager wants planner to:
## Analysis Sheet 5: Feeling well and good about self

<table>
<thead>
<tr>
<th>Form reference number</th>
<th>Name of person</th>
<th>Address</th>
<th>Locality</th>
<th>Sex</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Faith</th>
<th>Uses wheelchair inside</th>
<th>Uses wheelchair outside</th>
<th>Self-propels wheelchair</th>
<th>Prods, steps/stairs difficult</th>
<th>Has visual impairment</th>
<th>Has hearing impairment</th>
<th>Has speech difficulties</th>
<th>Uses communication equipment</th>
<th>Uses signing</th>
<th>Has to to be accompanied when out</th>
<th>Has to have 1:1 when out</th>
<th>Has ongoing health problems</th>
<th>Details of health problems</th>
<th>Lives with family carer</th>
<th>Relationship of carer</th>
<th>Age/estimated age of carer</th>
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</table>
## Analysis Sheet 5: Feeling well and good about self

<table>
<thead>
<tr>
<th>GOALS RE:</th>
<th>NOW</th>
<th>BLOCKS RE:</th>
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</thead>
<tbody>
<tr>
<td>My confidence</td>
<td>travelling difficulties</td>
<td>Date of review (if appropriate)</td>
</tr>
<tr>
<td>My appearance</td>
<td>Can't get support</td>
<td>Form completed by PCP facilitator</td>
</tr>
<tr>
<td>My self-understanding</td>
<td>No-one to teach me</td>
<td>Form completed by CM or care co-ordinator</td>
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<tr>
<td>Coping with life</td>
<td>Can't afford it</td>
<td>Manager suggested</td>
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<tr>
<td>Role/position in life</td>
<td>No-one to do it with company</td>
<td>Manager is doing</td>
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<tr>
<td>My health</td>
<td>Shaping the Future Together © The Foundation for People with Learning Disabilities 2005</td>
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</tbody>
</table>

Details/notes re: Now

Details: what wanting to continue

Details/notes re: continuing existing activity re: feeling well & good about self

Details: Planned Action

Details/notes re: blocks to continuing

Details: blocks to continuing

Details/notes re: Blocks

Details/notes re: Blocks

Planned Action

Coping with life

Role/position in life

My health

My appearance

My confidence

Improving my health

My self-understanding

Coping with life

Role/position in life

Details/notes re: Goals

Details/notes re: Now

Details: Planned Action

Can't get support

No-one to teach me

Can't afford it

No-one to do it with company

No opportunity locally

No-one to teach me

Can't get support

No-one to do it with company
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<tr>
<th>Form reference number</th>
<th>Name of person</th>
<th>Address</th>
<th>Locality</th>
<th>Sex</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Faith</th>
<th>Uses wheelchair inside</th>
<th>Uses wheelchair outside</th>
<th>Self-propels wheelchair</th>
<th>Falls/steep stairs difficult</th>
<th>Has visual impairment</th>
<th>Has hearing impairment</th>
<th>Has speech difficulties</th>
<th>Uses communication equipment</th>
<th>Uses signing</th>
<th>Has to to be accompanied when out</th>
<th>Has to have 1:1 when out</th>
<th>Has ongoing health problems</th>
<th>Details of health problems</th>
<th>Lives with family care</th>
<th>Relationship of carer</th>
<th>Age estimated age of carer</th>
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| Relationship with loving partner | ✓ | ✓ |
| Spending time with friends | ✓ | ✓ |
| Making friends | ✓ | ✓ |
| Spending time with family | ✓ | ✓ |
| Relationship with family | ✓ | ✓ |

**Details/notes re: Goals**

**Details/notes re: Now**

**Planned Action**

**Can't get support**

**No-one to teach me**

**Problem re: continuing existing activity re: friends/family/relationships**

**Can't afford it**

**No opportunity locally**

**Can't get support**

**No-one to teach me**

**Problem re: continuing existing activity re: friends/family/relationships**

**No-opportunity locally**

**Can't afford it**

**Can't get support**

**No-one to teach me**

**Problem re: continuing existing activity re: friends/family/relationships**

**Now**

**Details/notes re: Blocks to continuing**

**Details/notes re: Blocks to continuing**

**Planned Action**

**Date of review (if appropriate)**

**Form completed by PCP facilitator**

**Form completed by CM or care co-ordinator**

**Manager suggested**

**Manager doing**

**Manager wants planner to**
## Analysis Sheet 7: Where and how I live

| Form reference number | Name of person | Address | Locality | Sex | Age | Ethnicity | Faith | Uses wheelchair inside | Uses wheelchair outside | Self-propels wheelchair | Finds steps/stairs difficult | Has visual impairment | Has hearing impairment | Has speech difficulties | Uses communication equipment | Uses signing | Has to to be accompanied when out | Has to have 1:1 when out | Has ongoing health problems | Lives with family carer | Lives with another carer | Relationship of carer | Age/estimated age of carer | Details of health problems |
|-----------------------|----------------|---------|----------|-----|-----|-----------|-------|------------------------|------------------------|-------------------------|--------------------------|-------------------|-------------------------|---------------------|-----------------------------|------------------|-----------------------------|--------------------------|-----------------------------|---------------------|----------------------------|------------------------|------------------------------------------------|
|                       |                |         |          |     |     |           |       |                        |                        |                         |                          |                  |                        |                     |                             |                 |                            |                          |                             |                     |                             |                     |                                                            |
### Analysis Sheet 7: Where and how I live

<table>
<thead>
<tr>
<th>GOALS RE</th>
<th>NOW</th>
<th>BLOCKS RE</th>
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</thead>
<tbody>
<tr>
<td>Moving home</td>
<td>Who I live with</td>
<td></td>
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<tr>
<td>with</td>
<td>Where I live</td>
<td></td>
</tr>
<tr>
<td>Living</td>
<td>The support</td>
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<tr>
<td>with</td>
<td>The area I live in</td>
<td></td>
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<tr>
<td>Family</td>
<td>Physical property of my home</td>
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</tr>
<tr>
<td>Living in my home</td>
<td>Living in res care home</td>
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<tr>
<td>Living with others</td>
<td>In temp accom</td>
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<td>Living on own</td>
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<td>Home owner</td>
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<td>Details/notes re: Goals</td>
<td>Details/notes re: Now</td>
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<tr>
<td>Planned Action</td>
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<tr>
<td>Making for care manager to help</td>
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<tr>
<td>Can't afford it</td>
<td>Can't afford it</td>
<td></td>
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<tr>
<td>No-one to help plan/arrange it</td>
<td>No-one to help plan/arrange it</td>
<td></td>
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<tr>
<td>On housing waiting list</td>
<td>On housing waiting list</td>
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<tr>
<td>Waiting for care manager to help</td>
<td>Waiting for care manager to help</td>
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<td>Waiting for care manager to help</td>
<td>Waiting for care manager to help</td>
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<tr>
<td>Details: what wanting to continue</td>
<td>Details: what wanting to continue</td>
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<td>Details/notes re: blocks to continuing</td>
<td>Details/notes re: blocks to continuing</td>
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<td>Planned Action</td>
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<tr>
<td>Date of review (if appropriate)</td>
<td>Date of review (if appropriate)</td>
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<td>Form completed by CM or care co-ordinator</td>
<td>Form completed by CM or care co-ordinator</td>
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<tr>
<td>Manager suggested</td>
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</tr>
<tr>
<td>Manager is doing</td>
<td>Manager is doing</td>
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<tr>
<td>Manager wants planner to</td>
<td>Manager wants planner to</td>
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