Work in Progress:

Implementing Person Centred Planning in Oldham

Martin Routledge and Helen Sanderson

Foreword by Michael Smull

Working with local services in Cheshire, Greater Manchester, Lancashire, Merseyside and South Cumbria in moving towards better futures for people with learning disabilities.

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Dedication and acknowledgements

We would like to dedicate this publication to the memory of Gerry Smale and of Marsha Forrest.

Gerry made a direct contribution through his assistance to the Oldham Person Centred Planning Implementation Group in their analysis of work to bring about change in Oldham. More than this though, Gerry's approach to managing change has strongly influenced our work and will continue to do so in the future. His challenging but supportive style, based upon true integrity will long be remembered. One of our favourites was the challenge lobbed in when a group of us were getting a little self congratulatory about our achievements *'Essential Lifestyle Plans eh? If it's so essential how come everyone hasn't got one!'*. Thank you Gerry, mentor and friend.

Marsha, with her colleague Jack Pearpoint, made a major contribution to the cause of inclusion for people with learning disabilities in the North West as well as helping to produce some of the important tools now in regular use by person centred planners (PATH and MAPs). In a series of sessions in Oldham Marsha and Jack challenged and inspired a new generation of leaders – workers, people with learning disabilities and their families. Sometimes we were pushed well outside of our comfort zones. One of the authors of this publication required two stress balls to squeeze at first! In your face North Americans both, Jack and Marsha showed total commitment to inclusion: *'Which part of all don't you understand!'*. Our love to you Marsha.

The authors of this publication have tried to record and analyse the efforts of many people in Oldham who are on a long journey to achieve the inclusion of people with learning disabilities through partnerships and power sharing. In particular we have described the part that person centred planning is playing in this journey.

Many of those who should be acknowledged as contributors to this publication cannot be directly named in order to protect their annonymity. This applies to those people with learning disabilities and family members at the centre of person centred planning work and to staff teams working with these people. You know who you are, thank you. Fortunately many others can be acknowledged. These include:

Kim Doolan, Lilian Nelson, Naz Khan, Mary Whinnie, Kevin Howarth, Matthew Myrie, Joanne Keight, Bev Maybury, Karen Saville, Gill Goodwin, John Engwall, Rosemary Molyneux, John Steward, Tracey Cropper,Viv Slater, Julie Stansfield , Margaret Neyman, Jane Forrest, Janet Steward, Ken Stapleton.

Special thanks are due to Kim, the Person Centred Planning Co-ordinator, who has provided much material for this publication. Through her dedication and tenacity (bloody mindedness some would say!) she has made a major contribution to person centred planning in Oldham.

Foreword by Michael Smull

The continuing gap between best and typical practice in supporting people with disabilities is disturbing. It has been more than a decade since we learned how to do plans with people that reflected how they wanted to live rather than what was wrong with them.

Over the same time period we have seen some agencies that provide supports transform themselves so that the people who are using the services move toward the lives that they want. But the pace of change is glacial. While there are slowly increasing numbers of people whose lives reflect their desires and their journeys, they are still a small minority. The vast majority of people with disabilities continue to have lives where what is wrong with them plays a bigger role than what is important to them. We continue to see people with good person centered plans that have had no impact on how they live and many plans whose labels are person centered and whose content describes programs.

If we are to have a system that supports people in having lives in their communities we need to learn how to combine best practice in planning, organizational development, and organizational change. The report that follows describes one set of efforts to address these issues. It was clear to the people who led the efforts in Oldham that teaching how to develop good plans is necessary but insufficient. They looked to and used the work of people such as Gerald Smale to inform their efforts in organizational change. The results of their efforts are significant and hopeful. Through hard and thoughtful work, the lives of people have changed.

What is as significant to the reader is that they have shared what did not work as well as what did work. Those engaged in change typically learn more from what did not work as they learn from what did work. Unfortunately most reports edit out the problems that were not solved, the efforts that failed, or did not work as well as they hoped. Systematic, widespread change is dependent on shared learning. We need people who are committed to: making reasonable efforts rooted what has been learned; learning from the new efforts; and sharing the learning with the community of people who are striving to lead change. .

A system where only a small minority of people have lives that make sense to them is unacceptable. We must learn how to change our systems. It seems unlikely that we can create a blueprint for change but it seems possible to develop a kind of roadmap. Developing that roadmap requires that those who struggle to make the changes reflect on what they have done and share the learning. That is what this report provides.

Michael Smull
September 2000

Summary

This publication is for people interested in learning about developing person centred planning within organisations. It describes the challenges, successes and dilemmas experienced within Oldham Learning Disability Service (OLDS) as they pursue the implementation of person centred planning throughout the organisation.

- Specifically, this publication explores the problems experienced with previous approaches to planning; why a structured approach was required for the development of person centred planning and identifies three stages of development and implementation.
- The first stage was a period of initial learning and experimentation as people tried to make the existing system of planning more 'person centred'. Also in this stage a small group of people was trained in Essential Lifestyle Planning. The learning from experimentation and ELP training informed the second stage.
- In the second stage an Implementation Group was formed. Resources were found to employ a half time Person Centred Planning worker, and an implementation plan was developed. The group used a 'depth and breadth' strategy to address the issue of how to learn about planning in detail with a few people, whilst making changes in large numbers of people's lives. More ELP training was provided as people learned about planning in depth. Strategies to increase all staff's awareness of person centred planning and working with people who used services were part of the 'breadth' approach.
- In the third stage the Implementation Group evaluated the work to that point against its five agreed roles. It then set new goals to continue the work and started this.

The middle section of the publication describes some of the outcomes of person centred planning to date and issues arising from this work:

- Descriptions of some of the Essential Lifestyle Plans undertaken and facilitator reflections show the important differences between this approach to planning and previous approaches.
- Other outcomes and activities are outlined, including the development of more person centred practice and service changes resulting from this.
- Key learning for the organisation is described, including person centred planning with people from South Asian communities, responding to people with 'complex needs' and person centred planning within care management.

The penultimate part of the publication is an analysis of the progress made against five roles of the implementation group. The findings from this included:

- Moving towards person centred planning requires strategic leadership from senior managers and key people within the organisation to communicate the vision for change. This leadership has to be sustained over time. It has to be reflected in the according of priority to training and development activity around person centred planning and to the allocation of appropriate funding and staff resources.
- Implementing person centred planning requires different strategies to the 'cascade training' approach often used with Individual Programme Planning and similar approaches. Facilitators need to be trained and supported differently. Person centred planning requires "second order" changes in relationships with the people who are receiving support. This means that it is not simply a change in technique, but a different way of being with and supporting people. Therefore, the training and support for facilitators needed to include coaching and mentoring, a role that the Person Centred Planning worker and others were beginning to fulfil in Oldham.
- Balancing the enthusiasm of staff with the organisation's capacity to respond to the

changes people want in their life is a challenge. OLDS positively addressed this through the ‘depth and breadth’ strategy. This meant that while work was undertaken to improve best planning practice starting with small numbers, larger numbers were exposed to practical approaches to improve general practice.

- Being linked with other strategic changes in the same direction strengthens the implementation of person centred planning. OLDS was beginning to use person centred planning as a way of hearing how people who used the service wanted it to change.
- Person centred planning requires a different approach to assuring and developing quality. This is an area for future development in OLDS.

A final section offers a summary checklist from Michael Smull outlining why changing ‘from programmes to supports’ is difficult and offering guidance for those serious about building effective partnerships to promote inclusion.

Introduction

Purpose of the publication

Over the past four years, members of the North West Training and Development Team have worked with a number of districts in support of their efforts to build person centred planning with people with learning disabilities. It was agreed with one of these districts, Oldham, that the NWTDT and Oldham staff would work to produce a detailed description of the work being undertaken.

The purpose of this publication is to describe the experience of Oldham Learning Disability Service which is learning about and developing person centred planning . In doing this we aim to share learning and to raise and explore issues arising. We hope that this will be useful for others around the region and nationally who are themselves interested in the development of person centred planning.

The report is written:

- For people who have begun to explore person centred planning, and already have knowledge of the key principles and approaches. (For those wishing to start by reading about these approaches we would recommend looking at the NWTDT resource guide on person centred planning for useful materials (Sanderson and Kilbane 1999).
- For people struggling with the challenges and dilemmas inevitably thrown up in developing and promoting person centred planning, especially those people working for large organisations.

It is important also to say what this report is not:

- It is not a research report - there has been no attempt to formally evaluate process and outcomes. The narrative is constructed through the records and recollections of a number of people who have been significantly involved in the development and delivery of person centred planning, and collected together over about four years. There is clearly important research to be done but this is not it. Rather this paper aims to raise and sometimes discuss *issues* likely to be important to those developing or implementing person centred planning.
- It is not a report written by people who are neutral about either person centred planning or Oldham's efforts. The authors have themselves been significantly involved, directly or indirectly, with the developments. We hope, however, that we have been able to provide a thoughtful critique of the work which will be of use to others.
- It is (hopefully) not a document of praise to a coherent, structured, omniscient plan leading to activities achieving fully anticipated outcomes! Real life isn't like that. The Learning Disability Service in Oldham (OLDS) has not and would not claim to have started with totally clear, comprehensive and specified aims, objectives and methods. It has rather set off in a direction which considerable reflection had indicated likely to bear fruit, and is learning from its efforts.
- It is not intended to suggest that the ways that Oldham have gone about learning about and developing person centred planning will necessarily be appropriate elsewhere or that Oldham has achieved more success than other districts. It is hoped though that the learning will be of use to others, especially within fairly large commissioning and providing organisations.

Individual planning and Oldham

Oldham Learning Disability Service

Oldham Learning Disability Service is made up of specialist social services and health provision operating with informally integrated SSD and Trust management. The service is quite large, providing the great majority of specialist services for adults, with a small independent sector providing mostly supported accomodation. OLDS services are commissioned by the Social Services Department and by West Pennine Health Authority. Both agencies have supported the development of person centred planning.

Why has there been a structured attempt to introduce person centred planning into the Learning Disability Service in Oldham?

The short answer to this question would combine:

- A developing critique of previous individual planning approaches

and

- developments to the broader philosophy and culture within the service.

In common with other agencies, Oldham Learning Disability Service has operated systems of individual planning for people who use services. These systems were introduced:

- In acknowledgment that people should have the opportunity to plan their lives, and have the services supporting them reviewed and developed.
- To ensure that services are properly responsive to people's developing needs and aspirations within a complex organisation.

In recent years various factors led OLDS to reconsider the aims and objectives of their existing individual planning approach and how these might be best achieved. Although the approach to planning with people was set up with the best of intentions it was decided that it needed to change to reflect and promote developing service philosophies and culture.

Perceived problems with individual planning

Over a period of several years, particularly the last five or six, a developing critique of the existing system for planning with people using learning disability services had developed. This critique emerged from a range of sources, for example:

- Informal feedback from people with learning disabilities, staff and families.
- Formal consultations. For example when the local Joint Advisory Group for Learning Disabilities consulted with over twenty groups representing people with learning disabilities and families, the issue of the need for changes to individual planning was raised. A series of local day service conferences also identified '*service reviews'* as an area requiring change.
- Service evaluations. For example, in one day service managers and staff gathered the views of staff, people with learning disabilities and families about the existing system in a structured way in order to identify deficiencies and possible improvements.

Critique of the existing system

We believe that the following critique shows that Oldham Learning Disability Service has not been afraid to examine itself and seek to make improvements. The critique is an internal one, emerging from reflection and consultation. Our experience suggests that very similar issues arise in learning disability

services across the country though they have not always been recognised and responded to. The critique is not intended to denigrate the hard work of many people seeking to operate the previous system for planning or the efforts of those who set it up. At the time it was established, it reflected the state of learning and experience within services and was an honest attempt to help people to have a better life. Box 1 below lists some of the percieved problems and possible causes.

Box 1 - problems with individual planning **Perceived problem**	**Possible reasons**
The system could be alienating for people with learning disabilities and families.	Perceived over focus on individual's deficiencies to be 'fixed' rather than achievements to be celebrated and built upon. The system was seen as owned wholly by the service rather than the person and their family. It symbolised, and possibly encouraged, unequal power relationships. This was emphasised by the key decisions on timing, content and membership of planning meetings etc., all being taken by staff. People using services and family and friends had to come into the service building for the meetings. Some even likened it to going to school meetings. The methods used were seen as unlikely to welcome in and effectively involve people or their families through the formality, jargon, communication barriers, lack of sufficient time, focus on formal meetings and the numbers of people involved.
The system did not seem to be properly motivating the staff who were implementing it.	Some staff felt that they had not been properly prepared for use of the system or sufficiently involved in its development to take ownership. It felt to some like simply a management monitoring tool rather than a way of assisting people who used services to identify and pursue personal goals. Many staff felt intimidated by 'paperwork'. For some the system felt 'over academic' and rather than encouraging the creative application of their skills, it made them feel inadequate. Some argued that personal planning did not seem to be leading to real change for people being planned with. Generally speaking, they suggested that the planning did not seem to be leading to people being more included in the mainstream of the life of their communities. Goal set within the planning meetings seemed to be insufficiently ambitious and to focus on relatively minor changes to existing services.

Increasing numbers of people *were* making major changes in their lives - gaining employment, developing relationships, taking up education or other opportunities. This seemed, however, not to be consistently linked to outcomes of the formal planning system. It seemed to be much more likely to result from the determination and creativity of various alliances of people with learning disabilities, family, friends, service workers etc - what might be seen as informal planning. Some people saw this as having the effect of increasing alienation from the formal planning system which could be seen as either ineffective or at worst a conservative force.

Some of the questions being raised were:

- Are the main problems with implementation? These could include training and support for staff, information and support for people and families, management support and monitoring of planning.
- Are the objectives and approaches of the individual planning approach seriously inappropriate in some way? Are the concerns about the system based on fundamental problems with what it is trying to achieve, not just how it goes about this?
- What and who is the planning system for? Is it mainly a system whereby the service can review its contribution towards goals set with/for service users, focusing upon specific service inputs? Is it primarily a means by which the person can determine their goals and to identify, with service staff and others, how these can be pursued? Some shifts seemed to be towards the latter, but there are also requirements for the former.

Linked to these key questions, OLDS managers asked themselves what formal requirements for service monitoring needed to be considered. They wondered whether it was possible to incorporate these within a more person centred approach to planning with people or whether these two elements of monitoring service activity and individual planning needed to be separated in some way.

Care management assessments

In addition to these reflections upon the system used to plan with people already using services, the care management assessment system was also being reviewed. The assessment, carried out by care managers, collected information under certain predetermined categories in order to determine whether a person was eligible for the range of services made available within the service, according to legislation.This information was usually collected in interview/meeting sessions, and recorded on standard forms. Review of this system was initiated as a result of a number of developments:

- Work to develop effective, multi-agency policy and process for transitions between school and adult life led to dissatisfaction with the usual care management assessment process for this purpose. The needs of families going through transition are clearly for planning rather than simply assessment. This requires the building of effective relationships, and the careful exploration of needs and aspirations over a significant period of time. Care managers needed to be able to plan with young people and families, to enable choice, to avoid traumatic sudden changes and over dependence upon specialist services. This meant going far beyond “administrative” assessment, and required the development of techniques for creative communication, building of effective relationships and the facilitation of real choices.
- More generally, there was frustration that the assessment system could perpetuate over dependence upon existing specialist services. The system was seen too often to have the effect of directing people into existing service options. There was felt to be insufficient opportunity for creative exploration of alternatives. It was difficult to plan with people in ways which promoted redesign or adaptation of service options or to assist people and their families to build or strengthen non-service supports and opportunities. This seemed out of step with shifts that were taking place in other parts of OLDS. The service needed to shift the balance as far as

possible towards planning with people, not just assessing them.

Proposed solutions

Accompanying these questions and criticisms of the individual planning and care management systems were various general and specific thoughts on how to improve the situation (see Box 2).

Box 2 - Proposed solutions

- Changes to the format - involving people and their families in redesign. For example: simplify the format; hold meetings away from formal service settings and increase flexibility of process - not just meetings, not always at fixed intervals.
- Shift the emphasis towards 'positive planning' rather than remedying a person's perceived deficiencies.
- Those being planned with to exercise more power within planning - including decisions on where to meet, who to invite, when to plan, what to be discussed etc (See *Our Plan for Planning* Manchester and Liverpool People First 1996).
- Shift from a focus mostly upon services and their review - with the implication that only what happens within services is important in a person's life. Involve those important to the person, including friends, neighbours etc.
- Develop ways of listening to people who use services much more effectively - including spending the necessary time, not relying on formal meetings, more creative communication approaches.
- Develop ways of increasing the influence of people with learning disabilities within planning.
- Make sure that decisions made are actually put into practice to help a person to achieve their goals.
- Find ways of helping staff to value the process.
- Be clearer about the roles to be played by services and staff in achieving a person's goals.

The context of change – a shift in service culture

The critiques of the system for planning with people both reflected and were given impetus by ongoing shifts to the organisational culture within OLDS.

As with any cultural change it is impossible to give a linear description of events and developments leading to a shift. Within OLDS as in other districts over the past few years there have been changes to service provision and working methods and styles which reflect the continuing impact of the ideas and values of 'ordinary living'.

These changes, as they impact upon services and people, are never achieved evenly . In Oldham, the changes seemed to emerge from several (sometimes linked and connecting) sources:

- The demands and assertions of people using services - individual and group advocacy.
- Developing assertiveness of families and others supporting people with learning disabilities.
- Opportunities for staff reflection and development - sometimes internally, sometimes with external support.
- Management effort - represented by training, supervision, mentoring, formal direction, support for activities, service and policy development, funding etc.
- Connection to the networks of learning and development in the North West.
- Senior officer and political support which has assisted developments and culture shifts through resource and policy decisions.

These factors led to a continuing shift in the way many people working for OLDS view and therefore support people. Various commentators have talked of *'a new paradigm'*. This is summarised in the following box:

Box 3 – A new paradigm **Key question**	**IPP**	**Person Centred Planning**
Who is the person of concern?	The client.	The citizen.
What is the typical setting?	A group home, adult training centre, special school.	A person's home, workplace or local school.
How are services organised?	In a contiuum of options.	Through a unique array of supports available to the individual.
What is the model?	Developmental/behavioural.	Ordinary living.
What are the services?	Programmes/interventions.	Individualised supports.
How are services planned?	Individual programme plan based upon professional assessments.	Through a person centred plan.
Who controls the planning decision?	An interdisciplinary team.	The individual or those family or friends closest to the person.
What is the planning context?	Team consensus.	A person centred team or circle of support (group of family/friends who support the individual: Mount et al 1990).
What is given the highest priority?	Independence/skill development/behaviour management.	Self determination, relationships and valued social roles.
What is the objective?	To develop independence and change undesirable behaviours.	To support the person to have the lifestyle that they choose in their local community.

(Adapted from Bradley 1994)

People in OLDS would certainly not claim to be fully achieving the situation described in the third column. The shifts that have taken place are not even and fully comprehensive. It does appear to be the case, however, that there have been shifts in some areas of service and involving significant numbers of staff and managers.

This change is away from professionals and workers being seen as fundamentally different from the people they work with and simply applying professional techniques to *'problems'*. Instead it is towards a position whereby many workers are starting to see themselves as partners with people with learning disabilities and carers, playing a part in supporting people to identify and pursue their goals in life. This in turn leads to/links with moves summarised in Box 4.

Box 4 – Culture shifts **Away from**	**Towards**
Situations where families have little connection to the services being provided other than at a service led review once a year.	Partnership with group and individual contact, negotiation and collaboration.
A service view that all the things that people need should be provided by paid specialist staff.	A view that staff should assist in working out, with people, their needs and aspirations and help them to pursue these - including building relationships outside of 'services'.
Services and opportunities being provided within separate, large, congregated settings.	Inclusion in a much wider range of opportunties and activities.
	Increased flexibility and widening of options within existing services.
	New forms of service and supports.
	New forms and arrangements wherby those working in and using services can discuss and negotiate service activity and development.

As noted above these shifts are certainly not universal. They represent partial change in some areas of service and involving some managers and staff. There is always a danger that those in formal leadership positions might overstate the extent and pervasiveness of culture and attitude shifts.

This then was the context in which changes to planning developed in OLDS, which stimulated and supported the development of person centred planning.

Introducing Person Centred Planning to Oldham

Overview

Some managers and other staff of OLDS decided to take action to change planning with people using services. They eventually adopted an approach that combined focused learning about some approaches to person centred planning and an evolving implementation plan designed to incorporate this learning with a range of other activities.

In launching these changes the managers acknowledged from the beginning that they did not yet have the answers to some of the questions posed by the previous critique of planning and hoped that these would be discovered through the implementation of the plan.

The activity to date can be characterised as a series of stages:

- A phase of initial learning and experiment around approaches to improving individual planning. (Stage 1).
- An initial implementation phase which included the development of the Implementation Group which established the Person Centred Planning (PCP) Implementation Plan. (Stage 2).
- A further implementation phase. This included a review of initial implementation, further review and development (Stage 3).

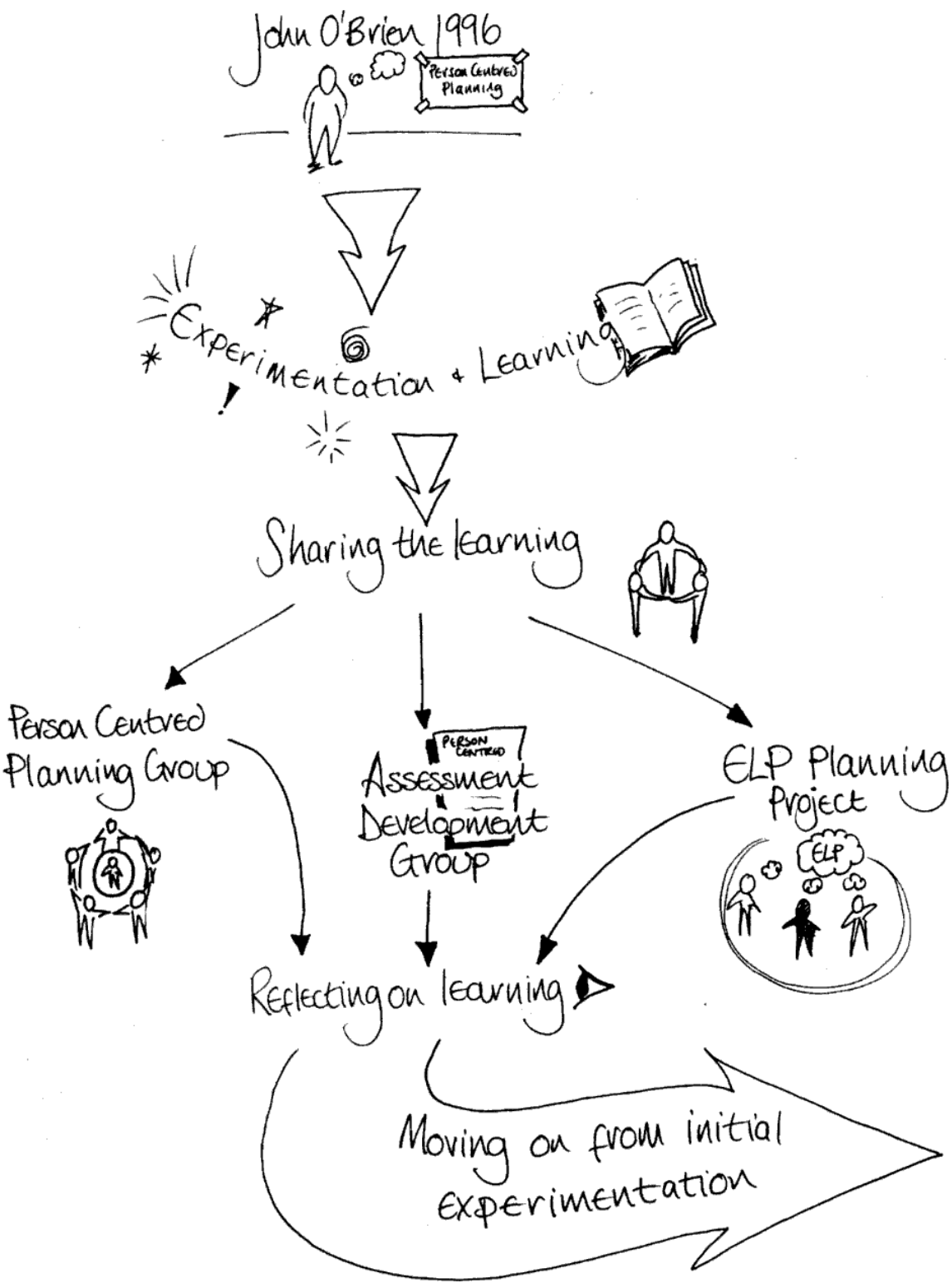
These stages and their key elements are described in the following sections. OLDS is currently in the mid stages of stage three. The following narrative should not be seen as describing a perfectly structured, logical series of events. Though the events and activities are described in phases, this is for ease of reading. While there was a logic and sequence to key events and phases they did not necessarily unfold in a wholly linear manner. It is also the case that the plan changes as learning is reflected upon. Equally there have been many spin offs and developments not formally linked to the Implementation Plan.

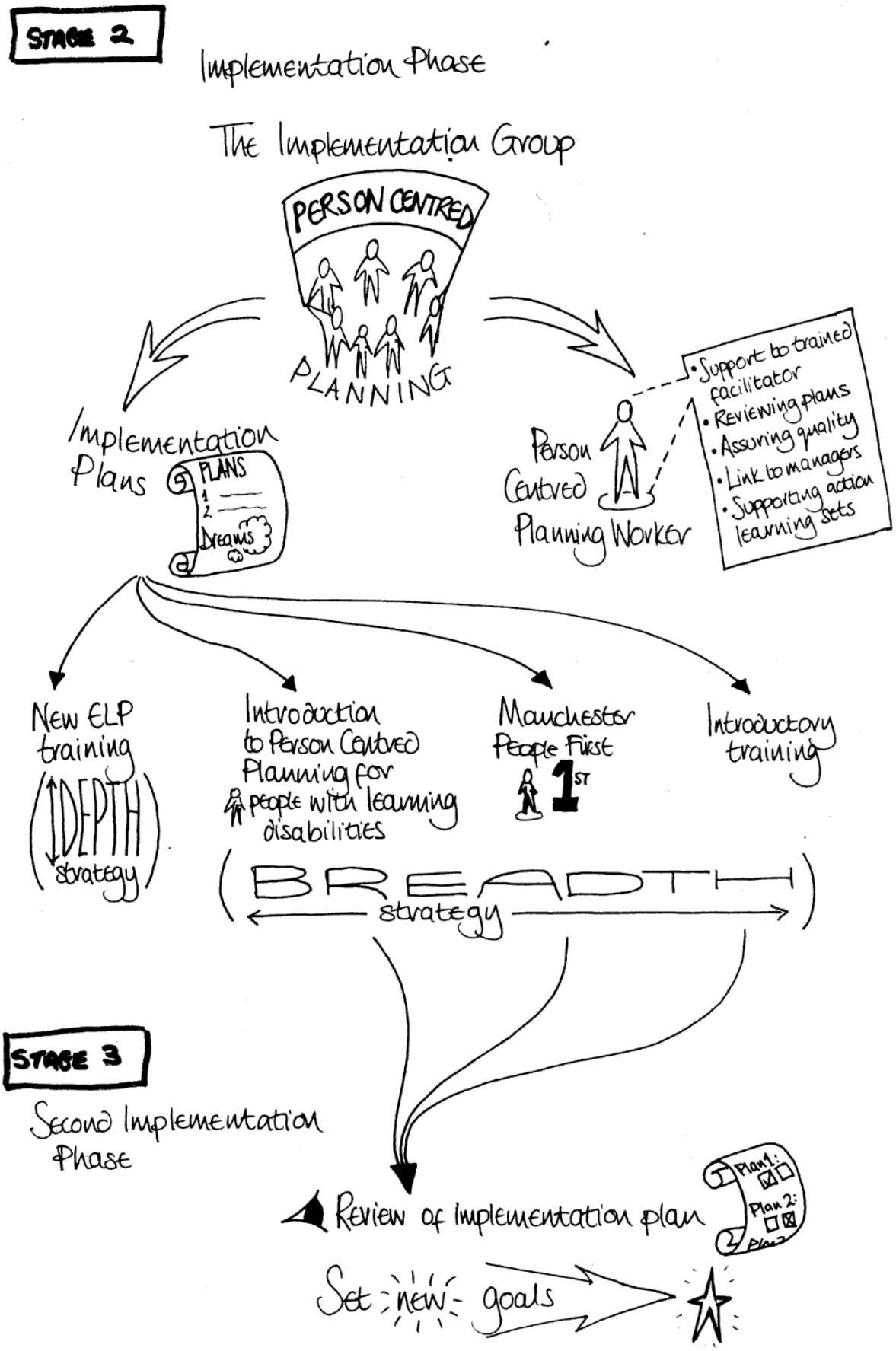
Quite a lot of detail about the planning and development process is provided in the section. In part this is to demonstrate what might be needed if service organisations are serious about trying to develop person centred planning for those using the services they commission or provide. We are already seeing examples of services making formal commitments to develop person centred planning without any clear idea about what this would take. The recent policy impact study *'Facing the Facts'* (DOH 1999) showed that the gap between formal commitment to 'ordinary life' principles and the reality of outcomes for people with learning disabilities and their families is very wide indeed. We fear this is very likely to happen with person centred planning.

Having made this point, for those readers who prefer to start with stories and more descriptive material you could skip to later sections and then return to look at the detail about what it takes to start to deliver such change.

STAGE 1

Initial learning and experimentation




STAGE 2
Implementation Phase
The Implementation Group
PERSON CENTRED PLANNING
Implementation Plans
PLANS
1
2
Dreams
Person Centred Planning Worker
• Support to trained facilitator
• Reviewing plans
• Assuring quality
• Link to managers
• Supporting action learning sets
New ELP training
DEPTH strategy
Introduction to Person Centred Planning for people with learning disabilities
Manchester People First
1ST
Introductory training
BREADTH strategy
STAGE 3
Second Implementation Phase
Review of Implementation plan
Plan 1:
Plan 2:
Set new goals

Stage 1: Initial learning and experimentation

John O'Brien 1996

The critiques of existing approaches led to a decision to use a development day with John O'Brien in November 1996 to explore approaches to personal planning.

This first workshop brought together some people who use services and families with staff and managers from OLDS and voluntary organisations. The aim was to start to think about *'where we wanted to go'* with individual planning.

As it developed this session helped the group to take a step back from the specific question about planning and became a kind of informal PATH for OLDS. It helped to clarify thinking about what people were trying to achieve via the resources of OLDS in general and the factors likely to support or hinder achievement of these objectives. It gave a chance to think collectively about the need for variety and creativity in service provision, breaking away from over dependence on specialist resources and people, and upon standardised approaches and methods of working.

Following from this session some members of the OLDS management team and others started to shift towards the idea that perhaps they shouldn't have one standard tool for personal planning which they tried to implement in a uniform way across services. The idea of taking different routes to reach a destination fitted with the need to both release creativity and energy and to engage the people making use of services and families in planning.

At the same time it was clear that the service did need to make sure that effective planning was happening with people in order to ensure that service staff were focusing their efforts to help people to reach their goals as well as to promote their well being. This introduced the issue that shifting away from a single tool, universally administered, might help to better fit methods with aspirations but would require significantly new ways of supporting and managing those involved.

Experiment and learning 1996/7

At this stage the OLDS managers decided that they would encourage a period of experimentation and learning around individual planning. This might involve either:

- Use of techniques to make the existing approaches more useful and effective, such as management arrangements to improve action from plans, use of more creative communication approaches, less formal settings, etc.
- More radical shifts of approach which could replace the existing planning procedure altogether with approaches shifting from a service review focus to a life planning one.

In support of and alongside this experimentation, a range of tools and techniques were being explored by some managers, staff, families and people with learning disabilities. Some of these were directly related to personal planning, others had more general aims but could clearly be of use in addressing many of the identified deficiencies. Some examples of this exploration are listed in Box 5.

Box 5 - Some examples of activity and learning:

- Several staff had been on courses such as PATH, and introductions to other forms of person centered planning and had looked at relevant literature. As part of the period of experiment, more staff were encouraged to explore these approaches via conferences, training days etc. Jack Pearpoint and Marsha Forrest played an important part with a series of visits to Oldham which stimulated thinking and inspired many people.
- For several years the Arts Development Unit, within the local authority Education and Leisure Services Department had been working with OLDS on a number of joint projects which had also attracted external funding. The relationship had been an evolving one, as workers from different backgrounds and with different formal objectives had explored the role of arts tools and experiences with people with learning disabilities. One of the outcomes of this experimentation had been some thinking about the role of arts approaches to assist people with learning disabilities to communicate their needs and aspirations and to pursue these. As a result of this thinking, for example, one project was set up whereby artists were attached to several services with the aim of supporting experimentation with new forms of personal planning.
- Total Communication - Communication Therapists within the Learning Disability Service have led a major program of developments within the section around the creative use of the widest possible range of communication tools. This work has many strands which have included the transmission and supported use of practical approaches to communication with people who use learning disability services, staff, and families. Five major conferences (each running over three days) have been held. This work has provided tools and motivation for further development and experimentation with planning.

Over the succeeding few months experimentation took place in various settings.

For example:

- A day service produced some new draft guidelines for planning and a system of management support. These sought to ensure that planning really took place for people and that it was more person centered, but not requiring over-standard methods - the idea being that various tools could be developed and used as appropriate. Linked to this were a range of creative and practical ways for people who use the service to represent their views in planning.
- A supported accommodation service focused upon the organisational and staff support arrangements needed to ensure that planning with people led to practical and useful action.
- A supported employment service developed tools by which people who do not communicate with words were able to identify and communicate their work interests and preferences.
- A day service worked on its use of multi media approaches, aiming to ensure that people using the service were able to show others involved in planning how they spent their time during the day, and their preferences.

Methods being tried within various settings and situations were fed back to organised sessions with staff and managers to encourage others to try new approaches.

A second session with John O'Brien was organised in 1997. Some of the attempts to address the deficiencies of the existing planning system were presented to a large audience of staff, families, and people who use the services. This session had a number of outcomes:

- It enabled the presentation of creative experiments and their results to a wider audience.
- It legitimised and encouraged "trying things". Some of the experiments had not worked to the satisfaction of those involved but they had learned from their tries and moved on.
- It encouraged further creative effort - John O'Brien put these attempts into a context which strengthened the belief that inclusion for people with learning disabilities depended upon determined

creative effort to break out of standardised service approaches

Other activities

1) Person centred planning group

To support the attempts to develop more person centered approaches to planning within OLDS, some staff formed a working group to share their experiences and ideas and to produce proposals for wider dissemination of person centred planning across the service. These were people who had got themselves onto courses and workshops and were excited at the possibilities of person centred planning for the people they served. Though this group did not continue throughout the whole period described here it had useful impact through continuing to inform and enthuse others.

2) Assessment Development Group

A further group was formed to explore ways of developing the assessment system. This was part in response to practical issues arising from the increasing size and complexity of the Learning Disability Service and in part an attempt to bring the ideas of person centered planning more into the assessment function. An *Assessment Development Group* was established with the aim of producing proposals for change to the system for assessment, care planning and resource allocation. As the work of this group progressed it was felt that OLDS would need to ensure coherence between any systems set up to make assessment/care planning more person centered, and the application of personal planning once people have begun use of some service.

3) Essential Lifestyle Planning project

This project grew from a session with an external consultant held for managers of the OLDS and others in the *Assessment Development Group* (see above). The aim of the session was for members of the group to ensure the development of a collective understanding of person centred planning. The session covered the origins of the development of person centred planning, the key principles, how it differs from 'traditional' planning, and an overview of the main styles and approaches.

In reflecting after this session, some members of the group agreed that in order to go beyond the phase of experiments described in this section, OLDS should do two things:

1) Consider what it would take to achieve improvements to planning for more and more people over time.

2) Undertake some structured learning about one approach to person centred planning through a focused program of facilitator training and an initial program of planning with a small number of people.

The program of training and planning was intended to both begin and inform the further development of a strategy.

Key elements of the ELP program

OLDS managers commissioned two external consultants (made available via Manchester Joint Service) to work with a nominated group of staff, train them in ELP and assist each person to plan with a person they supported. Staff who already approached their work in a person centred way and were committed and enthusiastic to develop their skills and experience in this area were invited to join the programme. The staff selected by the managers included:

- A senior manager of the service.
- Two care managers.
- Two care coordinators (These are workers placed within the care management team supported by care managers).
- A community support worker from the short term support service.

Those being planned with included:

- People with significant disabilities, including people with physical disabilities and who could not communicate with words.
- People who were seen to challenge the capacity of the service through their behaviours.
- A person from a South East Asian community.

- People in transition from services for children to those for adults.
- People using or likely to use short term support services.

Some of the outcomes for individuals and learning for the service are described in detail below

Reflecting on the learning

After John O'Brien's second visit a group of managers and staff within OLDS reflected upon what had developed. There now seemed to be a situation where several of OLDS services were taking more creative approaches to planning with people in general, and where some people with learning disabilities seemed to be getting better planning than previously. OLDS was still left with most people experiencing the previous planning system or none at all even if, in some situations, the application seemed to have improved.

Moving on from initial experiment

There were some dangers and dilemas in the period of experimentation.

With the encouragement of creativity might also come the risk of a little knowledge being a dangerous thing. For example one group of staff undertook a PATH with a person who used services but this did not lead to proper implementation and positive outcomes for the person. This example showed that though encouraging experimentation had clearly released energy and creativity, there were no clear means to ensure the quality of the emerging approaches.

There was some fear that without more focused learning and support, there might be the danger of temporary enthusiasm and activity fading and producing cynicism and pessimism.

Another factor was that demand had been created. Many staff around the service had been enthused by the experiments and were demanding access to training and support in order that they could shift towards more person centered approaches to planning.

The OLDS managers decided that the service needed to move beyond the phase of encouraged experiment towards development of a strategy to achieve gradual change across the service. They wanted to move towards a situation wherby:

- There *wouldn't* be a single universal tool for planning that OLDS required all staff to implement in the same way with all people - they had concluded that this alienates and de-motivates participants. They needed ways of encouraging creativity and allowing people to use their range of skills.
- There *would* be a set of principles and guidelines for planning in a person centred way (not the same as a universal system for doing it) This would include establishing the rights of people to be planned with.
- There *would* be a range of planning approaches to be used as appropriate.
- It was acknowledged that planning tools in themselves will not ensure good planning and therefore the necessary organisational, management, support, training and resource arrangements in support of better tools *would* be made.

In order to achieve this they would have to:

- Develop principles and guidelines for practice.
- Give clear roles to managers in order to make sure that planning appropriate to the person is taking place and that those doing the planning have the support needed to do this.
- Give clear roles to key workers and others undertaking planning.
- Develop competence in a range of planning approaches within OLDS to provide staff with mentors and supporters.
- Have introductory training on a range of approaches for managers and staff and more specialised training for some staff and others as appropriate.
- Have specific training for managers on how to support planning and avoid standardisation.

Next Steps

It was clear that this was a very ambitious project and one which would take a lot of time to follow through properly. OLDS managers were also clear that they wanted to avoid as far as possible the traditional approach to introducing this type of change. They did not want a short term program whereby managers and planners developed a tool which was then implemented in a top down process. The view was that if it took several years to develop systems and approaches that were properly owned, understood and which motivated people to involvement, this would be far better than the mirage of quickly achieved standard systems. This was part of long term cultural change to build partnerships between staff and people who use learning disability services.

At the same time as managers in a service organisation they knew that they were likely to fall back into traditional approaches and would need to continually review this.

Reflecting upon the progress to date and the tasks ahead the OLDS managers decided that they needed to:

- Learn more about the implementation issues around the introduction of person centered approaches to planning.
- Lay a strong foundation of understanding about person centered planning within the service which could be built upon in future.
- Build upon the interest in new approaches to planning amongst staff, people with learning disabilities and families by demonstrating practical effective methods which repaid the effort put into them by producing valued outcomes for people.
- Build skills and techniques within certain priority areas in order to lay the foundation for development in others.

Stage 2: Initial Implementation - 1998/9

The Implementation Group

As the ELP project developed, OLDS moved to structure and focus its work on person centred planning via the development of an Implementation Group. This group was developed under the direction of the OLDS section management team. It included members of the management team, facilitators from the ELP project, nominated members from across various service areas and some of those who had taken a lead in the phase of experiments and had a strong commitment to and ownership of implementation. Part way through the process OLDS were able to allocate resources (half time WTE) for a worker to play the role of person centred planning co-ordinator and to service the activities of the Implementation Group (see Box 6). The implementation of person centred planning was also prioritised within the OLDS Business Plan, supporting the allocation of staff time and other resources.

Over a period of several months, the group developed an outline Implementation Plan for 1998/9. The roles of the group were deemed to be to:

1. Implement person centred planning throughout the service.
2. Learn from person centred planning - how does the service need to change?
3. Support facilitators and help them develop their skills.
4. Communicate person centred values/what is the group doing through the service?
5. Evaluate the effectiveness of the planning taking place. Is it changing people's lives?

For each of these roles a number of targets were set. The outline plan was for three years. It identified key aims and targets for one year, three years and then a "dream" position to be achieved in the future. For example:

- In one year an agreed number of staff will have had the opportunity to attend a workshop led by People First in using *Our Plan for Planning* and developing Personal Portfolios. *Our Plan for Planning* will begin to be used across the service. Personal Portfolios will begin to be developed with service users who want them.
- In three years *Our Plan for Planning* is used to help people prepare for meetings throughout the service.
- Our dream - people are in control of their own meetings and record their lives in ways they want to.

Box 6 - Roles of the Person Centred Planning Co-ordinator

1) To service the Implementation Group.
2) To act as a consultant/support to the trained facilitators , including servicing an action learning set.
3) To review plans, and assure quality (including the development of a quality strategy).
4) To act as the link with NWTDT consultants.
5) To work with NWTDT consultants and service providers on the development of a person centred planning/Active Support project.
6) Research, exploring approaches to person centred planning elsewhere.
7) Link with the Service Manager re the above.

Year one plan

A more detailed plan for the first year was developed, costed and actioned (see Box 7).

Box 7 - Year One Plan - Outline **Desired outcomes**	**Reasons for focus**
The year one implementation plan sought to achieve a range of outcomes: • Continuing the training and support for an initial group of targeted staff in ELP, providing them with PATH training and then extending this to a second group. • Providing introductory information on person centred planning to all staff of OLDS. • Orientation to person centred planning for managers. • Offering team based follow up support for those interested in following up on the introductory material and introducing some person centred principles and approaches to their planning.	• To begin to build a foundation of knowledge, skills and enthusiasm which could form the basis of an eventual more systematic and service wide use of forms of person centred planning. Some of those trained could form the basis of a mentors group for the service. • To offer the opportunity for larger numbers of staff to begin to consider and explore person centred planning, as a basis for the larger scale take up in succeeding years.

Some detail of year one activity

Facilitator training and support

The ELP project has been described above and this continued into 1998. Support for this group was included within the year one plan, including an action learning set for facilitators and "buddy system" and occasional "retreat" opportunities. It was also intended to plan a project similar to the ELP project to look at what it takes to effectively implement PATH within Oldham in different situations. Delivery of this part of the plan was only partially achieved (see below).

Introductory training for staff

The intention was to offer one day introductory training to all staff of the LDS. The purpose was in part to satisfy a demand for information about person centred planning.

The introductory sessions could also point staff and teams to supports and materials which would allow them to make immediate progress in making their planning practice more person centred.

Sessions were set up with external consultants (Gill Goodwin and John Engwall) to provide introductory material for groups of 25 staff at a time. In the event logistical problems reduced the numbers on several of the days, and this proved a blessing as experience showed that groups of about 15 were more appropriate. As there were not sufficient resources to buy in consultants to cover all staff, members of the implementation group attended sessions and then reproduced the material for some staff groups. Logistical difficulties limited coverage but large numbers did access the sessions (see below).

In addition to the specific input on person centred planning approaches, members of the Implementation Group provided an overview of the development of person centred planning in Oldham and outlined the strategy for further development. This included pointing participants to opportunities to further develop their planning work including:

- The availability of literature and videos including Manchester/Liverpool People First's *Our Plan for Planning* and *Personal Portfolios*. This material could be used by teams to make immediate improvements to planning. The LDS had also purchased multiple copies of the book

People Plans and Possibilities (Sanderson et al 1998). This book provides a comprehensive overview of person centred planning including five of the main styles.

- Access to support from members of the Implementation Group. This was available on a consultative basis to teams seeking to develop their practice.
- Access to follow up training days run jointly with Manchester People First (see below).

It was emphasised in these sessions that the service was not at that point *requiring* staff to take up new approaches to planning, rather giving them the opportunity to explore possibilities which might aid them in their work to achieve better lives with people with learning disabilities.

Feedback from the sessions was generally very positive. As with any large staff group there were small numbers who did not feel the sessions useful but the great majority responded with strong interest. Some of the concerns raised by a minority included:

- Would the development of person centred planning raise expectations which the service could not meet?
- Some staff felt that they were working in a person centred way already – this wasn't teaching then anything new.
- A small number expressed the feeling that the sessions themselves symbolised top down management methods as they were required to attend.

Sessions with Manchester People First

An introductory series of one day sessions were offered to a number of teams who applied from the service localities. These sessions were made available as a follow up to the introductory person centred planning sessions. It was made a condition for take up that teams could not be staff only. They had to include people with learning disabilities and others close to them.

The sessions were jointly facilitated by members of Manchester People First, trainers working with the People First group and the person centred planning coordinator. After the first two sessions it was decided that redesign was necessary in order to fit the methods used with those participating. The sessions reported here are the redesigned version.

The key materials used were the Video *My Life My Story* and the booklet *Our Plan for Planning.* These were used to facilitate a series of sessions including:

- Information/exercises based around how to plan a meeting and opportunities to practice meetings. This was achieved using drama. People were helped to participate by using role play, pictures/photographs and objects.
- Information/exercises based around thinking about '*What is important in people's lives'*. This was presented using video. People were helped to participate by using pictures, photographs and objects and putting these together in a collage.

The main aim of the sessions was to offer the opportunity to a number of teams to explore some practical methods for making planning more person centred and which could be immediately applied. The person centred planning coordinator, as well as co-facilitating the sessions would also be available to provide follow on support for teams after the training. As noted above, a range of methods were used, including video, role play, drama, pictures, discussion. Advance planning and careful design meant that the sessions were able to achieve an explicit aim to involve people, whatever their level of disability. Jan's experience is an example (see Box 8).

Box 8 – Paula's experience of the People First session

Paula is a woman in her forties. She communicates using words photographs and objects. She attended the course with a close friend and her support worker (who she has known and trusted for fifteen years). Paula was asked to bring with her any important photographs and objects.

For the first exercise, 'Make a collage' Paula was able to use her photographs and some pictures cut out of magazines. Her friend and support worker have known Paula for many years, they know about her life and what is important to her. They were able to help her with the collage.

For the second exercise, *'Planning a Meeting'* Paula couldn't think what to do. She was reminded by her friend of something she had said she wanted to do earlier in the week She decided to base her meeting around this issue.

When presenting her ideas for a meeting Paula played a tape of her favourite song and used photographs and drawings to decide what she wanted to do. Having lots of cups of tea is essential to Paula. She also likes a piece of cake. Tea and cake were available throughput the day. Paula said that she really enjoyed herself. If she hadn't attended the course with people who know and care about her she would not have been able to participate in the way she did.

The early signs from this training with People First were quite encouraging. There was some immediate use of the material and learning. For example:

- One young man from a South Asian Community who attended with his mother and support worker was in transition from school. After the session he was supported to turn his collage into a plan and use this to present information about himself and his wishes to a supported employment agency.
- In another example, a young woman planned a party when her mum returned from Australia. She then put together a personal portfolio with her key worker at the day center she attends. She would then be able to present this information and what she has been doing to her mum on her return.
- In a third example, a couple had attended one session. They wanted to make some major changes in their lives and were unhappy with the services they are receiving. They attended with their social worker and support worker. After the session they called a meeting of people who they felt needed to hear what they wanted. They used the collage they had created to explain their needs and wishes.

Staff members who attended were generally very positive about being able to use the approaches in planning with people they worked with.

Introduction to person centred planning for people with learning disabilities

The annual three day Total Communication conference in Oldham in February 1999, included a workshop introducing person centred planning to people with learning disabilities. This was organised following discussions within the PCP Implementation Group about how best to provide useful information about person centred planning to people who use learning disability services. The person centred planning coordinator took the initiative and pulled together a range of workers to design and prepare the course. The content included:

- Introduction to person centred planning.
- A play *A home of his own* and small group discussion about the play.
- Time to look at different kinds of plans.
- Discussion chaired by Oldham Civil Rights Group.
- Information about person centred planning to take away.

An evaluation of the workshop noted, '*The person centred planning workshop appeared to be very well received by all those who attended it at the Total Communication Conference 1999. Most of the service users appeared to leave with a rudimentary understanding of the ideas behind person centred planning…..'*

The evaluation was used to examine in detail the successful features of the workshop and potentially helpful changes for future workshops which have now been built into the annual conferences.

Stage 3: Review of implementation - Spring 1999

A review of progress with implementation to date was undertaken in Spring 1999. The review and consideration of future activities and priorities was greatly assisted by a two day session with Gerry Smale, Director of Development at the National Institute of Social Work. This session for the Implementation Group, undertaken jointly with a group from Wigan, explored the application of the principles of the *Managing Change Through Innovation* approach to the introduction of person centred planning into a learning disability service.

After this session, the implementation group had a series of meetings supported by members of the NWTDT to review progress and plan the next implementation phase. The review showed that there had been considerable progress but that some objectives had not been achieved or only partly achieved (see Box 9).

Box 9 **Achieved**	**Outstanding/partially achieved**
A first group of 6 staff had received ELP training. Several people had plans which had clearly contributed to very positive outcomes (see below). The second group of 8 staff were being trained in ELP (this includes training for their managers).	• Those trained in ELP needed to review the implementation stages with the external consultant (Helen Sanderson - NWTDT). This had not taken place with all plans as agreed and there was some consequent concern about ensuring quality and implementation. • PATH training had not taken place. • Support systems for ELP facilitators had not developed to their full potential (action learning set, 'buddy system').
About 250 service staff had attended the introductory days which were generally very well received (based on evaluation responses).	• Significant numbers of staff had not received the introductory material for logistical reasons. Work was needed to ensure that induction and other existing or developing training provided sufficient and coherent introduction to PCP for new staff • Follow up support and take up after the introductory sessions for staff had been patchy and unstructured (though it had taken place in a range of ways).
New starters are offered introductory material via induction training.	• Further work was needed to incorporate person centred planning into a range of core and advanced training.
Some follow up training on Our Plan for Planning and Portfolios from People First (Manchester) had been provided.	• The People First training had not been completed and required some redesign at the point of the review (this took place and successful follow on training then happened).
	• Orientation for managers had been only partial and not covered all managers.

NB It should be noted that the above does not represent all of the activity or achievement, simply focuses upon the specific objectives.

In addition to the review against specific objectives the group explored thoughts and ideas around what OLDS might have done differently and concerns and frustrations that needed to be taken into account in the next phase (see Box 10).

Box 10 - Reflections and issues for considerations in respect of initial action plan

- A perceived need to get/make use of more 'technical' advice and supervision during training for ELP facilitators and for mutual support, mentoring etc.
- Concerns to introduce, at an early stage, systems and approaches to check and assure quality and implementation of plans.
- The tensions between speed of implementation of person centred planning and resulting threats to quality. A perceived danger here was that of reproducing previous systems and their problems through faulty implementation.
- The innovative nature of the program and its elements means that there is a need to invent and learn some things as implementation unfolds.
- As in any large organisation there are some people who do not agree with an innovation - issues about strategies to adopt in the face of disagreement.
- An agreement around the need to move, in the next phase, to careful consideration and action in respect of the 'system implementation' issues (see below).
- Issues around linking developing approaches to planning, where required, to processes needed by the service and/or required by the department or policy/legislation, without threat to their key aims.

There was a major issue around the dilemmas and possible paradoxes thrown up when introducing person centred planning within a large statutory service organisation. There are inevitable pressures and tendencies towards uniformity, 'equity' and speedy implementation. These may threaten the essence of person centred planning and lead to the reproduction of previous forms of planning with a superficial overlay of difference. There were significant concerns about the possibility of the needs of the organisation threatening the integrity of planning.

As noted above, members of the Implementation Group had had the opportunity of a two day workshop with Gerry Smale Director of Development and the National Institute of Social Work. The group reviewed relevant learning from this workshop in the context of the next stage of implementation planning. Learning and issues are listed in Box 11.

Box 11 Reflections on introducing the innovation of person centred planning

- Need to consider very carefully the 'adoptability' of the change/innovation. Given that introducing Person Centred Planning is a change that presents quite significant challenges to the organisation, its staff and managers, OLDS needed to carefully consider issues such as the general organisational effort required. This was not to be minimised but faced. There were questions around what needs to change what can stay the same? - for example making sure that existing good practice is not replaced or confidence undermined.
- Remember that the essential aim is better lives for people not simply compliance with process.
- Consider how to ensure that the ways OLDS are seeking to implement Person Centred Planning should be consistent with the key principles - otherwise there will be no trust.
- Linked to the above point was the need to build up the development, and think strategically - there is a danger of falling back into traditional policy/practice implementation methods and achieving only superficial and fragile change.
- Considering carefully how different stakeholders might define the 'problem' to which use of person centered planning might be a solution and incorporating responses to this within implementation.
- There are a wide range of people to engage over time. OLDS needed to think carefully about how to effectively engage people with different needs and the strategy for this, including key tactics to build strength and reduce threats.
- OLDS needed to ensure that ideas, experience and support flows freely and that there is no gatekeeping of these.

Second Implementation Phase – Summer 1999/2001

Having undertaken a review of the first phase of implementation the Implementation Group moved on to consideration of the next phase. A number of discussions were held which led to the production of a plan to run to April 2001. The approach adopted was to:

- Specify aims to be achieved by April 2001.
- Identify interim targets to have been achieved by April 2000.
- Set detailed objectives and action plan for the period to April 2000.

Targets for 2001

The Implementation Group identified a number of achievements that they wanted to have in place by April 2001 (see Box 12).

Box 12 - Aims for April 2001

- That all people using Oldham Learning Disability Services should have support from service staff in personal planning which meets agreed standards and operates according to person centred principles.
- That OLDS should ensure that appropriate planning is available to people at certain key points such as the transition from childhood to adulthood or in certain circumstances such as when very important decisions need to be made.
- That developing systems of assessment, service monitoring or review initiated by the LDS or required by external bodies fit as far as possible with person centred principles and practice.
- That OLDS is demonstrating its learning from the implementation of person centred planning through service development and shifts in the use of resources.
- That OLDS is linking effectively with other agencies, especially children's services, independent sector agencies and Health to ensure coherent support for people in helping them to identify and pursue their chosen lifestyles.
- That the LDS has sufficient resources and management/support arrangements in place to support commitments to person centred planning, including:

- A statement of LDS policy on person centred planning.

- Guidelines for staff and others.

- Training support for staff, people with learning disabilities, family members and others.

- Management arrangements.

- Sufficient numbers of trained facilitators deployed as mentors.

- Support arrangements for trained facilitators.

- Arrangements to monitor quality of planning and implementation.

Interim targets 1999-2000

In order to make necessary progress towards the aims to be achieved by April 2001, the group identified a number of interim aims to be achieved by April 2000. These are listed in Box 13.

Box 13 - Aims for April 2000

- Agree a program of prioritisation and targeting to achieve gradual full availability of person centred planning to those who wish to use it. Also to be meeting agreed top priority targets.
- To have arrived at decisions about what forms of person centered planning will be the main focus of effort within Oldham LDS and to have a sufficient number of staff and managers trained in these and available to assist and mentor those seeking to apply them, according to agreed targets.
- Engage with other key stakeholders to gradually build up coherent support for people in planning across organisational boundaries. This to include independent sector providers, education, children's health and social services.
- To build on developments to date in training and supporting facilitators and supporting developments in localities (see also sections on system and guidelines below).
- To have devised and written a clear policy and set of guidelines which staff, people using services and others can apply to ensure that each person using the LDS can have access to appropriate planning and support. The guidelines should specify:

1. What all people using services should expect from the LDS in respect of personal planning. This will include key principles in respect of how any planning approach should be implemented, ensuring person centredness.
2. Information about the main approaches to person centred planning and their applicability in different circumstances.
3. Responsibilities of staff and managers working with people to support access to appropriate planning and in implementation.
4. Sources of support assistance and information for staff and managers with responsibility for assisting planning.
5. Training to be available to staff, service users and families.

- To have devised a system which effectively supports the targets for implementation of person centred planning in the LDS. This system will link to the above guidelines and include:

Clarification and specification of staff responsibilities and support needs when planning with people.

1. Devising of arrangements to allow access to mentors/facilitators for people engaged in planning.
2. Clarification of arrangements for managing and supporting staff planning and implementing plans with people. There should be careful consideration given to the organisational, management and supervision arrangements necessary for effective implementation.
3. A system for monitoring development and implementation of plans.
4. Identification of training and staff development implications of agreed targets.
5. Identification of resource requirements.
6. Effective arrangements for supporting facilitators/mentors.
7. Effective arrangements for ensuring that learning from person centred planning activity is shared across the organisations and informs important decision making.

- To explore and consider the guidance from the DOH/SSI and Departmental requirements and developments with relevance to personal planning, including formal assessment and service reviews. From this exploration develop proposals to ensure necessary appropriate developments and 'fit'. NB This will not mean compromising PCP principles to fit with procedural requirements, rather to seek imaginative and creative solutions.

Action plan 1999/2000

The ensuing action plan for 1999/2000 listed specific tasks flowing from the interim (1999/2000) targets in detail. It included sections on: training ; planning/development; management/organisation; resource issues; support issues. For each specific task the plan identifies how it should be achieved, by who and when. It was necessary for the group to give consideration to sequencing and coherence of the plan elements.

It was agreed to use part of Oldham's allocation of NWTDT time for 1999/2000 to have a quarterly plan review meeting facilitated by a NWTDT member. The implementation group would continue to meet on a monthly basis to work on detailed delivery and coordinate ongoing development. Technical supervision would be provided to the person centred planning co-ordinator by the NWTDT.

The first review took place in late summer 1999. The review led to adjustments and the development of more detailed action planning in a number of areas. Some of the key developments to date (early 2000) have been:

Person centred planning and service reviews

It was notable that one of the central issues at the beginning of the whole process of development came into increasingly sharper focus. This was the issue of '*what and who is planning for'?* The implementation group put a lot of thinking into questions around how far reviews of services provided to individuals and person centred planning should overlap and where they should not. Proposals were developed and finally agreed. These aim to set out the differences and overlap/links between person centred plans and service reviews:

1) Reviews

OLDS have set out, in detail, the process for assessment and review under current legislation. This includes a range of means by which the person receiving service and family/advoccates can effectively influence the process – making it more person centred. The procedural guidelines try to establish a balance between this influence and the service responsibity for the process aimed at monitoring eligibility, quality, and appropriateness and cost effectiveness.

2) Planning

OLDS have now produced policy and guidance detailing what people using OLDs can expect in respect of person centred planning. The guidance draws a distinction between what all people using the services can expect within a reasonable period of time and what will be targeted at people in certain circumstances and situations. It is noted:

> "We know that in-depth planning methods require a great deal of commitment, time and training in order to be implemented correctly. It would be impossible (and sometimes inapropriate) to introduce in-depth person centred planning methods for all people who use the service at this stage of PCP development in Oldham. It was for this reason that we decided to find some aspects of PCP that are easier to implement, but still fit with in-depth person centred planning methods (so we are not compromising on quality)."

A rolling programme of training and development for staff, families and people with learning disabilities is intended to ensure, over time, that all people are supported in ways which guarentee that:

- All meetings held in connection with people who use the service follow the principles and approaches of the '*Our Plan forPlanning'* approach developed by Manchester and Liverpool People First groups.
- All people who would benefit get communication dictionaries.
- All those who wish it to have personal portfolios
- All people who wish it to have staff work to establish their likes and dislikes and desired new opportunties according to the approaches within Essential Lifestyle Planning.
- All those who would benefit and wish it have staff establish with them what is needed to successfully support them according to the approach used within Essential Lifestyle Planning.

An additional programme of training is intended to develop a new group of facilitators trained in additional person centred planning approaches to be available for those people

who require/request what OLDS now describes as 'in depth' planning (see below).

Training developments

The following programme has been agreed to start in 2000/1. Most of the training will incorporate the involvement of people with learning disabilities and/or their families. It will also involve managers at key stages so that they are informed about and can support the work needed after training courses.

Box 14 **Training course**	**Outline/Purpose**
Communication dictionary and passport workshop.	An eight week course for five people with learning disabilities at a time, their families/support staff. Communication dictionaries will be developed with people who do not use words to communicate.
Likes, dislikes and new opportunities.	A one day course for 5 people with learning disabilities at a time, plus family and support workers. This workshop aims to develop, through practice, a clear method for establishing people's likes and dislikes and to explore new opportunties and a plan to pursue these.
Our Plan for Planning.	A one day course for five people with learning disabilities at a time and their families/support staff. Linked managers will receive relevant input to support planning. The course promotes the use of the *Our Plan for Planning* methods, including setting up sytems for its use.
Personal Portfolios.	A one day course for five people with learning disabilities, their families/support staff. Linked managers will receive relevant input. Personal Portolios are a way of presenting information on our history and life, including a life story book, video, poster and story box.
To be succesful in supporting.	This course will look at people's important routines and what support they need to maintain these.
Team planning and team training.	Team planning involves putting together a person centred team plan, prior to the team putting together plans for people being supported. Team training is tailor made for particular teams. Teams from different services used by individuals are trained together.
Induction.	A three day course for new staff , one day of which explores the OLDS value base and person centred practice. It includes direct input from people using the service and input on practical approaches to implementing person centred practice.
Celebrating diversity.	A four day course, one day of which focuses upon person centred planning in the context of people from a range of cultures and experiences.
Person centred planning for managers.	Managers of the service will attend five linked day workshops with work to completed between the days. The course will include an audit of Oldham's progress in implementing person centred planning and link person centred planning and Best Value.
Graphics workshops.	This will be offered to people involved in 'in depth' planning in order to add to the skills they can deploy in their planning work.
Personal Futures Planning.	This is a five day course with 1-2 day follow up and problem solving. It will be offered to five people using services, their families, plus support staff. Managers will be included at key stages to ensure that they are informed/able to support teams. The intention is to add into the person centred planning 'toolkit' for Oldham.

Conclusion

The approach adopted by Oldham is analysed in more detail below. At this point it is worth highlighting that the stuctured and planned approach adopted, though having a number of deficiencies and drawbacks, has allowed the participants to keep focussed upon objectives and outcomes. Along with the energy and commitments of key participants, this has contributed to a range of outcomes and maintenance of direction.

Some activity and outcomes to date

Introduction

In this section we report on some of the outcomes of the person centred planning work that has taken place so far. In the first part we will look in a little detail at some of the outcomes and learning from Essential Lifestyle Planning work with several individuals. These stories aim to show both some of the important aspects and benefits of the person centred planning undertaken as well as issues and challenges arising in the planning and for the learning disability service generally.

In the second part we will outline wider developments in respect of person centred planning activity and organisational learning and changes linked to this.

Essential Lifestyle Planning – some stories

In mid 1999 the person centred planning co-ordinator reviewed 'formal' ELP activity in Oldham. A total of 24 plans were reported as having been completed or to be underway. These had been facilitated by the 14 people so far trained.

This section includes outline descriptions of Essential Lifestyle planning work with four of the individuals in the initial ELP programme. All of the four people have been described as having severe learning disabilities. One of the people has been diagnosed as autistic, three do not use words as a main method of communication and one has very significant physical disabilities. One young man comes from a South Asian community. Real names have not been used and permission granted to use the stories.

Karen's story

Karen was 18 at the start of the Essential Lifestyle Plan work. She was attending a school outside Oldham and would be leaving at 19. A care manager had been appointed to work with Karen, her family, the school and others in order to plan a transition into adult services and opportunities.

Reflections on Karen's plan: A personalised process - not focussed on fixing problems, but pursuing possibilities

Asked their views about the transition from school and the use of Essential Lifestyle Planning, Karen's family were very positive. They noted that it was something of a leap of faith for them based on previous experiences. They were concerned that this not be 'just another talking shop'. There had to be results, a real product, followed through and Karen mustn't be used. They needed to be convinced that the people involved had a real commitment to Karen. They described the process as very personalised. The ELP was seen to allow a very careful exploration of Karen's needs which in turn allowed her, her family and workers from several service settings to pull together and move towards meeting them.

This was different from previous experiences. The family felt that all through her school life Karen had experienced problems based upon the fact that people did not understand her well:

> "No one looked at the build up to breaking windows or hurting herself. Changes were made without thinking about the impact on Karen."

An important change noted by the family was that the ELP promoted a very different way of looking at Karen .They feel that previously the main focus had been on the outcomes of her behaviour. From early teenage years specialist challenging behaviour staff had been involved and developed approaches and ideas to help Karen adapt her behaviours. The family feel that use of these approaches was hindered by the insufficient joint work and coordination between some of the professionals and agencies involved.

The family feel that previously meetings had focused on problems and that in these meetings people didn't talk and think enough about Karen's possibilities and potential. The care manager involved also noted that he had become involved just prior to the ELP and that Karen seemed to have 'an incredible reputation'. Apart from Karen's mum, there seemed to be a very strong focus in all discussions about Karen on her behaviours. He noted that the parents described a series of professional involvements that unfortunately did not seem to have led to significant sustained improvements in Karen's life. Karen had a 'very thick file' he stated that the ELP process led to:

> "…people pulling out what they needed to know about Karen in a way that could help. There was a clear focus (leading to) clear objectives. The structure of the ELP, with clear tasks was very motivating. The results were clear in terms of what needed to happen, what she is like, what she needs, how to work with her."

The care manager described the comments of one professional, who had known Karen for a long time, when she saw the completed draft plan,

> "When I looked at the plan I just said, that's Karen, really describing her, capturing her".

ELP and Transition

The family felt that leaving school was a good time to do the ELP work. They stressed the vital importance of family information in the move between children's and adult services and the danger of ignoring this very important information:

> "You could put everything down. It triggers things off, lots of little things. You couldn't get this across just in a meeting"

Karen's parents felt that the very specific, detailed nature of the information collected was very important '…not oversimplifying'.

Comparisons with 'traditional' assessment and planning – detail, motivation and collective ownership

When asked to compare doing the ELP with more usual care management assessment and care planning, the care manager described the ELP as:

> "Having a feel of Karen, not like any other assessment or planning format. It put her behaviour in a real context - not just focus on her behaviour, seeing her anew. There was, 'a human touch in Karen's plan that isn't there in standard planning formats."

He felt that this had a major effect on himself and his colleagues, a *'shift in perception'* , promoting *'liking, commitment in others'*. He suggests that this change came gradually, that some of the service providers were a little suspicious at first, some taking the view that they would wait and see if the approach was really different and productive. People were being asked to do things that they hadn't done before and were understandably cautious. There were concerns about whether this was:

> "Just another new thing, a big document that no one will look at, that couldn't capture the person properly."

People wondered whether it would be practical to implement an ELP. They worried that constraints upon the service would mean that they could not respond effectively or creatively to identified aspirations. Issues arose within provider services around the practicalities and legitimacy of releasing staff and colleagues to be involved. At this point there was little knowledge about person centred planning generally and ELP in particular as staff had not yet received introductory training. This, however, was seen to change:

> "Providers were becoming valued individuals within the support system. Everything people said was put up on sheets, everyone's contributions were jointly included."

The sheer quality and relevance of the plan was seen to inspire people, along with the sense that they had been centrally involved in its development.

Karen's parents felt that the ELP process was a very different experience:

> "It was brilliant because everyone's views are taken into account. People were saying 'I didn't realise that!' Even we (the parents) learned things. We wouldn't have dreamed...you get in a pattern, you think you know it all."

The ELP process was seen to have the effect of:

> "Pulling out the rich detail from what the family know works. It is hard to pull out this detail from regular patterns."

Keeping on track

Some of the key tools used via the ELP process in an attempt to provide for Karen were:

- The detailed construction of the plan itself jointly developed, with collective ownership and the understanding of and commitment to Karen that this created.
- The development and operation of a 'core group', including care manager, Karen's mother, and staff from the main services, to jointly keep the plan alive/developing and to plan and oversee its implementation within the services. Karen's parents described the functions of this group as, 'Keeping it going/changing all the time, keeping it on track' The group now meets every three months, updating the plan and reviewing how to deliver it. They noted that new ideas are coming up all the time based upon the continuous learning taking place. It is interesting to note that a group with most of the core group members had been in existence around responding to Karen's challenging behaviour. The care manager's perception is that the ELP gave this group of people a powerful new motivation and clarity of goals around 'producing, implementing, focusing on the plan. A positive, problem solving focus'.

- Contracts for the main services, jointly developed, specifying precisely what Karen should receive, and how, accompanied by pocket guides as easy reference for staff. Again it was noted by the care manager and family that new tools and adaptations are constantly emerging and evolving.

These tools evolved from learning and experience. There were real problems for Karen within the two services. It is testament to the commitment to Karen and her family that those involved put great effort into adjusting, changing and learning.

Another factor identified by the Care Manager as building the confidence of provider staff was what he saw as the demonstrable management commitment and support for person centred planning, especially as training came on stream. He saw this as an important signal that effort and goodwill towards person centred planning was expected and would be supported.

Service and support outcomes – challenges and responses

One of the features of transition for Karen was that there were initially two main services involved in attempting to support her in her goals. These were a short term support service based within a large setting (for up to 12 people at a time) and an 'outreach' type of day service. In identifying Karen's essentials it was clear that consistency of support and coordination between the service providers would be vital. At the same time Karen had different needs and goals in different situations and these would have to be accommodated.

Both of the services were significantly challenged in adjusting themselves to meet Karen's aspirations. They needed to come to understand the detail of her requirements in very specific detail and to acknowledge and respond to the crucial nature of some of these. As with many districts, Oldham has historically struggled to support people labeled autistic and a number of people from the district are placed in services away from Oldham.

Both of the services were on a smaller scale than some short term support and day services in other districts but inevitably retained some of the constraints linked to trying to provide for numbers of people with different requirements.

Day service

Within the day service one of the key early needs was a high degree of consistency in the staff supporting Karen. The service learned how important this was when a key worker went on leave and there was no replacement who had developed an appropriate relationship with Karen. The outcome was that Karen had serious difficulties which meant that she could not attend the service for some time. Having learned by experience the service responded by ensuring that another key relationship was built with Karen to cover such an eventuality. They have been encouraged more recently that Karen seems to be accepting of some more staff. The care manager felt that a culture developed within the service which increasingly understood and accepted the need for service flexibility rather than trying to bring Karen back into line. Where short term flexibility was really not possible the staff team could identify what they needed to work towards changing within the medium term.

Short term support

In the short term support service, the family and care manager acknowledge that there was strong commitment to try to provide for Karen's needs and aspirations amongst key staff and managers and great disappointment by them that they were ultimately not able to do so. As with the day service an agreed contract was drawn up with the STS service and guides and training for staff provided. Karen was able to use the service for some time but ultimately this broke down. Karen's parents noted that:

> "It was hard to put it into practice somewhere like (the STS service) they couldn't deliver what was on the ELP."

A key problem was consistency of staff support in an institutional setting. It should be noted that we are not talking here of a traditional hostel type of service. Dynamic leadership, staff commitment and effective partnerships with people using the service and families have led to major developments in the short term support service in recent years, in the direction of flexibility and responsiveness.

The fact remains, however, that the service was based from a large setting with commensurate size of staff team and associated issues around individualising support. The SSD have recognised these problems and have made a formal commitment to reprovide to more suitable provision in the near future.

For some people the commitment and creativity of staff can go a long way to overcome these hurdles but certainly not for all. There is perhaps also some danger that in making real and enthusiastic efforts to provide for all people, sight can be lost of the reality that some people might simply not want to use the range of options that such a service can make available.

After the initial STS placement didn't work out another option was attempted, but was really placement born of desperation, not likely to provide more than a stop gap. Karen made it very clear that it was not for her. Increasingly the family and others involved in the ELP work were becoming clear that Karen would not be fitted in to an existing service and that support needed to be constructed around her.

A flexible response – Direct Payments

Again this was a major challenge to the organisation. As with many services most of the resources available are pre deployed and can be difficult to shift around flexibly. The commitment and creativity of those involved, however, led to the exploration of the possibility of a Direct Payment arrangement. This has recently been set up and will offer Karen and her family the opportunity to choose staff involved, ensuring they are right for her, are consistent and that the service is entirely flexible around her needs and wishes.

This was the first Direct Payment arrangement to be pursued for or a person with learning disabilities in Oldham. Though there were significant delays and frustrations it seems clear that the path to achieving it was greatly smoothed by the ELP process and the commitment, creativity and tenacity linked to this.The ELP will be used as the basis for the service to be provided and can help those involved to get to know Karen. The care manager described how the ELP process had helped the allies around Karen to find a way. The ELP showed what Karen needed and wanted, how long for, and the characteristics of the people to provide support.

Conclusions

At the time of writing Karen is growing up, becoming a young woman. Her family report that she generally seems to be feeling more comfortable with life, that she has changed a lot over the past few months. She seems happy in her day time activities. The family feel that the staff there are feeling more comfortable and confident with her. She is more willing to try things, and they understand that she really needs to understand what is going on and have developed their ways of planning and communicating with her.

In reflecting on the ELP process overall, Karen's parents described it as:

> "The best thing we have ever done."

It does seem that their engagement with this process and the alliances formed with service staff have really changed the life of this family in a strongly positive way. The care manager described the development of 'a momentum that couldn't be stopped' via the ELP process. He feels that the central and positive involvement of the family gave the plan great credibility with the providers. He feels that the format of the ELP and increasing confidence that it would help achieve real results helped Karen's mum to become much more than a passive recipient of service and indeed to take a leadership role.

Diane's story

Diane lives in a house with three other people with learning disabilities, staffed by social services workers. At the time the ELP started, she had recently moved from a temporary emergency placement having previously lived with her parents.

Getting to know Diane – the role of the ELP in building commitment

Diane was struggling to settle down in her new home. The ELP facilitator in this case was a senior manager within the LDS who had spent some time with the team working with Diane and felt that an ELP might help the team to properly get to know her and meet her needs better.

In summarising what she saw as the broad outcomes of the ELP work that took place, the manager noted:

> "The team saw her differently through learning about her in a different way. The ELP allowed the team to find out what the real Diane was like."

> "They came out with an excellent plan and through the process rebuilt the team, their own relationships and developed their skills. They became motivated and proud of their work."

Outcomes for Diane

Asked how Dianes's life had changed as a result of the planning, the manager focused upon her increased personal satisfaction with life and her new ambitions. These are supported by the staff team who might previously have been more likely to look for 'fixing' Diane's behaviours and not seen such ambitions as possible.

Diane is described as 'Assertive now in positive rather than negative ways'. This is linked in part to great efforts to develop means of communication through which Diane and the staff team can establish clear understanding. Diane is now looking for a job, with support from the staff team.

Useful aspects of the process for staff – focus on the positives, team training, evolving planning

In exploring the features of the ELP process which promoted these outcomes, the facilitator noted:

> "ELP doesn't allow a focus on negatives, it made people look for the positives. Doing an ELP on themselves helped. It makes them view their job differently. They understood how important it is to get as much information as possible. This was significant around 'small' things that are in fact extremely important. A great effort was put into looking at positives and what people at the beginning saw as major (problem) issues became insignificant. For example 'non-compliance' and 'manipulation'."

Describing her perceptions of the differences between ELP and previous individual planning, the manager suggests:

> "It's a constantly evolving process. Positive changes for a person lead on to a process of continuing change. Not just at fixed intervals. It's really helping the staff team to get and keep focused."

The manager gave the example of doing her own ELP, reviewing it and noticing important changes that she needed to incorporate for herself in order to get the appropriate support from others. If these changes happened for her why not for the people she plans with? This led on to her views about the importance of specific staff training:

> "It's crucial that any team put in training where they do it on themselves. It gives them a real understanding of the importance of getting it right. The vital importance of the 'little things'."

Supporting Diane to be at the centre of the planning

Diane is described by the facilitator as feeling valued by the process of the plan. She felt that people were showing interest in her and cared about her:

> "A member of staff worked very closely with Diane to help to make sure the plan was accessible to her, for example using graphics, so that she could sit down and tell other staff what the plan was all about. Diane was involved in all of the meetings. She chose who was to be involved, controlled the meetings, made her feelings plain. A structure was set up to support this."

In describing what were seen to be important elements of the process, the manager saw the ELP as:

> "A living thing. You can't do it unless there is the involvement of all the stakeholders. You can't do it quickly. It forces you to go through a process, not a list or a quick report. We were using venues, environments and formats meaningful to the person. You need to be aware not just to use one format. It has to change for every person that is planned with. You have to accept that you will make

> mistakes. In the past the process was clear and precise on paper, there was not a lot of risk involved (for staff). With ELP there is an element of risk involved. People will make choices that require creativity."

Problems

Asked to look at the difficulties involved in developing and implementing the ELP the manager focused on some specific issues and some organisational factors.

She felt concern about monitoring delivery of the plan, keeping it going, on track, monitoring achievements. There was a need to establish clear roles at team level.

In respect of her own involvement the manager felt that it had been important at this stage in person centred planning development in Oldham for a senior manager to have been involved in the detail of development of ELP in order to champion future developments. As coordinator of a locality she was in a position to promote and support further development within her geographical area of responsibility and to model the importance of person centred planning. She felt, however, that it was not appropriate for senior managers in general to be the focus of facilitator training. Her view was that priority in training facilitators and mentors should be given to people at operational manager levels or senior support workers.

This left her reflecting upon how best to ensure that more senior managers had enough knowledge about person centred planning in order to understand its role within a service.

Concluding thoughts

Reflecting generally upon the experience of facilitation, the manager said:

> "It was very enjoyable, an enlightening process. It's amazing what you find out about people. Teams get motivated. It links into your values and philosophies. As John O'Brien says, you 'remember the soul of your work'.

Imran's story

Introduction

A care coordinator within the care management team in Oldham undertook an Essential Lifestyle Plan with Imran. a young man who was almost 19 when the planning began. Imran was born in Pakistan and has lived for most of his life in England with his family. At the point at which the planning began he was in his last but one year at school.

The importance of communication issues and developments

In exploring the key action and learning that took place around planning with Imran. The care co-ordinator focused first upon issues of personal communication. Soon after the planning started the opportunity was taken to develop the existing communication dictionary used by Imran at school. The ELP process, which engaged key people who had a role in supporting Imran, identified communication as a major area of importance and allowed those involved to focus on improvements, which were then achieved. The group supporting and planning with Imran built up skills and tools in two main areas:

a) How to communicate more effectively.

b) How to respond to his communication.

This allowed people to get a much clearer idea of what Imran needed and wanted and to respond to this. They were able to find out what Imran wanted to do and what he did not want to do. One important example was that improved communication led to the understanding that Imran's leg gaiters needed to be changed. School activities were also changed as a result. Very importantly school staff were able to understand from the improved communication that Imran was very unhappy with his wheelchair. A referral led to him getting a new moulded chair. Another very important example was around food . The developed communication system also helped to improve links between professionals and Imran's parents.

The role of the speech and language therapist was seen as very important. The ELP process legitimised significant time input from the involved therapist which had not previously been possible. This investment of time, however, proved vital providing the possibility for real planning and leading to immediate significant improvements in Imran's life. Involvement allowed other people linked to Imran to develop important skills and tools for communication. This throws up issues around the availability and use of time by speech and

language therapists. These include the ongoing debate about the balance of time invested in being stretched thin providing direct work with individuals and time invested in other professionals and family.

Broadly speaking the ELP threw up a range of important changes that were needed and which could be worked on with the involved professionals. This was achieved because the ELP process promoted getting to know Imran very well. The care coordinator and others saw him and spent time with him in a wide range of settings, situations and environments, recording and checking their perceptions as they went along.

From planning to provision of service and supports – dislocation and challenges to service flexibility

Another set of issues explored were those around problems in transferring from planning to service provision. There were dislocations between the planning phase and the provision of supports to meet identified aspirations. In part these resulted from organisational rearrangements which were taking place within OLDS at this time. These unfortunately meant that initial planning with providers in one geographical area had to be switched to another.

Daytime activities

The ELP identified a range of preferences and possibilities that could be explored in helping to Imran to access satisfying and rewarding day time opportunities. Before these could be properly explored, however, he encountered a problem with one of his 'essentials'. It had been identified in his plan that the provision of personal care, including help going to the toilet, should be provided at all times by another man. The day service initially had real problems with this due mainly to a shortage of men on their staff team. This became a significant issue. The provider service questioned whether this was in fact essential and initially could not guarantee it. After a number of further meetings and discussions, the service was eventually able to find a way of guaranteeing this 'essential'. Reflecting on this problem, it was felt that if the provider staff had been involved at an earlier stage with the development of the plan it is likely that collective ownership and problem solving could have developed at an earlier stage.

A more strategic issue was that use of this day service by people from South Asian communities had been very rare, probably reflecting the ethnic make up of the geographical area. Whereas other services in localities with a higher population of South Asian people had been prioritised for development support, this one had not. This deficiency was highlighted by Imran's situation and a commitment made at senior management level to resolve it.

Having resolved this significant early issue the day service was able to make good progress. Commitment to Imran's plan and meeting his aspirations is seen to be developing. Linked to the low use of people from South Asian communities Imran faces real danger of isolation when using the day center itself. A core group of people, including service key workers and those involved in ELP facilitation have undertaken action planning to explore creative solutions to this, with a focus on looking to community possibilities and activities. The day service has deployed resources in support of this to aid 'community connecting' and networking for Imran in the area in which he lives.

The planning with Imran has thrown up other issues in relation to support for people from South Asian communities. There are issues around effective communication between his family and the service. OLDS has acted to provide a care coordinator from the Pakistani community but this worker is very stretched. She is having to continue to act as plan facilitator and link with the family for longer than might in future be necessary when OLDS has developed increased and broader competence in meeting minority needs.

Breaks from home

As a result of the transition planning using ELP, Imran also made use of a short term support service. Some previous service history made it difficult for Imran's family to consider him using the adult service short term support service. The relationships developed though the planning allowed the family to make the step of meeting with managers and staff. The service staff worked closely with the plan facilitator and the family to get a good

understanding of Imran's needs and preferences. A specific plan for short term support for Imran was developed, which included what he wanted and how he would be best supported. This led to work with the manager and staff team, the family, plan facilitator and care manager on the specifics of how to provide for Imran appropriately.

It is important to note that the situation in respect of the short term support service was made significantly easier as a result of the investment of development support for the service in making itself more accessible to people from South Asian communities. This resulted from an action research project which had taken place across the LDS and which led to an action plan for improvement. The action plan had prioritised support for a number of services, including the STS service. A development worker from the Pakistani community had worked with the service to develop a service action plan which prepared the ground very well for when Imran came to the service.

Some learning for Oldham Learning Disability Service

The work with Imran and his family provided much useful learning for OLDS both generally about how to better provide for people from South Asian communities but also specifically about undertaking person centred planning with people from these communities. It was seen as very important, to achieve full family involvement, that the plan was fully translated. The plan facilitator felt strongly that the translation of the plan was very important as a symbol of commitment from the service. This was done but presented real challenges to the local authority translation service! There were also issues of interpretation in planning and implementation meetings and a very great investment of time and effort by the plan facilitator who ended up playing many roles in the process. These issues will need to be addressed by the service strategically and have been referred to the LDS ethnic minority action planning group for attention. This group has identified a range of actions and these have been prioritised within the service business plan.

Liam's story

Introduction

Liam is in his early thirties. He lives with three other people in a house staffed by social services. He has lived there for about two years. He had lived in supported accommodation for all of his adult life, previously in a large hostel.

Helping Liam to be at the centre of planning

One of the very important things in Liam's planning was the need to think carefully and creatively about how to make sure he had a real opportunity to be at its centre. The plan facilitator, who knows him well, knew that he wouldn't want to do this at the day centre he attends. The staff at the centre had noted that he really enjoyed going on the bus so it was decided to do at least some of the planning on the bus. The plan facilitator, Liam and Paul, a worker from the centre who knows him well, ate on the bus. The facilitator explained the idea of the communication dictionary and Paul helped to interpret Liam's communication. Liam really enjoyed this. At other times he was not keen to attend traditionally structured meetings. Sessions were therefore put together around things that he enjoys. Toast, jam, music and chocolate were provided for participants. Liam sat on a chair at the door of the room participating on his terms.

Outcomes for Liam

The plan facilitator described changes for Liam that emerged from the planning and that clearly made a big difference to his life. One example was that previously Liam had arrived at the day service at 9.00 am and not gone out on an activity until 10.00-10.30 am. He had then returned about 2.30 pm and not gone home until 4.00 pm. He was not be keen to be involved in centre activities and would wait around, bored, pinching people's food and drink, leaving the centre and wandering. It was pretty clear that he didn't want to be there unless he was doing something that he wanted to do. So the plan led to changes. A minibus now picks him up on the way out from the centre rather than bringing him to the centre first to waste his time. There are no extra

resource implications of this for the service, as staff are there at his house. It just saves him from being bored and allows day service staff to do productive work rather than responding unconstructively to his boredom. This then extended to Liam going out from his home in a car with staff from his house.

> "We started off with the plan doing the things we knew he liked doing, and that was on a couple of things - he liked walking and he loved a bacon butty! The plan has led to new opportunities. Now he has his own car, he goes out more, he tries different things - so now people have a better, broader understanding of what he likes. We went to the Trafford centre - he loves the range of shops, and will choose items, he particularly likes the music shop. At one time you'd never have gotten him near there."

These changes have had many practical positive spin offs for Liam. With his support team of motivated, creative people he has identified things that are important to him and pursued these. One example is his link up with an old friend he had not seen for quite some time. The plan facilitator reports that in contrast to the past staff are now positively volunteering to be with Liam and do things with him:

> "The way that people see Liam is now completely different. For example, because he only goes to the day centre when he is going to see people for a purpose, he is happy to be there."

It took the process of the ELP to promote the breaking down of seperate planning between the day service and supported accommodation staff and produce the current much more productive joint planning.

Some important aspects of the process

- **Staff selection by Liam**

After doing planning with Liam, those involved decided to draw up a job description for staff supporting him. The key element of this was that anyone supporting him had to like him! This had already happened in a defacto way at his home where people had been gradually hand picked. At the day centre there were some people who were required to support him. It was agreed that only people who really liked Liam should get involved in his ELP and ultimately become part of his support team. This included Liam himself choosing people to be part of his team. The job description offers a deal to staff supporting Liam. If things are not felt to be working either way after two months Liam will look for new people. The outcome of this seems to be that Liam has support teams at home and the day service made up of people who really like him and are hence well motivated to make his plan happen.

- **The importance of communication**

As with several of the ELPs communication issues were vital for Liam. Great effort was put into the development of a communication dictionary with him, using the headings and methods within the ELP process:

> "All the people around were very keen on it, because it put his communication in a context. We used examples of when Liam was likely to communicate rather than any particular words. We looked at situations and learned through trying."

The resulting dictionary was seen to be:

> "...very practical. It says what you should do when. For example Liam doesn't like small spaces, they freak him out. If you end up in a small toilet, for example, in the supermarket he will go very stiff, he looks frightened to death and he put his hands against the walls. There were particular places, like a room in the day centre he hates. We could put this into the plan. Previously only some people knew this."

The dictionary was put together by using people who knew him really well, one from the day service and one from Liam's home. After drafting it was checked out with a wider group and amended. Whoever works with Liam now had access to the dictionary. This dictionary has had the effect that people understand him better and he feels people are listening to him and is happier for that. Now that people understand him better they do not push him into situations he doesn't want to be in.

- **Helping to keep Liam healthy and safe**

Another important issue arising in the planning with Liam was the potential dilemmas around keeping him healthy and safe. There were quite a few concerns. One example was around Liam's eating cigarette ends and the ensuing potential and immediate health problems. The group around Liam found out all they could about this. One consequence around this was asking for a screening for a zinc deficiency. A deficiency was indeed identified and Liam started tablets but this had no effect! The group with Liam

felt they had to find some way of helping him to avoid damaging his health. They felt also that one consequence of his eating the cigarettes was that he was often sick and he really hated this.

After very careful exploration with Liam (and trying a whole host of things!) a compromise was reached. If staff attempted to prevent Liam from picking up cigarettes, a struggle would always ensue, causing distress all round. People found, however that if you talked to Liam about it in advance, he will usually hand over the cigarette after getting it to his mouth. It was also found that one aspect of the enjoyment for Liam was in the search.

Alternatives to this searching for cigarretes were found. Staff working with Liam also now carry mints and he will ask for these as an alternative to searching for cigarettes.

In some ways, though, these ways of helping Liam have become less necessary. Not surprisingly, as he is now happier with how he is spending his time, and busier, his searching for cigarettes has become less of an issue.

Keeping planning and action alive

Kim spoke of how the ELP is kept alive with Liam. Initially there were meetings of the key people every two weeks, this graduated to monthly and now it is two monthly. These are used to review the plan and its delivery, to make changes where necessary, and to tackle significant issues arising. As Liam's life is changing, becoming fuller and richer, all sorts of issues arise that need to be creatively problem solved. One example provided was around safe driving issues now that Liam has his own car, looking at how he is supported when in the car to allow him enjoyment and safety from accidents. Lately this has thrown up problems but there is good commitment to resolve these. Several of the stories emerging from the planning with people stress the value of pulling people together effectively, undermining things such as inter staff disagreements and miscommunications.

Liam's plan facilitator stressed the importance of acknowledging that there will be differences and issues that will not be easy to resolve. She felt that to make a clear statement about this at the beginning and restate it throughout the process was very important. She felt that a clear acknowledgment that there would be unresolved issues at various points and that these would require negotiation, promoted honest and open work and created a safer environment for differences and even strong conflict of views.

Unlike in some other situations involving a range of stakeholders in planning, issues were less likely to remain hidden, causing problems as work to implement the plan progressed. People were also less likely to be driven apart by their differences if they knew that their issues would be listened to and honoured.

The facilitator felt that this really helped in coming to the decision to create a 'job description' and construct a team around Liam of people who really liked him and wanted to work with him. This is clearly quite counter culture in statutory services. The professional ethos and service requirements normally expect staff to work with any user of the service so long as their training and supervision provides them with the appropriate competence and support. In this situation staff were able to say that they did not feel that they were the best people to support Liam without criticism or consequence.

Some themes and faciltator reflections from the first ELP project

The Essential Lifestyle Plans completed as part of the first project were generally seen to have contributed to very positive outcomes for most of the involved people. There were exceptions to this, but even in these situations there was very important learning, at least some of which the service seems to be taking on board. At various points in the project the ELP facilitators reported their reflections around the pros and cons of Essential Lifestyle Planning. These reflections are summarised below:

Differences from other approaches to planning - placing the person at the center of the process

- In most of the examples there was a strongly expressed view that the ELP process gave people with learning disabilities significantly greater opportunities to influence their own planning.

  "It starts from the person, not from the objectives laid out in a format..."

It was noted that the person with learning disabilities was more likely to making the key choices around issues such as who was involved in the planning, where and how it took place etc.

- The individualisation of planning was often noted. An example would be the person from a South Asian community. The facilitator noted that the ELP approach gave an opportunity to highlight and respond to significant cultural issues around that particular person, not to generalise or stereotype for South Asian people.
- Linked to the above were comments about the comprehensiveness of the planning.

  "It doesn't miss important things for people. You learn so much more about people than you would with normal assessments."

  "It allows for 'deep' learning about a person and their situation."

  "You think you know someone!."

  "At first it can seem like you are collecting obvious information but you really find out that you can know someone better. You sometimes discover amazing things even if you thought you knew a person well. Little things that really matter."

  "Changes start to happen during the process and not just at the end of a plan. 'It's a living thing'."

  "Who gets involved is different."

Building productive relationships

Common themes in this respect included:

- There is opportunity for trust building, including with carers:

  "If we don't honour what people and families say we will destroy their respect for us and relationships."

- Real partnerships could develop with the full involvement of key people:

  "It undermines the us and them. There is power sharing. It allows the building of relationships. People work closely together on the detail of a plan. The process promotes contact between people who have a part to play."

- There were comments about useful effects in respect of coordination and team building:

  "It pulls all parts of the service together as well as people who offer informal support. It makes you think about the whole of a person's life. The participation of the majority of the team, not just key workers. Problem solving from shared understanding."

It was noted also that the process promoted opportunities to identify and do something about possible sources of conflict in a context of joint commitment to a person. There were also comments about some of the opportunities that this context of joint commitment could allow. These included an atmosphere which allowed risk taking and trying things which if they did not work could be learned from rather than promoting suspicion, pessimism and conflict.

Training/preparation

Several facilitators stressed the importance of doing an ELP for themselves in training:

"It's important for you to know what it's like and to show other people."

Some of those involved in the ELP work felt that it would have been better to have done more with teams so that they could be more supportive of the planning around individuals. As noted above this has been incorporated into the next stages of training and implementation.

Similarly, orientation and some involvement of first line managers was seen as vital. This has also now been better incorporated into future developments.

Transition

There were specific comments about the use of ELP in planning with people in transition from childhood to adulthood. It was noted that a longer term, more intensive, more detailed introduction to new services and opportunities promotes staff commitment and confidence with a person and their family.

Possible problems and difficulties

Time issues

Detail on how long facilitators and others spent in planning and related tasks was not collected as part of the ELP project. There was an initial intention to do this but problems arose in collecting this information. As part of the review we did ask some of those involved how the time they spent might compare to what they would expect to put in with people with similar needs referred to them. The two care managers noted that facilitating an ELP and following it through was quite time consuming. One reflected, however, that he would probably have put in a simliar amount of time with the person referred to him given the person's needs, without undertaking an ELP. He felt that his time had been used more productively than it might have been and that he had not had to deal with many of the time consuming issues that typically arise between services because the process had minimised these.

Several workers in supported accomodation involved in ELP work also noted that though significant time had been put into the work, it was very well spent. They noted that the process had provided a focus for their activities which they had not previously had, increasing the efficiency of their work. Some noted that they worked for periods of several hours a day with people over many years and that therefore time spent on planning need not be a problem. In some cases it was noted that with people often happier with their lives as a result of the outcomes of planning, time previously spent on responding to people's unhappiness could be better used.

These comments are not meant to minimise the time resources required to undertake Essential Lifestyle Planning. Research which explores the time taken by workers and others using this form of planning and comparing outcomes with other approaches would be very useful.

Service flexibility and gaps

As discussed in other sections of this publication, there was frustration that some services were not able to respond with sufficient flexibility to provide the supports necessary to meet aspirations identified in the planning. This was undoubtably true in several cases. Having said this, in a number of cases the identification of obstacles did lead to service adaption and in others to commitment at a senior level to take action to increase flexibility and broaden options.

At various points there were discussions about the anticipated fear that some had of 'raising expectations' without resources to meet these. Reflections during and after the project however were mostly that:

- When expectations are raised there is more chance of them being met!
- Many of the outcomes of planning did not require greater resources to help improve people's lives. Very often the changes were to how resources were used or how people worked together to offer support.
- The release of creativity and flexibility in the planning sometimes led to the creation of new resources without call on the specialist learning disability service.

Materials to support planning

Several of those facilitating ELPs stressed the importance of the availability of various materials and supports, such as video equipment, graphics training, resources for purchasing materials etc.

Wider developments across Oldham

A number of managers and practitioners from different parts of the service were asked for their thoughts about the impact and development of person centred planning to date. Clearly it is difficult to separate out the specific effects of the activity relating to the Implementation Plan from other developments. It seems that there are lots of connections and 'spin offs', for example between formal ELP training, the introductory training for staff, and the People First sessions and materials. These seem to be linking with various service and organisational developments in producing a wide range of outcomes. Some of these outcomes are outlined below.

In the service localities

Activity across the service localities is uneven, linked to the implementation approach. At the time of writing:

Oldham locality have most members of staff involved in formal person centred planning activity and so practice has developed at a relatively rapid rate. Some examples are:

- A supported accomodation network manager has overeen the implementation of person centred approaches to planning with 16 people who live in four houses.
- The day service within the locality have begun to implement planning that is more person centred with a number of people.
- A number of people have Essential Lifestyle Plans.

Failsworth locality have two staff members to date who have completed formal ELP training. The local service providing day time activities, have for a number of years, been promoting more person centred approaches to planning using personal portfolios, celebrations, and by focussing upon creative communication.

Chadderton locality have three people who have completed formal ELP training. In addition to this the Person Centred Planning Co-ordinator has helped facilitate three ELPs. They have also agreed to take part in the development of a person centred planning project. The exact content of the project has yet to be agreed but it will include the implementation of Essential Lifestyle Plans in a particular part of the locality. This was scheduled to begin in early 2000. In this locality a major project to undertake person centred planning with six people with 'complex needs' leaving school all at the same time was underway (see below).

Person centred 'thinking and practice'

One network manager , asked about the development of person centred planning in her locality commented:

> "If you are asking about the impact of person centred planning I would give you the example of one person who previously displayed very challenging behaviour and who now doesn't! This was a person with seclusion guidelines! She is now accessing work and college. These are things that would have been a dream and they are now a reality."

The manager described the work in her geographical locality around 'person centred values and practices'. This was seen to have enabled staff to 'focus, listen, spend time finding out what the person wants and dislikes'.

> "Staff are very enthusiastic and positive. They are getting a kick out of seeing people achieve things. At last staff can be treated as grown up!"

In this locality the focus to date had not been exclusively on a comprehensive approach such as Essential Lifestyle Planning. Staff had been on introductory sessions on person centred planning approaches and had viewed the People First video on developing personal portfolios and studied the *Our Plan for Planning* booklet. The manager felt that work with staff to think about their own lives and aspirations had been particularly helpful as had the portfolios material:

> "The staff very much enjoyed the portfolios and found using them with people very rewarding and useful."

Transition

Within care management, perhaps the most notable impact has been on the school leavers transition process. It is reported by the person centred planning co-ordinator that:

> "Involvement with school leavers, supporting them to plan for the future has become much more person centred."

It is suggested that that this in part has come about because some care managers and care co-ordinators have undertaken training in person centred planning. This has happened, however, in a context where the new role of 'care co-ordinator' was introduced into care management. The job title is something of a misnomer as the role seems to be more about 'support' planning and co-ordination. Four posts were first seconded into care management and then made permanent a year ago. Transitions work is an explicit priority for care co-ordinators. Each care manager is allocated people in transition and takes responsibility for development of a shared transition plan. Care co-ordinators work alongside care managers in developing and implementing the plan.

The person centred planning coordinator offered just a few examples of the increased creativity in transition work:

- A young man had decided that he wanted to go to college. He communicates using some words but frequently became upset when he was trying to tell someone something and they didn't understand. The Care Cordinator decided with him to put together a personal portfolio about his life using photograhps. This helped him greatly. When he began college he used it to communicate with people about his family, likes and dislikes and other important information.
- During the process of a care coordinator getting to know a person, the young man asked if they could drive a sports car. The Care Co-ordinator arranged for them both to test drive a sports car! During the test drive very important information about the person's thoughts, feelings and aspirations was shared.
- One young man said that he wanted to play football for Manchester United. Rather than immediately rule any such possibility out, the Care Co-ordinator took this at face value and explored possibilities with the person and with the club. Though a position on the playing staff did not ensue a job at the ground did. This was a compromise he was happy to make.

The work to make transition planning more person centred links with the development of multi-agency transition policy and a joint steering group to implement this. One of the consequences has been that the need for specific service developments have been more systematically identified. With individual planning starting from people's aspirations rather than simply identifying which of a limited range of specialist services they are eligible for, some new supports and provisions have begun to emerge.

One example is a joint project with community education to develop appropriate adult education opportunties for young women from South Asian communities who were often leaving school and simply staying at home. Another is the 'New Liberties' project which works with young people in transition in order to enhance their opportunties to access and develop adult leisure opportunties including linking itno a range of natural support opportunties. It is important to stress that these are not high cost services and both focus on taking advantage of mainstream opportunties and funding.

Training by people with learning disabilities

Following on from 'training' received by people with learning disabilities, a number of people decided that they wished to themselves offer training to staff and create opportunities to communicate their key issues to staff and managers. One outcome was that a group of people with learning disabilities, with the support of the NWTDT and external facilitators, have planned a conference for staff, managers and chief officers at which they will discuss what they want and need from services and how they wish to work on partnership towards change.

Links to the independent sector

As identified in the action plans, work has now taken place to bring staff and managers from local independent sector agencies into the training and development process.

More individualised living arrangements

In each locality work is starting to take place to respond to the wishes of some people who want to move out of small group homes and into their own place or with people of their own choosing. In a number of situations work has taken place to design new support arrangements around individuals and to take a more flexible approach to, for example, the specific location of accommodation. At the locality service level some resources have been deployed to support such arrangements. OLDS is anticipating that more people will desire more individualised arrangements in future. Linked to this learning and activity around individuals, OLDS has signed up for a twelve month programme with Housing Support Partnership in order to:

1. Explore the range of possibilities for widening options in supported accommodation/living.
2. Develop a medium term strategy for supported accommodation that both anticipates changes in demand and incorporates ways of responding to these in strategic plans (Joint Investment Plans, Business Plans).

Day activities and employment

For a number of years there has been a programme of shifting from large day services to use of outreach and community settings. These shifts have both been given impetus by and coincided with developments in person centred planning. Though there are of course constraints, there is a strong impetus to developing more individualised and outward looking 'day' supports. As this takes place boundaries such as 'day' services and 'short term support' are starting to blur. In the case of employment there is a long established supported employment service. Consideration is increasingly taking place, however, to supporting people's employment aspirations differently. Staff from other service areas are starting to see roles for themselves in supporting these aspirations, in some cases in alliance with families.

Beyond services!

It is noticeable that there are increasing debates and some activity around making sure that person centred planning is not simply about making lives within services better. For example a group of staff, people with disabilities and others are jointly working through a development programme on 'Making Community Connections'. There are an increasing number of examples where people are managing to get lives which are not wholly dependent upon service supports. It remains to be seen how far OLDS is able to/goes in shifting from making services better towards supporting people to build lives which are not lived wholly within services. There are some promising signs in work being undertaken to support people planning for adult lives (see other parts of this publication). Resources are also starting to be made available to support people with disabilities and families to develop their own skills in person centred planning. The danger remains, however, that person centred planning could remain primarily the province of service workers and that outcomes could be constrained by this.

Learning for the organisation

There has been some important organisational learning resulting from the person centred planning initiative. Sometimes this learning has been fairly easy to accommodate by OLDS, sometimes it has thrown up major issues that require significant attention. Some of the issues that have arisen are ones that were already known to the service but have been thrown into starker relief and led to focused debate with the increased possibility of resolution or improvement. Put together, these issues and others like them, have advanced and informed the general debate within OLDS about the limitations of congregated services with their inevitable institutional features. It appears that the search for more individualised, creative use of resources has been given even greater impetus, and this is reflected both in strategic planning and local action.

Support for people from South Asian Communities

As noted above, with a young man in transition from school who comes from a South Asian community the issue of same sex personal care arose. Within the ELP this was identified not surprisingly, as essential. Part of this young man's service was to be provided via the resources of a day service which initially found it very difficult to guarentee this, as a result of a relative shortage of men in the staff team and some issues around the service's organisational arrangements. As in most districts, experience in local services acessed by people from South Asian communities until quite recently had been that they and their families would have to compromise, often on important cultural or religious issues, in order to be able to use a service.

Research within Oldham had shown that some people had not been able to access services and others had had to put up with things they were uncomfortable with. It is likely that when these people had come forward for service in the past there had been an assumption that the service could only adjust to a certain point and then people had either to take up the service and compromise or not receive support.

OLDS has taken significant action over the past four years to change this situation but there is clearly still a risk to people who do not fit easily into existing ways of doing things. In this case the ELP meant that this issue had to be faced and responded to by the service providers. It was brought into stark and clear relief by being an 'essential'. Although it was difficult for the service to make the adjustment, the fact that the issue could not be avoided or sidestepped led to collective problem solving and a creative solution. The focus had also led to a number of other activities involving support from the wider OLDS to ensure that this person's needs and aspirations are met The significance of the issue again showed OLDS that further strategic action was needed to prevent discrimination.

Support for people with 'complex healthcare' needs

For one of the people who was part of the ELP project, very good planning by the care manager, the person's carer, school staff and other staff of OLDS did not, unfortunately, lead to the desired support outcomes within OLDS provision. Jean is a young woman who was 17 when planning started, living with her single carer and attending an out of borough school. Jean needs a great deal of support and has complex physical disabilities. It was felt by the care manager who acted as facilitator that the detailed process of ELP might be very helpful to support Jean and her carer in the transition from school. In important ways this proved correct. Many elements of the planning worked well and were very helpful.

Staff at Jean's school appreciated the planning process, feeling very involved and supported. There was good communication and effective joint work and planning over a period of about 18 months. The care manager feels that the

process promoted a sense of shared ownership and commitment to Jean.

Jean's carer is extremely committed to her and had a strong need both to be fully involved and to properly influence both the planning and support outcomes for Jean. She was very happy to use the ELP process. As a professional herself she was impressed by the time put in and the comprehensive nature of the process:

> "I can't believe the amount of trouble you are going to."

Staff involved in the planning showed themselves able to be flexible, spending time at appropriate times with Jean, including time outside of working hours and in a range of settings to get to know her properly.

Creative methods were used to get to know Jean and to record very important information for those who would be supporting her. For example, Jean needed very specific support in the areas of bathing and dressing, eating and her posture.

After an intensive effort to provide within OLDS, however, provision was finally made via a local independent sector service. This seems to have resulted from the inability of the provider services involved to offer the consistency of relationship, skilled support and flexibility required by the young person in order to meet her 'complex' needs and to satisfy the standards of her carer.

As the outcomes emerged a meeting was held involving the care manager, care management team manager, provider managers and members of OLDS management team, including the service manager. The purpose of the meeting was in part to review the outcomes and consider possible further service support for the person, but also partly to pull out the lessons for the service.

The group concluded that OLDS would find it difficult to properly meet the needs of other people coming through from school with similar levels of disability and health care needs without action to further develop service competence and coordination between key agencies and professional groups. In some ways this was not a surprise to OLDS. An increase in such challenges had been anticipated for some time and in some cases in recent years the service had managed to find solutions. As with the previous example though, the work undertaken to produce the ELP powerfully highlighted the specific service gaps and deficiencies.

The learning from this situation illuminated and informed some other work that had been taking place at a more strategic level. OLDS and the Health Authority had undertaken some work to identify the needs of young people who would be coming through into adult services in succeeding years and the changing profile of needs of people already using services. This included some joint assessments with a number of existing people using services who have particularly complex needs.

In the short term it had been identified in transition planning that a group of young people with very significant disabilities and health care needs would be leaving school in summer 2000.

The issues arising informed the early development of the Joint Investment Plan and priorities for joint action. It was agreed to urgently develop a project which would identify the needs and aspirations of this group of young people and their families and make recommendations to the joint commissioning group for service developments. These should ensure that appropriate services were in place to meet their needs and to enhance the general competence of services to support people with similar needs in the future. As a result a project group was formed.

The project group set up individual teams with core group members and others to work to undertake Essential Lifestyle Plans with each of the young people, alongside their families. Each of these groups would work to develop plans for individual actioning in support of the young people's transition. In addition, however, the project group would:

- Aggregate additional or new service input requirements emerging from the individual plans in order to make proposals for service development to the joint commissioning/investment planning group.
- Identify ways in which existing specialist and other services and providers of community opportunities could work together to assist in meeting the identified

needs both for the identified group and more strategic action for the future.

- Support the individual planning teams in exploring creative ways of meeting the needs and aspirations identified.

An important aim is to start from the people and seek to shift/develop services and resources to this end. The group aims to learn not only how to provide services for people with greater disabilities but how to provide the kinds of developing options and choices becoming available to people with less complex needs. It aims also to avoid channeling people to social care or health services/resources, specialist or generic, bringing appropriate resources together in the service of the individual support required.

At the time of writing, an outcome of this project recently announced is the development of a health in transition team of workers including speech therapy, nurse co-ordinator, physiotherapy and a dietician.

Shifting towards more flexible service design and provision

A third example, detailed above, is that of Karen for whom things that were vital to her happiness could not be provided within the main, building based short term support service despite the sincere efforts of staff. It seems no coincidence that she was the first person with learning disabilities in Oldham to obtain a Direct Payment. This experience has clearly added to pre-existing motivation to increase flexibility of support services but also to acknowledge that mechanisms such as Direct Payments must become used on a regular rather than occasional basis if supports are to be truly built around people. There is now a plan to develop more Direct Payments specifically for people with learning disabilities, with concrete local targets and the anticipated appointment of a dedicated Direct Payments worker.

Some thoughts on person centred planning and care management

The issue of person centred planning and care management has been the subject of some debate in recent times. In addition the last two reports of the Chief Inspector of Social Services have expressed concern about the performance of care management**.** Some debate centres on questions of the appropriateness and potential/lack of potential for the undertaking of person centred planning by care managers.

It would be strange to suggest that care managers do not try to work in a person centred way in their assessment, care planning, specification and monitoring work. A central aim of care management is to properly involve people and families in these processes.

Experience suggests, however, that care managers are often not able to achieve what they would like in this respect. Care managers often express concern that their case load sizes make it difficult to be as person centred as they would like, and that their roles are becoming increasingly proceduralised, with a focus on assessment for eligibility for specialist services. Thus the hope that care management could be an engine for change focused on individual assessment and specification is often not being realised.

Experience in Oldham, however, offers some good examples of workers within the care management service using Essential Lifestyle Planning and other approaches which have contributed to the achievement of positive outcomes.

In some of the examples, there is clearly evidence that an approach has been adopted which goes well beyond assessment and basic specification for service. These have included the development of a range of productive relationships, negotiations around flexible supports and the construction of effective alliances for further planning and action in the future. Care managers/co-ordinators have undertaken assessment and determined eligibility but they have also done much more.

We have seen a continuum from using a range of more creative approaches in assessment and

planning through to the use of Essential Lifestyle Planning to create a compelling image of a person's desired lifestyle and stimulate determined collective efforts to support this.

This does not mean, of course, that the activities of care managers will be sufficient or that they are likely *in themselves* to be able to achieve the long term formation of relationships and alliances which could support people in pursuing ambitions and opportunities beyond services. For this much depends upon the involvement and commitment of others. The process and outcome of planning with Karen is a good example where the involvement and commitment of her family were crucial. We would certainly not recommend that person centred planning be located only within care management.

So what should care managers do/be enabled to do? Our experience, as noted above, is that despite the variations in how care management operates, it is currently almost invariably the case that care managers carry heavy workloads. In such a situation it is very unlikely that all users of care management could immediately benefit from an approach such as Essential Lifestyle Planning. Oldham have shown, however, that a 'depth and breadth' strategy can produce a situation where some people receive support to develop an ELP while more can receive involvement from care management which utilises some person centred principles, tools and approaches. The key elements of the Oldham strategy have been:

1. Intensive training for some care managers and care co-ordinators (in the context of training in person centred planning principles and practical approaches for service provider staff, some families and some people in receipt of services).
2. The provision of additional staff resources into the care management team to allow for the required time to be invested in more person centred care management work.
3. Targeting of some care management resources to agreed priorities, e.g., transition.

In discussion with care managers involved with the ELP project the view was that this was how care management should really be done. They took the realistic view however, that with the resources likely to be available to care management in the foreseeable future, Essential Lifestyle Planning could only be focussed on a minority of people.

Some of the approaches and methods within ELP and other person centred planning approaches, however, could be more widely applied. Discussions with care managers and others led to something of a consensus around the value of investing time to undertake ELPs with people in transition from school or where important life changes were seen as needed or imminent. It was seen as particularly useful in circumstances where it was both difficult and very important to clearly establish a person's aspirations and the ways in which services could best support the person.

The experience in Oldham to date would also seem to suggest that if care managers are going to work on person centred plans with people, they need to engage as soon as possible in the process with important others. These include family, other non-service supporters and potential or actual providers of service. This seems vital in order engender collective commitment and problem solving. Experience cautions us against person centred planning being used simply to generate a care plan or service specification to hand over to an identified provider with the responsibility to deliver it.

The future?

While offering what might be seen as optimistic thoughts on person centred planning and care management we need to stress our view that the possibilities outlined above are only likely to come about if there is an explicit and followed through commitment to shift the culture and contexts within which care management typically operates. 'Ideal' type purchaser provider models or simple 'assessment, plan, specify, review' systems, with large case loads and no protection within these will not allow for the good use of person centred planning. If attempts are made to systematise person centred planning within care management in such a context, some concerns are very likely to be realised.

It is our experience that such systems will usually not properly allow for the effective involvement of people and their families which is sought in legislation and guidance. Where organisations decide to continue to operate such systems the best that can be hoped for would seem to be better practice in 'fair' allocation of resources and some modest shifts towards more 'user friendly' assessment practice. If this is how care management develops we would support O'Brien's position that it would be best to focus efforts to develop and support person centred planning beyond those with responsibility for commissioning services. People, their families and supporters, armed with person centred planning methods, could then work with allies within provider services or via Direct Payment arrangements to construct their own supports with the resources they are deemed eligible for.

Organisations could take the view, however, that in order to deliver on policy objectives around social inclusion, and the 'joined up' deployment of a range of provisions and resources to achieve this they need, over time, to broaden the aims, functions and uses of care management.

It is our experience that most care managers are not in a position to make full use of their skills and experiences when focussing upon assessment, care planning, specification and review and with large case loads. They are often frustrated when this takes up a large portion of their time. They can feel that they are merely gatekeepers to a narrow range of service options. Our experience is that many care plans are little more than outline service specifications. Despite the guidance and rhetoric of recent years this remains the case.

We would stress again at this point that we are not suggesting that such planning should be located with one professional group or only within the part of a service called care management. Oldham's experience is interesting in this respect. They have taken the approach of recruiting additional workers to support the care managers, based more on their skills and values than their professional background. In addition, the locality management system in Oldham brings together a range of professionals and managers typically seen as purchasers and providers and promotes the flexible involvement in planning of those deemed relevant to individual situations. This system promotes the early linking of those involved in assessment and those likely to be responsible for providing some of the supports needed. In this way planning is not the sole responsibility of the 'purchaser'.

The approach which seems to be beginning to develop in at least some of the localities adds in a community development function. The locality management teams, at the local strategic level, see their function being to both deploy the resources at their disposal and to forge links and relationships with a wide range of other service and community resources. This can provide a context within which action in support of individuals can be shifted from allocation of specialist resource towards activation and taking advantage of a potentially much wider range of opportunities and relationships – essentially to promote social inclusion

It is within this type of context that care managers could join with others and use person centred planning approaches to shift away from the typical processing of people between specialist children's services into the existing adult learning disability service system. It could offer greater opportunities to:

- Engage more effectively with formal and informal supports and resources, including those beyond the usual specialist social and health care providers.
- Make best use of and further develop the skills of care managers.

Analysis of implementation

Introduction

This section aims to review the steps taken so far by Oldham LDS in the context of literature on management of change and the implementation of person centred planning. This is done in order to extract lessons from implementation work to date which might be of use to others.

The literature on the management of change and the introduction of innovations points to a number of principles that may increase the likelihood of success in implementing person centred planning in a large and complex service like OLDS. This section draws from the work of Gerry Smale's *Managing Change through Innovation* approach, and that of John Kotter, Beth Mount, John O'Brien and Michael Smull amongst others. This is used to critique the process of change described in this paper and provide further ideas.

A retrospective view is a wonderful thing and we would like to stress at this point that our critique is intended to be supportive of Oldham's efforts!

Why a different approach was required

Typically when change is required within a service agency, either through dissatisfaction with the existing system , as happened within OLDS or through policy change at a national or local level, a familiar course of action is taken.

- This begins with managers devising a new policy, procedure or implementation strategy.
- This is then communicated to staff through papers, briefings and short training courses.
- As a result staff are expected to change their behaviour and implement whatever changes have been decided.

Individual Programme Planning was typically implemented through cascading information and training this way. Staff were sent on courses, procedures were written, new roles described and the system was expected to be put into operation. This approach had widespread acceptance. However research does not demonstrate that this is an effective way for disseminating new approaches to practice (Domoney 1992). Gerry Smale (1998) reminds us that there are serious dangers in proceeding in this way, as if you can change the web of relationships within an organisation and between staff and service users in the way that you design and build new machines.

There are two reasons why we cannot approach the implementation of person centred planning in this traditional way.

- The first is that the style of planning used cannot simply be imported without some modification

and

- Secondly person centred planning requires fundamental changes in our relationships with people with disabilities.

1. The planning process needs to be adapted or modified for each organisation

Person centred planning is becoming increasingly popular and fashionable within human services. This has generated an enthusiasm for an unquestioning, quick adoption. Smale has found, however, in both the literature on the adoption of innovations and the experience of the Practice And Development Exchange project (Smale 1998) that most innovations in human services need to be 'reinvented' to meet the particular circumstances of each different service.

This may sound like heresy to some. It was, however, important in the approach that OLDS took through the ELP project. By investing sustained effort and ongoing support the initial ELP group began to learn what it took to implement ELP within care management and other situations within the service. They discovered subtle adaptations to the process that made it more likely to be successful within Oldham. One example of this from

another service was to change the headings used to make them clearer for people. The original headings in ELP were 'Non-Negotiables, Strong Preferences and Highly Desirables'. An implementation group changed these for their service to 'Essentials, Importants and Enjoys'.

Adapting person centred planning styles in this context means learning by experience what it takes to successfully implement the process in the service. This should not mean trying to standardise and streamline the process. As Beth Mount states:

> "When the system takes over the planning process, the activity immediately loses its power, flexibility and responsiveness, quickly becoming one more intrusive, insensitive and ineffective activity."

John O'Brien and Herb Lovett (1992) specifically caution against managers and administrators developing forms and procedures for planning, instead of facilitators adapting the processes they use on an individual basis. OLDS managers are aware of these risks but need to continually review their activities in this respect. They face the dilemma of trying to achieve change from within the organisation and the pressures (internal and external) to achieve some form of equity of access to planning and outcomes.

2. Implementing person centred planning requires 'second order' change in key relationships.

Gerry Smale (1998) makes a very useful distinction between 'first and second order change'. Distinctions between types or orders of change are made by many writers. For Smale, the fundamental distinguishing factor is that first order change is a change in behaviour or procedure, and second order change requires a change in key relationships with people as well as different skills and knowledge. Second order change will typically be required in the implementation of person centred planning.

In our view person centred planning is fundamentally different from traditional IPP. IPP required that staff behaved in a synchronised and standardised way. Person centred planning requires that staff have a flexible and responsive approach to meet peoples changing circumstances, guided by the principles of good planning rather than a standard procedure. Staff need to be constantly problem-solving in partnership with the person and their family and friends, sharing power and decision making.

To achieve this will require second order change . Managers wanting to instigate second order change need to do so through example. For example you cannot order staff to involve service users in decision making without significantly collaborating with staff in the organisations' own decision making processes. Smale simply states that 'to empower service users, managers and policy makers need to empower their staff'. (1998 p149). In any change effort where the intention is to empower service users, this will require very different approaches and styles of management from those used by many managers. The Oldham mangers agonised, for example, around the voluntary or compulsory nature of involvement of staff in developing person centred planning.

- In Oldham, some efforts were made to hear from and involve staff in the decision making processes and lead by example. One of the ways that a senior manager led by example was by joining staff in the ELP project. Although this senior manager did not have the contact with service users that would enable him to directly plan with someone, he used the planning process with someone in his family so that he could still learn about it in practice. Another senior OLDS manager became directly involved in the project, facilitating a plan with a person and a staff team.
- Staff were also involved in days with John O'Brien to share what they were learning with managers.
- However, until the formation of the implementation group the decision making lay mainly with the senior management team. With the establishment of the Implementation Group there is a forum for involvement of people at different levels within the organisation to be part of the decisions made about the implementation process. We would suggest that the potential of this forum could be enhanced if access were further extended to include family members and people using learning disability services.

The role and function of the Implementation Group Change agents in person centred planning

As described earlier, the implementation group has five key functions:

1. To implement person centred planning throughout the service.
2. To learn from person centred planning - how does the service need to change?
3. To support facilitators and help them develop their skills.
4. To communicate person centred values/what is the group doing through the service?
5. To evaluate the effectiveness of the planning taking place, is it changing people's lives?

In this section we examine each of these, see what we can learn from the management of change literature and evaluate the progress that OLDS made in this area.

Role 1 To implement person centred planning throughout the service

a) Why is a group required?

As Smale (1998) states:

> "Change is a process that needs to be managed."

Like any successful journey it needs to be deliberately planned and continuously monitored so that changes in course can be made as required, and with a conscious allocation of staff effort to complete essential tasks and solve problems along the way. Some changes in organisations are much easier than others and are much more susceptible to 'traditional' methods. It is not enough to state what should happen in policy statements and procedures and to expect subordinates to behave differently.

One person alone, however senior, cannot effect the fundamental changes in services required to truly listen and respond to people through person centred planning. John Kotter calls the type of group required a 'guiding coalition' who form a critical mass for change in the organisation. This type of group needs to be powerful, in terms of opinion leaders, expertise and reputations as well as formal status. It needs to represent key stakeholders and often be lead by a key manager, with the head of the organisation as an active supporter. The group needs to spend time together, not just in the traditional monthly meetings but perhaps through away days to address the wide range of complex issues that need to be dealt with.

An implementation group can lead an organisation through the stages of development of person centred planning. These can be seen as:

Gestation: Who needs to be brought together to begin to discuss problems and to consider solutions and proposals?

Initiation: What activities need to be undertaken to turn good ideas into practical proposals for implementation?

Development: What action needs to be undertaken to adapt innovation to the particular circumstances pertaining to specific adoption sites? (Smale 1998).

The group in Oldham was formed in the third stage after the ELP program had identified some of what needed to be learned about implementing ELP within Oldham. The group had senior manager representation and included facilitators and enthusiastic people in the organisation. The group was initially co-ordinated by a senior manager. For an interim period it was co-ordinated by a change agent, who although experienced and committed to the development of person centred planning lacked the formal power to push developments. At the time of writing a senior manager has again taken responsibility. It is easy to think that as organisations become flatter and leaner that this should not be required. However the reality, as Kotter suggests, is often different.

Symbolically as well as practically it is our view that leadership is required from senior management within the group.

b) Early work of the group - clarifying questions, creating urgency and mapping the territory

Smale encourages us to frame implementation of innovations as a problem solving process. The advantages of this are that it helps the group keep the empowerment of people with learning disabilities at the forefront of their minds rather than the successful outcome being seen to be the implementation of a process. Success is people getting better lives, not an organisation getting a reputation for doing person centred planning well. Keeping focused on problems and solutions also helps avoid changing more than is necessary and ensures that existing good work is built upon. So rather than a 'we must adopt person centred planning' approach, different questions emerge, for example:

- What is the problem and for who is this a problem?
- Who wants to adopt person centred planning and for what reason?
- What problems does person centred planning solve and for whom?
- How do service users or customers see the problem?
- What needs to stay the same and what needs to change?

In OLDS these issues were addressed through listening to the dissatisfaction with existing planning from different groups of people including people with learning disabilities, hearing from people who were trying different ways of planning and spending time in reflection to identify what questions needed to be addressed. A danger for other districts and agencies is that person centred planning may simply be pursued because it is fashionable, without spending time listening to people.

According to Kotter this is crucial for developing a sense of urgency that will fuel the change. He states that over 50% of the companies he has watched make changes do not create a great enough sense of urgency, that is communicated boldly enough to 'drive people out of their comfort zones'. Handy (1981) also stresses the importance of this, suggesting,

'Create an awareness of the need for change. Preferably not by argument or rationale but by exposure to objective fact'.

Is there a sufficient sense of urgency in OLDS to propel and sustain change? This remains to be seen. After a promising start, the implementation group needs to continue to stress why the service needs to change. Harnessing the voice of people with learning disabilities and families to this is vital. Good work has began through the People First sessions and the Total Communication conference, however this needs to be extended so that people with learning disabilities and family members demand that the changes taking place do not lose momentum. Finding ways to include the voices of those receiving services in the implementation group will be a significant step forward. OLDS is now looking at ways of encouraging and enabling families and people with learning disabilities to themselves take the initiative in planning, rather than plans being undertaken always at the behest of services and with who and when they deem this possible.

Creating a sense of urgency does not, of course, preclude acknowledging the good work that already exists that needs to be built upon.

Beginning to answer the questions outlined above requires that the group has a good understanding of the people who will be affected by change and the culture of the organisation as well as person centred planning itself. This mapping activity is central to the *Managing Change through Innovation* approach that the Oldham group were introduced to through Gerry Smale. Briefly this requires that the group identify the roles that different individuals occupy in relation to the change, for example:

- Who are the opinion leaders?
- Who will be 'product champions' for this innovation?
- Who has to release resources?
- Who could sabotage the process?

In addition to these roles, the group must be aware of the emotional impact that implementing person centred planning could have on people, for example:

- Are they active or passive in the process of implementing person centred planning?
- Does person centred planning change their identity?
- Do they perceive themselves as winning or losing?

Mapping the territory also includes the culture of the organisation as well as the key players. These issues take time to address, hence the need for time together as a group through 'away days', for example. The issues are addressed in detail in Smales books, (Smale 1998), Smale et al 1993.

Dissenting voices

Before beginning to plan the first steps of the implementation, as part of clarifying the questions and mapping the people, the voice of those who disagree needs to be clearly considered.

Smale states that:

> "In many situations the chances of successfully managing change are improved when the convergence or divergence of thinking is made more explicit rather than left implicit. This means that managers wanting to change the practice of others will encourage a climate where disagreements can be openly expressed so that all possible information available is put into the decision. Ironically, convergence of thinking is more likely to happen when there is open disagreement and a free sharing of alternative points of view. Such open negotiations can end in agreed action, or perhaps more commonly, agreement to follow a course of action whatever personal agreements exist." (1998).

This is consistent with current thinking about 'learning' or 'innovative' organisations which stress the value of open communication to achieve a shared understanding and commitment to a vision (Mintsberg 1989, Peters and Waterman 1992, Senge 1990, Kotter 1995).

One agency that sought to adopt person centered planning said:

> "We have found people to be more attentive and responsive after frank discussion of barriers and uncertainties that surface when person centred planning is introduced."

One way of doing this is to have planned sessions for hearing about barriers and scepticism to person centred planning and to generally listen to people's concerns. This is counterintuitive to many organisations who want to discourage what they see as fruitless moaning, yet unless peoples scepticism is addressed it will either leak out in other situations, or go underground and emerge as efforts to sabotage the initiative.

Holburn and Vietze (1999) suggest that:

> "Person-centred planning and its assumptions are more likely to be understood and supported if employees can participate in a collaborative process in which this kind of message is heard - We want to go in this direction. We know it will not be easy. We also know that many of these ideas and practices conflict with what we have promoted in the past. Let us talk about those discrepancies and about how we can shift our course toward the new direction."

OLDS need to structure more opportunities to hear dissenters views. Some of these appeared in a training session, but it was not possible to set aside the training to address minority views. Unless opportunities are created to hear any disquiet there may be longer term negative consequences.

c) First steps in implementation - can we balance enthusiasm with capacity?

Some of the founders of person centred planning, John O'Brien and Beth Mount, advocate the implementation of person centred planning one person at a time. 'The assumption behind this is that to be effective a service needs to learn how to support people differently as a result of planning, rather than it becoming an 'empty service ritual'. They argue that this is only possible 'one person at a time'. (O'Brien and Lovett 1992).

Beth Mount suggests that it is natural to think that if something works for one person it is only fair for everyone to have the same opportunity. The reality though is that planning this way, without substantial investment and commitment will just lead to lots of people having plans but few people having different lives as a consequence. This was succinctly put by a staff member in an organisation where its enthusiasm for person centred planning resulted in 'grandiosity'.

'Our first step was to develop person centred plans for everybody in our agency, and when we finally finished that, we realised we didn't have the resources to accommodate many of them'.

This still sits uncomfortably with managers and staff who understandably promote

egalitarian principles and equality of opportunity which appear contrary to providing a better service for just a few, even initially. This has certainly been a constant dilemma for OLDS.

Although the 'one person at a time' approach has merit whilst an organisation is learning how to successfully implement person centred planning, our concern is that this approach may make a difference for a few people but not facilitate the organisational changes required to make person centred planning a reality for most people using services over time. Some research also suggests that it may not be the only tenable approach.

Lindquest and Mauriel (1989) compared two alternative strategies for adopting and implementing an innovation: a 'depth strategy' using demonstration sites to 'debug' the innovation before it was disseminated; and a 'breadth strategy' in which the innovation was introduced to people at all levels across the organisation. They found that those using the breadth strategy were less isolated and achieved more widespread adoption of new ways of working.

A possible solution to the 'one person at a time' versus 'equality of opportunity' dilemma is to simultaneously implement 'depth' and 'breadth' strategies as Oldham did. The depth strategy was to invest in high quality training and support of ELP facilitators over time to learn about implementing person centred planning. In addition the breadth strategy encompassed the introductory training for all staff and the opportunity to work with People First in developing portfolios with people and using *Our Plan for Planning*. Therefore:

- A small number of people developed high quality person centred plans from which lessons were learned that influenced other organisational changes that would affect many people

and

- Empowering people to tell their own stories and control what ever meetings they had was offered to many more.

Michael Smull recommends that implementation is approached by developing best practice (concentrated effort to develop good person centred plans) whilst making incremental changes to typical practice (increasing staff awareness of the principles of being person centred, finding ways to empower service users in meetings etc).

Who should receive training and support?

If it is agreed to invest resources in training and supporting facilitators to plan initially with a small number of people, how does the group decide who to train?

Facilitators

Traditionally, selecting people for courses has been based upon their formal role, (for example, all first line managers), or on getting representation from geographical areas or services. Implementing person centred planning challenges us to do this in a different way. Michael Smull (see below) suggests we can see potential facilitators as either 'naturals', 'learners' or people who are unlikely to have any talent for facilitation. The naturals in an organisation are those who clearly demonstrate person centred values and continually seek ways to improve how they translate these into practice. Learners are people who broadly share the values but need extra support in finding ways to put these into practice.

Smull suggests that when we begin to train people as facilitators of person centred planning that we first begin with the naturals. The rationale for this is that these are the people who will be most able to begin to put planning into practice, begin to create learning for the organisation and hopefully positive stories that can inspire and enthuse others. The naturals will then be the people who can offer extra support to the next wave of planners, the learners.

The people who we suspect will not be able to become effective facilitators even with great amounts of support, need to be found ways of practising their other skills. This may sound glib, but in reality services are not usually very good at supporting people to work to their strengths and acknowledge the areas that they are unlikely to perform well in. Being expected to undertake a role that people feel completely out of their depth in, even with lots of support, is extremely stressful and demoralising. This is not a good way of modelling being person centred with staff, and most importantly, is unlikely to empower a

person with learning disabilities to get the lifestyle they want through person centred planning.

In one such situation for example, a team of five senior support workers in an agency agreed that four of them (naturals and learners) would plan with all the people then supported, whilst the fifth person would take a greater role in some of the administrative work, which they were particularly skilled at and enjoyed.

So, in deciding who to invite to become the first facilitators, some thoughts are:

- To initially chose the 'naturals' within the service.
- To invite people to join rather than demand it.
- To invite people who are in a position to make changes in the person's life. For example, first line managers in residential services (training experience suggests that although key workers often make excellent facilitators, they lack the required power to make changes required for implementing a plan, for example finding different ways of scheduling staff time to better meet what the person requires).
- To avoid isolating new facilitators by only selecting one person from each locality or team. There are benefits in having a few facilitators in one area to support each other.

People using services

Again, in inviting people with learning disabilities to work with the first facilitators learning about planning there is a need to balance equity of opportunity across localities and services with an understanding of where good outcomes are most likely to be produced. One tendency has been to begin with people who provide the greatest challenges to our ability to serve them, or who are in the most desperate circumstances. Whilst these people are in many ways a priority, experience cautions about choosing them as the first people for new facilitators to learn about person centred planning with. We would not expect a newly qualified accountant to be given the most complex cases with a history of difficult relationships in his first week. As facilitators are learning to implement planning there is an argument for starting with someone who is in a situation where planning is most likely to be successful.

It is very important to note that we do not mean that people with the most significant disabilities or challenging behaviours are automatically excluded, the criteria above refers more to the support they receive from their team, its manager and the qualities of the facilitator. It is of note that all of the people participating in the initial ELP project in Oldham were people with very significant disabilities and who required high levels of support.

The criteria that we would suggest for the most successful outcomes when planning for people currently or potentially making use of service supports are:

- **An individual seeking change**

This could be the person themselves, a family member, a friend, an advocate or a member of staff. It must be someone who is committed to the person and has the energy and drive to change things directly or to keep bringing them to the attention of those who can. Beth Mount describes this person as the 'champion'. Family members and friends are more likely to be effective 'champions' as they are not constrained by working for the service.

- **A skilled facilitator (or a 'natural' being trained and supported)**

A facilitator can enable people to develop a shared understanding of the person, find a shared sense of direction and work together for change. This person must have a commitment to the values of inclusion and be skilled in finding ways to keep the person at the centre of the planning process.

The independent perspective which facilitators need to adopt and the way in which their authority comes from their skills and credibility rather than their job title may challenge traditional hierarchies.

- **A committed group of people around the individual**

Change is possible with just one person working on it but it is much more likely when there is a group of people with a shared purpose and passion. This group will be more effective when at least some of its members come from outside the formal service system

and have as their primary concern the well being of the individual whose life needs to change.

This shifts the responsibility for making change happen from a key worker or similar person nominated by the organisation to a group of people who are not all accountable to the service system.

- **An effective team manager who is committed to the person**

The team manager plays a crucial role in putting plans into practice through negotiating changes both with team members and with senior managers. She has to encourage the team to find creative ways of working with the person, to look outwards to the community, and to reflect on and learn from what they are doing. She has to balance flexibility and autonomy for the staff with continuity and stability for the person.

Devolving power to team managers to renegotiate the times, places or ways that staff work is difficult in organisations in which these are traditionally agreed centrally.

- **A service committed to change**

Managers need to be committed to change: in the culture of the service; its policies and procedures; the training it provides; the way it treats its staff; the way it expects staff to treat the people they support; and the way it uses its resources. The central aim becomes to enable people to have the lives that they want.

There are differing views about whether it is best to have facilitators working with people they directly support or whether some kind of distance is preferable. If the latter approach is taken the facilitator needs to work exceptionally closely with the team manager in facilitating the plan and its implementation. She also needs to be clear about where her role ends and whether she has a long-term commitment to monitor the plan.

In practice the decision about who to select to join the facilitators training group needs to be taken in conjunction with a knowledge of people in situations where planning is most likely to be effective as described above. This was the approach taken by OLDS. They generally invited '*naturals'* to join the programme , who were in positions of influence (for example care managers), who worked with people in situations where they believed planning would be successful. There were a few exceptions to this.

One of the people would be described as a '*learner'* who was also a direct support worker. The combination of the person requiring significantly extra support and not being in a position to arrange his own time to meet the person etc, contributed to the planning situation breaking down.

A second example is described earlier in the paper, in Denise's story where the facilitator was a senior manager who was therefore not in direct contact with the focus person. Although the planning was successful, she describes the challenges of working as a senior manager in this role.

Developing a vision and a strategic plan

Once the group has formed, clarified the problem and questions related to it, used this to create a sense of urgency and mapped the territory. The next step is to formulate this into a vision and a strategic plan. Kotter suggests that the group needs to form a compelling idea about where this is all leading, which may initially be 'blurry' but is refined over time.

This happened in OLDS through describing their dream, and then agreeing what that would look like in three years time and in a years time. Other groups use the PATH process to begin to achieve this. To check how well vision is understood, Kotter asks whether each member of the implementation group could give a five minute explanation of the vision to anyone who asked.

Role 2 To communicate person centred values/what is the group doing through the service?

One danger for implementation groups is that they see their role simply as the first task covered here, the implementation of person centred planning.

To effect the changes required for staff to really listen to what people want in their lives,

and for the service to change to deliver this as much as possible, requires the ongoing communication of how this is a different way of being with and working with people.

The importance of mapping out the key players in any change has already been discussed. For this task it requires that as well as people's roles in the organisation and the possible emotional impact of the change, the group needs to identify the best way to communicate with them. As well as staff and managers, this needs to extend to Human Resources, Finances, and Training and Development who will all be affected by the change. Communicating the vision and consulting on it requires that the group utilise all the variety of ways that communication takes place within an organisation, for example posters, memos, newsletters, and courses.

Depending on the individual's roles, different people will be more greatly influenced by different methods of communication. The people who will be most enthusiastic about introducing person centred planning often have large networks both inside and outside the organisation. They are more likely to be influenced by mass media, direct personal contact with other people and through visits and attendance at conferences and professional meetings. People who will take longer to adopt to person centred planning will be mainly influenced by local experiences of positive planning and by contact with those who experience the change as positive.

For this reason, another key task of this communication strategy is to create and communicate 'short term wins'. This echoes some of what has been written earlier about planning for successful outcomes. However, these stories need to be shared throughout the organisation to persuade people that planning in a different way is possible *here in this organisation*.

As Kotter reminds us, change takes time, and the implementation of person centred planning risks losing momentum if there are no short term wins and short term goals to meet and celebrate. Most people need compelling evidence within the first 1-2 years that the journey is producing the expected results.

As well as communicating the vision - what the group is doing and how changes are taken place, the group must invest in demonstrating how this is a change in values, a second order change. This communication needs to be in deeds as well as words. The leadership of the organisation needs to 'walk the walk as well as talk the talk'. Kotter clearly states that:

> "Nothing undermines change more than behaviour by important individuals that is inconsistent with their words."

How well did OLDs communicate the vision and work of the group? Again the group made a promising start that now needs to be developed further. The initial learning from the first few people to be planned using ELP as part of the ELP programme was shared at a large feedback session attended by many people from the organisation. These 'short term wins' began to demonstrate what ELP could mean in Oldham. The vision of person centred services was shared as part of the introductory days where a member of the implementation group introduced each of these days by sharing what the group was doing and the vision for the future. The induction training was changed to include aspects of person centred planning. The group began to map out the significant people, their roles and how to best communicate this to them when they began the MCTI approach with Gerry Smale.

The next steps for the group are to build on each of these areas. The leadership of the organisation will be key to how people see person centred values *demonstrated* as well as *discussed* in Oldham.

Role 3 To support facilitators and help them develop their skills

Providing the organisation with information about the changes that are required and that are taking is place is very important but not enough. Extensive support is required for people to begin to act on this information. Person centred planning requires new skills, new knowledge and new ways of thinking. To

achieve this requires mentoring and coaching. Michael Smull reminds us that in the absence of adequate support people will revert to what they know, and do traditional planning but with new labels. One example of this is what Marsh and Fisher (1992) call the DATA effect, where people believe that they are 'Doing All That Already' and therefore they just change the label from IPP to PCP.

Both managers and practitioners can underestimate how difficult it is to change practice. Smale (1998) states that there is a naïve assumption that people can always do what they want or intend to do. These simplistic ideas surface as problems in the management of change when those introducing innovations and managers making changes in policy assume that once a change in ideas has been communicated or a decision made to adopt a new policy, then a new approach to practice will follow. Many managers would probably agree, at least in principle, that is important to get their staff to `own` a new way of working and that it is necessary to be clear what is required of them to practice in a different way. They may think that this is enough. Many managers underestimate the difficulties involved in changing what people do.

Typically, the support given to people to make such changes is a few days training and then people are expected to change the way they work. Sometimes people do not even get training, just a new set of procedures to carry out and forms to use. The implementation of person centred planning needs to be significantly different from this as evidence suggests that practice cannot always change in this way, and that more extensive staff development activities are required (Schon 1983, Schon 1987, Argyris 1982, Smale 1983, 1987).

To achieve this in the implementation of person centred planning means moving towards:

- Extended courses for facilitators that focus on the implementation of planning with an individual, not just the planning process ('work based learning'). This will include opportunities for reviewing progress, giving people feedback on their work and problem solving with them.
- Establishing mentoring for facilitators
- Investing in people to become 'local experts' in planning.
- Developing 'buddy systems' for facilitators and helping them prioritise spending time supporting each other.
- Having 'retreats' for facilitators to continue to reflect, share and learn with external facilitation.
- Developing Action Learning Sets for problem solving.

OLDS has adopted each of these strategies. One of the most significant has been investing in a planning co-ordinator, and one of her roles is to develop and evaluate these activities. Just establishing these support mechanism is only part of the answer as OLDS has found, helping facilitators to prioritise using them has been another matter. Often it is countercultural for staff who are very busy to see taking time to reflect on their work as a priority. This an important way that the culture of an organisation needs to change to become one that learns and reflects and not just doing and fire fighting. The managers and leadership of an organisation need to take a significant role in leading this by doing it themselves and therefore giving permission to others to follow them.

Role 4 To learn from person centred planning - how does the service need to change?

Whilst the above will increase the chances of more people being listened to through person centred planning, and more people getting better lives through staff changing the ways they work to respond to this, for many people their will be obstacles that prevent all of the plans being acted upon.

Hearing what these obstacles are and problem solving ways of removing them is another key role of the group. This can be one of the most difficult as the policies, procedures and structures of the organisation will start to be challenged.

This will often require managers to change and make the transition to new ways of managing - person centred planning is about sharing power and control at its heart. Smull suggests that for most organisations sharing power and control requires new policies and practices as we move from a passive 'professional know best' approach to an active, questioning, learning culture; from a blame culture to an accountability culture and to create a culture of partnership rooted in respect and trust.

To begin to address this, first the implementation group needs to find ways of hearing what the obstacles are. This could be through the planning co-ordinator, through action learning sets, through retreats specifically for this purpose and through using external consultants. Once obstacles have been identified, they can be catergorised as:

- lack of knowledge/skills
- problems with policies
- problems with the culture or
- problems with the implementation process.

Role 5 To evaluate the effectiveness of the planning taking place, is it changing people's lives?

The final task of the Implementation Group is to keep track of how effective person centred planning is in addressing the initial problem, and how the group is managing the implementation process. In evaluating person centred planning it is necessary to ask:

- How well are people empowered in the planning process?
- How good are the plans (for example including how well they reflect what is important to the person, in the actions being allocated to people with dates for achieving them).
- Are goals being achieved and people's lives changing as a result?

In the sections above, an ELP stores and learning for the organisation there are examples of how Oldham's services have begun to change in direct response to what has been learned from person centred planning.

This now needs to happen in a more structured and systematic way via the implementation group and its links to developing strategy.

The person centred planning co-ordinator is now addressing the issue of developing a system to evaluate the effectiveness of person centred planning.

Conclusions

Oldham have made a start, over the past four years, in exploring how person centred planning can contribute to the goal of inclusion for people with learning disabilities.

- They have adopted a structured, focussed and strategic approach, taken appropriate external advice, reviewed and learned from their experience.
- They have found that proper implementation of person centred planning requires a substantial effort and strong leadership.
- A good start has been made and there seem to be firm possibilities that the positive improvements to people's lives already being achieved will provide motivation for keeping on track with implementation. There are potentially powerful forces that could still dissipate the efforts to date. It is the challenge for the next few years for OLDS to show that they can maintain their progress and that the foundations already laid are strong enough to achieve this.

Putting it all together - Why is it so hard to shift to a situation where people with learning disabilities share the power? What do we need to do?

In reviewing the work to date in Oldham, the Implementation Group and those supporting the work have continuously tried to draw out lessons to inform what they do next. In essence the group is always asking what it takes to shift the organisation and those working for it further towards real power sharing with people and their families. For this final section of the publication we have reproduced an amended version of Michael Smull's paper *Changing from Programs to Supports.* This paper offers a checklist type summary of a great deal of learning about what those genuinely working towards partnership and inclusion will need to do to achieve this.

Why is this change so hard? – four reasons

1. During the change you have to develop new ways of doing things alongside the old ways

Oldham have adopted a 'depth and breadth' approach acknowledging that this change is major culture change which cannot be implemented via short term transformation. This involves building up new ways of planning while making incremental changes to existing ways. These 'dual systems' inevitably result in people 'layering on' paper requirements. In the medium to long term you cannot run these 'dual systems'. Person centred support has to mean another way of thinking not just another way of doing.

2. Person centred services require new skills *and* new knowledge

- New skills require mentoring and coaching – It is not enough to impart knowledge via courses etc.
- If people aren't supported in the new ways of working they will revert to what they know.
- In the early stages you need to focus effort on people who are 'naturals' at person centred planning, and support people who have some talent and motivation. Don't put a lot of effort into people who do not show motivation or talent. This is counter culture to many of us but seems to be what works. This was certainly Oldham's experience.
- Managers need to be exposed to enough experience of person centred planning and its potential effects to be motivated to develop means of shifting from old ways to new ones. Many of us were taught formally or informally in a 'command and control' approach to management.

3. The shift to person centred services is about sharing power and control but this is difficult and in effect counter culture in our organisations

- For most people with disabilities and families, exercising power and control requires new knowledge and skills.
- For most organisations sharing power and control requires new policies and practices.
- There are those who do not want to share power.

4. Developing person centred services is as much about changing culture as about changing practice. Signs of success are likely to be where:

- Managers view issues and problems 'through the lens' of helping people get the lives they want. Where they keep their eyes on that prize. They need to do this in their problem solving and in their dealing with rules and regulations.
- There has been significant movement from a passive 'professionals know best' culture to an active, questioning, learning culture.
- There has been significant movement from a culture of blame, where people mostly

watch their backs, to one of true accountability or responsibility for helping people get the lives they want.

- A culture of partnership has been created, rooted in respect and trust between service people and people with disabilities and their families.

What are we learning about strategies for change?

We need to look for, create, and take advantage of opportunities to establish best practice. Local best practice examples demonstrate that 'it can be done here' and produce a clear destination of where you want to go. This has clearly worked in Oldham. However, it needs to be acknowledged that best practice examples are a necessary but insufficient ingredient in a change strategy. Only doing best practice is not likely to bring about enough change within a reasonable time period. In Oldham many people were hungry to work on improving planning. A balance had to be struck between the 'one at a time' approach and responding to this hunger. This is not an easy balance to strike and there are clearly risks. We do believe, however that it is necessary to:

- Find opportunities to make incremental changes in typical practices. This involves creating change within existing ways of doing things which demonstrate that change is possible and gets people comfortable with it. This work needs to move typical practice in the direction of best practice. Those practising this strategy need to be ready to take opportunities when a series of incremental changes creates the opportunity to establish best practice.
- Look for ways to change expectations and create positive pressure for change amongst key stakeholders:
  - The first requirement for change is discontent with how things are, the second is pressure.
  - Top down pressure is uneven and inconsistent – policies and people come and go.
  - Pressure from self advocates and families can be more constant and consistent.
  - Where there is top down support, create pressure from staff of the service.

Implementing change

Those who are looking to achieve lasting change towards person centred planning need to remember:

- Look for opportunities to start with success.
- Start where the people who are doing the work are.
- Start with listening and observing to see where people and organisations are in practice – what they do, their organisational culture – not just what they say!
- Always look for opportunities for best practice while remembering that change within current ways of doing things builds confidence and makes 'outside the box' change easier to achieve.
- Change strategies that are more ambitious than the resources to support them fail, and in their failure confirm the cynics who are saying that this is just a fad.

What should we do?

1. We need to look for the opportunities to initiate and support efforts to change organisational culture:

- If are trying to shift towards leaders and managers consistently viewing all issues/problems 'through the lens' of helping people get the lives that they want we must:
  - Remember that we are working to change culture, 'organisational habits'.
  - Understand that changing a habit requires consistent efforts where those who participate can remind the leader when there is lapse.
  - Remember that finding solutions that reflect what is important to people may well require increased problem solving skills. In Oldham there was acknowledgement of the need to release people's creativity through supporting the development and use of these skills rather than formulaic implementation of process.

This is likely to be a significant training/mentoring issue.

- We need also to remember that although we are looking for the best outcome we will occasionally need to settle for the 'least evil' one available. Where we settle for this we will need to let those affected know what we are doing and lobby for change.

- We need to work to change the planning process to establish/support a learning culture:

  - Lay the foundation for a learning culture. Train those who will implement planning in the principles of planning and learning before you start.

  - Start with simple plans that establish a framework for learning.

Turn the learning wheel.

- The person and those who spend time with the person should note what they are learning.

- Provide organised time for reflection.

- Have the professionals practice their new roles as consultants, 'synthesizers' and facilitators (who help deepen understanding, suggest new ways to understand and solicit/suggest new things to try).

- Continuously teach person centered *thinking* – look for and use the 'teaching moments.

- Develop the skills needed when what is being done doesn't work eg coping with risk, finding new ways to understand behaviour, defining responsibilities.

- While helping people get what is important in everyday life look for, build and make use of opportunities to help people be connected to their communities.

- Go from blame to accountability. Understand the problems and pervasiveness of a blame culture. In a blame culture there is no creativity and responsibility is to be avoided not accepted.

- Build respect, trust and partnership. To do this there are some key pieces of learning that need to be acted upon:

  - It starts with who you select/recruit.

  - It is crucial to match talents with jobs – who should work with whom.

  - We need to work out how to keep the people we want.

  - We need to monitor how we are doing with regard to respect, trust and partnership and act on what we learn.

2. Measure the strength of the workplace for opportunities for change. Rate the opportunities based on:

- Effort required (organisational readiness, ease of change).

- Talents of those who would lead the effort (naturals, learning, untalented, opposed).

- Potential gain.

Sustaining change

To sustain change we should:

- Help managers to see what we are trying to do. They could spend time with one or two individuals who are moving towards more individualised support based on person centred planning. They can be kept well informed of efforts and progress and share learning

- Establish a forum where managers can reflect on what is being learned and develop interventions/supports to overcome obstacles and sustain change.

- Those involved in the change effort must:

  - Meet regularly.

  - See this as time to reflect and problem solve (not a time to do crisis management).

  - Have the support necessary for success (they may require an outside facilitator).

  - Have a process where they reflect on successes and difficulties and ask what each suggests about issues with:

  - Knowledge and skills/competencies.

  - Policies, structures, rules, management.

  - Organisational culture.

  - Organisational change.

- Based on what they have learned, design interventions to respond to problems while supporting success.

- Remember that they and the organisation must build and celebrate short term

successes and have opportunities for renewal.

Concluding Comment

Although bringing about the kinds of changes discussed in this report is without doubt difficult, there is no doubt that it is worth it. Support is available from a range of agencies and other sources, including the North West Training and Development Team. NWTDT can link up people working in this way for mutual support, provide training person centred planning and offer advice on implementation strategy and tactics.

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