# People as Partners Project

# MAKING SENSE OF SDS
# A SERIES OF GUIDES FOR PROVIDERS

## Guide 4:
## Support planning and the provider's role

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http://www.scottishcare.org/people-as-partners/

**Making Sense of SDS**

**A series of guides for providers**

This guide is part of a series which is designed to introduce providers of older people's care and support services to the Social Care (Self-directed support) (Scotland) 2013 Act which came into effect on 1 April 2014.

This particular guide will explore one of the key themes within the Act and its accompanying Statutory Guidance. As part of the Supported Persons Pathway the Guidance and Act places a great deal of emphasis on the development of a support plan or personal plan. The support plan is recognised as a mechanism which will enable the supported individual to arrange the necessary supports and which will allow practitioners ensure that the identified needs and outcomes are likely to be met.

Changing the way in which individuals are assessed for social care services lies at the heart of the new legislation. Moving from a tick-box assessment model which identifies tasks and outputs to one where quality of life indicators and personal outcomes are identified is central to person centred social care and support.

This brief guide explores what the Act and Guidance documents say about support planning and in so doing highlights the range of ways in which older people care and support providers can become more engaged and involved in the process.

**What does the Act and Guidance say about support planning?**

The SDS Act presents a major shift change in relation to the role of the supported person in the planning process. Although over the last few years many local authorities have been developing models of outcomes assessment the Act makes it a statutory requirement to ensure that assessment procedures fully involve the individual being assessed. The model is one of full participation not mere consultation. The new duty in the Act embeds a model of co-production, of involving the supported person in the choice and planning of their support to the extent and degree that they may wish to be involved.

The first thing that is worth noting in the Guidance is the central role that the four SDS Statutory Principles play in the support planning process:

"*The support plan should be developed in line with the statutory principles in Section 1 of the 2013 Act and in line with this guidance. The plan should cover certain key aspects such as the personal outcomes which help to shape the plan, the resources (both financial and non-financial) which will help to meet those outcomes, the choices available to the supported person to arrange their support and all associated information.*" (Guidance Section 9.1)

The statutory principles are a fundamental part of the outworking of the Act and also have a critical role to play in the development of any individual support plan both in terms of the process but also the final product.

**Collaboration**

The professional must collaborate with a supported person in relation to the support plan. It is not appropriate for a practitioner to develop the support plan on his or her own. There must be an inclusion of not only the supported individual but any key individuals whom that supported person wants to include and involve. If providers have previously been involved in an individual's support it may very well be that they and their staff are requested to be involved in this planning stage. It is often the case that provider staff know an individual very well and may be chosen by the supported person to be a key ally in developing their individual support plan.

**Involvement**

The supported person must have as much involvement as they wish to have in the assessment.

**Informed Choice**

The supported person must be offered the range of choices which are available to them and the practitioner must undertake this in a manner which enables the individual to not only understand the choices that are possible but what the selection of individual options might mean for them personally and practically and not just theoretically.

**Participation and dignity**

The support planning process represents a real opportunity for an individual to be supported in making decisions in a way which enhances and maximises their participation and does so in a manner which embeds dignity in the support relationship.

The Guidance goes on to suggest a list of 'key ingredients' which it considers should be part of support planning for an individual, namely:

- The people and things that are important to me
- The main risks and how we will manage them
- The people who can help me to achieve my outcomes
- Where I can go for information and support
- My personal outcomes
- The things (knowledge, funding etc.) that will help me to achieve my outcomes
- The things that I can do
- How I will arrange my support

The process of getting answers to these key questions, of creating something from these disparate ingredients is in itself key to the support relationship and again there is opportunity for provider engagement and involvement. The Guidance states of this process:

"*The support planning process - the act of considering the outcomes and pulling together a plan - can make a significant difference to the person's life. In light of this the support plan should be developed in a collaborative way. A good support plan will demonstrate a link between the individual's eligible needs, their outcomes and the support required to meet those needs and outcomes. It will be written in language that the supported person understands. It will be presented in a way that is engaging and helpful to the supported person as they embark on their pathway through support. It may include pictures alongside text*." (Guidance Section 9.2)

And:

"*The support plan may be developed in any type of format but it should be framed in such a way that it can be used as a living document. It should focus on what the person wants to achieve with the right help, rather than simply putting arrangements in place to stop things from getting any worse. It should be capable of acting as a reference point for the supported person, the professional, the provider and, subject to the person's wishes, other important individuals in the person's life. The parties involved should be able to return to the plan, review the plan, add to the plan or make changes over time*." (Guidance Section 9.3)

There are many insights from other services which might be useful in considering how these statements about support planning can be embedded in the provider-supported person relationship and in what follows we shall consider both some of the practical tools which might be utilised in the creation of individual support plans and the general principles of what a good support plan might look like.

**Support plans ask the right questions and try to answer them**

The User and Carer Guidance for the Act has a helpful list of eight questions which it suggests need to be answered during the support planning process. You will note how they relate closely to the themes in the National Guidance quoted above.

1. What are the things and people that are important to you?
2. Where can you go to get the information and support you need?
3. What are the things that you can do yourself?
4. What are the main risks and how will we manage them?
5. What are the things you want to do?
6. How will you arrange your support?
7. Who are the people who can help you do the things you want to do?
8. What are the things (like information or funding) that will help you to do the things you want to do?

It is very important that whatever tools are used by the supported person, their family or advocates, a provider or a practitioner, that the support plan helps the individual move closer towards achieving the outcomes their assessment has identified as being important to them. The support planning process, just as the assessment process, is not about a tick box exercise or simply getting a task completed but rather is intended itself to further an individual's choice and control over their support. Support planning is not about fitting a person into available service provision but identifying in creative ways how a person's outcomes might be met. Its starting point is the individual's own personal assets, '*which could be their experiences, their resilience and motivation, their circumstances and life history, their family and community supports.'*

In instances where there may be a concern about reduced capacity it is important to support the application of principles of participation and choice to promote the least restrictive option that is of most benefit to the person.

**Support plans have a future orientation**

All effective and meaningful support plans have a future orientation. What is meant by that is that a support plan must have a sense of a dynamic and direction about it. This is often exemplified in some of the models and tools which are used (and which we will discuss below) which use language such as 'path' 'goal' 'north star' 'dream' 'aspiration.' There is a sense in which the planning process helps an individual to

identify what is and what is not working in their life at present; what might be the blocks and barriers which they are facing and what practical steps need to be undertaken in order for the individual to move forward and achieve the outcomes which they want. It is not wishful thinking or day dreaming but rather a clear articulation of what someone wants to achieve and a practical identification of the necessary steps to be taken in order to be successful in whatever goal is identified as important.

**Support plans build on strengths and capacity not deficits and needs**

In an earlier Guide[1] we reflected on the degree to which traditional assessment models often emphasised the needs and deficits a person had. At its worst this almost led to a situation where in order to successfully get a support package or service an individual either over-emphasised their needs or was encouraged to do so. Support planning is based on an outcomes philosophy which recognises that the individual has abilities and capacities; that the individual is the 'expert 'in their own life and can do much themselves to direct any support they feel they need and achieve the outcomes they want. It suggests that an individual has strengths and abilities which can be utilised and harnessed in the achieving of the aims and wishes they want. It is positive about the person, recognising the networks of contact and relationships they possess, and it seeks to use the assets and abilities all individuals have. It is an optimistic, glass half-full approach to life.

**Support plans are about universal needs**

Support plans fit well into an outcomes philosophy which articulates the reality that what most people want met in their lives is more than just the basic needs that have often been provided in traditional services. Of course it is important to be healthy; to be fed and watered and well-nourished; to be safe from harm; warm and cared for. But life is more than what might be described as 'maintenance.' When people identify what they want most – they mention the importance of relationships with family and friends; they talk about keeping the roles which gave them purpose and identity in their communities and neighbourhoods; they speak about the rewards achieved through challenging themselves in new learning and new activity; they express the enjoyment they gain through exercise and social contact. Such 'universal' need for connection, community and contact are as important in support planning as the basic needs of care and support.

**Support planning is a collaborative activity**

There are lots of ways in which an individual can develop their support plan. A plan can be developed by the individual on their own; it can involve the family, friends and advocates of the individual; it could be undertaken in collaboration with someone who has particular skills as a planner and who knows local opportunities and choices

[1] See Guide 3: Outcomes assessments – the provider's role

well; it can be developed with the aid of the practitioner who has undertaken the outcomes assessment or indeed it could be developed using a mixture of all of these.

However, the most effective support planning process is rarely undertaken by a solitary individual. Whilst we know our own lives better than anyone else it is often also the case that we can be our harshest critics or can sometimes be so immersed in our own challenges and issues that we fail either to see the opportunities or to recognise alternative courses of action. Thus support planning at its best is a collaborative process.

The individual is encouraged to get those who are most important in his or her life to become involved in planning the support which will help them to achieve their aims and outcomes. In this regard it is likely (as has been seen elsewhere in support planning contexts) that the staff of provider organisations will increasingly become involved in assisting in the planning process. We all of us benefit from the insights and creativity of others, especially if those others have regard and interest in and for us. So, staff who work closely with an individual, for instance in a care home environment or supporting someone in their own home, might in many instances be viewed by the supported person as a key advocate and ally in helping them get what they want and achieve their outcomes. Providers need to recognise that resourcing and equipping their staff to become more aware of and involved in the support planning process can bring huge benefits to the individual being supported as well as the staff member and thus the wider organisation.

**Support planning should 'think outside the box'**

There is a real opportunity in self-directed support to think creatively about ways in which it might be possible for individual outcomes to be met. At its best support planning demands a creativity and a willingness to think of alternative solutions and to think 'outside the box' of traditional service responses.

The person who has traditionally attended a day centre five days a week and then decides to use some of that financial resource for instance to purchase a season ticket to the local football club is an example of someone taking control, exercising choice and using his or her budget in a way which meets their outcomes in a more creative way.

As time passes what we will inevitably see is the creation of micro-social care provision and the greater use of universal and ordinary services to meet the identified needs and outcomes of supported individuals. There is a real opportunity for providers to begin, in their own way, to innovate and develop alternative service models and to identify opportunities which they might wish to advance. It would be a mistake for creativity to be left to those outside the traditional service sector when there is the potential to use so much skill and experience within to create dynamic, responsive and contemporary supports.

## Support planning uses the right tools

One of the core skills of any activity is knowing what tool will help us get a particular job done and in the most effective and successful way. Hammering a nail into a wall is best achieved with a hammer not a screwdriver! So, knowing what tools exist and what job they do in support planning is very important. There are many training courses and learning programmes on offer which help individuals recognise the relative merits and benefits of using different planning tools. Some of the tools used in traditional support planning are those which have originated in learning disability service delivery including MAP, PATH and Essential Lifestyles planning. In addition, as developments from person-centred planning the InControl organisation has developed a support planning model and a set of associated tools.

Providers need to consider whether it would be beneficial for their staff to be trained in support planning tools and their use and how they would utilise them in their organisation. At a basic level having a number of staff aware of the principles and core elements of some of the typical tools which are used in support planning and outcomes assessment would be beneficial to an organisation.

## Support planning has the individual in the centre and in control

As in person-centred planning, one of the principles of good support planning is that the individual who is being supported is 'in control' and at the 'centre.' The principle is that no decision should be made without the primary control of the person being supported. This is, after all, the supported person's plan not that of the practitioner or the provider – it is the person's life not the agencies case! This requires a considerable amount of skill on the part of the individual involved in directing any planning process, exercising an appropriate mix of challenge and consolidation; of creativity and familiarity; of innovation and maintenance. Support planning needs to be an open and transparent process where there is a mutual regard for the contribution of all present. There needs to be a willingness to address disagreement in a constructive and respectful manner and a refusal to accept easy compromise.

In whatever format the support plan is designed, be it the written word, a video clip or set of photographs (all of which could be valid support plan presentations), the plan needs to be written or communicated in a format that the supported person understands. Both the process and the final product needs to reflect the person's understanding and engagement but also their unique identity, including age, ethnicity, nature of disability, language etc.

## Support planning takes appropriate risk

There are three main reasons why a support plan may be considered to be unacceptable and thus rejected by a practitioner or local authority at sign-off stage, namely:

- It does not meet the stated outcomes of an individual
- It would lead to placing the individual at risk of harm
- It would lead to an improper or illegal use of public monies.

One of the hardest of these to address is that of risk. The Act and its Guidance speaks about 'risk enablement' and the importance of supported individuals being able to exercise appropriate risk in their lives. For many practitioners and providers risk enablement brings its own particular challenges. We will examine some of these issues in a future Guide. However, for the purposes of support planning, all parties involved in the planning process must honestly and openly identify the risks that potentially might be engaged in any planned activity. Is the identified risk appropriate? Is it a proportionate exercising of risk in order to achieve the aim which is agreed and accepted by all? Are there ways in which any identified risk can be mitigated or alleviated?

Risk cannot be sidelined in support planning but rather should be a critical component. Such discussions need to recognise that when we are exploring risk in support planning and whilst the individual is at the centre of the plan, the duties of statutory practitioners and concerns regarding risk to others both form an important part of the planning process.

## Support planning is resource realistic

Another reason why a plan might be rejected is that it suggests an action where monies might be used in an actual or a potentially illegal way. A more subtle financial risk to effective support planning is that the plan is unrealistic in what can be achieved within the constraints of any allocated or indicative budget. Whilst the best planning process should always leave room for re-visiting the indicative budget as a result of changes identified during the planning process, there has to be a financial realism. If it will be impossible to resource what is being planned for then either the indicative budget is erroneous and thus needs re-visiting to achieve the identified outcomes, or the plan itself is unrealistic.

## Support planning must show how outcomes are met

Individual outcomes are the end point and focus of all good support planning. We have talked about how important that driver is to the development of an effective plan. A critical element of the plan is an articulation of how these outcomes will not only be met but how it will be agreed and decided that they are being met.

It is therefore very important that there is a clearly articulated model of evaluation and monitoring built into a support plan. This will help the individual recognise that they are indeed achieving their identified outcomes. Further, it will also be a critical part of any provider engagement that they are involved in developing any monitoring system. It is essential that providers are involved in determining how they will be assessed as contributing to the achievement of any individual outcomes within an individual plan. In this regard providers need to be very clear what outcomes they are able to assist in achieving and those which lie outwith their competence or responsibility. This inevitably involves dialogue not solely with commissioners at a contractual level but most importantly with the supported individual.

The achievement of outcomes within a support relationship involves collaboration, co-production and communication. The supported person and provider need to work together towards achieving outcomes. It is important to note that a clear articulation needs to be agreed between what is an output and what an outcome might be. For instance, an individual may have an outcome which is to remain part of their community and develop new interests and relationships. It might be agreed that one way of so doing is to use money to enable attendance at a local activity, e.g. a bowling club. Simply enabling that to take place is not achieving the outcome. Work needs to be undertaken to ensure that supports exist (as far as possible) to enable the individual to develop their contact in the club to such an extent as to enable the connections and networks that they want and desire.

There needs to be an honest exchange, clear parameters of responsibility and a robust system of conflict or complaint resolution. It is stating the obvious to say that not all outcomes will be achieved or are achievable – this is not a failure but a given reality. Most of us learn what can be achieved through the act of starting and trying rather than not attempting in the first place or determining success or failure through a paper exercise!

It is also a given that not all supported person-provider relationships will work out as planned and thus it is very important that there are clear systems to ensure meaningful intervention when these instances occur. All such processes should be articulated either in detail or in outline in a support plan.

It is equally important that the support plan describes arrangements for what happens within a crisis situation, that consideration is given to what may need to happen if things go wrong and thus a good effective support plan should contain a contingency or back up plan.

**Support planning is ongoing**

The final general observation about support planning is that it is part of an ongoing process not an end point. The support plan should always be an interactive and live document not gathering dust either metaphorically or in reality. It must be continually reviewed and revisited to ensure outcomes are being met. There should be clear

timescales for such a reviewing process. People change in their expectations and in their desires and thus there should always be flexibility within all support plans for such real-life change to be reflected in the process of supports which enable individuals to live their lives.

The provider is a critical co-agent in the process of ensuring that support plans are a true reflection of life rather than an imaginary tale of what might never happen. Providers need to consider practical ways in which support plans can be at the heart of service delivery. Further, providers alongside supported individuals need to regularly review the support given to achieve the outcomes; and identify whether circumstances have changed and what process of review or reassessment need to be considered in order to ensure that the support plan is fit for the job it seeks to do.

**The Six Senses Framework and Older People's Support Planning**

A great many of the tools and templates for support planning are based on or have originated within learning disability and physical disability services. Providers of older people services may need to consider, alongside the supported person and practitioners, what tools are a best fit for individuals who are using their services. In addressing this challenge there may be need and opportunity to develop new frameworks and templates that take account of the distinctive needs of older people in independent living through care at home services and in care home and care home with nursing services. There are real opportunities here for providers to be at the heart of the development of such person centred models for older people care and support.

One potential resource which could be developed and utilised might be the **Six Senses Framework**.

The Senses Framework is based on the concept of 'relationship centred care.' It was developed for people with dementia in care homes, with a focus on the importance of relationships between the person, their relatives and staff. Although developed for use in a care home setting it was adapted for use in a hospital setting for the NHS Lothian Leading Into the Future programme.

The Senses Framwork was proposed by Mike Nolan and colleagues (2003) at the University of Sheffield, as a way of understanding the triangular relationships between the person with dementia, the carer and care staff. Six senses are highlighted:

- **A sense of security – feeling safe**
- **A sense of belonging – feeling part of something, having a place**
- **A sense of continuity – linking the past, present and future**
- **A sense of purpose – having a goal to aim for**
- **A sense of achievement – feeling you're getting somewhere**
- **A sense of significance – feeling that you matter**

Nolan et al (2003, 2006) argue that the six senses are essential for satisfying relationships between each person – and that a gap in any area will adversely affect quality of relationships.

Although this Framework has been used to consider service delivery for older people where there might be reduced capacity or dementia, it is arguably a rich model for the delivery of an outcomes focused service for some older people in care at home and care home service support.

Diagrammatically a new template utilising this perspective could look like this:


It would then be the task of the practitioner and others, including the provider, to use these 'senses' as the reflective guide to enabling an individual to achieve their outcomes. Readers will also, perhaps, see how such a tool could also be used as part of the outcomes focused assessment itself. A support plan using such a framework might seek to explore some of the following questions with the older person and their advocates:

**A Sense of Security**

What will help you feel that you are safe? How can you be free of pain and feel well? How can your comfort and care be maximised and be made more personal? How can supports enhance your rights and confirm your dignity? How can you be enabled to take control, make decisions within acceptable boundaries of risk?

### A Sense of Continuity

How can it be ensured that you have a carer(s) who you know and are familiar with and vice versa? What will help to ensure you feel that your care is consistent and continuous without you having to say the same things time and again? How can your own story and biography be at the heart of your support? How can staff be encouraged to learn from you and to recognise how you change?

### A Sense of Belonging

How can you be made to feel part of the community you are living within, whether that is in a care home or independently? How can you be supported to maintain old and form new relationships? How can you be helped to keep in touch? How can you be supported to keep going to the places you enjoy?

### A Sense of Purpose

How can you be helped to engage in activities which you like and in which you find meaning? How can you be enabled to discover new areas of interest and explore new possibilities for yourself? And do all these to the extent that you might want and when you might want to do so?

### A Sense of Achievement

How can you be enabled and encouraged to identify new goals and aspirations? How can you be made to feel that you have a role to play and a contribution to make to your own life and the lives of those around you?

### A Sense of Significance

How can you be made to feel that you 'matter'? How can you be enabled to exercise valued roles in the community and in your own networks? How can you be made to feel that you can influence and change others, that you can make a difference and that you have something to contribute?

The above is just one set of suggestions using a slightly different model. What matters is that providers engage with the support planning process, use their immense experience of supporting older people to ensure that tools and templates are fit for purpose and that individuals are able to develop support plans which are meaningful for them and deliver for them the outcomes they want.

### Useful further reading

- For details of support planning models and templates, see InControl work, including:
  - In the Driving Seat and Top Tips
  - From Presence to Participation.
  - Matching Staff

- Life and Support
- A Step-by-Step Guide
- Support Planning and Older People

  http://www.in-control.org.uk/media/85688/person%20centred%20planning%20evidence-based%20practice.pdf

- Further planning tools can be found at:

  www.scie.org.uk/

  www.pcpmn.cswebsites.org/

  www.inclusive-solutions.com/pcplanning

  www.iriss.org.uk

- Reshaping care and support planning for outcomes

  http://content.iriss.org.uk/careandsupport/assets/html/info.html

- Information about the Senses framework is freely available online and can be used to promote and develop positive relationships within care settings.

  http://www.crfr.ac.uk/reports/JM%20briefing%20-%202.pdf

  http://www.docstoc.com/docs/12992829/GRiP-The-Senses-Framework-Improving-Care-For-Older-People-Through

  Nolan, M., Brown, J., Davies, S., Nolan, J., Keady, J. (2006) The Senses Framework: Improving Care for Older People through a Relationship Centred Approach GRIP: University of Sheffield

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