coalition for collaborative care
ACTION FOR LONG-TERM CONDITIONS

Progress in Personalised Care and Support Planning

Alzheimer's Society United Against Dementia

helen sanderson associates

think local act personal

RCGP Royal College of General Practitioners

Checking your progress in delivering Personalised Care and Support Planning

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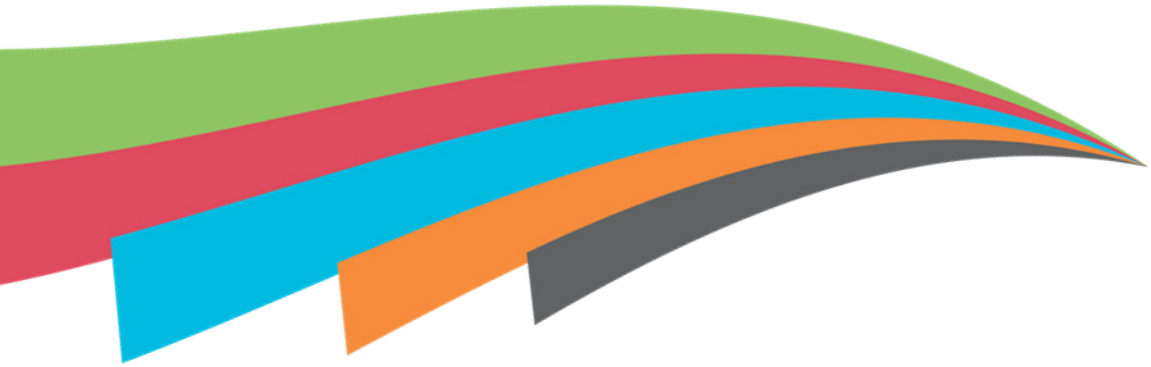

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Forewords

Catherine Wilton
Coalition for Collaborative Care Director

I heard a moving story a while back, about a woman's experience of care and support planning, in this case linked to a personal health budget that had enabled her to keep well, despite ongoing and challenging health conditions. She initially described a catalogue of encounters with health professionals, lots of appointments and conversations being duplicated. No one was taking overall responsibility for her care, and she had not had the opportunity to share what was important to her in her life and how she thought her conditions could be managed better.

Luckily for her, she was eventually given the chance to go through a much more meaningful care and support planning process. This enabled her to articulate her own issues, develop solutions in partnership with professionals and access and design the right support at the right time from a range of options available.

For me her very real story, experienced by so many still, demonstrates that better conversations are vital if we are to shift away from 'what's the matter with you?' to 'what matters to you?' The route to better care, outcomes and lives is through a real and equal collaboration between those providing care and support and people with long-term conditions and their families and carers.

Ensuring care and support planning becomes a mainstream activity and not just available for the lucky few, is one of the core aims of the Coalition for Collaborative Care (C4CC). We are a partnership of national organisations committed to achieving a better deal for people with long-term conditions. At the heart of our vision are our three 'C's: *Better Conversations* between health professionals and the people they support, growing and nurturing strong *Communities* to promote and support wellbeing and *Co-production* with people and families.

Drawing on the online resource developed with Think Local Act Personal,(TLAP) and work done with the TLAP and C4CC co-production groups to explore 'what good looks like', this document describes the things people might be saying or hearing about care and support planning at different stages of implementation, providing organisations with a baseline to build on.

It is a collaborative effort with C4CC, the Alzheimer's Society, the Royal College of General Practitioners, TLAP and Helen Sanderson Associates and provides practical information for organisations wanting to explore how well they are doing in care and support planning and to identify areas for improvement.

We hope you find it useful!

Sally Percival

Chair of the Think Local Act Personal Partnership and Chair of The National Coproduction Advisory Group

One of the most important people in my life is my mum, and I want her to be as happy as possible, she has several long-term health conditions and requires a high level of care. The only way to ensure my mum is supported the way she wants is to work together in partnership with everyone involved with her life. Mum's voice has to be central to every conversation we have. Traditionally professionals have been hesitant about personalised care and support and relinquishing control, but professionals need to work with people and turn "I" in to "we".

Personalised care and support planning doesn't just happen by chance there needs to be several vital components for it to work well. One important aspect is co-production; co-production values everyone as equals and is built around people, not around systems and processes. Instead of fitting people into existing services and boxes, we must all work together to find the best way to achieve the outcomes that matter to each individual and although coproduction isn't rocket science, it is absolutely necessary if personalised care and support planning is to be effective. It must start with the important question "what is most important to the person to have the life that they want"; of course that question cannot be answered without us all working together with each other as equal partners, but importantly putting the person at the centre. Everything within the care and support plan must be designed and developed with the person receiving care and support, that is the only way it can be authentic. The plan must then be shared with all the appropriate people; it is no good having a great plan that remains hidden and unread.

So what is the impact of good personalised care and support planning? Well it is life transforming; it gives people a life that's worth living. Having a really good care and support plan will not give my mum more days to her life but it has given her more life to her days!

Jeremy Hughes
Chief Executive at Alzheimer's Society

One thing has been clear to me for some time. Now is the time to take action.

There are 850,000 people in the UK with dementia, by 2021 it will be over one million and by 2051 this figure will reach over two million. The annual cost of dementia to the economy is estimated at £26.3 billion, £10.5 billion more than the cost of cancer.

When confronted with these staggering figures, it's easy to lose sight of the cost to the individual. Each of these 850,000 people has their own concerns and fears, but they also have their own hopes, strengths and connections too.

Today people with dementia are not getting the help and support they need. Often they struggle to be part of their community, receive poor care and have their most basic needs and preferences overlooked. People with dementia are treated as second class citizens and this must change.

Too often assessments are focused on revealing deficits and problems, shaped by eligibility and budgets and not enough by what really matters to people. Instead we need open conversations, alive to new possibilities to be found in each person's individual circumstance. Health and social care services need to be properly resourced, genuinely integrated and individually responsive to the diverse range of needs the system must do more to meet.

By having new person centred conversations, professionals in dementia care can collectively make better interventions and deliver more meaningful outcomes with people, based upon choice, control and community. We must act now. Get it right for people living with dementia and we will have gone a long way to getting it right for all of us.

The clarity and practicability of this toolkit is very likely to hold the key to significant and transformational change. The strength of a resource such as this is in the way it acknowledges that each organisation will be starting from a unique place. The most important thing is building on what works, moving as quickly as possible away from

what is holding progress back, and working together to get to where we need to be for the future.

Alzheimer's Society is proud to support this toolkit. We are looking forward to working with our partners to ensure these person centred principals and practical steps have a real and measurable impact on care and support planning for people living with dementia.

Our vision is simple: a world without dementia. We make no apologies for our ambition and we believe that moment will come. We work relentlessly for a cure and every day we get a bit closer.

Until that day, we are determined to create a society where those affected by dementia are supported and able to live their life without prejudice. The approaches laid out in this toolkit are an important step along this bigger journey.

Professor Nigel Mathers
Honorary Secretary RCGP

There is now a general consensus amongst policy makers, professional bodies, health charities and NHS managers that safe and effective care can only be achieved when patients are 'present, powerful and involved'[1] at all stages. However, personalised care and support planning (or collaborative care and support planning (CC&SP) as the Royal College of General Practitioners refers to it) is still not the "norm" in NHS clinical practice.

The findings of patient surveys have been consistent in reporting that we (the clinicians, the managers and the patients) are not delivering person-centred care, nor is it being implemented "at scale" in any meaningful way. In a recent survey[2], for example, only 3.2% of patients with long-term conditions (LTCs) report involvement in developing their own care and support plan. The gap between the rhetoric and the reality remains uncomfortably wide.

This self assessment tool, commissioned by NHS England and developed by the Alzheimer's Society and Helen Sanderson Associates along with input from a number of organisations including the RCGP, brings together the current thinking and resources on CC&SP and is a simple way for you to develop an action plan that will enable you and your practice to move towards demonstrating excellence in CC&SP. It is based on the personalised care and support planning tool[3] developed by Think Local Act Personal (TLAP) and the Coalition for Collaborative Care, which is the same model which the RCGP uses on its CC&SP programme, and which the RCGP has endorsed as part of core business for general practice.

General practice is key to delivering person-centred care for people with LTCs and multimorbidity. The art of building relationships with people and understanding them in order to empower others to reach their full potential remains central to general practice. More and more we, as GPs, are meeting patients who have the ability and/or the motivation to self-manage, who are often having to manage multiple conditions at any one time, and whose needs cross over the boundaries between health and social care.

The RCGP recognises the importance of CC&SP for general practice and as such will be introducing a new module into the GP curriculum which focuses on caring for

patients with long term conditions (subject to GMC approval). All GP trainees will be learning about the importance of understanding the need for better conversations between themselves and the people that they support. The embedding of these behaviours, skills and competencies into clinical practice will ensure future sustainability for this way of working.

This Progress for Personalised Care and Support Planning tool has been developed by the Alzheimer's Society. Therefore some of the examples remain specific to people with dementia. However don't be put off by this; this is a tool that is valuable for you as an expert generalist, not just in relation to any one condition. From the systems that need to be in place to enable CC&SP, to the skills, behaviours and competencies that the workforce need in order to deliver it, this self-assessment tool will enable you and your practice to ensure you are delivering the highest quality person-centred care for all patients.

We are all on a journey, and not many of us are at a point where we can say we are delivering the best person-centred care yet. Regardless of where you are on the journey, this self-assessment tool offers something for everyone; you may already be working in this way and score yourself highly in each section, or you may come to find that you have some way to go. Either way, the resources, approaches and action plans laid out in this toolkit are an important step along the bigger journey.

[1]NHS England, Five Year Forward View (2014) Available at: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[2]NHS England, Overall Patient Experience Scores: 2014 Adult Inpatient Survey update (2015) Available at: http://www.england. nhs.uk/statistics/2015/05/21/overall-patient-experience-scores-2014- adult-inpatient-survey-update/
[3]http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/

Introduction

"Personalised care and support planning is part of the different relationship being forged between people with health and care needs and services. It recognises and values lived experience, alongside clinical expertise and empowers and enables people to shape and manage their own care. It is a key ingredient in a variety of transformation programmes, grappling with issues of improvement and sustainability across the NHS and local government, including New Care Models, Pioneers and Integrated Personal Commissioning Programmes." Sam Bennett, Deputy Director of Personalisation & Choice, Head of Integrated Personal Commissioning and Personal Health Budgets, NHS England (Source: TLAP, Personalised Care and Support Planning tool)

Personalised care and support planning is about starting a different kind of conversation about health and care which is focused on what's important to each person, leading to a single plan that is owned by the individual. It is delivered through multi-disciplinary teams, with a single coordinator supporting the person through the process. It is about having different conversations; it is focused on community rather than just services, and is rooted in co-production. Personalised care and support planning is set out as a legal right in the Care Act 2014, alongside personal budgets, for everyone with eligible social care needs, including carers. It is also part of the vision for the future of the NHS in the Five Year Forward View, which describes the importance of people and communities gaining far greater control of their care.

Getting care and support planning right is essential for people to gain more choice and control over their life and the support they are receiving. This self-assessment tool will help you to evaluate how well you are delivering personalised care and support planning at the moment, highlighting any areas of strength and areas where you might be able to improve your services for the people you support.

Personalised care and support planning in health, social care and education

In health, personalised care and support planning is expected to become the routine way in which health care and support for self-management is brought together through a proactive approach for each person, by signposting to available activities within a supportive community and coordinating with social care when necessary. This approach will apply to both long-term health and immediate well being. Personalised care and support planning is a requirement for anyone who accesses a Personal Health Budget, and is one of the fundamental shifts that the Integrated Personal Commissioning programme is seeking to effect.

In social care, personalised care planning has become a central component of government policy. The Care Act 2014 introduces a duty for councils to make sure that a personalised care and support plan and personal budget is provided for anybody who is eligible. Statutory guidance describes in detail how this should work to put people in control and enable a more holistic approach to meeting needs and

promoting wellbeing. Personalised care planning also helps to decide how a person's needs can be met in the ways that work best for them as an individual and for their family, and determines how the person's personal budget will be spent.

In mental health settings, the care programme approach (CPA) has long been used for people with enduring mental health issues, to ensure that long-term care and support is organised around their wishes. This process can be enhanced and improved through incorporating personalised care and support planning.

In educational settings, when a young person is 18 years old, they are eligible for an Education, Health and Care Plan. This can be integrated into a personalised care and support planning approach, bringing all the resources together around the individual.

About Progress in Personalised Care and Support Planning

"Personalised care and support planning is a 'meeting of experts'. It brings together those with lived experience and those with technical expertise to identify all the issues, develop solutions and initiate actions... Essentially, PCSP builds on the person's assets and resources, ensuring they are in the driving seat of decision making." TLAP, Personalised Care and Support Planning tool.

Progress for Providers[4] is an established and well-regarded series of self-assessments. This version of Progress for Providers is a self-assessment directly based on the Think Local Act Personal/Coalition for Collaborative Care resource on personalised care and support planning[5]. This resource was commissioned through NHS England in order to bring together the current thinking and resources on care and support planning, and to co-produce a personalised and integrated care approach. It has been developed to support the Integrated Personal Commissioning sites in their efforts to develop new approaches to truly integrated care.

This resource also reflects the Care Act 2014[5], which requires that everyone has one plan and that every plan results in outcomes, not just actions or service prescriptions. As part of this work, the co-production groups from TLAP and the Coalition for Collaborative Care developed a set of statements about what good looks like in relation to personalised care and support planning.

Who is this for?

This resource has been co-produced with the Coalition for Collaborative Care, Think Local Act Personal, Health Education England, the Royal College of GPs and the Integrated Personal Commissioning team, with their Voluntary sector partners Helen Sanderson Associates and the Alzheimer's Society.

This self-assessment tool is targeted at teams who provide care for individuals who have complex care needs. These teams need to be developed locally, but are likely to incorporate social care, community and voluntary organisations and a wider range

[4]Progress for Providers series: A range of simple self-assessments to enable providers to deliver more personalised services. https://progressforproviders.org/

[5]Think Local, Act Personal, Care and Support Planning Tool: http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/

of health care providers working together to deliver placed based care. However, the principles articulated are applicable across all settings, from the individual GP practice unit to a network / locality of practices. Through the systematic embedding of personalised care and support planning, that recognises the importance of multi-disciplinary – at different levels in the system and with a variety of skill sets represented - individuals with a range of care needs will be supported to make decision about what's important to them, their carer's and their families. We hope that it will be used by:

- The Coalition for Collaborative Care and TLAP members, as they introduce and embed personalised and collaborative care and support planning.
- The Integrated Personal Commissioning sites. It will also be useful for New Models of Care (Vanguard) and Pioneer sites.
- GPs and doctors, as collaborative care and support planning is being introduced into training.

How to use it

There are three sections to this Progress for Providers self-assessment:

The first stage looks at what needs to be in place for the five stages of personalised care and support planning.

The second section looks at the workforce - in particular, what needs to be in place to enable teams to deliver personalised care and support planning.

The third section looks at what needs to be in place at an organisational or systemic level to introduce personalised care and support planning.

Each section covers a key area of change, and has five statements to choose from. You choose the statement in each section that best corresponds with your progress to date (statement 1, 2, 3, 4 or 5). If you are **Getting started**, you are likely to tick the first or second statement. If you are making some progress, then perhaps you will tick the third statement. **Good progress** is likely to mean that you would tick the fourth statement. **Excellent progress** would mean that you are ticking the fifth statement. The fifth box is cumulative; to score a 5, you should be delivering the good practice described in statements 3, 4 and 5. Few organisations will be able to score 5s in every area.

Once you have assessed your progress, you can use this information to develop an action plan. The action plan should describe you how you are going to develop and change to move towards statement 5 ('excellent progress'). For example, if you score a 3 in one area, your action plan should focus on how you could move from a 3 to a 4 or 5. In this way, Progress for Providers can help you to decide where to focus your energy and resources. This makes Progress for Providers a practical tool to support you to move from evaluation and thinking to action and change.

There are a range of resources to support you to develop and move towards 5s - from eLearning to face-to-face training and support. Some of these can be found at the end of this resource, together with templates for action planning.

Finally, a note about language and ongoing learning...

Care and support planning has to be both personalised and collaborative, and we use both of these terms throughout the document.

Working Together for Change is a process to co-produce change at a local and system level. It was tested and further developed through a Department of Health-funded programme in health and social care, and is one example of how to co-produce change using information from person-centred reviews and care and support plans. You can find out more here: http://www.thinklocalactpersonal.org.uk/Latest/Working-together-for-change-using-person-centred-information-for-commissioning/. More examples will be included in further versions of this tool.

We know that this resource is not perfect, but thought it was helpful enough to share. The IPC sites are developing and evolving practice in personalised care and support planning, and the next version of this resource will start to be developed in April 2017.

Contents

Section 1

Personalised Care and Support Planning Process

Section 2

Developing and enabling teams to deliver personalised care and support planning

Section 3

What needs to be in place to enable effective personalised care and support planning?

Section 1

Personalised Care and Support Planning Process

There are five stages to personalised care and support planning – preparation, the conversation, recording, making it happen, and the person-centred review.

1 Preparation

In order to hold different conversations, it is necessary that both the individual and the practitioner are prepared and fully understand the purpose of personalised care and support planning, as well as what will happen when. This step is the key to effective personalised care and support planning, and there are three elements to this: preparation for the process, preparation by the individual, and preparation by the practitioner and the team.

a Preparation for the process

This step involves making sure that each individual knows the purpose of personalised care and support planning, what to expect and when, and how to ensure that the person is at the centre of the process and the decision-making. Preparing for the process includes considering whether the person needs any support to prepare for the conversation - and, if they do want support, deciding how and by whom this will be provided.

Tick one box ✓

1	We don't share any information with the person about personalised care and support planning at the moment.	
2	We know we need to have a way to explain the process to people, but we are not sure how to get started.	
3	We have a standard way to share information about personalised care and support planning; for example, everyone is sent a letter that tells them about it.	
4	We have a clear process established for introducing people to care and support planning, and this includes telling people why it is important, what it is, and what will happen when. We find out the best ways for the person to receive information (for example, by email, letter or phone call), and schedule appointments to fit in with the person. We make sure that consent issues are addressed, and know when and how to involve advocates. We assign someone to each person to support them if they want help to prepare for the conversation.	
5	We have a flexible process that is tailored to each individual. We have a range of ways to share information about why we are introducing care and support planning, how it works, and what will happen when (for example, accessible information in different formats and languages, or a visual of the timescale). We find out the best ways for the person to receive information (for example, by email, letter or phone call), and schedule	

		Tick one box ✓
	appointments to fit in with the person. We make sure that consent issues are addressed, and know when and how to involve advocates. We talk about what support the person may need to prepare for the conversation, and have a range of resources that we can share with the person to choose from. If the person wants support, we also talk about who they want to support them. We can offer people support from peer supporters, volunteers and advocates if required.	

b Preparation by the person

1	We don't have any ways to support the person to prepare.	
2	We know that we need to develop support for people to prepare, but are not sure how to start.	
3	We have a standard way to support people to prepare – for example, we send out questions that we ask people to complete before the conversation. We arrange who will have the conversation, the date and the time, and we send this information to the person.	
4	We have some resources to help people to prepare for the conversation. The person can prepare with their family, and we also have a team member with the role of supporting people to do this. People cannot choose who they want to help them prepare.	
5	The person has information and resources to think about what matters to them now, what their aspirations are for the future, what is working and not working for them now, and what they want to change. The person has a range of resources available to help them to do this (for example, written prompts, short films on YouTube where peer supporters talk through the process, and a group process called Planning Live). The person can choose who they want to support them to think about this – whether this is family and friends, a practitioner who they already work with, a peer supporter or a volunteer. The person confirms who they want to have the conversation with, when and where.	

c Preparation by the practitioner

1	The person who is doing the conversation has the person's notes with them. We don't do any further preparation.	
2	We know we need to do more to prepare, and we are looking at how to do this.	
3	The practitioner involved checks whether the person has had all of their tests, and makes sure that this happens.	
4	We cover preparation at a multi-disciplinary meeting when we look at each person's case and make sure that tests have been done, and everyone can comment.	

		Tick one box ✓
5	The practitioner reviews all the information about the person - including any previous plans - and identifies any gaps in tasks, tests or assessments, involving other team members as necessary. If further tests or assessments are required, they ensure that these happen in a way that reflects what the person wants, and that the person is central in the process. If it looks like the person could be eligible for a personal budget, they arranges for an Adult Social Care Assessment with her colleagues and the person. They checks that the person has received the results of any tests, and explanations about what these results mean, before the conversation. They summarises what is working and not working, from her perspective and from the team's perspective, based on her preparation before the conversation.	

2 The conversation

The conversation is between the person and a practitioner (coordinator), along with whoever else the person wants to involve (e.g. family members, peer supporters). The conversation reflects the principle that people are the experts in their own lives, and decide on their own priorities. They are the primary decision makers about the actions that they take in relation to managing their long-term condition, their support and services. Therefore, the conversation starts with what matters to the person. The focus on health and care practitioners is not simply on meeting the person's health and social care needs, but enabling the person to achieve their outcomes. Each individual's outcomes are informed by what matters to the person, their aspirations and their needs. People are more likely to act upon decisions that they have made themselves, rather than those made for them by a practitioner. There are three areas that are covered in the conversation. The first step is to establish what matters to the person and their priorities; the second involves looking at ideas and options to get to outcomes. Once the outcomes have been agreed, the conversation moves to deciding on next steps, contingencies, recording, and when and how to review progress.

a Starting with what matters to the person and their priorities

1	We start by only looking at the health information and diagnosis.	
2	We know we need to include what matters to the person, but we are not sure how to do this yet.	
3	We have a checklist that we go through that starts with what matters, and covers health, risks, contingencies and actions. It still feels like a health conversation with health-related actions.	
4	We have a flexible process and always start with what matters to the person, and we are getting more confident about not going straight to actions and making sure to put health issues in the context of the whole of the person's life.	

		Tick one box ✓
5	We start by hearing from the person about what matters to them, what they want in the future and their priorities for change. We think together about how to build on what is working and change what is not working. We explore the person's health needs and the impact on their life, and talk about the health information in relation to this. We don't go straight to actions; we explore what the person has already tried and learned. This happens at the person's pace, and it feels like a conversation between equals.	

b From ideas and options to outcomes

1	The practitioner suggests actions to address the person's health needs.	
2	We know we need to look at options, but we are not sure how to go about this.	
3	The practitioner suggests options for the person to choose from, and we set actions around these - but we are not confident about the difference between outcomes and actions, or personal budget information.	
4	We always look at different options, and ask the person for their ideas. We agree on outcomes, but these are not always as well-defined and clear as we would like. We talk about what is available in the community.	
5	We know what the person's priorities are, and look at the resources that they have available to address these (e.g. friends, family, community). If the person is eligible for a personal budget, we talk about the indicative allocation and the different ways that it can be spent (e.g. direct payment or Individual Service Fund). We look at ideas and options for meeting the person's priorities using the resources available and what is available in their local community. This includes support for self-management if needed. We agree clear and specific personal outcomes.	

c Next steps, contingencies and review

1	The practitioner records actions at the end of the meeting.	
2	We agree on actions with the person, and that the practitioner will send them a date for the review.	
3	We agree on actions and look at potential risks, and set a date for the review.	
4	We agree on actions to meet the person's outcomes, and look at risks and any contingency plans. We take a person-centred approach to risk. Reviews always take place six months after the conversation.	

		Tick one box ✓
5	Based on the ideas we talked about, we put together an action plan to achieve the outcomes. We talk about any risks and contingencies that we need to put in place, what we need to record and who this will be shared with. We take a person-centred approach to risk. We look at how we will know if things are going well, what would tell us that we need to review, and decide how to keep track of progress and review (in a way that fulfils our requirements of a six-month review, but has more frequent and informal reviews if the person wants these), specifying who is responsible for this.	

3 Recording

There needs to be one single plan that is recognised by the person as 'their plan'. Even if there are separate assessments, the personalised care and support plan is the overarching plan. If the person has a personal budget, the care and support plan needs to be agreed by the relevant authorised person/people.

To comply with the Care Act, the personalised care and support plan needs to clearly show the person's indicative budget, as well as their assessed care and support needs and outcomes. It must also include the budget option decision (direct payment, Individual Service Fund, or managed account) and the budget itself. The plan needs to include the services provided by the council, along with any further advice or information that needs to be provided to them in order to support their wellbeing. The plan has to be signed, and must include the next review date.

a One plan

1	We have multiple places where we record information, in order to reflect what different stakeholders need.	
2	We know that we need to streamline our recording, but we are not sure how to do this.	
3	We have aligned our paperwork and streamlined it, it is accessible to most of our colleagues but not the person themselves.	
4	We have our records on an electronic system that is accessible to staff members and to the person in question. We don't have the flexibility to print out one-page profiles or other information for the person if they want it.	
5	The personalised care and support plan is a summary of the decisions, outcomes and actions agreed through conversations with the person. The outcomes are person-centred and clearly link to what matters to the person as well as their assessed needs. The information is recorded in a format that is useful to the person (for example, a one-page profile) as well as to the practitioner. The record is easy to navigate, can be produced electronically and in a paper format as needed, and can be accessed by the person and the health and social care practitioner (with permission).	

Tick one box ✓

b Signing off the personal budget element of the Personalised Care and Support Plan (in accordance with The Care Act)

1	The personal budget has to be signed off by a panel/multiple people, and this is a long process.	
2	We are streamlining our signing off process, but it still takes more than one person to sign it off and the process takes over four weeks. Plans often have to be changed and re-submitted because they do not meet the criteria.	
3	We keep the person informed of progress with their plan getting signed off, and plans are signed off in a panel within four weeks.	
4	We keep the person informed of where their plan is up to, and aim to have plans signed off within two weeks.	
5	We have a co-ordinated, streamlined process for efficiently and quickly agreeing personalised care and support plans in under two weeks. The person is involved in the process as much as possible, and we keep people informed of what is happening.	

4 Making it happen

The actions to be taken to achieve the person's outcomes are built from the person out. They begin with supporting self-care – seeing whether the person would benefit from health coaching, assistive technology or other approaches to enable them to more easily manage their long-term condition. Then, actions may focus on the person's natural supports and any actions that they are happy to take, as well as exploring whether further support could help; for example, Community Circles or Side-by-Side Volunteers. Then, we look at what is available in the community – local resources, such as TimeBanks, and opportunities to connect and contribute. Some actions may include making use of voluntary and community services, universal services, and specialist health and social care services. Finally, if the person has a personal budget, there will be actions using the budget to achieve their outcomes

a Self-care

1	We only focus on existing health and social care resources.	
2	We know self-care is important, but we are not sure about how to address this in planning and action.	
3	We make sure that the person is aware of the importance of self-care as part of our conversation with the person.	
4	We talk to the person about improving their self-care as part of the conversation, and we are building ways to actively support self-care.	
4	During action planning, we always explore what could enable the person to manage their long-term condition. We have a range of options to offer people; for example, health coaching and assistive technology.	

Tick one box ✓

b Support from family, friends and community

1	We only focus on existing health and social care resources.	
2	We want to think more broadly than just using existing services, but we are not sure how to do this.	
3	We make sure that we talk about support from family and friends as part of the conversation, but don't usually have any actions that relate to this.	
4	We have started to invest in community, and make sure that everyone involved in planning knows what is possible and available. We are seeing more plans that include actions around family support and community.	
5	When planning, we think broadly and creatively about ways to support the person, including exploring whether family and friends can provide support, as well as community opportunities. We have invested in a wide range of options - both for helping families to coordinate their support (for example, Rally Round and Community Circles), and for opportunities within the community such as TimeBanks, Spice, and support from Side-by-Side.	

c Facilities and services that are available to all in the community, such as parks, libraries, cafes and leisure centres, specialist health and social services

1	We only focus on existing health and social care resources.	
2	We want to think more broadly than just using existing specialist services, but we are not sure how to do this.	
3	We are starting to pay attention to the facilities and services available in the community and we can see how to use these more in addition to specialist services.	
4	We are getting a much better balance in supporting people to use community resources as well as specialist services.	
5	We always focus on community resources before looking at specialist health and social care services. When the person's outcomes require specialist support from health and social care, we work to design this around the person, rather than simply slotting people into existing services.	

Tick one box ✓

d Using a personal budget to buy support

1	Personal budgets are usually allocated as managed budgets with social workers.	
2	We offer managed budgets and direct payments.	
3	We are trying to make the processes for using direct payments easy and straightforward, and we have an organisation that can help people to broker their support and recruit PAs.	
4	We can support people to use direct payments and Individual Service Funds, and people can choose from different organisations to support them in this.	
5	We are able to support people to easily use direct payments and Individual Service Funds, and have a range of ways to support people to employ personal assistants and choose providers for Individual Service Funds. There is lots of information about what is possible, examples of people using their budgets creatively, and support from peer supporters.	

5 Person-centred review

Personalised care and support planning is not a one-off event, but a continuous process of discussion and review reflecting the ongoing changes and priorities in a person's life. The decision about when and how to review the personalised care and support plan is made during the conversation stage. This is in addition to a more formal review every six months – a person-centred review. If an independent advocate was involved in the preparation and conversation stages, then they should be involved in the review as well.

In addition to the six-month review, other reviews might include self-review (with family and friends) or telephone review. These reviews should be proportionate, reflecting the person's needs and circumstances. They can also be built into support programmes such as peer-to-peer or community activities, rehab, 'staying steady', weight management groups, or other elements of a local 'More than Medicine' programme.

The Care Act states that reviews can be planned (i.e. agreed in advance through conversation with the person), unplanned (i.e. triggered by a crisis or sudden change in circumstance) or requested (i.e. called for by the individual or their carer or family member when deemed necessary).

Tick one box ✓

a Reviewing progress

1	We only do the required statutory reviews.	
2	We want to build in more flexibility around how we are doing reviews, but are not sure how to do this.	
3	We include the topic of how the person wants to review their progress in the conversation, and have a few different standard ways to do this.	
4	We have a range of ways to enable people to reflect on their progress in a planned way. We make sure people know how they can request a review, or what could trigger a review.	
6	We co-design with the person where and how often they want to review their progress, and offer a range of ways to do this. This includes simple ways to keep in touch about progress (e.g. texts, calls and emails), as well as supporting people to get together and look at how they are getting on. We specifically ask people how we would know if a review was required – what their personal triggers would be (for example, a health crisis or change) and how they could request a review.	

b Person-centred reviews – starting with what is working and not working

1	We do our reviews in a standard way – often by phone or through a brief meeting.	
2	We want to put more emphasis on reviews and introduce a more person-centred approach, but we are not sure how to do this.	
3	We have started to introduce person-centred reviews. These always begin with a reflection on what is working and not working from the person's perspective.	
4	We always use the person-centred review process, and make sure that we support the person to think about who they want to involve.	
5	We always use the person-centred review process, starting with what is working and not working from different perspectives. We support the person to decide who they want to be involved, and when and where they want to have the review. We see the review as just as important as the conversation – a way to keep exploring what matters to the person and what they want to change.	

Tick one box ✓

c Reviewing and updating outcomes

1	We do our reviews in a standard way – often by phone or through a brief meeting.	
2	We want to put more emphasis on reviews and introduce a more person-centred approach, but we are not sure how to do this.	
3	We check outcomes in every review to see whether they have been met or not.	
4	In our person-centred review, we look at outcomes – what has worked and not worked, and what has changed. This would trigger a re-assessment if required, and fulfills the review requirements for personal budgets.	
5	We always use the person-centred review process, looking at the outcomes agreed in the conversation, what has worked and not worked in achieving these, and what has changed. We check whether the outcomes need to change and be updated (including a reassessment if required, and fulfilling the requirements for personal budgets).	

d Options, next steps and updating records

1	We do our reviews in a standard way – often by phone or through a brief meeting – and use this to update our records.	
2	We want to put more emphasis on reviews and introduce a more person-centred approach, but we are not sure how to do this. At the moment, we update our records to add more actions.	
3	At the end of the person-centred review, we look at the outcomes/updated outcomes and decide together who needs to do what to move towards them. We then record this and update our records.	
4	We make sure that we look at different options to achieve the outcomes/updated outcomes, and then decide which ones to take forward. We decide together who needs to do what to move towards them, and we record this and update our records.	
5	For each outcome, we look at options and decide which ones to prioritise. At the end of the person-centred review, we clearly know where the person wants to be in a year's time, and have clear outcomes and SMART actions to move towards this. We make sure that there are actions to update the records, ensuring that the person has access to any information that they want as part of this.	

Tick one box ✓

e Using this information to co-produce service and system change

1	We only use this information to complete our records.	
2	We know that there are opportunities to use this information further, but we are not sure how to do this.	
3	We are introducing processes such as Working Together For Change as a way to use information from person-centred reviews to co-produce change.	
4	We work in partnership with our co-production group to use processes such as Working Together For Change on at least an annual basis to systematically look at information from person-centred reviews – working with service users, practitioners, managers and commissioners to look at what this means for service and system change.	
5	We have six-monthly review sessions using processes like Working Together for Change that we deliver in partnership with our co-production group. We make sure we include service users and carers, along with people from health and social care and from the community and voluntary sector, to systematically look at information from person-centred reviews and co-produce priorities for services, systems and commissioning. The priorities and actions are communicated throughout the system regularly, so everyone knows both what has been agreed and the progress being made. This information is included in annual reports for the relevant stakeholders.	

Section 2

Developing and enabling teams to deliver personalised care and support planning

This section looks at what is needed to enable teams to have the values, capacity and capability needed to deliver personalised care and support planning. As well as being information that can be used in its own right by services and systems, it also complements and supports personalised care and support planning for Integrated Personal Commissioning.

Values and behaviours of practitioners

The TLAP personalised care and support planning resource identifies key assumptions and beliefs that should drive the behaviour of practitioners. In order to improve, services should therefore be designed to support this new way of working. These values should be at the heart of the training and support programme for staff, and need to be the organising principles for local design teams.

These are:

- People are in charge of their own lives, and are the primary decision-makers about the actions they take in relation to the self-management of their conditions and their support and services.
- People are the experts in their own lives and aspirations, and decide on their own priorities.
- The focus for health and care practitioners is not simply to meet the person's health and social care needs, but to enable the person to achieve their outcomes. Their outcomes are informed by what matters to the person, their aspirations and their needs.
- A person is more likely to act upon the decisions they make themselves, rather than those made for them by a practitioner.
- Practitioners need to recognise people's assets, strengths and abilities, and aspirations – not just their needs – and support them to live their lives as well as possible, in a way that reflects what matters to them.
- People are interested in their lives rather than devices or diseases, so care has to be coordinated around the whole person's needs, aspirations and outcomes.
- The conversation between practitioner and service user is a meeting of equals and experts.
- Care and support should be focused on helping people to live in a way that reflects what matters to them and allows them to be part of their community, to stay well, and to manage their conditions.
- Where deterioration and death are inevitable, discussing this can be a helpful component of a care and support planning conversation.
- The personalised care and support planning conversation (how the care plan is agreed) is more important than the plan itself.

Service design principles for personalised care and support planning

When designing care and support plans, it is important to provide a range of people and options for the person to choose from during the planning process – making sure there is a balance between overall continuity and effective use of the practitioner's time and skills.

The following principles will also help to guide the care and support planning process. Naturally, these are linked to the values and behaviours that staff need to display, but have an increased focus on the process itself:

- Everyone involved must understand the care and support planning process, knowing what to expect and their role in it.
- No major allocation of resources should be made until the views of the person about what's important in their life and the outcomes they want to achieve have been identified and recorded.
- Tasks, tests and assessments should be separated from discussion of outcomes and what is important to the person.
- Where relevant and possible, assessments should be jointly shared between health and social care. Assessment by itself is not an intervention, but could lead to some immediate problem solving and early actions.
- Care should be organised holistically around the person in ways that connect the NHS, public health and social care, and community and voluntary organisations – so that people have to tell their story only once, and the focus is on supporting the person to achieve their outcomes.
- Care and support planning is a generic approach appropriate to a variety of contexts which should be routinely linked together as they are introduced (e.g. caring for people with one or more long-term conditions, the recovery model in mental health, preparation for ageing, and end of life care).
- Everyone experiencing the Integrated Personal Commissioning (IPC) care and support journey should have a single named coordinator who acts as a consistent point of contact. This person will provide coordination and timely support, especially in terms of the development of a person's care and support plan and coordinating the delivery of a wide range of services. They must also work exceptionally closely with the person – who should be in control of their journey and their support – as well as their family/carers.
- The single named coordinator could be, for example, a social worker, a nurse, or someone working for a voluntary or community sector organisation. They could also be a peer supporter, a family member, or even the person being supported themselves. The person holding the role does not necessarily have to be a qualified professional or practitioner. The key is to offer the choice of who the single, named coordinator should be to the person being supported.
- People should have to see as few different care practitioners as possible, understand the roles of those they see in supporting care delivery, and be kept informed during the whole process in a way that works for them.

- Decisions should be made as close to the person as possible.
- The process should be proportionate to the person's needs and circumstances – there is no one size that fits all.
- Where people have a personal budget, they must have choice and control over how it is used, and have whatever support they need to decide how to spend it to meet their outcomes.
- Care and support planning is a continuous process, evolving over time; not a plan that happens only once. The plan is not the outcome.
- Documentation must be owned and accessible by the person, as well as by health and care colleagues.
- Practitioners should assume capacity unless otherwise assessed.

What does the workforce need to know in advance in order to effectively deliver personalised care and support planning?

This mix of values, behaviours, processes, principles and knowledge means that it is crucial for staff to be well-informed and trained before implementation of personalised care and support planning can be a success. It is therefore important that:

- Everyone understands the whole personalised care and support planning process, including the philosophy, and is able to explain the process and its purpose to the person, as well as their own role in this process.
- Everyone involved in personalised care and support planning needs to be trained appropriately. Training is best undertaken within each team to cover the flexibility of roles and functions that are needed. People should have knowledge and skills in person-centred practices – for example, one-page profiles, person-centred reviews, and Working Together For Change.

Training needs

- Teaching about what works needs to be provided, using methods which model the personalised care and support planning approach itself – i.e. they should be solution-focused, and recognise the assets and strengths of the learners and the local community.
- It is the responsibility of the practitioner to reflect on their style of consultation/conversation and assess how it is supporting the person.
- It is also the responsibility of team managers and senior leaders to create a space in which practitioners can reflect and learn about their own person-centred practice.
- Embedding new habits/skills takes time and support for self-reflection, and reinforcement needs to be provided using a facilitation approach.

Models of learning delivery

A variety of models could incorporate these principles. For example, blended learning could be designed, providing eLearning about person-centred thinking alongside face-to-face sessions to embed attitudes and practice skills.

Ongoing support and supervision

As organisational roles become more flexible, decision-making is delivered closer to the person and specialist skills become spread across teams. As a result, formal arrangements within teams for supervision and support will become even more important. Using a person-centred approach within a supervision model, and embedding person-centred principles and practices, is an essential component of changing the underlying philosophy of care delivery.

Within IPC, it has been recommended that every supervision includes a specific period of time set aside to reflect on person-centred practice and identify areas for personal development with regard to personalised care and support planning. Similarly, it has also been suggested that there should be a dedicated time at every team meeting to share success stories and challenges, providing an opportunity to discuss potential solutions.

Context

The context for joint personalised care and support planning for people living with health and social care needs will be determined by local commissioning and contracting decisions about pathways and models of care. These will describe:

- The groups/characteristics of individuals suitable for personal care and support planning.
- How relevant individuals (or 'cohorts') will be identified. Individuals already known to adult social care who have personal budgets may be referred for personal care and support planning at review.
- Placement on the system to prompt a person-centred review and initiate the process.
- Accountability for ensuring that care and support planning occurs for each person and meets quality standards.
- How the appropriate information sharing requirements have been put in place.

In areas taking Integrated Personal Commissioning forward, personalised care and support planning is a fundamental key shift.

Collaborative, personalised care and support planning involves addressing all of the person's physical, mental and social care needs and will often (though not exclusively) be based in primary care, with a multi-disciplinary team that brings together a range of skills and disciplines[6]. In some communities or situations, the responsibility for personal care and support planning may be assigned to a separate community or intermediate care organisation, and may be located within

Accountable Care Organisations in the future. Personalised care and support planning may be commissioned as a preventative proactive intervention, using risk stratification done through local commissioners or a risk register or frailty tool, usually based in general practice who holds a registered patient list. Councils may also place social care practitioners in multi-disciplinary teams as part of their prevention duties, providing targeted advice and support around a range of issues to those not currently above the national eligibility threshold for state-funded care. Multi-disciplinary teams can also include colleagues from the voluntary and community sector.

[6]MDT approaches are formally reflected in key NHS England programmes, too, including Integrated Personal Commissioning (IPC) and Multi-Speciality Community Providers (MCPs).

1 Preparation

This step involves identifying and understanding what new roles and ways of working are needed within a team. There needs to be someone responsible for preparing the process, holding discussions, coordinating appointments, and working closely with the practitioner or coordinator. We have called this person the administrator, and it could be a separate position or it could be integrated within other roles. Part of the preparation is making sure that the person gets the support they need to prepare, and this could include support from one or more other people in the team. We have called these people supporters – they could be practitioners in the team that already know the person, volunteers, advocates, or peer supporters. The voluntary and community sector has an important role here. The third role is the practitioner or coordinator, a named person who ensures that any tests and assessments are completed, including Adult Social Care Assessments as required. The practitioner makes sure that these happen in ways that reflect the discussion that the administrator had with the person about how to keep them at the centre of the process and how they want their information. Getting the preparation stage right shapes the whole process, and contributes to the prevention agenda.

The context of personalised and collaborative care and support planning will include deciding who to prioritise, and how this will happen – for example, through risk stratification.

a Preparation for the process – administrator

Tick one box ✓

1	We don't have a specific role or function for preparation.	
2	We expect people who are already doing similar roles in the team to cover this.	
3	We have looked at the requirements for this role, and decided whether to review existing roles or create a new role to fulfil this function.	
4	We have a person specification and job description for this, and we are recruiting people/assigning this role and looking at any training requirements.	
5	We have a range of people who take the function of administrator, and they have had the training and support to be confident and competent. They communicate with the person in their preferred way to explain the process and ensure that they are at the centre of decision-making. This includes asking whether the person wants a visual, audio or written record to enable them to go back over the information. This person is confident in explaining the different resources available and using person-centred thinking tools to help (for example, relationship circles). The administrator can support the person to decide who they want to support them, and can help them to choose peer supporters, advocates or volunteers if needed (for example, she has personal profiles of volunteers who can provide support, and can help the person to decide who they want to help them). The administrator coordinates appointments and supports the practitioner, ensuring that they have the information that they need from the conversation (for example, how the person wants information).	

Tick one box ✓

b Preparation for the person – supporters

1	We don't have a specific role for supporters.	
2	We know we need to have people available, but are not sure how to make progress on this.	
3	We have clearly identified the role requirements, and are having conversations with peer supporters and colleagues from the voluntary and community sector about this.	
4	We have agreements in place with organisations from the voluntary and community sector, as well as peer supporters, and know how practitioners can fulfill this role as well. We have identified people for the role and are putting training and support in place.	
5	We have a range of people who work as supporters, including through the voluntary and community sector and through peer support, and have the capacity to support anyone who wants help. Supporters enable the person to think about what is working and not working for them, their aspirations for the future, and what matters to them now. They are able to use a range of person-centred practices and resources (e.g. Fink cards, one-page profiles, YouTube clips) to do this. If they are peer supporters, advocates or people from the voluntary and community sector, they feel confident working alongside people in other roles within the multi-disciplinary team. They support the person to think about how they want to share their information as part of the conversation, and who else they might want to involve.	

c Preparation by the practitioner and team

1	We don't see this job as requiring a specific role.	
2	We recognise that this is a different way of working, and have added this to everyone's roles.	
3	We have identified who in the team is best placed to take up this role, and what capacities we will require of them.	
4	We have practitioners with this role, and are providing training to enable them to do this. Practitioners/coordinators have conversations with relevant colleagues to build a rounded picture of the person they'll be planning with.	
5	We have practitioners/coordinators in place who are confident and competent in sifting and reviewing clinical and social care information with their colleagues, and can make proportional judgments about whether additional tests and assessments (including Adult Social Care Assessments) are required, ensuring that these happen in a person-centred way that reflects the preparation for the process. This includes thinking about risk in a person-centred way. Practitioners take an asset-based approach to their work, can use a range of person-centred practices, and can pull together a 'working and not working' summary from their perspective and from their team colleagues' perspectives.	

2 The conversation

The conversation brings together the preparation that people have done, and is the place to explore what matters to the person, their priorities and outcomes, and ideas for moving towards these. For many practitioners, this reflects a new way of working – instead of giving advice, they are facilitating a coaching-style conversation for shared decision-making. People are the experts in their own lives, and the conversation supports people to take more control over their lives and their health. The conversation also requires a different way to think about enabling thoughtful risk-taking, supporting people to explore ways to achieve their outcomes.

a Starting with what matters to the person and their priorities

		Tick one box ✓
1	We expect our staff in existing roles to be able to do this, but we don't have any monitoring in place to evaluate whether this has been done.	
2	We know that we need to look at different roles, functions, competencies and capacities, but we are not sure how to do this yet.	
3	We have identified the values and competencies related to the conversation, and know how to talk about what matters to the person and their priorities. We have started a programme of face-to-face training for staff.	
4	We have a programme of training and support designed with our co-production group, and co-delivered with them. This includes blended learning, and is focused on training teams together.	
5	We have a blended training (face-to-face, coaching, eLearning) and support programme for health, social care and voluntary and community colleagues. It has been designed and is being delivered in partnership with our co-production team, or people with lived experience. We are focused on training people within their teams, and sometimes across teams as well, so that we resolve issues and build relationships at the same time. Some of the learning is experiential, including listening skills to enable the person to share what matters to them, as well as health coaching. We can see people having 'aha' moments. Our programme includes specific person-centred practices; for example, using one-page profiles, facilitating person-centred reviews, and shared decision-making. We provide ongoing mentoring and coaching, support through online communities, and opportunities to reflect (e.g. through action learning sets). All training and support is based on performance outcomes (we can see the difference in how people work), and we evaluate these.	

Tick one box ✓

b From ideas and options to outcomes

1	We expect our staff to be able to do this already.	
2	We know that we need to look at how to enable staff to be aware of different options and generate ideas together, but we are not sure how to do this yet.	
3	We have created resources for the coordinator to use to share different options, and we have a face-to-face training course that shows different ways of generating ideas with the person. People know how to link this to personal budgets, and are honest and transparent about the resources available and different ways that they could be used.	
4	We have a wide range of local resources available for people and coordinators. We have worked with the co-production group to make sure these are accessible and useful to people. We have developed local training and support with the co-production group for people to practice and become competent in generating ideas and options, evaluating them together, deciding on priorities and then matching this to local options and possibilities. We have specific training on outcomes, and test people's competence with this in practice.	
5	We ensure that our range of resources (people, places, community opportunities, and services) are accessible in different formats and reflect the different ways that people prefer to have information. We have a blended training and support offer, co-developed with the co-production group, that focuses on performance. Coordinators are competent in generating ideas and options, evaluating them together, deciding on priorities and then matching this to local options and possibilities. We have training on outcomes, and are confident that all outcomes are specific and person-centred, linked to assessed need, changing what is not working, and moving towards the future the person wants. Everyone involved can talk about different ways to have a personal budget, explain the pros and cons of each, and support the person to make a decision.	

c Next steps, enabling risk and review

1	We expect our staff to be able to do this already.	
2	We know we need to look at how to look at contingencies and take an enabling, person-centred approach to risk, but we are not sure how to do this yet.	
3	We have face-to-face training on person-centred approaches to risk, developing contingencies and different ways to think about reviews.	
4	We have worked with the co-production group to develop an enabling, person-centred approach to risk and thinking about contingencies, and our blended training and support reflects this.	

	Tick one box ✓
5 We have a blended training and support offer, co-developed with the co-production group, that focuses on our enabling person-centred approach to risk and developing contingencies. We have support for coordinators as they develop their skills and competence, and this includes lots of opportunities to practice and get feedback.	

3 Recording

The Care Act (2014) states that people should have one plan. The care and support plan is that plan, and also needs to link to other plans and records as needed (for example, Advance Decisions).

Within IPC, there should be a summary document/plan that can act as an overview for any and all other care and support plans an individual has. This summary does not replace the necessary detail that must be included in other plans. However, the summary should include the key points and top tips that we must know about a person, as well as details common to all plans, and must reflect what is important to them and how we best support them. It should also explicitly link to any detailed plans a person may have for the future.

Recording has to work for the person, the practitioner, and the organisation. This includes gathering information to inform commissioning and quality assurance.

Where the person is eligible for a personal budget (including an integrated budget for Integrated Personal Commissioning), the plan has to include their assessed needs, their outcomes and how the budget will be spent to achieve these outcomes (in line with Care Act and Personal Health Budget requirements). It must be outcome-focused and not function as a 'service specification' (e.g. 'provide home care three times a day').

a One plan

1 We can still only record in multiple places, so have no need to train staff to do anything differently.	
2 We know we need to train staff to think differently about recording and try the shared system, but we are not sure how to do this.	
3 We are delivering face-to-face training to all our colleagues, both in health and social care and in the voluntary and community sector, about sharing a single record and having one plan. We are introducing people to the person-centred practices that they will find useful (e.g. one-page profiles, relationship circles, communication charts). People are trained to agree on the detail and wording that works for the person and the practitioner. We can easily use information from the personalised care and support plan to inform other areas where we need to record information (for example, a Mental Health Crisis plan).	
4 We have blended training to support everyone to use the shared, single record, and to make sure that the person has the information that they want (for example, a printed copy of their one-page profile).	

	Tick one box ✓
5 We have worked with the co-production group, health and social care workers, and the voluntary and community sector in order to think about the language that we use and how we create one plan together. Our blended learning and support enables consistency of recording across all sectors, and keeps the person at the centre of this. The training and support includes how to work with the person to make sure that the plan is implemented, and practitioners are clear about their role in this.	

b Agreeing the personalised care and support plan and any personal budget element (in accordance with the Care Act)

1 The plan, along with any personal budget element, has to be signed off by a panel/multiple people, and we expect them to know how to do this without training.	
2 We know we need to do more to make sure that signing off the plan and any personal budget element is consistent amongst the different people involved, but we are not sure how to do this.	
3 We have face-to-face training to make sure that everyone involved in signing off plans and incorporated personal budgets knows the criteria to use, and does this consistently. We know that anyone presented with the same plan would sign it off in the same way. Staff comply with Care Act requirements and (for joint/integrated circumstances, such as under Integrated Personal Commissioning) expectations around PHB usage and management, as well as local data collection requirements.	
4 We have blended learning opportunities to make sure that everyone signs off plans according the criteria in the Care Act (and Personal Health Budget regulations where applicable) and the values that underpin them, enabling people to use their budgets flexibly to meet their outcomes. Practitioners understand that people own their plans, and are aware of a range of ways to keep a person informed of where their plan is up to.	
5 We have blended learning and ongoing support so that our coordinated, streamlined process offers consistency for people in how their plans are signed off. A person owns and controls their plan. Staff know how to look at options with the person about how they want to be kept informed, so that they know what is happening with their plan at all times. Staff do this in a way that fits with the person's communication preferences.	

4 Making it Happen

'Making it happen' includes how people are supported to self-manage their own health; how family, friends and community can provide support; and how people can use personal budgets. For many staff, this represents a change in thinking and practice from suggesting service solutions to focusing on self-care, community resources and personal budgets.

Tick one box ✓

a Self-care

1	We expect practitioners to know about this without training.	
2	We know self-care is important, but we are not sure about how to address this in training for staff.	
3	We have training to make sure that all practitioners are aware of the importance of self-care as part of the conversation with the person.	
4	We have learning opportunities for colleagues from health, social care and the voluntary and community sector to learn about specific practical strategies to support self-care (for example, health coaching).	
5	We have ongoing blended learning opportunities, coaching, mentoring and support to ensure that there is always a conversation about self-care – and we can offer practical ways for people to develop their motivation, skills and knowledge in doing this, if they so wish.	

b Support from family, friends and community

1	We expect staff to know this and do it already.	
2	We want to think more broadly than just using existing services, but we are not sure how to do this, or how to equip our staff in this.	
3	We make sure that colleagues know the range of community resources in the area, and can share these with people when they are thinking about options. We have training on how to support and involve family and friends. The team is able to signpost people to resources.	
4	We have worked with the co-production group, and with local community groups and leaders, to provide training and support on using community resources to help people achieve their outcomes. We have training sessions on options for engaging with families, friends and neighbours, as well as initiatives like TimeBanks, Local Area Coordination and Community Circles.	
5	Our blended learning, support, coaching and mentoring enables people to think broadly and creatively about ways to support the person – including exploring whether family and friends can provide support, as well as community opportunities. Our staff are all confident in knowing what could help, and explaining the options (e.g. TimeBanks, Spice, Local Area Coordination and Community Circles) to people so that they can make an informed decision. Staff know exactly how to connect people with the community resources that they want to use.	

Tick one box ✓

c Using a personal budget to buy support

1	We expect staff to know about personal budgets without training.	
2	We know that not everyone is confident in talking about personal budgets or how to use them, but we are not sure how to get started on changing this.	
3	We have some face-to-face sessions for staff on personal budgets and the three deployment options, how to use them, how to talk about them in care and support planning conversations, and how to get help from colleagues.	
4	We have co-designed training with the co-production group, who help us to deliver it. People are able to talk confidently about the three deployment options, direct payments and third party support (including Individual Service Funds), the pros and cons of different ways of having a budget, and where to go/what to do to take these options forward.	
5	We have blended learning and ongoing support so that everyone is confident about personal budgets and the ways that they can be deployed (including direct payments and third party support, such as through Individual Service Funds), as well as what they can and cannot be used for. Staff can help with the next steps to support people (such as employing personal assistants, or choosing providers for Individual Service Funds). The ongoing support includes up-to-date stories and examples to share with people about the difference that personal budgets can make.	

5 Review

The review is given the same emphasis as the conversation. It provides a time to reflect on progress, revisit outcomes and plan how to move forwards. The review is introduced at the conversation stage – thinking about how to approach this as an ongoing process, as well as holding a meeting each year. Information from person-centred reviews informs the co-produced process called Working Together for Change, going on to inform service development and commissioning priorities.

a Reviewing progress

1	We expect staff to know how to do this without training.	
2	We want to build in more flexibility around how we are doing reviews, but we are not sure how to train and support staff to do this.	
3	We have awareness training for staff on different ways that reviews can take place.	
4	We have training for staff on different ways to do reviews, what should trigger a review, and the person-centred practices that can help – for example, 'working and not working from different perspectives' or '4 plus 1 questions'.	

		Tick one box ✓
5	We have co-designed blended learning with the co-production group, offering staff a range of ways to develop their competence in different approaches to reviews and the person-centred practices that can help. We have action learning sets and other reflective processes for people to share progress and problem-solve together.	

b Person-centred reviews

1	We hold our reviews in a standard way, often by phone or through a brief meeting, and staff do not need training in this.	
2	We want to introduce the person-centred review process, but we are not sure how to do this.	
3	We offer training in person-centred reviews for all coordinators.	
4	We have training for person-centred reviews, and the co-production group is involved in delivering this.	
5	We have blended learning approaches to enable coordinators to deliver person-centred reviews, ensuring that everyone knows what they are and why they are important. We provide ongoing support through coaching, mentoring, online communities and action learning sets.	

c Using this information to co-produce service and system change

1	We do not co-produce change, and therefore do not need any training on this.	
2	We know that there are ways to use information from person-centred reviews to develop services, but we are not sure how to take this forward, or what it means for our role.	
3	We have awareness training in approaches like Working Together For Change, and we are training local facilitators. Staff know how to collect information at the person-centred review, and can explain to people what happens to the information and how it is used in Working Together For Change.	
4	We work in partnership with our co-production group to use Working Together for Change, and have a training and support programme to enable them to deliver this. Staff know how to collect the information and make sure that it is at the right amount of detail, and can explain the Working Together For Change process.	
5	We have blended learning opportunities for everyone to learn about what Working Together For Change is, as well as providing facilitators to deliver the sessions. We are part of a larger community of people delivering Working Together For Change, so we have lots of opportunities to reflect on practice and keep developing based on best practice. Staff are clear about their role in Working Together For Change and can confidently explain it.	

Section 3

What needs to be in place to enable effective personalised care and support planning?

1 Co-produced vision

Tick one box ✓

There must be a clear vision for change, delivered through collaborative and personalised care and support planning across a local system. The vision needs to be co-produced with people with lived experience, families and carers.

1	We do not have a vision for personalised care and support planning.	
2	We have a documented vision, but this was not co-produced with front-line staff, people with long-term conditions, people with care and support needs, and carers.	
3	We have a shared vision developed with some health staff and front-line staff, people with long-term conditions, people with care and support needs, and carers.	
4	Our vision was developed with front-line staff, people with long-term conditions, people with care and support needs, and carers, and people from health and social care. This has been shared across health and social care and with the community and voluntary sector, and agreed at a senior level.	
5	We have a system-wide, co-produced vision statement—developed with front-line staff, people with long-term conditions, people with care and support needs, and carers, along with workers from health and social care and the voluntary and community sector—that clearly describes how important care and support planning is, and what we are working towards. This includes having a shared, common approach; different conversations are recorded on a single plan that is owned by the individual. The vision statement has been developed with and agreed by senior leaders from each sector, and is widely shared. Everyone involved will be able to tell you what the vision is, and their role in achieving this, and there are resources to make it happen.	

2 Commitment to co-production

Effective personalised care and support planning reflects a change in relationship with patients, people and families, where solutions are co-produced together. This needs to happen at an individual level during the conversation with the person, and throughout the approach to development, implementation and evaluation.

1	We are not clear on how co-production is different from consultation or general partnership work.	
2	We understand what co-production is and how this is different from consultation, and we are planning to build co-production into some areas of our work.	

	Tick one box ✓
3 We have looked at how we work and know when we have been consulting with people and when we have been using co-production. We are working with existing groups, such as patient champions, and changing our relationship with them from consultation to co-production, and/or establishing a co-production group to work with us.	
4 We have made a public commitment to use co-production in how we establish care and support planning. We have a co-production group who are helping us to develop our plans and practice.	
5 We demonstrate our commitment to co-production through published information and through our behaviour – how we are co-producing all aspects of personalised care and support planning. This includes having people with lived experience supported through a co-production group and peer network – ensuring their involvement in establishing the vision and framework for the organisation, their representation in the key decision-making forums, and their contribution to delivering our workforce strategy and evaluation.	

3 Shared understanding of what good looks like

For implementation to be effective and make a difference for people, everyone involved needs to know what good personalised care and support planning looks like – in practice, in experience, and on paper/IT systems too.

1 We are confused about many aspects of care and support planning.	
2 We think we know what it is and how it works.	
3 Different teams and departments know what good looks like, but we do not have a shared system-wide understanding across health, social care, and the voluntary and community sector.	
4 We have a shared understanding of what good looks like, along with our colleagues in health and social care and in the community and voluntary sector. We have involved and consulted on this with patients, carers and service users.	
5 Our system-wide, co-produced vision is underpinned by a shared understanding of what effective personalised care and support planning looks like, including how this fits with the different statutory responsibilities that we have – for example, in relation to delivering the Care Act – and how it is tailored around the person and proportionate. We have clear information that describes our vision and what good looks like, and colleagues use this to inform their practice and evaluate their progress. People using services have access to this information so that they know what to expect.	

Tick one box ✓

4 Leaders and champions

Effective change is not simply about introducing a new process; it is a change in hearts and minds. This requires enthusiastic and committed leaders and champions at all levels in a system – and, of course, including patients, service users, families and carers.

1 We don't have any leaders or champions for personalised care and support planning.	
2 There are people within the system who have a responsibility for personalised care and support planning.	
3 We have people who are championing personalised care and support planning in some places and departments, but not across the system as a whole. There are people who have the role of leading the implementation of personalised care and support planning.	
4 We have clear leaders for personalised care and support planning across health, social care and the voluntary and community sector, working in partnership with the leaders in the co-production group. We are spotting champions and supporting them – for example, through a network.	
5 We have leaders and champions for personalised care and support planning throughout the system – in health, social care and the voluntary and community sector, at different levels and places within organisations, working alongside patient and carer leaders. The leaders and champions take an active role in promoting good practice in personalised care and support planning, problem-solving, making sure resources are available, challenging practice that is inconsistent with the vision and values, and sharing good practice and success stories. We have a champions network that supports champions and shares practice and learning.	

5 Framework and action plan for personalised care and support planning

There needs to be a clear way for the vision to be delivered, and a clear picture of how and when this will happen in the short-term, medium-term and long-term. The framework and action plan should be co-produced across the system, clarifying the roles and resources needed for success.

1 We do not have a framework or action plan for developing personalised care and support planning.	
2 We have a task group or equivalent who are developing a framework and a short-term yearly action plan.	
3 We have a framework and a medium- to long-term plan for personalised care and support planning, and this has been signed off by the relevant people in one part of the system (health, social care or the community and voluntary sector).	

	Tick one box ✓
4 We have a joint 3-5 year framework and action plan that has been agreed across health, social care and the community and voluntary sector, and this was co-produced with people who use services, patients, families and carers. It is linked to resources, has clear milestones, and includes governance and data issues.	
5 There is a clear link between our co-produced vision and our framework for personalised care and support planning. We have a 3-5 year action plan and have the skills, competencies, values and resources to deliver co-ordinated assessments, as well as a range of information, advice and tools to implement personalised care and support planning. It is connected with other relevant plans (for example, sustainability and transformation plans) and includes governance and data issues. The action plan is being implemented, and we have a streamlined and person-centred process from assessment to planning and review. Everyone is clear about their role in delivering this and what this means for their work.	

6 The context for personalised care and support planning

At the beginning of introducing collaborative and personalised care and support planning, the context of 'who and where' needs to be specified, until it is 'business as usual' across the system.

1 We are not sure where or with whom we will start to introduce personalised care and support planning.	
2 We have a group who are looking at the context for care and support planning, and they are looking at priority groups and areas, but we have not made clear decisions yet.	
3 We are clear about who (which groups of people) we are prioritising, and which areas. We know how we will identify individuals (for example, through risk stratification).	
4 We are clear about the context of care and support planning, where and who we should prioritise and offer care and support plans to first, how we will make this happen, and the resources we need to do this.	
5 Our framework provides a clear context for who we are and how we plan to start introducing personalised care and support planning. Systems are in place to know the characteristics and groups of individuals who are suitable for personalised care and support planning, and how they will be identified. There are prompts within the system to trigger personalised care and support planning where appropriate, and we have mechanisms in place to ensure that this takes place and meets our quality standards. We know how we will go from the first cohorts to making personalised care and support planning the process that is offered to everyone. We have appropriate information governance arrangements in place.	

Tick one box ✓

7 Multi-disciplinary teams in place

Multi-disciplinary teams are the way through which personalised care and support planning will be delivered. However, these multi-disciplinary teams will include colleagues from health, social care, and the community and voluntary sector.

1	We are expecting our existing teams within their existing structures to use personalised care and support planning.	
2	We know we need to have one or more different multi-disciplinary teams in place, including colleagues with a range of skills from health, social care and the community and voluntary sector. We have started to think about what this means in practice.	
3	We have started to change some teams to be multi-disciplinary that include colleagues from health, social care and the community and voluntary sector, and they are based together or work together virtually. We are working on how to have advocates and peer supporters available.	
4	Most of our teams are multi-disciplinary teams reflecting health, social care and the community and voluntary sector. People have access to advocates and peer supporters.	
5	All of our care and support planning is delivered through multi-disciplinary teams, who are either based together or work together virtually. They include staff from health, social care and the voluntary and community sector, and therefore our teams have a range of clinical and professional expertise (including – but not limited to – GPs, nursing staff, social workers, allied health professionals, pharmacists, and education workers where appropriate), and include specific cohort specialisms and roles (e.g. Approved Mental Health Practitioners) depending on who they are working with. We have arrangements in place for advocacy and peer support.	

8 Workforce strategy to embed personalised care and support planning

Delivering effective and collaborative care and support planning will require more than training existing staff; it needs to be underpinned by a workforce strategy across the system.

1	We are expecting the existing staff team to deliver personalised care and support planning.	
2	We are expecting existing staff to deliver personalised care and support planning, but we are providing additional training for them to do this.	
3	We have looked at the functions and roles required to deliver personalised care and support planning, and have developed a workforce strategy to reflect this. We are sharing this across the system.	

	Tick one box ✓
4 Together, across health, social care and the community and voluntary sector, we have developed a joint workforce strategy that identifies roles and functions; required values, attitudes, skills and knowledge; and a range of ways to train and support staff. We are looking at ways to build internal capacity – for example, 'train the trainer' programmes.	
5 We have identified the functions and roles we need to implement the framework, and the required values, skills and knowledge. We have a resourced and co-produced workforce strategy that delivers integrated and coordinated training, coaching and mentoring support for volunteers and peer supporters, as well as colleagues from health, social care (and, where necessary, education), and community and voluntary services. Training is delivered in partnership with our co-production group. Learning opportunities range from tailored 'awareness' sessions and online learning to in-depth training for key coordinators, depending on roles. The strategy includes how job descriptions, meetings, supervision and appraisal will reflect care and support planning.	

9 Evaluation and learning

There needs to be a process for checking progress against the vision and 'what good looks like', as well as learning from experience and identifying what is working and not working.

1 We think that our existing monitoring and quality assurance processes are adequate.	
2 We know that we need to evaluate the impact of care and support planning, and we have a group looking at this.	
3 We have decided how we want to evidence the impact of care and support planning and identify areas of improvement. This is happening in different departments, but is not connected across health, social care and the voluntary and community sector.	
4 We have worked with people with lived experience, and connected our approaches to evaluation and learning across the system. They are proportionate and contain a balance of impact, stories and ongoing learning.	
5 We have a co-produced, proportionate approach to evaluation, and are aware of the stories and metrics that we need to collect in order to evidence the impact and learn how to improve the way we deliver personalised care and support planning. This includes specific processes where people who use our services directly contribute to the ongoing development of how we implement personalised care and support planning.	

Section 4
Actions and resources

Summary of actions

Section	What do we want to work towards? (the next statement in the section)
Section 1 Personalised Care and Support Planning Process	
1 Preparation	
a Preparation for the process	
b Preparation by the person	
c Preparation by the practitioner	
2 The Conversation	
a Starting with what matters to the person and their priorities	
b From ideas and options to outcomes	
c Next steps, contingencies and review	
3 Recording	
a One plan	
b Signing off the personal budget element of the Personalised Care and Support Plan (in accordance with The Care Act)	
4 Making it Happen	
a Self-care	
b Support from family, friends and community	
c Facilities and services that are available to all in the community, such as parks, libraries, cafes and leisure centres, specialist health and social services	
d Using a personal budget to buy support	
5 Person-centred review	
a Reviewing progress	
b Person-centred reviews – starting with what is working and not working	
c Reviewing and updating outcomes	
d Options, next steps and updating records	
e Using this information to co-produce service and system change	
Section 2 Developing and enabling teams to deliver personalised care and support planning	
1 Preparation	
a Preparation for the process – administrator	
b Preparation for the person – supporters	
c Preparation by the practitioner and team	
2 The Conversation	
a Starting with what matters to the person and their priorities	
b From ideas and options to outcomes	
c Next steps, enabling risk and review	
3 Recording	
a One plan	
b Agreeing the personalised care and support plan and any personal budget element (in accordance with the Care Act)	

	What are we going to do? (action)	When will this be achieved? (date)	How will we know that this has been achieved?

Summary of actions (continued)

Section	What do we want to work towards? (the next statement in the section)
4 Making it Happen	
a Self-care	
b Support from family, friends and community	
c Using a personal budget to buy support	
5 Review	
a Reviewing progress	
b Person-centred reviews	
c Using this information to co-produce service and system change	
Section 3 What needs to be in place to enable effective personalised care and support planning?	
1 Co-produced vision	
2 Commitment to co-production	
3 Shared understanding of what good looks like	
4 Leaders and champions	
5 Framework and action plan for personalised care and support planning	
6 The context for personalised care and support planning	
7 Multi-disciplinary teams in place	
8 Workforce strategy to embed personalised care and support planning	
9 Evaluation and learning	

	What are we going to do? (action)	When will this be achieved? (date)	How will we know that this has been achieved?

Detailed action plan

Top priority

Why is this your top priority?

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

What will have changed? What will you see? What will you feel? What will you hear?

Detailed action plan

Next priority

Why is this your top priority?

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

What will have changed? What will you see? What will you feel? What will you hear?

Detailed action plan

Next priority

Why is this your top priority?

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

What will have changed? What will you see? What will you feel? What will you hear?

Detailed action plan

Next priority

Why is this your top priority?

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

What will have changed? What will you see? What will you feel? What will you hear?

Resources

Better Conversation: An informal health-coaching coalition of organisations and individuals unified in wanting to improve conversations between the health and care system and people seeking care, their families and communities.
http://www.betterconversation.co.uk/

Coalition for Collaborative Care – A Co-production Model: A simple guide to help organisations embed co-production into their day-to-day working, describing the values and steps needed to ensure the voices of people with lived experience are included in decision-making, from commissioning to co-design and co-delivery.
http://coalitionforcollaborativecare.org.uk/wp-content/uploads/2016/07/C4CC-Co-production-Model.pdf

EHCP Journeys: Providing real-life examples of what it is like to go through the Education, Health and Care Assessment and Planning Process (EHCP) from the perspective of children, families and young people who are going, or have gone, through it.
http://ehcpjourneys.com/

National Voices – A Guide to Care and Support Planning: A guide designed for anyone who has health and care needs over time, or cares for someone who does.
http://www.nationalvoices.org.uk/sites/default/files/public/publications/guide_to_care_and_support_planning_0.pdf

National Voices – What is the Role of Voluntary, Community and Social Enterprise (VCSE) Organisations in Care and Support Planning: A discussion paper considering how VCSE organisations can meaningfully contribute to the care and support planning process and offers practical examples of the diverse ways in which it is happening.
http://www.nationalvoices.org.uk/sites/default/files/public/publications/what_is_the_role_of_vcse_organisations_in_care_and_support_planning.pdf

National Voices – A Narrative for Person-Centred Coordinated Care: Commissioned by NHS England on behalf of the National Collaboration for Integrated Care and Support, this final version aligns with TLAP's Making it Real initiative.
https://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf

NHS England – Care Planning Booklet: Enabling commissioners and health care practitioners to deliver personalised care. This handbook has been jointly developed with the Coalition for Collaborative Care.
https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/

Think Local, Act Personal, Care and Support Planning Tool: An online tool designed to inform and guide leaders, commissioners, planners, clinicians and practitioners through designing and delivering personalised care and support planning for people with a variety of health and social care needs.
http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/

Think Local, Act Personal, Delivering Care and Support Planning – Supporting Implementation of the Care Act 2014: Guide designed to help councils develop their local arrangements and approach to care and support planning for both adults with care and support needs and carers. The guide reflects the wellbeing principle of the Care Act (2014) with a particular focus on lean systems and processes that help achieve outcomes for people.
http://www.thinklocalactpersonal.org.uk/_assets/Resources/SDS/TLAPCareSupportPlanning.pdf

Think Local, Act Personal – Making It Real: Setting out what people who use services and carers expect to see and experience if support services are truly personalised.
http://www.thinklocalactpersonal.org.uk/Browse/mir/aboutMIR/

Think Local, Act Personal – What Good Looks Like:
The co-production groups from TLAP and the Coalition for Collaborative Care developed a set of statements about what good looks like in relation to care and support planning. This was also made into a self-assessment.
bit.ly/cspposter
bit.ly/cspassessment

Think Local, Act Personal – Co-production Ladder of Participation: A film to explain the different types of participation, using football as an example to make it easier to understand.
https://www.youtube.com/watch?v=kEgsJXLo7M8

Progress for Providers series: A range of simple self-assessments to enable providers to deliver more personalised services.
https://progressforproviders.org/

Realising the Value Programme: Enabling people to take an active role in their own health and care by strengthening the case for change and identifying evidence-based approaches.
http://www.nesta.org.uk/realising-value-programme-reports-tools-and-resources

Royal College of General Practitioners - Collaborative Care and Support Planning Programme: Supporting primary care to embed collaborative care and support planning for people with long-term conditions.
http://www.rcgp.org.uk/clinical-and-research/our-programmes/collaborative-care-and-support-planning.aspx

Royal College of General Practitioners – Stepping Forward: Commissioning principles for collaborative care and support planning: A guide to support commissioners and practice staff to implementing collaborative care and support planning.
http://www.rcgp.org.uk/-/media/Files/CIRC/Care-Planning/stepping-forward-web-061015a.ashx?la=en

Working Together for Change: A process for co-producing change that uses information from person-centred reviews.
http://www.helensandersonassociates.co.uk/wp-content/uploads/2016/01/Working-together-for-Change.pdf
http://www.helensandersonassociates.co.uk/person-centred-practice/working-together-change/

Year of Care / House of Care: The House of Care describes four key interdependent components that, if implemented together will achieve person-centred, coordinated care for people living with long-term conditions and their carers.
http://coalitionforcollaborativecare.org.uk/aboutus/house-of-care/

No Assumptions: narrative for personalised, coordinated care in mental health: http://www.thinklocalactpersonal.org.uk/_library/MakingItReal/NoAssumptionsFinal27_August.pdf

Helen Sanderson Associates: Helen Sanderson Associates can provide bespoke training and support in bringing personalised care and support planning to scale within the workforce, including face to face training, coaching, e learning and a range of resources.
http://www.helensandersonassociates.co.uk/what-we-do/training-courses/care-support-planning-courses/
https://hsaonlinelearning.org/product/personalising-care-and-support-planning/
http://www.hsapress.co.uk/publications/fink-cards.aspx