Putting **People** First
Transforming Adult Social Care

Working together for change:
using person-centred information for commissioning

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Foreword

The vision of Putting People First can only be realised by empowering people who use services, their carers and families to play a leading role in shaping and driving the changes they want to see. This means at all levels, from the individual directing their own support to people's engagement in decision making and planning for the health and wellbeing of their whole community. It means finding ways to enable people to design, deliver, and evaluate services so that they become a shared responsibility between citizens, councils and their partners.

Working together for change is a simple process for putting people using services at the heart of commissioning. As an innovative approach to community engagement and an active method for planning change that will help us to put people first – I commend this report to you.

Phil Hope
Minister of State for Care Services

Executive summary

> **This report describes a simple six-stage process that uses person centred information (for example from person centred reviews, person centred plans or support plans) to drive strategic change and commissioning.**

Working together for change is a structured approach to engagement with people using services to review their experiences and determine their priorities for change. It is a systematic process for planning change with people, which provides powerful insights into what is working and not working in their lives as well as their aspirations for the future. It can be used to ensure that co-production with local people and families is at the heart of social care transformation programmes, as a vehicle to improve community engagement in the Joint Strategic Needs Assessment and as a tool for strategic commissioning.

It is compatible with work conducted by the Department of Health in parallel to this project to design an outcomes-focused review process that works for people and provides performance information for councils, i.e. it is this information in individual and aggregate form that drives the working together for change process.

Helen Sanderson Associates (HSA) designed the six stage process that has been built upon in this work.[1] The Department of Health's Putting People First Implementation Programme worked with HSA and several Local Authorities in early 2009 to test and refine this method for collating and analysing person-centred information for use in strategic commissioning.

Whilst this is not a detailed evaluation, the experience of testing working together for change with four councils has shown the approach to be flexible, transferable and effective. Commissioners have begun to identify ways in which it can improve local commissioning, in some cases are planning to extend its use into other service areas, and are considering what it might take to embed the approach within council systems.

The following sections explain what working together for change is, why it is important and what it can add to the current range of information sources available to commissioners.

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1 *'From Individual to Strategic Change – driving change with person centred information'* Sanderson et al (2009)

Working together for change: what is it?

Working together for change is a simple, six-stage process that uses person-centred information taken directly from individual reviews, support plans or person-centred plans to inform strategic planning and commissioning. A full explanation of these stages is included later in the report.

Briefly, the six stages are:

**1) Gathering the person-centred information – ** e.g. from individual outcomes-focused reviews

**2) Transferring the information into a usable format – ** involves transferring statements to individual cards which captures the top three things that are working and not working in people's lives and the three things most important to them for the future

**3) Clustering the information into agreed themes – ** this happens during the course of a full-day workshop and includes naming each cluster with a first-person statement to best describe the theme of the information

**4) Analysing the information – ** this also happens during the workshop and includes analysis of possible root causes for things that aren't working in people's lives and a consideration of what success might look like if people's aspirations for the future were realised

**5) Action planning – ** conducted on the basis of the clustering and analysis, different stakeholders plan what they will do differently

**6) Sharing information – ** information about the process is shared with others, particularly the actions that have resulted

The process should be conducted cyclically – perhaps annually, so that the impact of previous action is understood, further actions can be taken to change the things that are not working for people and people's aspirations for the future can continue to drive local strategy and commissioning.

Why is it important?

This section explains why working together for change is important in relation to: Co-production and current policy, the Joint Strategic Needs Assessment and measuring the impact of personalisation. Collectively, these illustrate that working together for change provides:

i) A proven, effective approach to ensuring co-production with people using services in social care transformation

ii) A model for ensuring effective community engagement in the Joint Strategic Needs Assessment

iii) A way of understanding and measuring the impact of personalisation, especially when taken in conjunction with the outcomes-focused review process.

Co-production and personalisation

'Putting People First highlights the importance of co-production in the transformation of adult social care:

> *"It seeks to be the first public service reform programme which is co-produced, co-developed, co-evaluated and recognises that real change will only be achieved through the participation of users and carers at every stage."*

> **Putting People First,** DH, 2007.

This means at all levels – from the individual directing their own support, to effective engagement with local people in decisions about the health and wellbeing of the whole community. While co-production is understood in a number of different ways, there is broad consensus that at its heart co-production refers to a shift away from professionally led and process orientated practices towards systems that support the active engagement of local citizens in the design and delivery of public services.

The New Economics Foundation gives a useful description of co-production being: *'not about consultation or participation – except in the broadest sense'* but *'about broadening and deepening public services so that they are no longer the preserve of professionals or commissioners, but a shared responsibility.'*[2] Put another way, co-production requires more of services and commissioners than ensuring there are effective mechanisms for feedback – it is about creating shared ownership and working collaboratively to produce better outcomes.

This is no small aspiration. The value of co-production in the design and delivery of certain municipal services and the improvements that have resulted have been described in academic circles since the 1970s. It seems clear that some services are naturally more predisposed to co-production than others dependent on the possibility and

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2 *Co-production: A manifesto for growing the core economy, New Economics Foundation, 2008*

perceived benefits of active user engagement. In social care, where service solutions are increasingly personalised and mediated through ongoing dialogue between users and professionals, the opportunities for co-production are correspondingly strong. Indeed, the emphasis personalisation places on treating people as experts in their own care rather than passive recipients of services makes the current policy landscape particularly conducive to co-productive approaches.[3]

Co-production is inherent to self-directed support (SDS). By exercising choice and control over the supports required in their lives, people using SDS are on an increasingly even footing with professionals. The emphasis within Putting People First on the importance of social capital, conceived as the informal support, social networks and community resources available to people in addition to or instead of formal services, ensures this is about more than supported consumerism. SDS is genuinely co-productive as it mobilises all available resources towards achieving better outcomes.

How does co-production apply to commissioning?

The recent Local Authority Circular, *Transforming Social Care* notes that councils need to 'ensure that people and their organisations are much more involved in the design, commissioning and evaluation of services and how their needs are met.'[4]

At the individual level, some innovative practice has lately emerged that puts people and families at the heart of the commissioning process. This has involved using anonymised support plan information in tender documentation and enabling individuals and families to play a leading role in determining successful bids to deliver support. It has also involved the development of individual service funds, which empower people to work directly with providers to determine how their budget is used to achieve their agreed outcomes.[5]

It has proved more difficult for local authorities and their partners to develop successful models of co-production in strategic commissioning. Local people are rarely able to drive organisational change and shape the availability of supports and services in their area. Working together for change offers a simple approach to using information collected from person-centred reviews in a structured, co-productive environment, to address this problem.

There are additional reasons to use working together for change discernable in the current policy landscape, particularly in relation to Learning Difficulties. The systematic use of person centred planning to inform community and service development was one of the recommendations in the first *Valuing People* implementation guidance (2001).

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3 *SCIE's recent briefing on co-production for a far fuller investigation of the academic research on co-production and its application to social care,* **Co-production: an emerging evidence base for social care transformation**, *SCIE, March 2009*

4 *Local Authority Circular, Transforming Social Care, LAC, DH, 2009*

5 *Flexible contracting for personalised outcomes, DH (forthcoming 2009)*

Although there are some examples of this happening, it has not become widespread practice. We are yet to see significant numbers of community and service organisations using person centred planning as a way to inform and direct their strategic planning. *Valuing People Now* strengthens and restates this requirement. For example, it makes specific reference to using person centred planning to directly inform the changes needed regarding what people do during the day.

Valuing People Now requires learning from person centred planning to make change at an individual and strategic level, and states that:

> *"Services will have person centred plans for everyone they support. They will use this to review and improve the support they provide to individuals to ensure that agreed outcomes continue to be met"*

And;

> *"The Office of the National Director will work with the Putting People First Team to explore how person centred information can be used to inform strategic commissioning and will demonstrate good practise throughout their regions"*

Valuing People Now, DH, 2008

The Joint Strategic Needs Assessment (JSNA)

The Local Government and Public Involvement in Health Act (2007) introduced the statutory requirement for upper tier Local Authorities and PCTs to jointly undertake Joint Strategic Needs Assessments (JSNAs). The Department of Health (DH) guidance on JSNAs (December 2007) describes the process as designed to 'identify the current and future health and wellbeing needs of a local population,' to inform Local Area Agreements and commissioning across health and social care. It also sets parameters around the collection of a minimum dataset on needs. The core principles of JSNA are described as: partnership working, community engagement and evidencing effective ways that needs are met.

The DH guidance gives particular attention to the importance of community engagement at all stages throughout the process, 'from planning, to delivering and evaluating.'[6] While the suggested minimum dataset for JSNA includes domains on 'service users' and 'public demands' and identifies resident satisfaction surveys as possible sources, the guidance is explicit that these 'should be supplemented by information gained through active dialogue with local people, service users and their carers.' LINks and Citizen Panels are possible forums, though Partnership Boards and specific reference groups could be equally appropriate.

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6 *This reflects the emphasis strong and prosperous communities' places on recognising that citizens and communities know what they want from services and what needs to be done where they live. It also reflects the first of eight steps to effective commissioning the DH identified in the* **Joint Commissioning Framework for Health and Wellbeing – putting people at the centre of commissioning***.*

The importance of finding methods that support people to work together effectively is also stressed in the guidance, though practical examples are thinner on the ground.

In practice, at least anecdotally, ensuring meaningful community engagement in the JSNA has presented a significant challenge. This is perhaps unsurprising given the scope and complexity of the issues involved, but finding better methods for involving people will be critical to their lasting impact. Many areas have now identified more effective community engagement and better use of qualitative information as key improvement areas for their second JSNAs. Working together for change is one approach that Local Authorities and their partners may wish to consider (and that some are already employing) to achieve these aspirations.

Measuring the impact of personalisation

Measuring the impact of social care has long been a preoccupation and a statutory requirement for those involved in delivering and commissioning it. The ultimate ambition – ensuring better lives for people by understanding the outcomes of social care interventions and ensuring value for public money.

The Department of Health's work on the new National Indicator Set for Local Government describes three types of evidence necessary to demonstrate outcomes in health and wellbeing – activity, results and experience. 'Activity' refers to the volume and type of inputs and outputs involved in a particular

intervention, for example the time spent and the tasks completed during a domiciliary care visit. 'Results' refers to the measurable impact of an intervention, such as the reduction in hospital readmissions as a result of re-ablement. 'Experience' refers to the self-attested experience of the user, such as positive feedback about a service obtained through a satisfaction survey. None of these is evidence of an outcome taken on its own, but a good indication of the outcome can be obtained by considering them in combination. Therefore:

Activity + Results + Experience = Outcome

Current work to revise the NIS is identifying metrics for 'activity,' 'results,' and 'experience' in line with the outcomes described in the social care white paper, *Our health, our care, our say*. These are overarching measures for national benchmarking, performance assessment and understanding progress towards key policy objectives. At a local level, councils need additional information to measure their own performance and that of commissioned services and to understand the outcomes for local people.

The transformation agenda means that many previous measures are becoming less useful and councils are having to develop new ways of understanding outcomes. Some approaches focus on identifying "objective outcomes" (such as improved health or lower residential care admissions), while others focus on "subjective outcomes," which concern what is important to individual people. Both are important.

Mapping these against the NIS equation illustrates the point:

> **Objective**   **Subjective**
> **(Activity + Results) + (Experience) = Outcomes**

The Department's work on outcomes-focused reviews (available elsewhere in the personalisation toolkit) focuses on "subjective" outcomes. One benefit of outcomes focused reviews is in providing a better source of "subjective" information than is available through satisfaction surveys. Arguably, the information gathered from these reviews is significantly more than "experiential" in the way that satisfaction surveys are. The use of open rather than closed questions to probe the outcomes of a support plan means that while describing

"experience," these reviews also describe "results" from the individual's perspective.

This potentially changes our understanding of the NIS equation, where reviews are subjective measures of both results and experience:

> **Objective**   **Subjective**
> **(Activity + (Results) + Experience) =**
> **Individual Outcomes**

Outcomes focused reviews provide "subjective" data about individual outcomes. Using this same information in aggregate form to drive the working together for change process provides the opportunity to draw wider conclusions about outcomes for a group of people, or population.

Information sources for commissioning

Commissioning is often described as a series of activities that occur in a cycle. This starts with an identification of need and analysis of the market and available resources, progresses through the specification of supports or services, leads to procurement of a service and monitoring of the resultant contract and continues through reviews of the contract to ensure it meets the needs intended to the quality expected.

At strategic level, commissioning is less directly involved with the tendering of contracts and more acutely engaged in shaping the availability of services for the medium-long term, in conjunction with partners and in pursuit of strategic objectives.[7] Increasingly, commissioning at all levels is shaped by the outcomes that commissioners and individuals identify as important, rather than the volume of activity expected.

Commissioners draw upon a range of different information so that the services and supports they directly commission and the markets they seek to shape by other means, reflect the needs of their local populace; support the strategic direction of the commissioning authority and ultimately lead to improvements in the lives of local people. Some of the information sources commissioners draw upon reflect statutory, regulatory or performance requirements while others reflect an accumulation of experience of what works locally.

While developments like the JSNA are significantly improving the scope and quality of information that commissioners work with, it is still possible to identify limitations with the common dataset. The table below illustrates some possible limitations:

Data source	Possible limitations
Socio-demographic data	Highlights needs rather than aspirations
Strategic needs assessments	Can be overly mechanistic and process led
Analysis of available resources	Tends to exclude social capital
Performance and regulatory	Historical
Market intelligence	Distorted market view
Previous experience	Imaginative constraints
Frontline staff	Often limited input
Consultation	Often occurs after development of the strategy
Satisfaction surveys	Often closed questions

7 *For a thorough description of the activities associated with strategic commissioning see* **Commissioning for Personalisation**, *DH 2008.*

The table highlights some recurrent themes in relation to the paucity of qualitative and person-centred information available to commissioners, especially if co-production and community engagement are considered increasingly important goals. Some of these limitations require further explanation in this context:

1) **Highlighting needs rather than aspirations:** Formal processes for collecting commissioning information tend to concentrate on identifying needs within a locality or specific demographic, whether at macro level and in the medium/long term, or at micro level and reflecting immediate concerns. This kind of information, including the modelling of future need and demand on the basis of demographic trends, is a vital reference but it doesn't reflect the whole picture of what commissioners need to know. The missing element often relates to the aspirations local people have for the future, for themselves, their families and their communities. At a strategic level, where commissioners are planning for the longer term, a clear view of what people want for the future is important. Assembling this kind of information systematically has often proved difficult.

2) **Can be overly mechanistic and process led:** A general criticism levelled at the first round of JSNAs has been that the process has sometimes become the end in itself. This means that once a JSNA has been produced (often a substantial document, dense with quantative data) it has been placed on a shelf where it is destined to remain until there is a pressing requirement to update it. This has rarely been the starting intention, but it has been the reality in some cases. Arguably, the problem can be attributed to the abstract nature of much of the information when seen from the public's perspective and the wider challenge of making commissioning more accessible and understandable – what does this tell me about my community and what has it got to do with me? It is unquestionably difficult to develop JSNAs that both inform daily commissioning activity and are recognised as valuable by local people – but this has to be the aspiration!

3) **Tend to exclude social capital:** Any commissioning process will include an analysis of the resources that are available to meet the needs that have been identified. Almost universally this tends to focus solely on the financial and other resources available within the commissioning authority (or authorities). For co-production to be effective, community resources should be factored into any resource analysis and subsequent service design from the outset.

4) A distorted market view and imaginative constraints: These two limitations can be taken together as they represent two sides of the same coin. The implication is not that commissioning wilfully distorts the market, rather that ones perspective of 'what's out there?' is often built up through experience over time of commissioning certain types of services, in certain ways and from certain providers. This knowledge is undeniably valuable (especially when taken in tandem with performance information), but when the traditional designation of services (into domiciliary care, daycare and residential care for example) begins to fragment and change as seems likely under the personalisation agenda, this information and can also serve to reinforce a outmoded habit. Even where there is recognition that current patterns of investment in services may not remain applicable, it can sometimes be difficult to 'think outside the box' about the different ways people may choose to meet their agreed outcomes. This is also true for people using support who may find it equally difficult to think outside of traditional service boundaries.

5) Consultation and satisfaction surveys: While consultation and satisfaction surveys can be useful sources of qualitative information, in practice they are too often limited by the use of closed questions and by the timing of the exercise. Consultation often happens once the plan or strategy has already been written rather than as part of a process to develop the plan from the bottom up. This tends to mean that consultations ask about agreement or disagreement with a particular course of action. In such instances the scope of possible action and more importantly, the identification of the problem that the strategy is trying to solve, have already been determined. A genuinely co-productive approach would stress the value of meaningful engagement with people using services at all stages, in design, delivery and evaluation, rather than as 'feedback,' however useful.

While working together for change is not a panacea for all of these limitations, it does offer a practical solution to many of them. It provides a means of generating and analysing qualitative information for commissioning. It serves to highlight people's aspirations as well as their needs. It recognises the value of engaging people from the outset, involving them in setting the direction for strategic change.

One result of the limitations outlined above is that it is often extremely difficult for commissioners to demonstrate any direct link between what they have commissioned and what local people have said that they want and value. More than anything else, working together for change seeks to provide this golden thread, the transparent audit trail between what people said was important and what was commissioned as a result.

The working together for change process

Process diagram
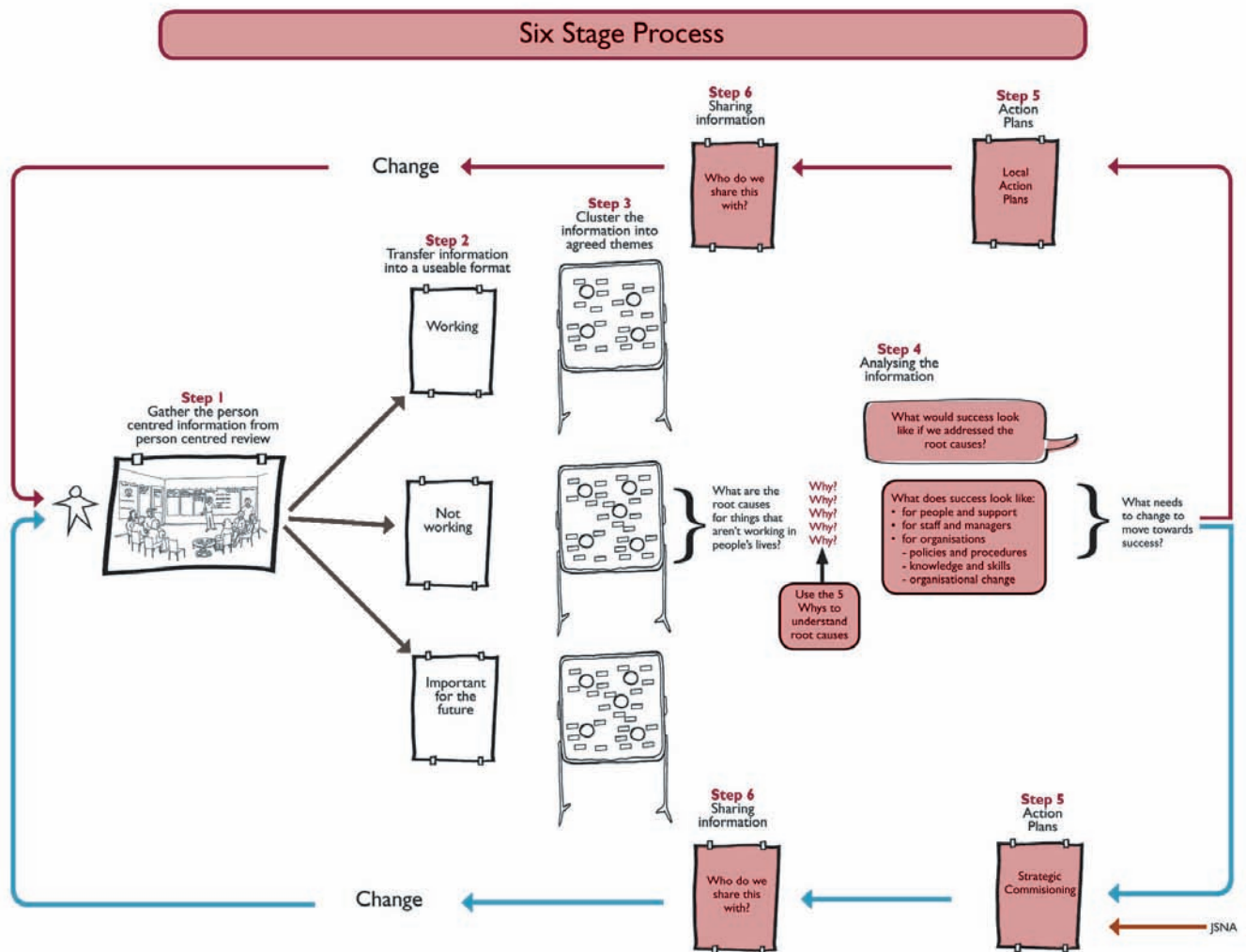
The diagram above is a summary illustration of the working together for change process. On the left hand side is the individual person-centred review, or outcome-focused review. The review results in 'actions for individual change.' This means that for each individual review, actions are agreed that change what is not working for the person and respond to what they have identified as important for the future.

At the same time, the person is asked to prioritise certain information from their review to be taken forward into the working together for change process. This diagram shows this information, combined with other reviews, being thematically clustered during the working together for change workshop.

These clusters are then analysed so that the group develops an understanding of the things that are working that can be built upon, the things that are not working that need to change for people and the things that will guide further change in the future. This information informs changes in local action planning (the red line) and changes in strategic commissioning (the blue line), where the information can be used alongside other information sources, or as part of the Joint Strategic Needs Assessment.

Preperation: Clarifying the purpose and people.

The **PURPOSE** of the process is to listen to what people are saying about their lives and the services they receive through person centred information, and to think about the changes necessary to enable people to get more of what's working in their lives, and to change what's not working through strategic commissioning.

The **PEOPLE** who should be involved are those with the power to make and influence strategic decisions.

At the beginning of this process it is essential that commissioners, strategic decision makers. and people using services come together to clarify exactly what information they want and how they will use this to inform strategic commissioning and decision-making.

The different elements of person centred information can be aggregated to provide specific information.

Here are some examples:

Person Centred Information	When aggregated can provide information on
What is working from the persons perspective (or parents/carers perspective)	Best practices in the service. With this information we can explore: • what it would take for this best practice to become widespread • what we can learn from this success to make it more likely that it will be come typical practice.
What is not working from the person's perspective (or parents/carers perspective)	What needs to change? This may relate to service levels that are insufficient, or services that are ineffective. With this information we can explore: • what it would take to change what is not working • what the root causes might be When collected routinely and analysed cyclically this information provides a way of checking whether previous actions have had the desired effect in changing things that were not working for people.
Person Centred Information What is important to the person for the future This section can provide specific details about: • activities • support • community locations.	**When aggregated can provide information on** What people may want in the future. With this information we can: • map this against what is already present • explore any market development requirements.

Other consultation and listening methods can sometimes be accused of using closed questions and leading to pre-determined outcomes. Because the questions 'what is working in your life?' and 'what is not working in your life?' are entirely neutral and non-proscriptive, the answers provided will tend to reflect people's genuine concerns and priorities from their experiences of day-to-day life and the services that support them.

Key decisions for the introductory planning meeting:

1) What specific information do we want to gather from the person centred support plans or reviews?

The suggestion from the DH project is that as a minimum you should consider collecting the top three things that people said were working and not working in their lives as well as their top three aspirations for the future. Doing this requires that individuals are asked to prioritise this information as part of their review (either specifically for this process or as part of all reviews). A template for this which was used during the project is attached in appendix 2.

2) Who will we do reviews with?

● What size sample?

● Within a geographical area?

● People who use a particular service?

The DH project and other testing of this approach would suggest that the minimum dataset you can work with effectively is information from 12 reviews while there is limited value in considering more than 60, after which the clustering and analysis tends only to reconfirm existing themes.

The DH project tested the approach in a number of different ways – defined by a geographical area (in Lancashire), by users of a particular service (in Wigan) and across a whole locality (in Richmond on Thames). It would seem that the process is equally applicable whichever way you choose to cut the cake, though the type of actions that result will be correspondingly different. For example, if focused on a particular provider (such as a supported living provider), actions may result to make immediate improvements where specific issues are identified (see Lancashire example below). Alternatively, if covering a whole locality (e.g. older people across a whole council area), longer-term actions may materialise that shift the whole direction of commissioning for older people's services. Both are valuable, one at an operational and one at a more strategic level.

The project tested working together for change in two learning difficulties services, one older people's service and one older people and physical disability service. The choice arose from the funding split for the project (between Putting People First and Valuing People Now) and the pragmatic intention to test usage with older people –

more than 70% of the customer base for social care. We believe that the approach is equally applicable and transferable to other service areas (e.g. mental health and sensory impairment) with the major determinant of success being the ample representation of commissioners/local decision makers and those using services at the workshops.

3) How will we gather the information?

- Will we use person centred reviews, person centred plans or support plans?
- Will we use our existing facilitators if we have them?
- Will we use this as an opportunity to train new facilitators and coach their first plan or review?
- Will we bring in independent facilitators?
- How will we manage the logistics of the process?

To some extent, the answers to these questions will be predetermined by your answers to question two. For example, choosing to focus on LD services may lead you to use existing facilitators already trained and versed in person-centred approaches, while choosing to focus on older people may lead you to include a training element in the project if there are no existing facilitators in the service. (Note that facilitators may mean care managers but can also mean employees of user led organisations or providers who have taken on these roles).

4) Who needs to be at the workshop?

- Who needs to be part of looking at this information to be able to use it to inform strategic decisions?
- Who else would find this helpful?

Again, answers to these questions will to some extent be determined by your answers to question 2. In general, experience from this project suggests that the workshops should not be too large or too small – no more than 25 and no less than 15. Critically, there should be good attendance from the people whose information is being analysed and a full range of perspectives represented for the event to be genuinely co-productive.

This does not necessarily mean the inclusion of people whose reviews are part of the data, rather that people or groups should attend that are able to reasonably reflect their views. For example, none of the older people who had been reviewed in Gloucestershire were able to attend the workshop, but there were five delegates from the Gloucestershire Older People's Assembly in attendance which worked very well. Likewise, in Wigan three learning disabled self-advocates and their supporters, as well as parents of learning disabled young adults were present.

The six-stage process

Step 1: Gather person centred information

Person centred information can be gathered from person centred plans, support plans or person centred reviews. Each of these processes typically use the questions 'what is working and not working' and 'what is important for the future.'

Where other information is required, the person centred review process can be adapted to provide this.

What are outcomes-focused reviews?

An outcomes-focused review is the process the DH has developed with people, families, carers and councils for reviewing a person's individual support plan. It is a way of carrying out person-centred reviews that measures progress towards the goals set out in their plan for people using personal budgets.

It can also be used to collate performance information about individual outcomes (*see page 8*) and to provide the information required for working together for change, though other methods can also be used.

Moving towards a different review process is part of the challenge of introducing self-directed support. While there will undoubtedly be local differences, the expectation is that all such reviews should be person-centred and there is good evidence to support the efficacy of this approach.

The critical point is that you can't do working together for change without doing person-centred reviews!

Step 2: Transfer the information into a usable format

The next step is to make sure that the information is in a format that can be used during the workshop. The process for doing this depends on the number of people who have provided person-centred information, and is either done before the meeting if there are more than 30 reviews, or at the meeting if there are less then 30.

You need to decide whether to use all the information provided under each heading ('working,' 'not working' and 'important for the future'), or to prioritise and select only one or two statements for each heading.

There are different ways of recording the information to share at the Workshop:

- In East Lancashire, they had information from over 90 reviews. They had printed the information using a very large font and cut the paper into strips so that each strip contained a statement from the person about something that was working or not working in their lives or was important for their future;
- In Richmond, 12 reviews had been especially conducted. Delegates worked in three mixed groups to transfer this information onto colour-coded cards for the three headings as the first exercise at the workshop;

- In Wigan, the information was presented in tables from the reviews and then transferred at the workshop to green (working), red (not working), and blue (important for the future) cards.

There is some benefit in transferring some or all of the information at the workshop as this helps stakeholders to appreciate the integrity of the data. If transferred in this way it is preferable that the individual reviews are anonymised.

This information is then clustered at the Workshop.

Step 3: Cluster and Name

(This stage takes place at the full day workshop.)

The individual information, either on cards or on paper strips (*see above*), is arranged with similar information to form thematic clusters. This is done separately for "working," "not working" and "important for the future" information, using a separate pin board for each.

The facilitator helps the group to do this using a card call technique, i.e. each piece of information is read to the group who jointly decide whether it is similar to information that has already been read out and should join an existing cluster, or whether it is different from the other information and should form a new cluster.

It is perfectly OK for some clusters to contain lots of information and for others to contain single statements. It is important that everyone has an opportunity to contribute and to challenge the clustering of this information.

Each cluster, or theme, is then given a 'name' agreed by the whole group. The names must be as short as possible and written as first person, or "I" statements.

For example, the three person-centred statements:

"I have only one friend,"

"I only have staff in my life" and;

"I don't see many people during the day"

might reasonably be clustered together and named by the group:

"I am lonely."

Where the group is working with information from 30 reviews or less the clustering can be done by the whole group working together. Where there are more than 30 reviews it may be preferable for two or three people to arrange initial clusters on several boards simultaneously, and for the group to review each other's work and come to agreement on any changes.

This step can be time consuming but is very important because the themes that the group identify will form the basis of further analysis and action planning – so it's worth spending the time to get it right!

Step 4: Analyse

(This stage also occurs at the full day workshop)

Once you have arranged all of the information into named clusters, the next step is to make sense of the information and analyse it as a basis for action. The processes used here depend on the specific person-centred information that the group has decided to use.

Here we show how "what is working?" and "what is not working?" might be analysed, what the purpose might be and what process you might follow to do this during the workshop.

What is working?

This information can tell you about good practice to celebrate. You can use this information to:

a) *Identify specific situations that are working well for people, so you can 'drill down' to understand the key components of this and think how it can be replicated.*

In East Lancashire three of the success themes were:

- I live as independently as possible
- I feel better (health)
- I stand up for myself.

The group talked about what had happened to achieve these outcomes for people. The commissioners talked about the 'provider
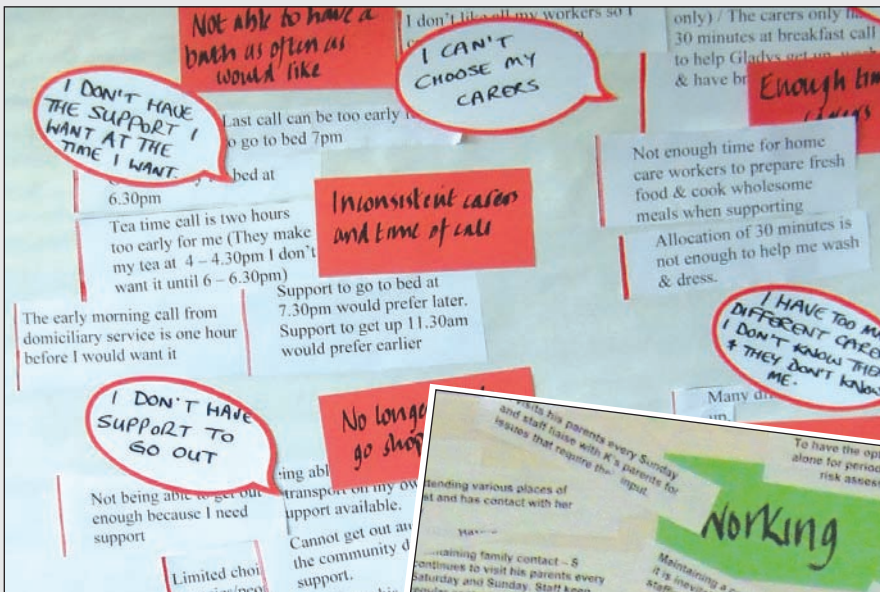
Not working
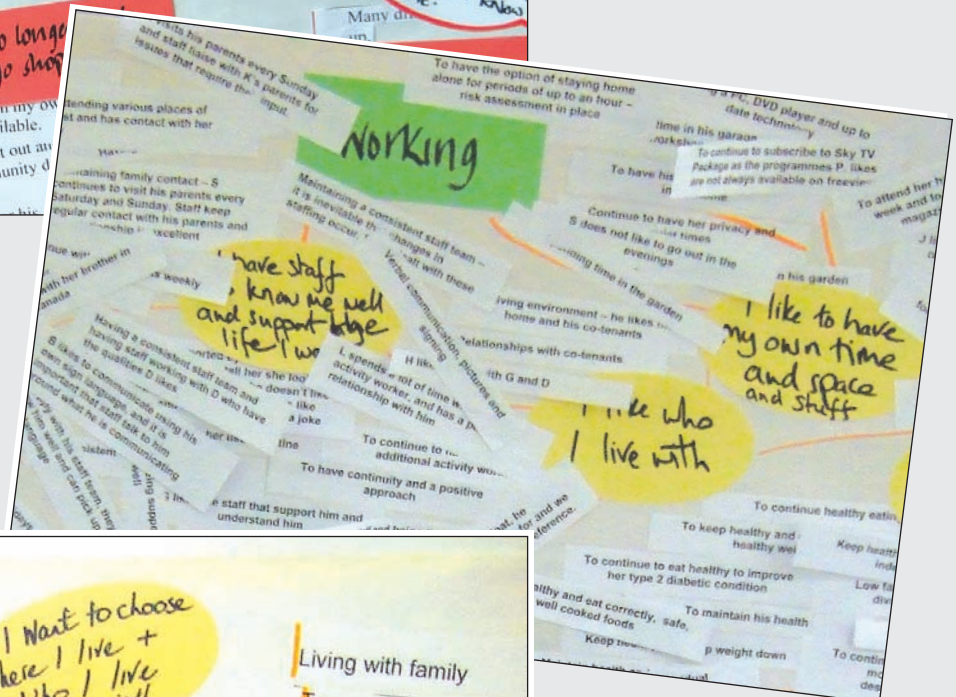
Working
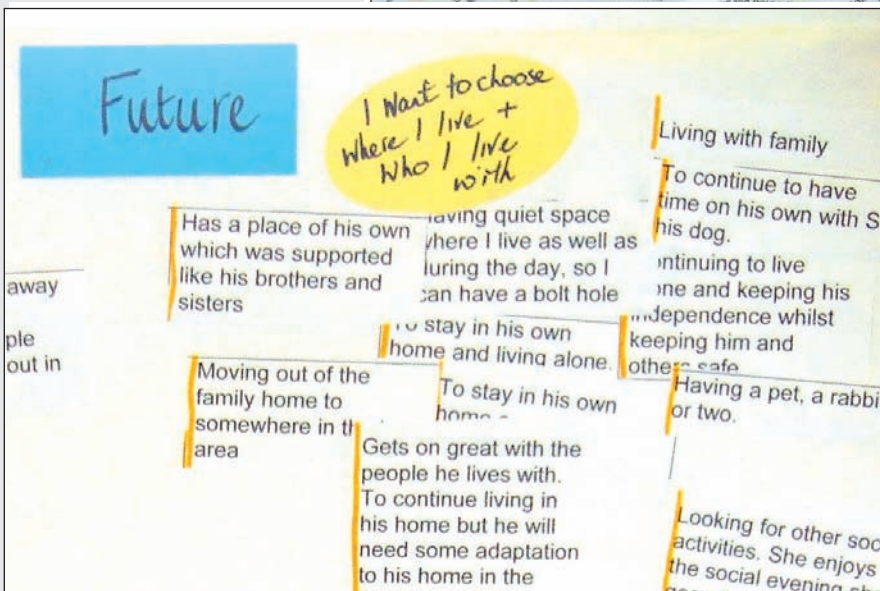
Important for the future

pathway' that had been used, and the impact that this had had. The providers talked about the work that they had done to create person centred change with people. They agreed that key elements of the provider pathway process for developing individual service funds had made a large contribution to these changes. This confirmed for the commissioners that their plans to expand this approach were likely to be beneficial for people.

There are a range of approaches from 'Appreciative Inquiry' that can be used here.

b) *Identify success stories to share more widely across the organisation.*

One of the ambitions shared by Jean in the 'important in the future' section, was to do more public speaking. The group thought about how they could help Jean to achieve this and share success stories. One suggestion was that Jean helped in the training of other staff in person centred outcome focussed reviews, as well as finding other opportunities to be a speaker at local events.

What is not working?

This information creates an agenda for change. You may decide to consider all of the clusters, or to focus on those you consider most important to change – determined by voting where everyone has a say. As with the "what is working?" clusters, you can use this information in different ways:

a) *Generate immediate actions*

Sometimes the information is so straightforward that there is an obvious action or range of

actions indicated. At individual level you should find that the person's review has put right much of what was not working, but action may also be required at an organisational level.

b) *Consider the underlying causes and what success would look like if the issue were resolved*

Often, it is useful to spend time thinking about the root causes of something that is not working, and to understand these fully before determining what action to take.

A simple process that can be useful here is the '5 Whys.' This means working in small groups to interrogate an issue by brainstorming as many reasons why this might be the case. The trick is to think as broadly as possible without resorting to financial answers until all other possibilities have been explored.

Example A: In Gloucestershire one of the clusters was:

> *"I am not treated with respect or as an individual by my paid carers"*

The group who worked on this cluster came up with the following list of possible root causes:

- Paid carers are too task focused and not outcome focused
- Poor quality and caliber of the paid carer
- We do not match paid carers to older people
- Paid carers get poor quality training and supervision
- We don't know the older people well or
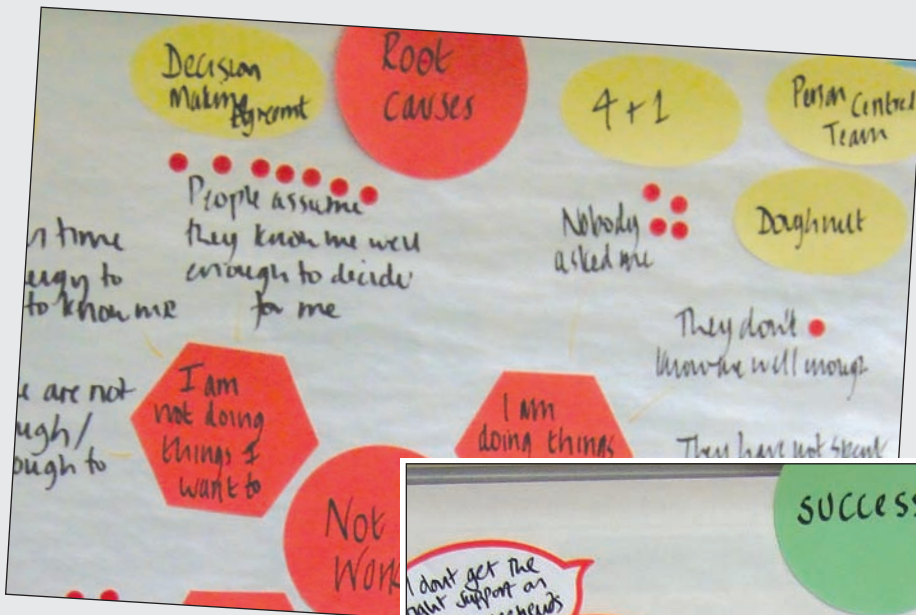
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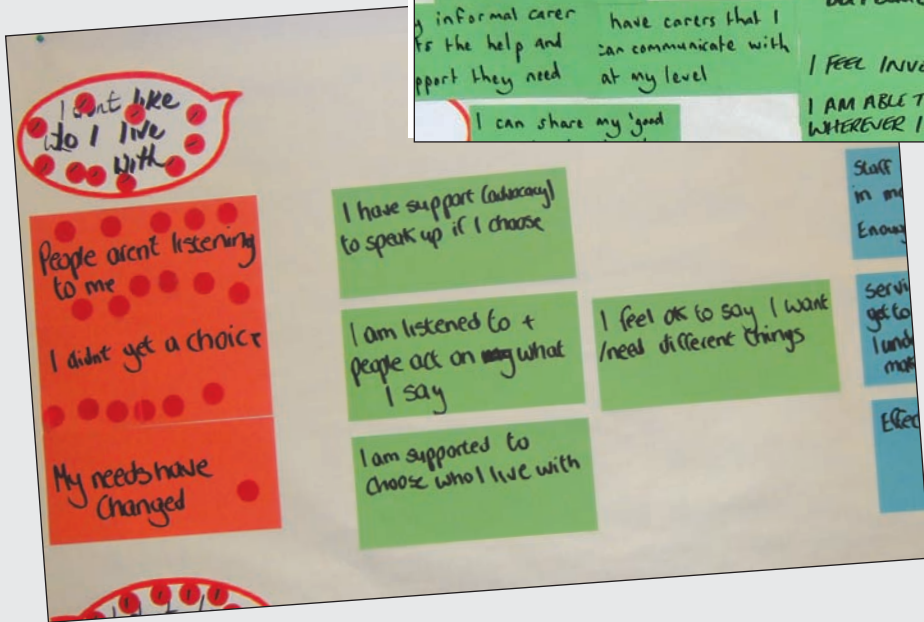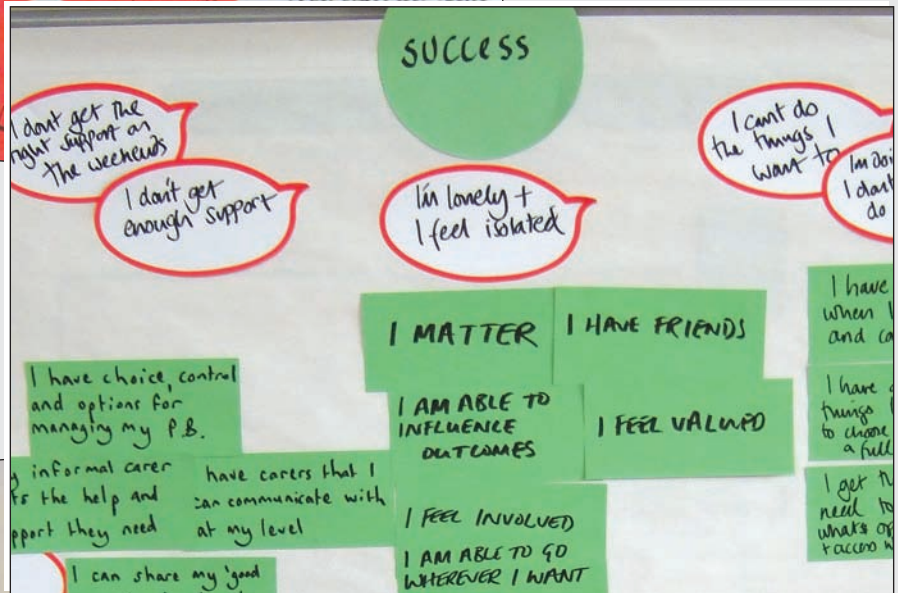
understand them. Information is not recorded for carers to use.Once the root causes have been identified, then look at what success would look like if these were addressed. In Gloucestershire the group decided that if the root causes were addressed, then success would mean that older people would say:

"My carers listen to me and understand what is important to me"

"I look forward to my carer visiting me"

The staff supporting older people and their managers would say:

"I love my job"

"I get good training and support"

"It is easier to respect others when you are respected yourself"

"I have all the information I need – we have written information about what matters to the person and how best to support them"

Example B: In Richmond, one of the clusters was:

'I feel lonely'

Possible root causes for this are:
- We do not put enough emphasis on relationships when we contract services
- Staff don't know how to connect people
- Staff don't see this as part of their job. They do not have time to do this
- We are not paying staff to help people with their relationships

- Providers don't see this as a priority
- CQC does not inspect on this, so Providers don't see it as important
- It is not part of induction training – or any training staff get
- This is not thought about when we think about housing – we do not think about locality and supporting relationships
- Staff don't support people to think about how they can meet people and develop relationships or support existing relationships
- Care managers do not see this as important when looking at placements.

Here is what success could look like if these were addressed:

For people:

"I have friends in my life"

"I feel supported to meet new people if I want to"

For staff and managers:

"Supporting people with relationships and helping them meet new people is part of my job"

"I am supported to do this – through training and by my manager"

" There is time to do this as part of my work role"

"I am pleased that I can make a difference to people by helping them have friends"

" We know that supporting people to make and keep friends is important to those who commission our services"

"This work is costed into our contracts"

"We are evaluated and monitored on how well we do this"

"We are proud of how we are making a difference to people, and that people have friends"

Step 5: Action Plan

This is the "so what?" part of the process. You will have identified some common themes and issues from the person-centred information, you will have considered possible root causes and you will have thought about what success would look like should the issue be resolved. In short, you will have developed some insight and some shared understanding about the things that are important to people. So what actions will you take as a result?

The process of action planning depends on the decisions made at the beginning about **purpose** and **people**. The different groups of people will need to either plan how they will use the information, or action plan directly based on what the information shows them.

It is important that all groups represented at the workshop are involved in action planning – commissioners, providers and user groups. Wherever possible, actions should be specific, realistic, tangible and measurable. Critically, they also need to be 'owned' so that somebody is held accountable.

In Wigan one of the 'not working' clusters that the group worked on was "I don't like who I live with". After considering possible root causes and thinking about what success might look like, providers committed to the following actions:

- Ensure that staff know people well (what is important to them and how to best support people) and record what they learn in a person centred plan.

- The person centred plan includes 'matching' information to help people think about who they may want to live with (if anyone) and information about decision making (communication chart and decision making agreement)

- Review the processes that are used for making decisions about who lives together and ensure that these are as person centred as possible

- Use person centred reviews to ensure that there are opportunities for people to say what is not working in their life (including who they live with)

- Continue to support people to move from group homes into individual tenancies where they want to

- Work with the Commissioner to develop individual service funds.

Commissioners committed to the following action:

- Review the block contract tendering process to develop a new framework where people can opt out of the block contract and have a personal budget.

'They can use their personal budget to stay with their existing provider if they choose through and individual service fund.

Wigan People First committed to:

● Hold an event with other people with learning disabilities to see how many other people this was a problem for.

There are further illustrations and examples of action planning included in *Appendix 1*.

Step 6: Share information

A crucial final step is to share the information – most importantly the actions that have emerged, with the people who shared the information with you through their reviews, and with other people who need to know or would find it useful.

A simple 'Who' needs to know 'What' and 'How' action plan for sharing information should be created at this stage.

In East Lancashire the Commissioners decided to work with their providers group to share what had been learned from this process.

The individuals decided to form a Tenants Association to share the actions from the process with other people who used the service.

Data presentation and comparison

Richmond's "working" data:
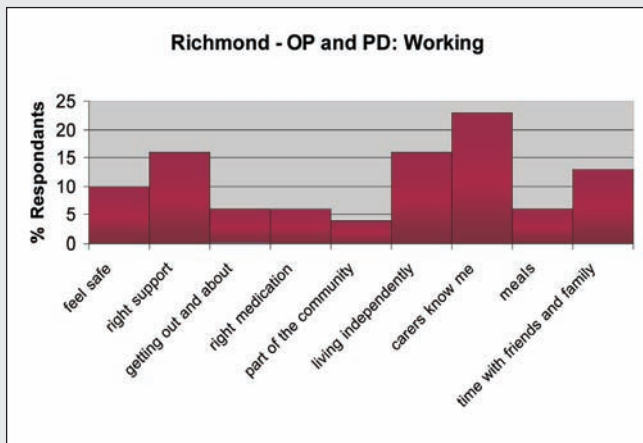
Richmond's "not working" data:
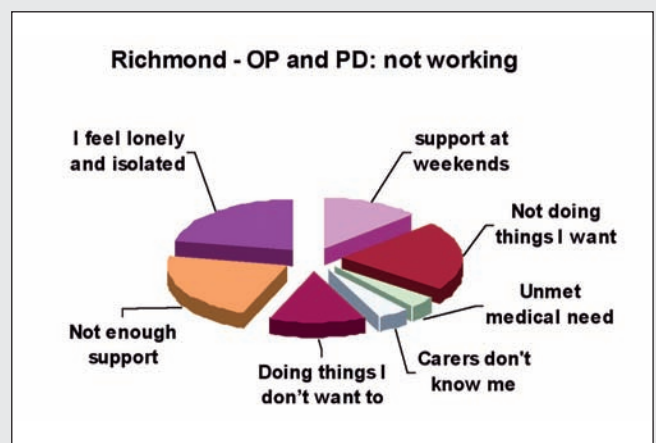
Wigan's "working" data:
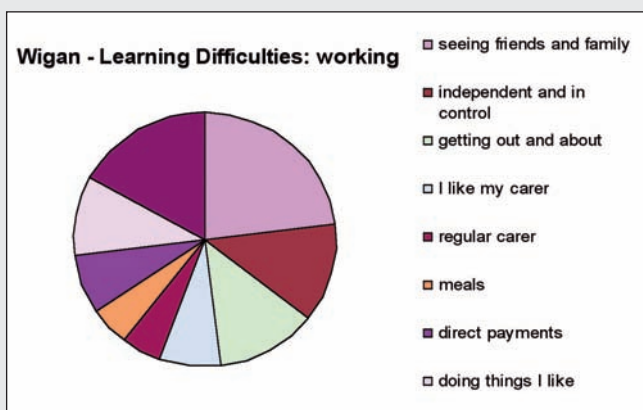
Wigan's "not working" data cross-referenced against the priorities that delegates set for action:
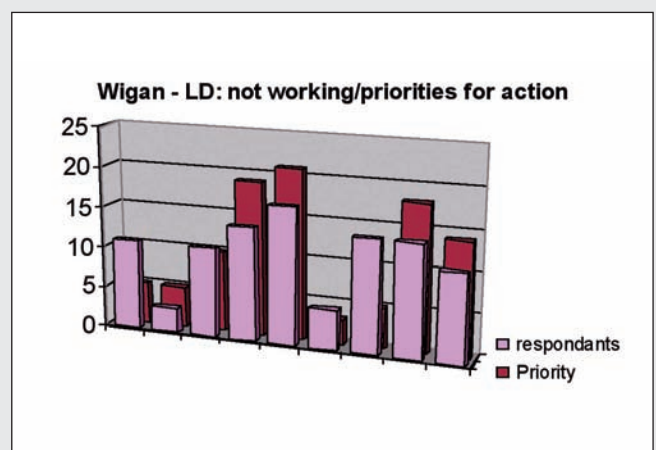
Bar chart illustrating geographical comparison of mock "not working" data:

Not working - geographical comparison
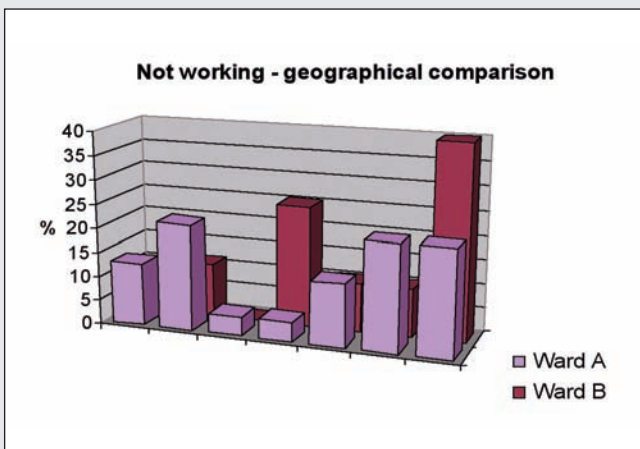
Bar chart illustrating comparison of mock "important for the future" data across different user groups:

Comparison of important for the future: mock data
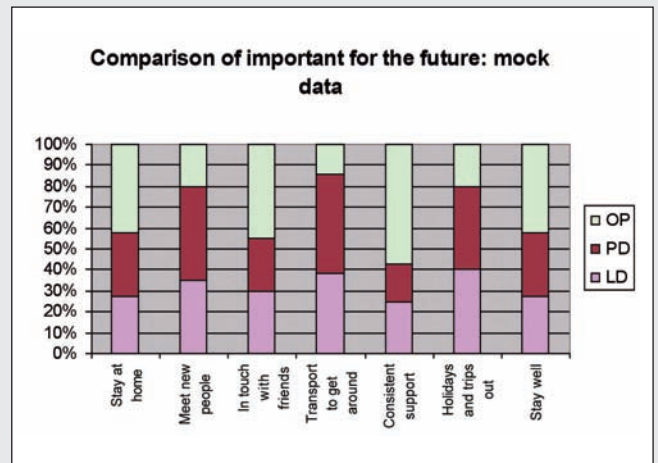
Bar chart of Wigan's "important for the future" data:

Wigan - Learning difficulties: important for the future
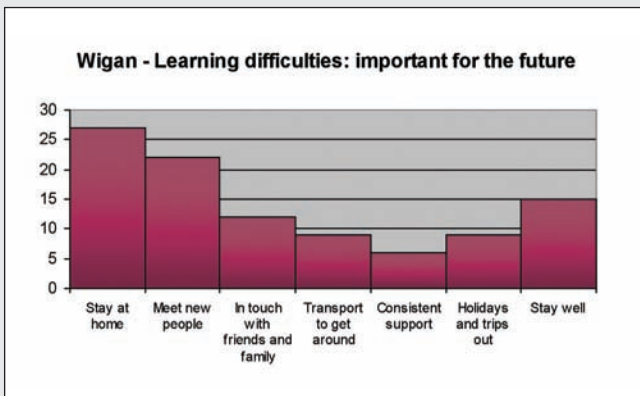
Evaluation

This section describes a number of key considerations when using working together for change based on a "light touch" evaluation of its application by four councils. The evaluation at each event used the familiar questions of "what worked?", "what didn't work so well?" and "what needs to be considered for the future?" The primary intention was to record people's experiences of using the process and their ideas for improvement, rather than to apply academic rigour to evaluating the resulting actions – which will take longer to become fully apparent. The comments and observations of delegates from events in Lancashire, Wigan, Richmond on Thames and Gloucestershire are drawn upon throughout.

This section should be read in conjunction with the specific pointers given for each of the six steps in the previous section. There is also a list of facilitators "top tips" below to guide planning for the workshop/s.

Make it part of your programme

While working together for change can be used in isolation, there may be added value integrating it into a wider work programme to maximise potential cross-benefits. The most obvious value may be to commissioning work streams, as part of the JSNA or the basis of a specific service review, but the information

and analysis generated can be useful in other ways – for workforce development, systems redesign or corporate planning for example.

Most obviously, the process requires that you are doing person-centred reviews. It is important that any parallel work you are doing to design this process locally takes into account the information requirements of working together for change. Introducing the process alongside changes to your reviews will ensure you are extracting information for commissioning from the very outset.

"Not just talk, we developed a clear action plan with a range of functional and strategic outputs"

Get the right people there

This seems an obvious point, but it is worth stressing! For working together for change to be effective, it is imperative that the right people are in the room for the whole event or series of events. The process allows multiple perspectives to be heard and it is the diversity of different stakeholders' views that makes the process valuable.

The 'right people' will obviously depend on the scope you have set for your project but the bare minimum is strategic decision makers from commissioning, people using services and/or their representatives

and managers from provider services – especially if these are under specific review.

Other possibilities might include colleagues with corporate responsibilities, people from other statutory organisations, user led organisations and local advocacy groups – anyone who might reasonably be able to take action and/or influence change relevant to the project.

"It was good to have people from commissioning, providers, users and carers in a room together working to a shared agenda"

"I valued the opportunity to discuss with colleagues from different disciplines"

"It would have been good to have Health colleagues represented"

Spend time on the positives

While there may be a natural inclination for delegates to gravitate towards information about what isn't working it is worth spending the time to dwell on the things that are working for people. There can be as much value in recognising and learning from success as there is in problem solving.

Delegates remarked that celebrating success was not something their organisations were particularly good at doing and thought that working together for change events could be used to highlight best practice.

Experience has shown that finishing for a mid morning coffee break after the clustering and naming of information about the things that are working in people's lives helps to build positive momentum and ownership of the process from the outset.

"It was good to finish with positive statements about what success should look like"

Don't jump to analysis

There will naturally be a temptation to question and interrogate the information about what is not working and to start thinking of solutions as you go but it is better to work through the process systematically and delay action planning until later.

It will not always be possible to fully understand the context of certain statements, in which case the information should be taken at face value rather than explained away.

The richness and power of this information source is that it relates to real people's lives in their own words. This can be compromised and diluted if statements are qualified or dismissed by the group, so any lack of clarity or specificity should be tolerated!

"Clustering statements in people's own words was the most useful; the person-centred reviews were very powerful"

"It was good to have a diverse set of people looking at the data – statements are very powerful when they are in the service user's words"

Make enough time for action planning

While we believe that working together for change is a useful approach to analysing data and identifying themes to inform strategic planning, it will not directly determine the actions that should result. It is worth considering covering steps 1 to 4 in a one day workshop and making additional time available for the subsequent action planning that you do – a further half or whole day.

Since the action planning is done in stakeholder groups (rather than mixed groups) it would be possible to integrate this into pre-existing management meetings. The important thing is to ensure there is an opportunity for others to comment on proposed actions – particularly those whose review information has been used for the process. As with any action plan, accountability for making it happen, senior commitment and recognisable milestones for implementation will make real change more likely.

The Department of Health is planning further work to test a range of approaches to action planning with this information.

Meanwhile, some examples of actions resulting from working together for change are included in appendix 1.

Replicate and integrate

For working together for change to be effective in driving changes in organisations and in commissioning it will need to be repeated and embedded rather than remaining a discreet project within a particular service area. It will be important to revisit person-centred information to determine if the changes you and others have planned are being felt by individual people and having the desired effect on their lives. Equally, the things that people identify as important for the future may change over time and will need to be updated with sufficient regularity.

There are various considerations for embedding working together for change within systems, including:

- Making sure that all reviews are person-centred and extract the right information
- Ensuring that electronic systems can routinely collate this information so that samples do not have to be amassed manually
- Considering software that can analyse and group a wider range of information – e.g. from all reviews
- Linking working together for change to the local cycle for JSNA

- Using working together for change in shared services and with a wider group of stakeholders – e.g. Health, the Police

- Establishing other "objective" performance measures alongside data from working together for change so that outcomes can be fully understood.

Facilitators Top Tips

- Ensure people know what they are coming to

- Allow enough time for effective pre-planning

- Allow enough time on the day – this can easily overrun!

- Make sure you think about what it will take for everyone to participate, for example we had induction loops and microphones in Gloucestershire

- Involving people who have actually experienced the reviews adds an extra depth to the process

- Use 'rounds' to ensure that everyone's voice is heard

- Make sure that there is great wall space or use/hire pin boards

- Agree how you will feedback to everyone about the impact of the day on commissioning

Conclusion

Working together for change is a potentially powerful tool that councils can use to ensure that the current changes in adult social care are co-developed and co-produced with people and families. It is a tried and tested method for generating and analysing qualitative data for commissioning which can improve the linkages between strategic decision makers and the people that they serve.

This report has illustrated how person-centred information can drive strategic change in organisations and effect improvements in commissioning. It has also described how this simple process can be practically useful to councils who are undertaking joint strategic needs assessments and/or are seeking to better understand and measure the outcomes of personalisation.

When used alongside other data sources, the information from this process can help commissioners to engage people in shaping the local availability of services.

The Head of Commissioning in one of the sites for this project described the process as "the very heart of good commissioning," because it demonstrates the "golden thread" between what people said was important and what was commissioned as a result. While the full co-productive potential of personalised social care will take time to realise, working together for change is a flexible approach with tangible benefits that can be used now to move us in the right direction.

APPENDIX 1:
Worked examples

Older People

What older people said was not working

"Some talk over my head.. I feel like a package, not a person."

"Agency carers...there are too many of them...men and women thinking they can do it. I will do it myself."

"I am not allowed to use a wheelchair to push myself around the house due to the risk of scraping my knuckles on the door jamb."

"Having to be washed in a cold bathroom as my carer gets too hot."

Cluster name

"I am not treated with respect or as an individual by my paid carers."

What are the possible root causes for this?

Paid carers are too task focused and not outcome focused.

The quality and caliber of the paid carer.

We do not match paid carers to individuals.

Paid carers get poor quality training and supervision.

We don't know people well or understand them. Information is not recorded.

Example 1

What does success look like?

older people

"My carers listen to me and understand what is important to me."

"I look forward to my carer visiting me."

staff and managers

"I love my job."

"I get good training and support."

"It is easier to respect others when you are respected yourself."

"I have all the information I need - we have written information about what matters to the person and how best to support them."

What providers can do to work towards success

- We will look at how we recruit staff and see how we can recruit more locally, and have people working a wider range of hours.

- We will look at matching staff to individuals. We will develop one page profiles with individuals, and support staff to develop their own one page profiles as well. We will use the 'matching staff' person centred thinking tool to get better matches (personality characteristics, hobbies and interests as well as skills). Staff could use their one page profiles to introduce themselves to the people they support.

- We will review how we supervise staff and use staff one page profiles to look at how we are supporting staff, as well as how well staff are supporting individuals. We will use a 'person centred' approach to supervision

- We will re-evaluate the training that we provide for carers, and look at how we enable staff to work in person centred, respectful ways. We will teach staff person centred thinking tools so that they can understand the difference between what is important to people and what is important for them, how best to communicate with people who don't use words to speak, and how to support people to make decisions and have more choice and control in their lives.

What user and community groups could do to work towards success

- The local older people's parliament offered to work with providers in the recruitment and training of staff.

What commissioners can do to work towards success

- Analyse review data further to determine if/where people have reported that relationships with their care staff are working particularly well to better understand what makes for local best practice and encourage replication by other providers.

- Develop Individual Service Funds for domiciliary care services to empower individuals to design their own support and express preferences regarding care staff.

- Use this and other priority areas identified through co-producing commissioning to set the overarching outcomes for an outcomes based approach to commissioning for all future older people's services.

- Commission specific direct payments service for older people to encourage more older people to direct their own care through direct payments - offering specific support with employment, legal and HR issues.

- Consider designing or commissioning a web based database for personal assistants/care workers that supports person-to-person transactions (e.g. slivers of time) where individuals can build networks of care staff and choose between them.

Older People

What older people said was not working

Cluster name

What are the possible root causes for this?

"I don't see anyone other than staff during the day."

"I feel lonely."

"I feel lonely."

We do not put enough emphasis on relationships when we contract services.

"No friends."

Staff don't know how to connect people.

"Only staff in my life."

Staff don't see this as part of their job. They do not have time to do this.

We are not paying staff to help people with their relationships.

"Not much to do and no one to do it with."

Providers don't see this as a priority.

"I am lonely."

CSCI does not inspect on this, so Providers don't see it as important.

"I spend most of the time by myself and I don't like this."

It is not part of induction training - or any training staff get.

This is not thought about when we think about housing - we do not think about locality and supporting relationships.

"I don't get out much or see other people."

Staff don't support people to think about how they can meet people and develop relationships or support existing relationships.

"Only one friend."

Care managers do not see this as important when looking at placements.

"I only see staff and my family once a month."

Example 2

What does success look like?

older people

"I have friends in my life."

"I feel supported to meet new people if I want to."

staff and managers

"Supporting people with relationships and helping them meet new people is part of my job."

"I am supported to do this - through training and by my manager."

"There is time to do this as part of my work role."

"I am pleased that I can make a difference to people by helping them have friends."

"We know that supporting people to make and keep friends is important to those who commission our services."

"This work is costed into our contracts."

"We are evaluated and monitored on how well we do this."

"We are proud of how we are making a difference to people, and that people have friends"

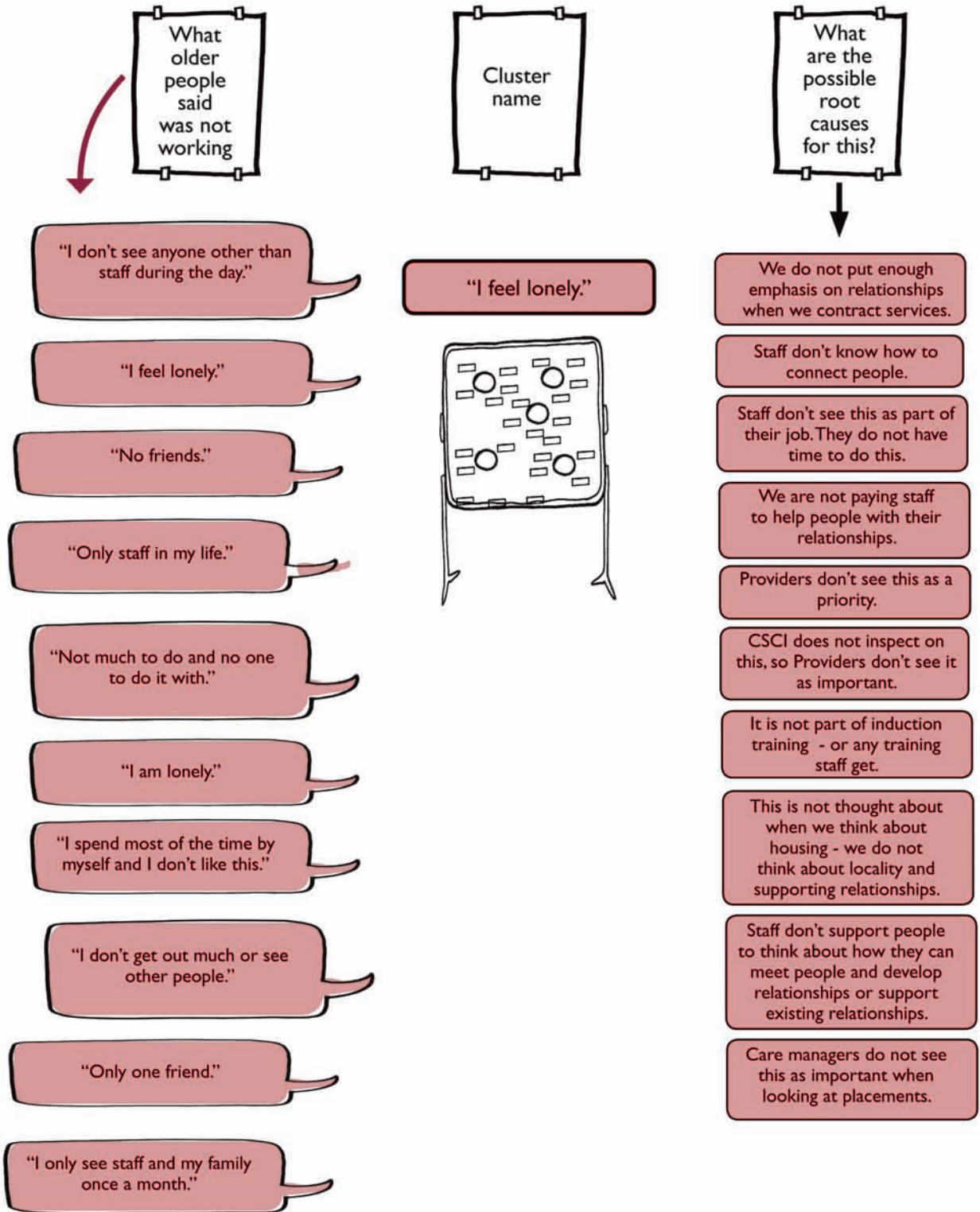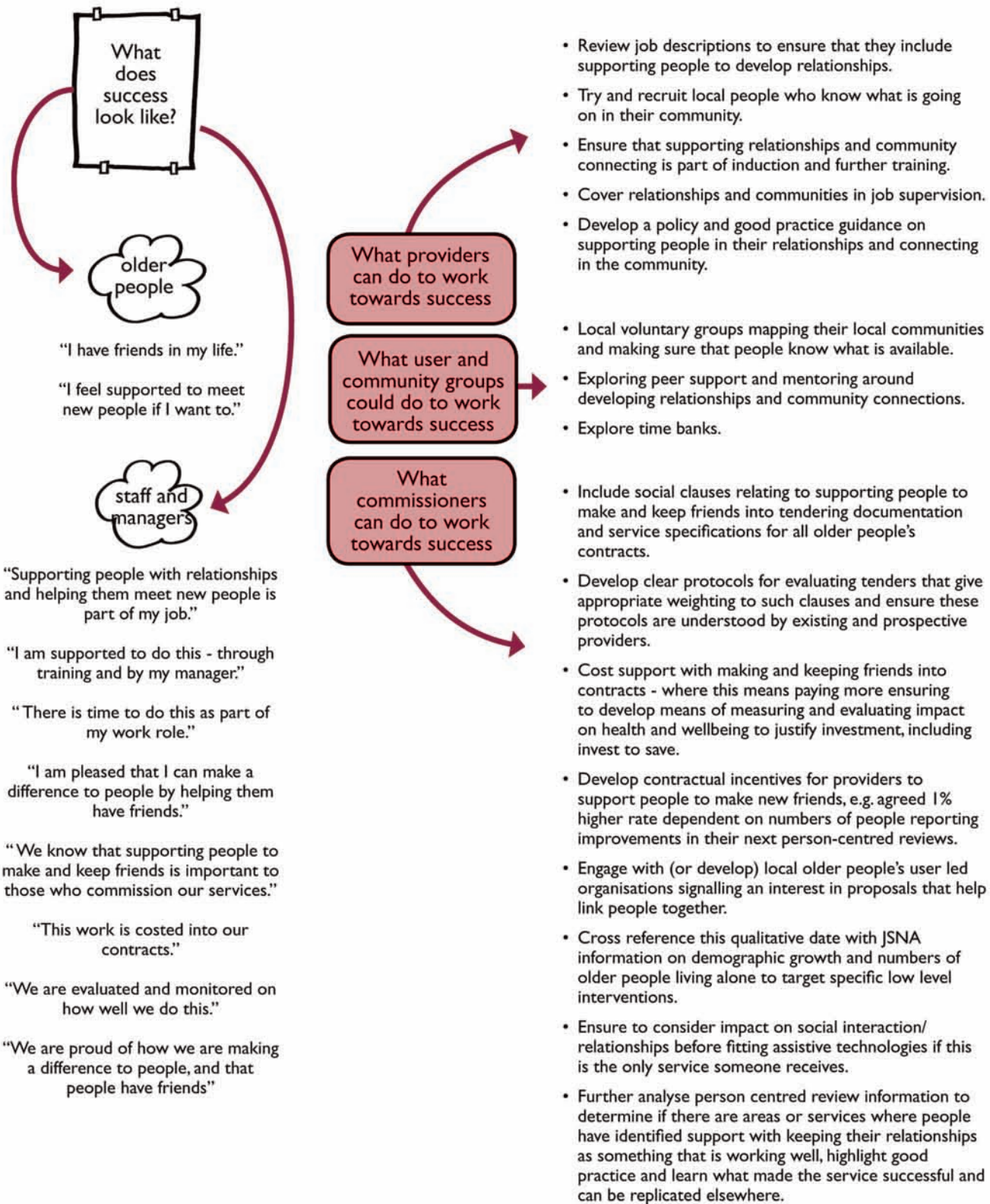**What providers can do to work towards success**

What user and community groups could do to work towards success

What commissioners can do to work towards success

- Review job descriptions to ensure that they include supporting people to develop relationships.
- Try and recruit local people who know what is going on in their community.
- Ensure that supporting relationships and community connecting is part of induction and further training.
- Cover relationships and communities in job supervision.
- Develop a policy and good practice guidance on supporting people in their relationships and connecting in the community.

- Local voluntary groups mapping their local communities and making sure that people know what is available.
- Exploring peer support and mentoring around developing relationships and community connections.
- Explore time banks.

- Include social clauses relating to supporting people to make and keep friends into tendering documentation and service specifications for all older people's contracts.
- Develop clear protocols for evaluating tenders that give appropriate weighting to such clauses and ensure these protocols are understood by existing and prospective providers.
- Cost support with making and keeping friends into contracts - where this means paying more ensuring to develop means of measuring and evaluating impact on health and wellbeing to justify investment, including invest to save.
- Develop contractual incentives for providers to support people to make new friends, e.g. agreed 1% higher rate dependent on numbers of people reporting improvements in their next person-centred reviews.
- Engage with (or develop) local older people's user led organisations signalling an interest in proposals that help link people together.
- Cross reference this qualitative date with JSNA information on demographic growth and numbers of older people living alone to target specific low level interventions.
- Ensure to consider impact on social interaction/ relationships before fitting assistive technologies if this is the only service someone receives.
- Further analyse person centred review information to determine if there are areas or services where people have identified support with keeping their relationships as something that is working well, highlight good practice and learn what made the service successful and can be replicated elsewhere.

Older People and People With

What the person said was not working

Cluster name

What are the possible root causes for this?

"I don't' like to trouble anyone - so I often don't ask for help."

"I don't always ask for help when I need it"

No body asked me or knows me well enough about things that need changing.

"I don't share my mail with supporters, as I don't want to bother them."

People need prompting or encouraging from someone who knows them well.

"I don't tell people when my health is not good."

I find it hard to ask for help - I feel other people need it more than me.

It is easier to stick up for someone else than for yourself.

I feel I am losing my independence when I ask for help.

Physical Disabilities Example

What does success look like?

people

"I have dedicated time when I can talk to my support worker about what I need."

"I feel it is easy to ask for help because it is encouraged."

"I am encouraged to speak up for myself and ask for help, and supported when I need help."

"I can go to my tenants association and talk to them about my problems."

staff and managers

"When we are spending one to one time with people, we are not on the buzzer and cannot be called away - our time is guaranteed for the person."

"We really value the time we spend sitting down and talking with the people we support."

"We make sure that each person has a supporter who knows them well."

What providers can do to work towards success

- Use 'Learning Logs' to record how buzzers are being used to understand this more.
- Ensure that every person has a one page profile that describes what matters to the person, how best to support them, and includes how to support people to speak up. Include 'decision making agreements' in person centred information to ensure that staff know how to support and encourage people to make their own decisions.
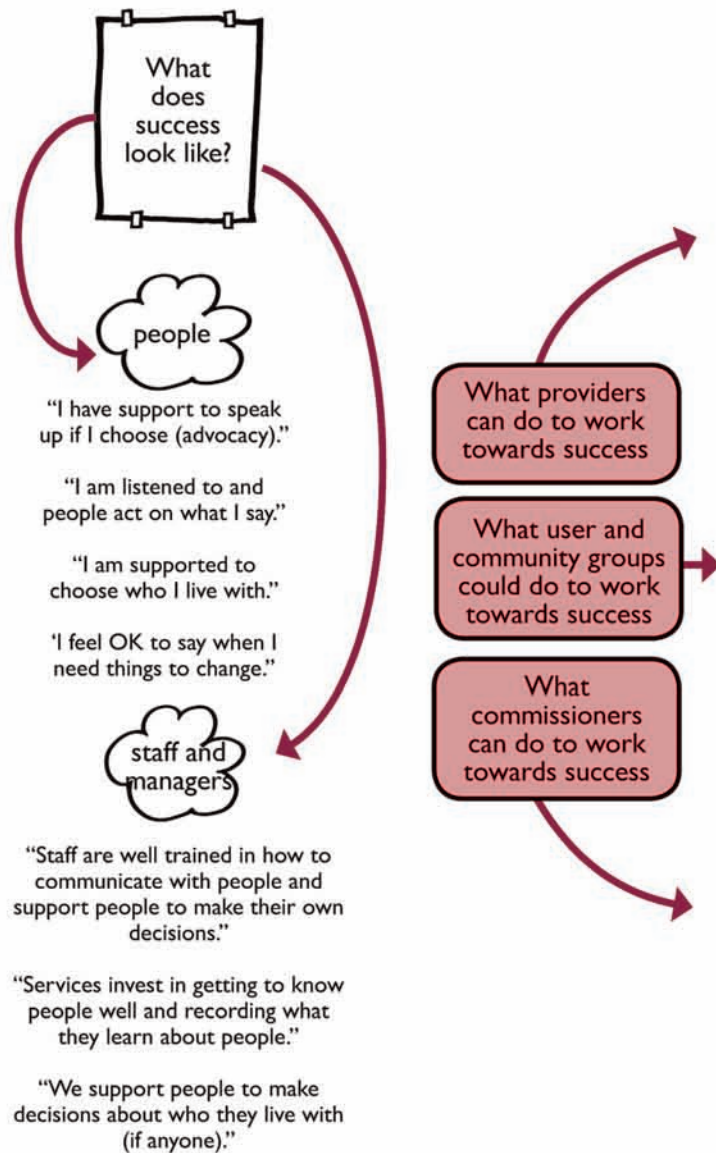- Look at how to match individuals and key support staff based on shared interests and personality characteristics (for example using matching staff tool).
- Stress the importance of spending time with people and talking to them in recruitment, job descriptions, supervision and team meetings, and all training. Train people in active listening and person centred thinking.
- Rethink with commissioners the design of the buzzer system with staff.

What user and community groups could do to work towards success

- Form a tenants association the following week

What commissioners can do to work towards success

- To put in short term additional resource into service to learn about the buzzer system, what needs to be different and explore possibilities for change.
- Change the service level agreement (SLA) to reflect this.
- Use this experience to work with other local providers and to generate other models of offering similar service that will not create a situation like this one with the buzzer.
- Review current commissioning arrangements for older people's advocacy/self-advocacy.
- Build/cost 1:1 time between care staff and individual residents into supported living contracts so that older people have designated time each week to discuss issues and requirements - if this requires additional staff time, develop measures with the provider to determine any preventative benefits, e.g. properly targeted services helping to reduce hospital admissions.
- Build evidence of person centred practice into new contracts and service reviews - signalled through provider forums;
- Use information from co-producing commissioning to drive inclusion of NI128: user reported dignity and respect, into Local Area Agreement supported by local performance indicators.

People With Learning

What the person said was not working

Cluster name

What are the possible root causes for this?

"He lives with loud people so he spends a lot of time in his bedroom not coming out."

"I don't like who I live with."

People are not listening to me.

"The compatibility of the two people who live together."

I did not get get a choice about who I live with.

I find it hard to ask for help - I feel other people need it more than me.

It is easier to stick up for someone else than for yourself.

I feel I am losing my independence when I ask for help.

Disabilities Example

What
does
success
look like?

people

"I have support to speak
up if I choose (advocacy)."

"I am listened to and
people act on what I say."

"I am supported to
choose who I live with."

'I feel OK to say when I
need things to change."

staff and
managers

"Staff are well trained in how to
communicate with people and
support people to make their own
decisions."

"Services invest in getting to know
people well and recording what
they learn about people."

"We support people to make
decisions about who they live with
(if anyone)."

**What providers
can do to work
towards success**

**What user and
community groups
could do to work
towards success**

**What
commissioners
can do to work
towards success**

- Ensure that staff know people well (what is important to them and how to best support people) and record what they learn in a person centred plan.
- The person centred plan includes 'matching' information to help people think about who they may want to live with (if anyone) and information about decision making (communication chart and decision making agreement).
- Review the processes that are used for making decisions about who lives together and ensure that these are as person centred as possible.
- Use person centred reviews to ensure that there are opportunities for people to say what is not working in their life (including who they live with).

- The People First group decided to hold an event with other people with learning disabilities to think and talk about this issue.

- Develop local KeyRing scheme and recruit a Community Living Volunteer to support members of the network to retain the tenancies they want with the people they want in the community.
- Develop system to share anonymised support plan information with providers of people who have been "matched" (or who wish to live together) so that they can develop solutions that will help support them together.
- Allow people and families to lead tendering process so that they can chose more appropriate support living arrangements.
- Require evidence of person-centred practice in new service specifications and reviews of existing services.
- Systematic disinvestment in residential care where there are historically high levels of investment - channel greater investment into community services and supported living arrangements that support personalised approaches.

APPENDIX 2:
Person centred review feedback

Review for:	Date of review:

Review facilitator:

People attending review:

Location of review:

1) What are the three most significant things that are important to the person from their important to me now sheet?

2) From the person's important for the future section, what are the three most significant things?

3) What are the person's main priorities in the whats working section of the review?

4) What are the person's main priorities in the whats not working/what needs to change section of the review?