



# The Emergence of Person-Centred Planning as Evidence-Based Practice

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## ABSTRACT

Recent research (Robertson *et al*, 2005) has demonstrated that person-centred planning (PCP) leads to positive changes for people. This research shows how PCP is associated with benefits in the areas of community involvement, contact with friends, contact with family and choice. This paper briefly describes this research and its recommendations. In addition it explores the implications for managers and professionals supporting people with learning disabilities.

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**KEY WORDS:** PERSON-CENTRED PLANNING; EVIDENCE-BASED PRACTICE; LEARNING DISABILITY; SERVICE DEVELOPMENT

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## Introduction

The White Paper *Valuing People* (DoH, 2001) made a significant step towards making person-centred planning (PCP) available to people who wish to plan their lives in this way. In support of this ambitious goal, a number of initiatives have been introduced to support people in implementing PCP. One such development was the research (Robertson

*et al*, 2005) carried out as part of the Learning Disability Research Initiative. In this article we contend that, because of this research, PCP can now be considered as evidence-based practice, and we look in detail at the implications for policy and practice.

The article will analyse a number of different issues. It will explore the impact that the introduction of PCP can have on the life experiences of people with learning disabilities, the costs associated with the introduction of PCP and the organisational factors that can impede or facilitate its introduction and effectiveness. Finally, the practice relevance of the research will be addressed through exploration of the roles professional are able to play in supporting both the research and PCP.

## The research

Robertson has led the largest international evaluation of the outcomes of PCP to date. It was a longitudinal study that explored the efficacy, effectiveness and costs of introducing PCP for 93 people with learning disabilities. The research took place over two years in four localities in England.



The four sites were selected on the basis of perceived commitment to PCP, and included:

- an inner London Borough
- a large rural area in the South of England
- two metropolitan boroughs in the North of England.

The sites also represented a variety of social, cultural and economic groups. One was a generally affluent area, a second was a diverse community, and one area was among the 10% most materially deprived in the UK.

The participants were the first 25 people in each site to be offered a plan. They are described as having a ‘full range of intellectual disabilities’, and were aged between 16 and 86; 61% were men. Most people (73%) lived in supported accommodation.

*Table 1*, below, highlights the approach used in the research to answer each of the questions that were the focus of the research.

positive outcome noted in each of these areas that indicates that PCP is evidence-based practice.

### The impact of PCP on the life experiences of people with learning disabilities

Perhaps the best way to indicate the impact of PCP on the life experiences of people with learning disabilities is to consider Luke’s story (*Box 1*, overleaf).

Baseline data from the research demonstrated that there was little change in people’s lives before the introduction of PCP. After its introduction, for those who received a plan, positive changes were found in six areas: social networks, contact with family, contact with friends, community activities, scheduled day activities and choice. PCP resulted in a 52% increase in the size of social networks, a 140% increase in contact with family members, a 40% increase in the level of contact with friends, a 30% increase in the number of community activities, a 33% increase in hours per week of

What impact does the introduction of PCP have on the life experiences of people with learning disabilities?	Training in PCP and support was provided to the four localities. The researchers followed the first 25 people who had a person-centred plan in each site for a two-year period. Interviews and questionnaires were used at this stage.
What costs are associated with the introduction of PCP?	The researchers documented the costs associated with developing and implementing PCP in each of the four sites. In addition they determined the impact of the introduction of PCP upon the costs of support for the first 25 people who formed the population sample.
What organisational factors impede or facilitate the introduction and effectiveness of PCP?	The researchers undertook interviews with managers and practitioners in each of the four sites. They also reviewed documentation and attended relevant meetings.

### Outcomes of the research

The outcomes of the research can best be demonstrated by consideration of the three key areas the research set out to consider: impact on life experience, costs and supporting structures. It is the

scheduled day activities and 180% more choice. Essentially, therefore, the research supports the current emphasis in health and social care policy on using PCP to improve the life chances of people with learning disabilities.



**Box 1: LUKE'S STORY**

Luke used to attend a large day centre with about 70 other people. He was described as being unmotivated and shy, and seemed to prefer his own company, isolating himself within the large building. Although he was enthusiastic about helping out in the kitchen, most of each day Luke preferred to sleep. This caused problems with his sleep pattern, which in turn affected his behaviour and his family.

Luke was part of the research and began his essential lifestyle plan in 2001. As a result, he left the day centre and is now supported from a community base by support workers.

Luke now plays snooker at a local club, and he shops with little support around his local precinct, where all the shop assistants know him. He uses the local railway station and enjoys a drink and a game of darts at his local pub, The Elizabethan. Luke's weekly visits to the gym have improved his weight and health and he has started cooking. He is a member of his local library, where he knows all the assistants; he enjoys having his own library card and delights in choosing his own books.

There are activities that Luke has tried out but chosen not to continue. For example, he played badminton with three other people at a local sports hall but didn't enjoy his time there. For the first time Luke was confident enough to be able to tell his staff that he would rather play snooker.

Today Luke is confident and healthy. He is happy, and so is his family.

PCP was a crucial part of the changes in Luke's life. He has more control over his life and spends more time doing the things that are important to him. His family describes him as happier and healthier.

In addition to these benefits, the research found that people were 1.5 times as likely to be perceived as at risk, either in or out of the home or in traffic, and had a 67% increase in the number of health problems reported. It appears that PCP had no apparent impact on building inclusive social

networks, employment, physical activity or medication, leading to the statement in the research report that PCP may be helpful but is not sufficient to promote social inclusion to the desirable level.

The research also found that PCP worked better for some people than others. If someone had mental health, emotional or behavioural problems, autism, health problems or restricted mobility, they were less likely to get a plan.

**Costs associated with the introduction of PCP**

PCP was found to be largely cost-neutral, and therefore is described as being both efficacious and effective in improving the life experiences of people with learning disabilities.

The direct training and implementation costs per participant were £658 if calculated across all 93 participants. However, these costs are likely to fall over time, as local capacity is built and training is carried out by external trainers but undertaken in-house. The average weekly cost of the service provided to individuals in the study rose by 2.2%, but this increase was not statistically significant.

**Organisational factors that impede or facilitate the introduction and effectiveness of PCP**

The research suggests five factors that lead to improved outcomes for people who are supported by services. They are:

- a facilitator committed to PCP, which the research found to be the most powerful predictor of successful outcomes for people
- a facilitator who had planning as part of their formal job role – planning was more effective where people had dedicated time and an acknowledged planning role. (Interestingly, the research found that having a facilitator who was a member of support staff was associated with benefits for the size of social networks, but had disadvantages for community activities, contact with friends and contact with families.)
- personal involvement of the individual in accordance with the guidance for PCP (DoH,



2002), which stressed the importance of people having an opportunity to lead planning; this was supported by the research findings, as people who took an active role in PCP (for example in directing their own meetings) had more positive change in their lives

- a person-centred team (Sanderson, 2002); 'leadership, stability of staff and evidence of the prior existence of person-centred approaches' were associated with improved outcomes
- managers actively involved in planning; several of the PCP facilitators were first-line managers, and this was again associated with better outcomes.

The research report concludes with a number of recommendations, including an exhortation to:

*maintain and enhance investment in Person Centred Planning. Develop robust procedures for ensuring and monitoring equity of access to and the impact of planning and to develop local capacity for change. In order to achieve this, services will need to invest in leadership in Person Centred Planning, build the capacity of first line managers to use person centred thinking and planning, and find effective ways to support facilitators and link learning from planning to organisational change.*

*Continued learning about the conditions under which Person Centred Planning delivers maximum benefits for people with learning disabilities is essential.*

These findings mean that PCP clearly is evidence-based practice, is largely cost-neutral yet results in people having more choice and more to do in their lives. This obviously has implications for both managers and professionals.

### **Implications of the research for practice**

These findings create an imperative for managers and professionals to consider how they can contribute to ensuring that PCP is used to enable positive changes for people. It is no longer

acceptable for people to dismiss PCP as another fad, unsubstantiated by research.

### **What does this mean for managers?**

The direct implications for managers include choosing and supporting facilitators and developing person-centred teams.

#### *Choosing and supporting facilitators*

Traditionally, selection of people for courses has been based on their formal role (for example all senior support workers), or on getting representation from geographical areas or services. Smull and Sanderson (2005) suggest that potential facilitators could be classified as 'naturals', 'learners' or 'unlikely to have any talent for facilitation'. The naturals in an organisation are those who clearly demonstrate person-centred values and continually seek to improve the ways in which they translate them into practice. Learners are people who broadly share the values, but need extra support in finding ways to put them into practice. When managers are considering whom to begin to train as facilitators of person-centred planning, they should begin with the naturals. The research supports this view, as the commitment of facilitators to PCP, and therefore to the values of inclusion, is the most significant predictor of success.

Providing people with training to be facilitators is a beginning, but it is not enough. In the research, facilitators were given training and ongoing support, for example through action learning sets, facilitator buddy groups and directly through a PCP co-ordinator.

Managers also have a significant role in supporting facilitators, through supervision as well as by ensuring that they have time to plan and attend support meetings or action learning sets. Investing in ongoing support is a way to retain facilitators and ensure their effectiveness in using PCP to enable people to make positive changes in their lives. Some organisations use a joint approach to training, by training facilitators and their managers together. The programme teaches



facilitators and their managers person-centred thinking skills, then the facilitators learn about facilitation while the managers learn about developing person-centred teams, then they come back together to learn about implementing plans.

#### *Developing person-centred teams*

PCP is based on deep listening to discover what is important to people, what support they need, and their hopes and dreams for the future. In developing person-centred teams (Sanderson, 2002) managers extend these principles to how they support and lead staff. Thinking about leadership as a collective capacity for creating something of value (Senge, 1990) underpins the person-centred team approach. Managers can use person-centred thinking tools (Smull & Sanderson, 2005) to develop a strong sense of valued purpose, clarity about where staff can use their creativity and judgement and what their core responsibilities are, as well as getting a better match between service users and the staff who support them. There are specific tools, for example learning logs and 'four plus one questions', that managers can use to help the team record and act on what they are learning. The development of person-centred teams is based on research on implementing person-centred plans (Sanderson, 2000), and is further supported by the recent research, which particularly indicates that plans are more likely to be successful where there is leadership and the team is using person-centred approaches in its work.

This research also suggests that individuals do different things with their time as a result of developing and implementing a person-centred plan; this often involves increased contact with friends and family or greater participation in community activities. These shifts in experience naturally require changes in the way that teams manage their time to support people to do different things. Teams need to be flexible in order to support a person to make these changes in their lives, and be responsive to further changes. A team that invests time and resources in person-centred

team development could result in better outcomes for individuals as a result of PCP.

PCP therefore requires a different way of working, reflecting different priorities – as one manager, Lucy, describes (*Box 2*, opposite).

#### **What does this mean for professionals?**

The ways in which professionals are able to engage in PCP were articulated in the model proposed by Kilbane and Sanderson (2004), in which professionals were identified as having four ways in which they could contribute to PCP: introducing, contributing, safeguarding, and implementing/integrating PCP. For each of these, a summary of possible involvement is offered, with implications from the research highlighted in order to inform any specific practice implications for professionals.

#### *Introducing PCP*

Introducing the idea of PCP to an individual or their representative can happen during conversations with professionals, whether in a meeting or when visiting a person's home. This discussion includes offering people information about how to get started with PCP, and supporting them to lead their own plans or find a facilitator.

Introducing PCP to an individual or family requires a level of knowledge about it, for example what it is, styles, applications and resources. Also important is the local infrastructure that needs to be in place in order to support planning, such as implementation groups, courses and contacts.

Key factors to be considered therefore include that professionals can:

- help ensure that people who are less likely to get a plan, according to the research findings, have information about PCP and how to develop a plan if they wish to
- support people to lead their own plans, or work with families in this way (see *Box 3*, opposite).



**Box 2: A DIFFERENT WAY OF WORKING**

Because of Kevin's learning disabilities, he has spent most of his life in an institution. He has received residential services for as long as can remember; he is very quiet and passive, and does not make great demands.

At one stage, he was resettled and lived with two other men. Over a couple of years these two men died, and the service was looking at the best way to support Kevin.

I managed the service and was the budget holder, and was trying to find the best solution for him. I decided that he could not remain in a three-person tenancy, but we could not afford to support him on his own. I managed another tenancy about three miles away, and the men there and Kevin had shared some activities and got on well enough, so I suggested that Kevin could move into this property. At the time, he appeared happy with the arrangement.

We started to develop person-centred plans as part of the research project, and supported Kevin in developing an essential lifestyle plan. When we introduced person-centred planning, Kevin said, 'I want to stay here. I don't want to move in with them.'

I am ashamed to say that, because all the plans were in motion, I blocked this idea and set about persuading Kevin to move. Thankfully, the staff team felt empowered enough by their person-centred planning training to challenge my decision.

When I reflected on the team challenge to my decision, I was amazed that the urge to manage my budget efficiently had completely overshadowed my responsibility to Kevin. At the time, I had not considered that he had the right to change his mind, and that my responsibility was to him and not to financial expediency. This was a shocking revelation, as I have always believed myself to be person-centred by nature.

Following this challenge, I completely altered the way that I was looking at Kevin's housing needs. My priority became to find

ways of keeping Kevin in his present home. He could not afford to live on his own, and so I met the landlord and managed to change the tenancy from three-person to two-person. We introduced Kevin to another man, and when they had got to know each other they decided that they could share the accommodation. Kevin now lives happily in his new home. He gets on very well with his co-tenant.

**Box 3: SUPPORT FOR PCP**

Lucas chose a student nurse to help him with his plan. He lived with three other men and wanted to move. The local self-advocacy group, People First, was running a course called Listen to Me for people who wanted to use person-centred planning to make changes in their lives. Lucas asked John, a student nurse he knew, to help him. John supported Lucas to think about and record how he wanted his life to be, and supported him to arrange and speak up at his meeting, and to follow up on actions. Six months later, Lucas is living in his own place.

*Contributing to PCP*

The contributions that any professional could make to a plan include facilitating the plan (if they are trained and experienced), being a member of the planning process throughout the whole planning process or just a part of it, and contributing to actions resulting from the plan as part of implementation.

In order to contribute to a plan, a professional must be invited to do so by the person whose plan is being developed. This requires clarity about the focus of their contribution and commitment to completing any resulting actions.

Key implications of the role of professionals in delivering this aspect of PCP include the following.

- The research suggests that the role of managers is a key factor in the success of plans. It is possible for professionals to collaborate with and support



managers in ensuring that plans are implemented.

- Professionals can be actively involved in supporting PCP; for example, a speech and language therapist could support people to find ways to ensure that people who do not use words to speak are enabled to be at the centre of their planning process. The research indicates that this is a factor in positive outcomes for people from PCP.
- Consider training to become a facilitator.

#### *Safeguarding PCP*

Professionals have a significant role in safeguarding the quality of plans and planning. A professional who has knowledge, experience and understanding of person-centred styles and approaches could identify aspects of a plan that are of low quality and do not reflect key features of PCP (DoH, 2001). Learning from professionals about how to make plans happen can be shared with local implementation groups.

To be successful in safeguarding PCP so that more positive outcomes are achieved, professionals should understand its key features and know the elements of the various planning styles and the criteria that represent quality. In addition, it is important for them to be familiar with the quality process being used by local services and the local PCP implementation group, as well as keeping up to date with developments in PCP.

#### *Key implications*

- Professionals are in a strategic position to contribute to safeguarding the quality of PCP over time. They can work with implementation groups to highlight emerging evidence about factors that increase positive outcomes from plans, and to share learning from and with colleagues. For example, a PCP co-ordinator attends the community team meeting once a quarter. She asks the team what, from their point of view, is working and what is not working in the local implementation of PCP. She feeds this important

information back to the implementation group, who use it as part of their quality process.

- Use specific research evidence to inform the focus of efforts to safeguard PCP. For example, learn about and share ways to support people to become active in development of their own plan, and contribute to team development to increase positive outcomes from plans and ensure that plans are available to everyone.

#### *Integrating PCP*

Once a professional has experience of introducing, contributing to and safeguarding PCP, integration of PCP in professional practice can take place at individual, local and system levels. For all professional interventions, person-centred thinking and approaches can be integrated into everyday professional practice by:

- spending time with the focus person and their supporters, reading the plan and increasing understanding of the person through the plan as part of any initial work
- using information from plans to influence practice, for example arranging meetings or activities with the person in the mornings if their plan indicates that this is a good time, or using learning logs
- recording outcomes, new learning and actions resulting from professional interventions in individual person-centred plans
- using person-centred thinking tools to enhance existing practices; for example, a care manager, when reviewing a contract, might use the process called 'working and not working' in reviews to gather information about what is working and not working from the person's, the family's and staff's perspective (*Box 4*, opposite).

## **Conclusion**

In this article we have outlined the essence of the major research initiative that has just ended, and which has clearly identified person-centred planning as evidence-based practice. We have discussed the outcomes of the research in relation



**Box 4: INTEGRATING PCP IN PRACTICE**

Vera, a physiotherapist, used a person-centred thinking tool called 'four plus one questions' as part of the review of a dysphagia group. For each individual who attended the group they explored four questions.

- What have we tried?
- What have we learned?
- What are we pleased about?
- What are we concerned about?

and then agreed what they would do next. The physiotherapist said that it helped them to focus on how dysphagia affects the person rather than on the actual swallowing problem.

to quality of life indicators, cost and factors that increase the likelihood of successful plans for people. We have also considered the implications of this research for professionals and managers involved in supporting people who have a learning disability to achieve the lives they want for themselves. A core message of the research is that these issues are not too complex for managers and professionals to address, and that they cannot continue to ignore PCP, because we now have the evidence that it makes a positive difference for people.

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