Progress for Wigan Ethical Homecare Providers

Checking your progress in delivering personalised, outcome-focused support for people living at home in Wigan

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For further information about the development of Progress for Providers, please see *Progress in Personalisation for People with Dementia*, Trevor Adams, Martin Routledge and Helen Sanderson (2012) www.helensandersonassociates.co.uk

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This Wigan version is based on the original Progress for Providers for homecare.

Foreword

Joanne Willmott

Assistant Director, Adult Social Care, Wigan Council

Wigan Council is at the forefront of the radical reform of public services to support our residents to live great lives, based on the "Wigan Deal", a new relationship with people, communities and providers.

The Deal is a simple idea with a profound impact and is made up of five design principles:

1. Having a Different Conversation.
2. Knowing Your Community Better.
3. Attitudes and Behaviours of Staff.
4. Co-location of Teams and Partner Agencies.
5. Giving Permission and Freedom to Redesign and Innovate.

By applying these principles we are developing a diverse and sustainable market, working in partnership with local people and ethical providers who share our vision, behaviours and commitment to an asset-based approach. We want to commission and deliver services which enhance resilience and independence, helping people live rich and vibrant lives, connected to their local communities.

> Valued, connected and resilient people, living in the right home, with the right support will be happier, healthier and more independent.

The principle of "giving permission and freedom to redesign and innovate" is at the foundation of our partnership with our ethical homecare providers and Helen Sanderson Associates, an internationally recognised social enterprise, at the forefront of person-centred innovation.

We are excited about the further reform of homecare, working together to develop an asset-based, outcome-focused wellbeing model that meets the aspirations of local people and supports the sustainability of the health and social care system. We are proud of the work we have already achieved in Wigan through the development of the Ethical Homecare Partnership and the delivery of high quality homecare. We now want to be courageous (an important Wigan deal behaviour) and are committed to co-producing a radical new model of homecare that liberates providers, frontline staff and customers from the constraints of "time and task". Our model will support people to live happy and healthy lives connected to their local communities, with homecare seen as an exciting and creative career pathway for people with the right values and behaviours.

The Wigan Context
Ethical Homecare Partnership

In Wigan we have developed an Ethical Homecare Partnership, working with 11 ethical, committed and compassionate providers to deliver a new model of homecare, based on collaboration and asset-based working.

We used a new model of commissioning and contracting to robustly test the market in order to ensure we are only working with ethical providers who share our values and demonstrate their commitment to the Wigan Deal. We worked with customers and carers to develop a range of "I" statements that form the core part of the specification to ensure homecare meets the aspirations of Wigan residents. Some examples are:

- "I want you to know me well enough to recognise when I am feeling unwell, acting early so that I have the best chance of getting better quickly."
- "I want you find out about the things that make me 'tick' and support me to maintain and find new interests and activities."
- "I want you to support me to live a life beyond my home, maintaining friendships, making new relationships and sharing my skills and interests with others."

In the main, the 11 ethical providers are local or regional and all have an evidenced connection and commitment to Wigan. The model is place-based with a lead provider for each neighbourhood, with providers collaborating to manage spikes in demand to support the sustainability of the health and social care economy. This is bringing new people into the workforce, as providers have established "walking rotas" where local people who know the community can work locally, without requiring access to a car. Wigan's excellent delayed transfer of care figures demonstrate that our approach to market shaping is translating into a high quality, sufficient supply of homecare.

There has been a carefully managed transition period and all new providers are now fully in place. A "Homecare Big Night Out" was held on Saturday 25th March, for customers, families, care workers and providers – some comments included:

- "This is unique across the whole country. Wigan Council listened, thought about what people, carers and providers want and built a partnership based on shared values and trust."
- "We've changed from being competitors to collaborators and friends."
- "We stand united in Wigan."

Key elements of the Ethical Homecare Partnership include:

- Focus on personalised care and outcomes for the individual.
- Working with health partners to understand overarching system benefit – better care at home might cost more per hour but costs less per person.
- Embedding different conversations and community connection into the homecare model.
- Shaping the market for self-funders.
- Payment of the Wigan fair price for care to providers, based on agreement to open book accounting.
- Wider Deal for Providers offers such as free flu jabs and Deal training.
- Improved use of new technology to reduce providers' back office costs.
- Robust and comprehensive quality assurance and contract oversight, co-produced with customers and carers.
- All care workers must be paid at least the National Living Wage.
- Staff must be paid travel time and expenses in between individual visits to customers.
- Extensive use of substantive contracts for care workers.
- Clear career path and extensive programme of training and qualifications for care workers.
- There are no 15 minute calls to deliver personal care.
- A commitment that every member of staff in the organisation is trained and updated in having new conversations with residents that focuses on assets rather than need. Wigan Council are committed to supporting providers to implement and embed The Deal approach through the offer of high quality training as part of the overarching reward and support package for ethical providers.
- That leadership across the organisation create the climate for staff from different professional backgrounds to work together in a positive, open and trusting climate.

- That services are co-ordinated in a place in a way that is informed by a deep understanding of the community assets and capability in that place to support residents to be connected to their community and each other.
- That organisational leadership facilitates and promotes three key competences for the workforce:

  Be positive;

  Be courageous;

  Be accountable.
- The organisation embraces positive risk taking and permission-based working, with the workforce liberated to demonstrate innovation and creativity on a daily basis.

Next Steps

We know that we are on a journey to a radical new homecare model. We have built the foundation of this through the development of the Ethical Homecare Partnership and are now ready for the next phase of reform.

We are delighted to have developed a partnership with Helen Sanderson Associates, an internationally recognised social enterprise leading innovation in social care, who are working with us to move away from a reductive approach of "time and task", working closely with partners to be one of the first areas to develop asset-based, outcome-focused homecare at scale. We will also be testing out a Wigan version of the Buurtzorg model, introducing the concept of integrated Wellbeing Teams, who are able to provide a fully integrated health and social care offer of homecare. All of these plans underpin our commitment to outstanding homecare services in Wigan.

Introduction

This publication is a self-assessment tool for managers to use with their staff to check how they are doing in delivering personalised support for people living at home. 'Personalised support' is a key aim of national policy and means tailoring support to the individual, and enabling them to have as much choice and control over their service and life as possible, rather than supporting everyone in the same way. This means learning what matters to the person and ensuring that any support wanted and needed is shaped by this. Using person-centred thinking tools and approaches helps staff to provide the best support that they can in ways that reflect what is important to the person. Working in this way is not about doing more, but about doing things differently.

Progress for Wigan Ethical Homecare Providers: Checking your progress in delivering personalised, outcome-focused support for people living at home in Wigan reflects the Wigan Deal principles as well as the Department of Health's guidance *Personalisation Through Person-centred Planning* (2010), and contributes to achieving the Making it Real markers of progress developed by the national Think Local Act Personal Partnership.

This publication is primarily for managers of domiciliary homecare services that support people in their own homes. It may also interest families who are looking for a homecare provider or who want to know how person-centred a service is. We know that to achieve 4s and 5s in the workbook requires significant partnership working between commissioners and providers of homecare; however, we believe that innovative providers can still make significant strides in this direction.

How to use the tool

The self-assessment tool asks you to look at the practices, policies, knowledge and skills of you and your staff team and at the experience of the person receiving homecare and their family. It takes about 40 minutes to complete the self-assessment.

Each topic enables you to score yourself on a scale of 1 to 5:
If you tick boxes 1 or 2 you are starting to look at and act on the topic.

Tick box 3 if you are making some progress in that area.

Tick box 4 if you are making good progress in delivering person-centred support in that area.

Tick 5 if you are delivering truly personalised services and using person-centred practices in that area (including individualised funding).

Once you have scored yourself on these criteria, you can transfer the scores to the summary sheet on pages 24-25 which then provides an overview of how you are doing.

You can use this assessment tool:

- By yourself, for individual self-reflection.
- With your manager, to agree goals.
- With your team to agree team and individual goals.
- With other managers, for example as a practice group, or as part of an organisational development programme.

We have split this version into Bronze, Silver and Gold. As well as using this for self-assessment, members of the Commissioning and Contracts team will support you by looking at your results and exploring next steps with you.

What next? Actions and resources

Once you have assessed your practice, you can use this information to develop an action plan. The action plan should describe how you are going to develop and change and move towards statement 5 (excellent practice) for each topic. There is a blank action summary on pages 27-28.

You can check on your progress by doing the assessment on a regular basis and tracking your scores over time. This will give you an overview of where you have improved and where you need to progress further. Even if progress is slow, it's important for you and the whole staff team to record and celebrate your achievements.

We hope you find this Progress for Providers useful as a way of thinking about the progress you are making and how to move towards delivering truly personalised support for people receiving homecare.

Helen Sanderson and Michelle Livesley
Helen Sanderson Associates

Contents

To achieve Bronze

To achieve Silver

To achieve Gold

To achieve Bronze

Tick one box ✓

1 We see and treat the person as an individual, with dignity and respect. What we appreciate about the person is recorded on their one-page profile (must achieve 5)

1	We have only very basic information about the person and their needs. Staff struggle to describe the person in a positive way.	
2	We see the person as an individual as much as possible, but we only have information about their care needs. Most of the time, people are referred to respectfully.	
3	We see the person as an individual with strengths and qualities. People are consistently described and treated with dignity and respect.	
4	Staff describe people positively. We have recorded information about the qualities and strengths of each person we support. We don't just record this; we try to use it in our day-to-day support and in our conversations with them. Dignity is seen as everyone's business and every staff member sees themselves as a 'Dignity Champion'.	
5	We know and have a record of each person's gifts and qualities, for example on their one-page profile. We use a variety of ways to communicate how we value each person. We use the information about what we value about them in their day-to-day support. They are described and treated respectfully and positively, as individuals, by all staff. Staff feel comfortable expressing positive feelings to people. We exceed dignity in care standards.	

2 We understand and respect the person's life history which is gathered in first 6 weeks in Wellbeing Teams (must achieve 4 or above)

1	The only information that we have about the person is in the care/ support plan. Any record of their life history is likely to be in the context of negative experiences or behaviour.	
2	We know it is important to know about the person's life history but we don't have time to do this.	
3	We are committed to finding out about each person's life history and have started to work with a few people to write their histories when we have time.	
4	We have recorded histories for most of the people we support. We have different ways to record and share people's history, according to what the person wants. We are starting to use this information in our conversations with people. We have a plan to complete histories for everyone for whom this is relevant.	

Tick one box ✓

5	We know and have an appropriate record of each person's history. This is recorded in a way that works for them and is proportionate (for example on a history map, life story book, timeline, scrapbook, memory box or DVD). We use this information in our day-to-day conversations and support. We share ourselves through our own life stories.	

3 We know and act on what matters to the person (must achieve 5)

1	We focus on performing the tasks described in the care/support plan. We do not know what matters to each person.	
2	We know we need to recognise what is important to people, but we don't have the time to do this. We make sure that staff use the person's preferred name.	
3	We have started to find out about and record with the person what is important to them, and we are using person-centred thinking tools to help us do this (for example good days and bad days, relationship maps, learning about people's routines). This information is starting to change how we support people.	
4	Most people have a record of what matters to them (for example a one-page profile). Staff use this information in conversations and how they support people. New staff use this to get to know the person quickly.	
5	We know what is important to each person we support. This is clearly recorded where relevant and includes specific detailed information. This could include relationships, sexuality, routines, interests and ways of participating. Every person has a one-page profile. Staff intentionally work to make sure that what is important to the person is happening purposefully in their day-to-day life. Where there are obstacles to achieving this, these are shared with the managers, who help to find ways around this. The person is able to use their budget/hours flexibly, and everyone is aware of what this is and how it is being used.	

4 We know and respond to how the person communicates (must achieve 3 or above)

1	We support people by following our policies and procedures; we do not specifically record how people communicate.	
2	We realise that we need to understand more about how people communicate and what they are trying to tell us. We recognise that everyone is able to communicate.	

Tick one box ✓

3	We have started to introduce communication charts as a first step. Staff are now beginning to understand that all behaviour is communication and are developing their skills in observing, recording and communicating with people.	
4	We use communication charts with the majority of the people for whom this is appropriate. Staff understand their own role in effective listening and communication and know how to respond to people.	
5	We know and respond to how the person communicates. This is clearly recorded (for example using communication charts) and staff know what a person means when they behave in certain ways and how to respond. Information about the person's communication is up to date and used consistently by all staff.	

5 We support individuals to be in the best possible physical health and to remain as independent as possible (must achieve 3 or above)

1	We focus on the tasks recorded in the care/support plan and maintaining the person's health and general wellbeing.	
2	We focus on improving the person's wellbeing. We have systems in place that monitor progress.	
3	We are committed to supporting people to live safely in their own homes. We signpost them to any services they might need to ensure that they remain independent, and encourage them to have regular health checks.	
4	Everyone we support has a care and support plan, which includes outcomes to enhance their independence and wellbeing. Staff are clear what just enough support for the person is and regularly review whether the person is being over-supported (for example using the working/not working tool).	
5	We pride ourselves that people are in the best possible physical health and are being supported to remain as independent as possible. We know and have a record of the best ways to support each person to be healthy. We regularly review people's progress with them (for example using the person-centred review process), looking at what's working and what's not working, and we agree with them how our input needs to adapt to their changing needs. We explore with them how their independence can be promoted further and how our support could reduce as their independence and natural support networks increase.	

Tick one box ✓

6 Staff know what is important to each other and how to support each other (must achieve 3 or above)

1	My team members do not know each other very well.	
2	I have started to work on ways that I can help the team know more about each other; what matters to them as people and how they can support each other at work (for example, starting with one-page profiles for everyone).	
3	I am learning what is important to my team and how best to support them. We are all aware of how to support each other and what is important to each other and we are working at putting this into practice.	
4	My team and I have all documented how best to support each other and what is important to each of us. We know how we make decisions as a team and the best ways to communicate together.	
5	As a team, we know and act on what 'good support' means to each person. This information is recorded (for example, in a person-centred team plan). We regularly reflect on what is working and not working for us as a team, and what we can do about this. We have a culture where we appreciate each other's gifts and strengths and use these in our work wherever we can.	

7 Family members have good information (must achieve 3 or above)

1	We do not see our role as providing information for families. We answer questions that families have, when we have time.	
2	We try and help families as much as we can when they ask questions.	
3	We have leaflets and information within the person's home and tell families about these if they have any questions. We also point them to other sources of information, such as our website.	
4	We proactively make sure that families have good information about what is happening in their family member's life and about our organisation.	
5	Family members have all the information they need and feel that information sharing is a two-way process, when they want it, in everyday language. This is through a range of resources, such as newsletters, social media and one-to-one sharing. Family members know what is happening generally, as well as in the life of their family member.	

Tick one box ✓

8 Staff know what is expected of them (must achieve 3 or above)

1	I think each team member has a general sense of what is expected of them.	
2	All staff have a generic job description and work to organisational policies and procedures.	
3	I know that staff need to be clearer about what their important or core responsibilities are and where they can try out ideas and use their own judgment. We have started to have discussions in the team about this.	
4	Some staff are clear about what is expected of them and where they can make decisions themselves. There are still some grey areas that we need to explore more. We are using person-centred thinking tools (for example, the doughnut) in clarifying expectations and decision making.	
5	Staff know what is expected of them – they are clear about their core responsibilities and where they can try new ideas in their day-to-day work. Staff are clear about their role in people's lives and know what they must do in relation to the people they support and team, administrative or finance responsibilities. Staff know how to use person-centred practices to deliver their core responsibilities. Staff know where they can use their own judgment and try new ideas or approaches, and record what they are learning about what works and does not work when they use their own judgment. Roles and responsibilities are clearly recorded, and this is reflected in job descriptions.	

9 We know what is working and not working for the person, and we are changing what is not working (must achieve 5)

1	We do not know what is working or not working for the people we support.	
2	We want to learn what people think is working and not working in their lives. We are not sure how to do this and are fearful that we will not be able to respond and make the changes they want.	
3	We have started to routinely ask people what is working and not working from their perspective about their life and the service they receive (for example, as part of a person-centred review).	

		Tick one box ✓
4	Staff are confident in supporting people to tell us what is working and not working. This happens for everyone at least once a year. There is an action plan developed from this.	
5	We have a process to learn what is working and not working for the person, from their perspective. We have actions (with a date and a named person responsible) to change what is not working. The actions are regularly reviewed with all key people, including the person. We have created a system that will gather this information from people so that we can strategically plan what needs to happen in the service.	

10 We know and act on what the person wants in the future (outcomes) (must achieve 5)

1	Our job means focusing on the here and now.	
2	We think it would be good to plan for the future, but we are not sure if it is our role and we don't have the time to do this.	
3	We are trying to help some people think about their future and what we may need to do to help with this.	
4	We help everyone think about their future; what they may like to try or do. We have a record of this and actions that we are working on. This may include advanced decision-making agreements.	
5	We know what people want in the future; their dreams, hopes and aspirations. We have gathered this information from the person and those who know, love and care about them. We explore a range of resources to deliver on the outcomes by using the Support Sequence. There are specific, measurable, achievable and timely actions for us to help people to achieve their wishes (outcomes). We are clear about our role in this and how to support the person to make changes themselves. We review progress with the person and check out whether the person's budget or hours need to be used differently. We are aware of any advanced decision making arrangements.	

To achieve Silver

Tick one box ✓

11 The person is supported to make choices and decisions every day (must achieve 3 or above)

1	The people we support are not consistently involved in decisions about their lives.	
2	We realise that people should be involved and included in any decisions about their lives; however, we do not know how to do this yet. We also recognise that this could help people feel more in control.	
3	We have started to develop decision-making agreements with people and tried out different approaches to help people to make decisions. We are using different ways of engaging families to assist in the process.	
4	The use of decision-making agreements is common and we have many examples of people making decisions about what is important to them. We are struggling to ensure that this includes people with capacity or communication issues. Staff support people to record their decisions. We use advocacy from others where necessary.	
5	Staff know the decisions that are important to the person, how to provide support with these decisions and how the final decision is made. This is recorded (for example in a decision-making agreement) and includes decisions about how the person's budget or support hours are to be used. We have supported some people to make decisions that we don't agree with, and manage the tension in this. We support people to extend the range and importance of the decisions that they make to have more control over their lives, through advocates if necessary.	

Tick one box ✓

12 Families contribute their knowledge and expertise (must achieve 3 or above)

1	We get our information about the people we support from the files.	
2	We know that families have information about the person and we try and get this when we can.	
3	We make sure that we talk to the family and get all the information they have for our records.	
4	We work with the family to learn about the person's past as well as who they are today. We record this information in a person-centred way. We invite the family to reviews.	
5	We acknowledge the expertise of families as those who know and care most about the person. Families contribute to our understanding of the person; for example their history, how they prefer to be communicated with, what matters to them, their aspirations for the future, how they are best supported and their connection to the community. We proactively work with families to enable them to contribute to person-centred reviews (for example, by arranging them at times that suit the family).	

13 We have knowledge, skills and understanding of person-centred practices (must achieve 4 or above)

1	None of the staff has any understanding or experience of using specific person-centred thinking tools or practices.	
2	We know that we need to develop our skills, knowledge and understanding of person-centred thinking tools, but have not developed any plans to do this and are not sure how to begin.	
3	We have a plan to develop our understanding of person-centred thinking, and some of the team have begun to use person-centred thinking tools and approaches. We have started to look at some of the information available on person-centred thinking (for example, the short films on person-centred thinking on YouTube).	
4	I am using person-centred thinking tools and approaches myself, and all the team know about and are successfully using several of the tools. I have a one-page profile and so do each of the team, and we are using this in our work together.	

Tick one box ✓

5	We each have our own one-page profile and we use this to inform our practice. We are all confident and competent in using person-centred thinking tools, using them consistently in all areas of our work to enable people to have as much choice and control as possible in their lives. Everyone can describe the person-centred thinking tools (why and how you can use them and the benefits to the person) and talk about their experience of using them, and the outcomes achieved.	

14 Our team has a clear purpose (must achieve 4 or above)

1	We have an organisational mission statement created by the senior manager/management team/owner. This complies with requirements. We have not considered how this should be reflected in the way we work.	
2	We think it would be helpful for the team to think about our purpose as a team, but I am not sure how to go about this.	
3	We have begun to talk with staff about what our purpose is and to think about how we can record this.	
4	We are clear about our team's purpose and how this fits with the organisation's mission statement. We have developed this together as a team and with people using the service.	
5	The organisation's mission statement informs the team's purpose. Everyone understands the connection between the mission and their individual purpose and role. The team knows what their team purpose is and what we are trying to achieve together. All team members know their purpose in relation to the people they support, their team and the rest of the organisation. This is recorded (for example in a purpose poster or team purpose statement). The team's purpose informs the work of the team and there is evidence of this in practice.	

Tick one box ✓

15 Staff feel that their opinions matter (must achieve 4 or above)

1	I make all decisions; I don't involve my team. I chair team meetings and set the agenda. I set the agenda for supervision and appraisal.	
2	I recognize the need to find a way to listen to my staff team, value their opinions and engage them in decision making. I am trying to improve how I do this.	
3	My team have some involvement in setting team meeting agendas. I still make most of the decisions.	
4	I regularly meet with my team and discuss issues that they raise (in team meetings and other day-to-day opportunities). They contribute to team meeting agendas and make suggestions for supervision discussions. Some staff make suggestions for new ideas or changes. We are starting to use person-centred thinking tools to listen to each other.	
5	All staff feel that their opinions are listened to. Team members are asked for their opinions and consulted on issues that affect them. Team members feel confident in suggesting new ideas or changes to me. We regularly use person-centred thinking tools in the team to listen to each other's views and experiences (for example, 4 plus 1 questions).	

To achieve Gold

Tick one box ✓

16 We support people to initiate and maintain friendships and relationships and to be part of their community and civic life (must achieve 5)

1	The only people in the person's life are family and paid staff. We don't see it as our responsibility to support people's other relationships.	
2	We realise that people might want to meet and make more friends in the community, but can't see how we can do this within our current resources. We are not sure how we would begin to find out who is (or could be) important in the person's life.	
3	We have started to work out how we can support people to build and maintain relationships as well as being part of their community and civic life. We have started to understand what is in the local community and we are developing relationship maps. Staff are putting a greater focus on people's interests and friendships.	
4	We have tried a number of approaches to support some people to maintain and build their friendships, relationships and community and civic life. We know who is already important in the person's life (for example, by using a relationship map). As a result, more people have increased opportunities to actively take part in community life.	
5	We support people to maintain relationships that are important to them (including sexual relationships) and to make new relationships within their wider community and civic life. We use community maps that show the places and people that are important to the person. We actively support people to be contributing members of their community in any way that works for them, and record this (for example, recording gifts or using "presence to contribution"). We explore ways to get the most out of community resources; for example, by developing a Community Circle around the person. We have a culture that creates positive, mutual, valued relationships between staff and people being supported.	

17 We have an agreed way of working that reflects our values and there is a person-centred culture of respect and warmth (must achieve 5)

1	Staff are focused on getting the daily tasks done. We don't really think about values; we just get on with the job.	
2	Staff know the importance of treating people with respect. We realise that we need to explore our values and beliefs as a team and how this can inform our practice.	

Tick one box ✓

3	Staff know the importance of developing good relationships with people. We have started to think together about our team values and how we work together. We know what is working and what needs to change.	
4	We have agreed our values and team principles, and this is reflected in the quality of the relationships that we develop with people we support. We have developed an action plan that addresses what needs to change, in partnership with people we support.	
5	Staff have a clear, recorded set of values that underpin their work and agreed ways of working in respectful, warm and positive ways. Staff are comfortable in sharing information about themselves to develop warm and trusting relationships with people they support. Staff are clear that their role is not task-focused but relationship-focused and is about valuing people. The team principles and ways of working are clearly documented (for example, ground rules, team charter, person-centred team plan, team procedure file). The team regularly evaluates how they are doing against these agreed ways of working (for example, by using what is working and not working from different perspectives).	

18 We support family relationships to continue and develop (must achieve 5)

1	It is not our role to get involved in relationships between the family and the person.	
2	We try and help to maintain relationships within the family, but we have limited time for this.	
3	We do what we can to help families stay connected and maintain relationships, and support them in their caring role (where appropriate).	
4	We proactively support people to maintain positive relationships with their families. Staff see this as an integral role and spend time exploring how the person can stay in contact with their family and what we can do to help; for example, making sure that the person is supported to send birthday and celebration cards.	
5	We support people to remain an active part of their family, continuing with relationships and family celebrations that are important to them. We support families as circumstances and relationships develop and change. We actively work with families to share their perspective through person-centred reviews and learning what is working and not working from different perspectives.	

Tick one box ✓

19 Staff are thoughtfully matched to people and rotas are personalised to people who are supported (must achieve 4 or above)

1	I write staff rotas based upon staff availability. The rota meets the requirements of the service. There is a system for staff and people who use the service to make requests.	
2	I have identified the preferences of people who are supported and the staff (for example, using the matching tool and one-page profiles). I write the rotas and take these preferences into consideration where possible.	
3	Sometimes people who are supported are matched to staff with similar interests, but the service needs still take priority.	
4	My team and I know what individuals' preferences are, how they like to be supported and what is important to them. These preferences are acknowledged in the way that the rota is developed, so that we get a good match between the person and the staff who support them. Rotas are developed around people using the service, based on the support they want and the activities they want to do, and who they want to support them.	
5	Decisions about who works with whom are based on what the person supported wants. Where the senior staff make this decision, it is based on which staff get on best with different individuals, taking into account what people and individual staff members have in common (for example, a shared love of gardening) as well as personality characteristics (for example, gregarious people and quieter people), necessary skills and experience. People can choose different staff for support with hobbies and interests, and personal care.	

20 Recruitment and selection is values-based and person-centred (must achieve 4 or above)

1	Staff are recruited to the team based on formal job descriptions that have been developed by the organisation.	
2	I know I should involve the people who receive a service in recruitment, but I am not sure how to go about this.	
3	I have started to look at 'good practice' examples of ways to involve people in recruiting their support staff. We have started to explore how we can develop job descriptions that reflect what is important to the people we support.	

Tick one box ✓

4	We have worked with people and identified ways for them and their families to be involved in the recruitment and selection of their staff. This happens some of the time. We have developed personalised job descriptions and adverts based on what is important to the person and how they want to be supported. We use the matching tool in our recruitment processes.	
5	Our recruitment and selection process demonstrates a person-centred approach. We recruit people who can deliver our purpose by selecting people for their values, beliefs and characteristics, not just their experience and knowledge. Where people's funding is individualised, job descriptions are personalised to the people who are supported, using information from the matching tool. It is common practice for people to be involved in recruiting their staff, in a way that works for them.	

21 We have a positive, enabling approach to risk (must achieve 4 or above)

1	I encourage my team to make sure people are safe and do not take risks. We adhere to all required legislation.	
2	I am aware that I need to encourage my team to become less risk averse. I am not sure how to do this.	
3	I am working with the team to help them take a responsive and person-centred approach to risk. We are starting to use this in some situations.	
4	We use a person-centred approach to risk most of the time. We involve the person, their family and others in thinking this through. I ensure everything is documented and adheres to the relevant legislation.	
5	We ensure that risks are thought through in a person-centred way that reflects what is important to the person, and decisions are clearly recorded. The person and their family are centrally involved in the way that we do this. We support people to take the risks that they want to take.	

Tick one box ✓

22 Training and development is matched to staff (must achieve 4 or above)

1	All training is based on statutory requirements. I make sure that we meet minimum legal and statutory requirements.	
2	I recognise that I need to find a way for training and development opportunities to reflect the needs of the service we provide to people, and motivate the staff.	
3	I have started to think about how I can introduce learning and development opportunities to staff that will reflect the needs of people who receive a service, and also encourage and develop the team members. I have begun to look at what is working and what is not working for individuals as well as researching what is available.	
4	We have identified all training needs and learning and development opportunities, and have a plan in place. Training and development opportunities reflect the needs and wishes of people who receive a service, and have been agreed with team members. Person-centred thinking and approaches are central to our approaches to training. We comply with all legal and statutory requirements.	
5	We provide development and training opportunities to all staff, including volunteers, that focus on increasing choice and control for people we support and delivering an individual, person-centred service. Within a few months of starting with the organisation, new staff have induction training that includes using person-centred thinking and approaches to deliver our purpose. Our training enables staff to be up to date with best practice in delivering choice and control for people using homecare services and using person-centred practices to enable people to live the lives they want. We know that the senior staff are key to delivering a person-centred service, and we have specific training and support to enable them to use a person-centred approach in all aspects of their role and to coach their staff in using person-centred thinking skills.	

23 How staff are supported, including supervision, is person-centred (must achieve 4 or above)

1	I set the agenda and make the arrangements for staff supervision. I meet the minimum requirements.	
2	I am aware that staff support and supervision practice needs to be reviewed. I am not sure how I can change the current arrangements.	
3	I have started to think about involving people who receive a service in staff supervision. I have talked to people and staff about how we might go about this. Most members of staff have supervision meetings.	

Tick one box ✓

4	All staff (including the manager) are supervised, and people who staff support usually contribute through sharing their views with me before the supervision session. Supervision results in actions, and the meetings are documented. I have started to use person-centred thinking tools in supervision sessions.	
5	If part of a traditional homecare service, each staff member including the manager, has regular, planned, individual supervision. Supervision includes giving staff individual feedback on what they do well and an opportunity to reflect on their practice. Staff are coached to develop their skills in working in a person-centred way. There is a clear link between training and supervision and what people do when they are at work (for example, when people attend training, managers expect to see a difference in their work, and this is discussed in their individual supervision). The views of people supported and their families are very important in the supervision process, and people are asked for their views before supervision. If the workers are part of a self-organising team, each team member is supported to reflect on their practice via regular, scheduled peer support sessions and coaching sessions. All the team members are trained to give and receive feedback compassionately and to hold themselves and others to account.	

24 Staff have appraisals and individual development plans (must achieve 4 or above)

1	Most of my staff have an appraisal. I set the agenda and assign objectives.	
2	I have recognised that people who receive a service and their families should be given the opportunity to give feedback on the support they receive from staff. I am not sure how I should go about this. Staff have appraisals but do not really contribute to the agenda or any development plan.	
3	I have a plan in place to ensure that each member of staff receives an annual appraisal. Where possible, I try to seek the views of people who receive a service and their families.	
4	We have a variety of ways for people who receive a service and their families to contribute their views to staff appraisals. All staff are asked to reflect on what they have tried, what they have learnt, what they are pleased about and whether they have any concerns. We then agree what actions need to be taken from all the information gathered.	

Tick one box ✓

5	Team members get positive feedback about their work, and have annual appraisals and individual development plans. Annual appraisals include feedback from people supported and their families, about what is working and not working about the support they receive. If the worker is part of a self-organising team, feedback is also gathered from the team and the Community Circle. This informs goals for the following year and is central to the individual development plan.	

25 Meetings are positive and productive (must achieve 4 or above)

1	We have occasional team meetings, but not everyone attends or contributes.	
2	There are frequent team meetings. I set the agenda and chair the meeting. There is little structure to the meetings and they are not as well attended as they could be.	
3	I schedule regular team meetings. The meeting tends to be an information-giving forum and does not often include problem solving or celebrating successes.	
4	We have regular structured team meetings which are documented. Actions are agreed, recorded and followed up. They are well attended and most people contribute.	
5	Our team has regular, productive team meetings that are opportunities to hear everyone's views and contributions. Team meetings include sharing what is going well and problem solving (for example, practicing using person-centred thinking tools to solve problems). Outside of formal meetings, people are encouraged to use peer support (for example, practice groups and action learning sets).	

Action plan

On the following page, we have included an action plan. You can use your score to plan your next steps. Look at each section and what the next statement suggests you may want to work towards. You can use this to record what you are going to do to achieve this, who will be responsible for this, and when you want this to be achieved.

Summary of actions

To achieve Bronze	What we want to work towards (the next statement in the section)
1 We see and treat the person as an individual, with dignity and respect. What we appreciate about the person is recorded on their one-page profile	
2 We understand and respect the person's life history which is gathered in first 6 weeks in Wellbeing Teams	
3 We know and act on what matters to the person	
4 We know and respond to how the person communicates	
5 We support individuals to be in the best possible physical health and to remain as independent as possible	
6 Staff know what is important to each other and how to support each other	
7 Family members have good information	
8 Staff know what is expected of them	
9 We know what is working and not working for the person, and we are changing what is not working	
10 We know and act on what the person wants in the future (outcomes)	
To achieve Silver	
11 The person is supported to make choices and decisions every day	
12 Families contribute their knowledge and expertise	
13 We have knowledge, skills and understanding of person-centred practices	
14 Our team has a clear purpose	
15 Staff feel that their opinions matter	
To achieve Gold	
16 We support people to initiate and maintain friendships and relationships and to be part of their community and civic life	
17 We have an agreed way of working that reflects our values and there is a person-centred culture of respect and warmth	
18 We support family relationships to continue and develop	
19 Staff are thoughtfully matched to people and rotas are personalised to people who are supported	
20 Recruitment and selection is person-centred	
21 We have a positive, enabling approach to risk	
22 Training and development is matched to staff	
23 How staff are supported, including supervision, is person-centred	
24 Staff have appraisals and individual development plans	
25 Meetings are positive and productive	

What we are going to do (action)	Who will be responsible for this (name)	When this will be achieved (date)

Detailed action plan to achieve Bronze

Top 2 to 3 priorities

Why are these your priorities?

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

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

Detailed action plan to achieve Silver

Top 2 to 3 priorities

Why are these your priorities?

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

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

Detailed action plan to achieve Gold (optional)

Top 2 to 3 priorities

Why are these your priorities?

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

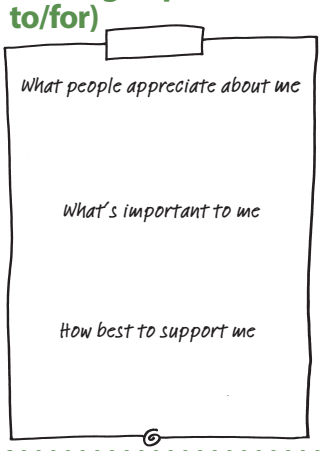
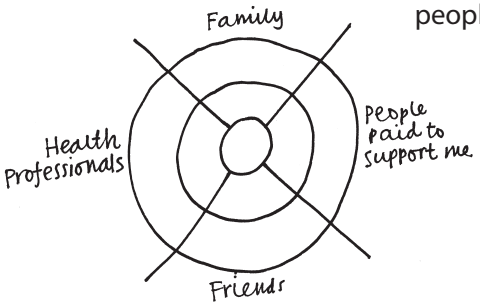
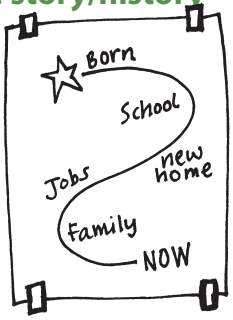
From outside the organisation

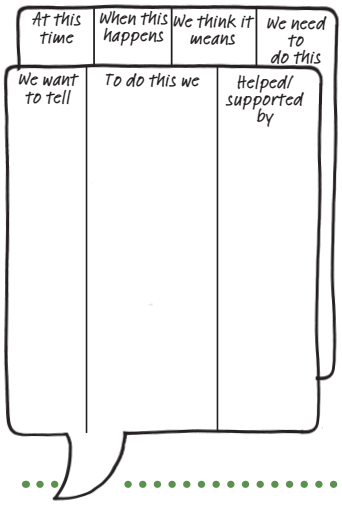
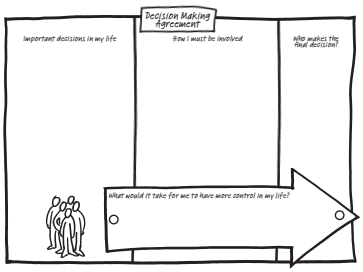
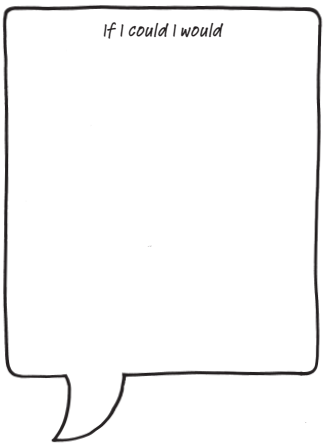
How will I know I have been successful?

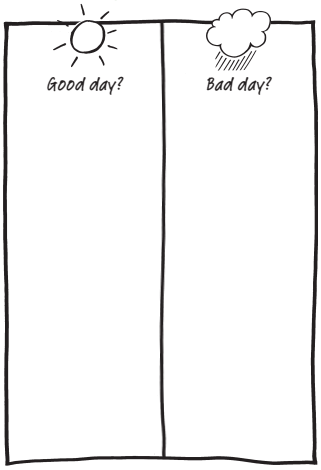
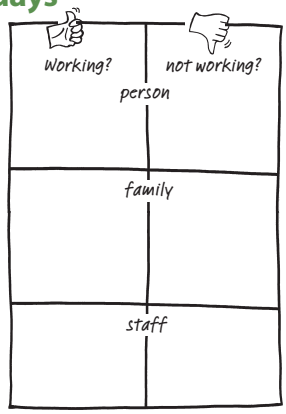
What will have changed? What will you see? What will you feel? What will you hear?

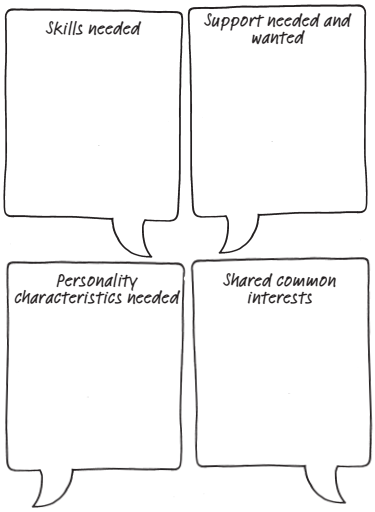
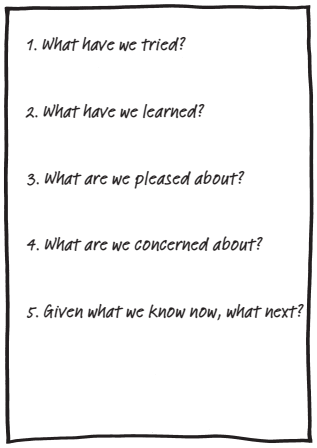
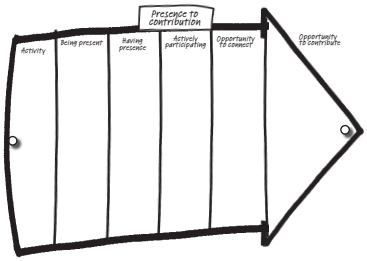
Resources

www.wellbeingteams.org
www.community-circles.co.uk
www.communitybook.org

Person-centred thinking tool	What it does	How this person-centred thinking tool helps
One-page profile (sorting important to/for) 	Separates what is important TO someone (what makes the person happy, content and increases wellbeing) from what is important FOR them (the help or support they need to stay healthy, safe and well) while working towards a balance between the two.	• Identifies what must be present, or absent, in the person's life to ensure they are supported in ways that make sense to them, whilst staying healthy and safe. • A quick summary of who the person is and how to support them for all staff and others. • The basis for making changes using a one-page profile with working/not working.
Appreciations 	Identifies the qualities that people value and admire about the person. Helps supporters to see what makes the person unique.	• Acknowledges and appreciates a person's gifts and qualities. • Ensures we see people for who they are and counters the frequent focus on what is wrong. • Identifies those who have a personal connection with the person and those who really know what is important to them. • Part of a one-page profile.
Relationship circle 	Identifies who the important people are in a person's life.	• Learn who is most important to the person. • Sees if there are any important issues around relationships. • Helps identify who to talk to when gathering information. • Identifies relationships that can be strengthened or supported.
Life story/history 	Our histories make us who we are — with history comes regard. Gives people the opportunity to understand and appreciate the person in the context of their own story.	• Shows us how best to support the person in the context of their past life, which may represent current reality. • Can be used to frame meaningful conversation. • Helps supporters empathise with the person and see their role as ensuring a good quality of life for them.

Person-centred thinking tool	What it does	How this person-centred thinking tool helps
Communication charts 	A quick snapshot of how someone communicates. Important whenever what the person does communicates more clearly than what they say.	• Helps us focus on people's communication, whether they use words to speak or not. • Provides clear information about how to respond to the way the person communicates.
Decision making profile and agreement 	These tools help us to understand how much power, choice and control someone has over decisions in their life. The decision-making profile creates a clear picture about how a person makes decisions and how they want to be supported in decision making. It describes how to provide information in a way that makes sense to that person; this could be how they want you to structure your language, or whether they want written words, symbols, pictures or perhaps an audio format.	• Enables people to be in control and to make decisions at the end of their life. Helps us to think about decision making and increasing the number and significance of decisions people make. • The Mental Capacity Act requires us to take all practical steps possible to enable a person to make their own decisions. • A decision-making agreement can be used to make clear how to involve someone in important decisions in their life. Can inform best interest decision making and advance decision making.
If I could, I would 	Gives people an opportunity to think about how they would explore their aspirations in terms of what they would like to do, achieve or experience.	• Contributes to developing outcomes with the person.

Person-centred thinking tool	What it does	How this person-centred thinking tool helps
Working/not working  	Analyses an issue or situation across different perspectives. Provides a picture of how things are right now, and how this compares with the way people want to live and be supported. Enables us to reflect on what is actually happening in someone's life and to change what needs to be changed.	• Clarifies what to build on (maintain or enhance) and what to change. • Helps in looking at how any part of a person's life is working, people providing paid support are doing in their work, any effort, activity or project is working. • Helps with mediation where there are disagreements. • Use to create actions from a one-page profile.
Good days and bad days  	Explores what makes a good day and what makes a bad day. Enables the person and their supporters to make changes which will result in more good days. Helps us explore what the information we capture reflects about what is important to someone and how best to support them from their perspective.	• We see what needs to be present and what needs to be absent in someone's life. • Provides information to someone who may not know the person well. • Gives us ideas for ensuring that lots of good moments and experiences that lift a person's spirit are present on a daily basis. • Provides information for a one-page profile.
Learning log Date | What did the person do? | Who was there? | What did you learn about what worked well? | What did you learn about what didn't work?	Directs people to look for ongoing learning through recording specific activities and experiences.	• Provides a way for people to record ongoing learning (focused on what worked well and what didn't work well) for any event or activity. • Tells us what is important to and for individuals and families. • Can replace traditional notes or records to help us see the importance of moving away from focusing on getting tasks done, to truly supporting people to have a good life based on our continual listening and learning. • Can be used to focus on someone's whole life or specific areas of their life, e.g. someone's health or how someone likes to spend their time.

Person-centred thinking tool	What it does	How this person-centred thinking tool helps
Matching support 	Provides a structure to look at what skills, supports, personality characteristics and shared interests make for good matches.	• Encourages the person, and those around them, to think about what kind of paid support they want and need when recruiting team members. • Ensures that the person likes the people who are supporting them, making it more likely they will have a good quality of life.
4 plus 1 questions 	Helps people focus on what they are learning from their efforts. Given this learning, what needs to happen next?	• Gives a structured way for everyone to be listened to and describe what they have learned. • Useful in review meetings and individual work with families. • To review actions from plans and plan further actions.
Presence to contribution 	Encourages creative thinking about activities and how we can use them as opportunities for participation and contribution. Identifies activities that the person is already, or wishes to be, involved in.	• Promotes being included, living life to the full, doing interesting things and making a contribution as a full member of the community.