care inspectorate

GUIDE FOR PROVIDERS ON PERSONAL PLANNING

CHILDREN AND YOUNG PEOPLE

GUIDE 2:
Children and
young people

Contents

Introduction

There is a growing commitment to shift from input health and social care systems to a system that will focus on personal outcomes for people who experience care. This means services have to record and measure '**what matters**' to a person in order to demonstrate how they are meeting their personal outcomes.

The aim of this guide is to support staff in services to develop personal plans for children, young people and adults. These have been developed collaboratively by colleagues within the early learning and childcare, children and young people, and adults inspection teams. National policy, legislation, evidence-based practice and real-life examples of people experiencing care have underpinned the development of the guides.

This guide is for managers and their staff to help improve how personal planning is undertaken. It will help inspectors to evaluate personal plans in a more consistent way during scrutiny and improvement work.

What is a personal plan?

The Health and Social Care Standards (HSCS) set out what we should expect when using health, social care or social work services in Scotland. During the development and consultation phase of the Health and Social Care Standards, 87% of respondents agreed that the standards described what people should expect to experience.

The standards apply across all health and social care services. They describe what people, irrespective of age or ability, should experience when using a care service, as we are all entitled to the same high-quality care and support.

The standards define a personal plan as:

'A plan of how care and support will be provided, as agreed in writing between an individual and the service provider. The plan will set out how an individual's assessed needs will be met, as well as their wishes and choices'

You can find relevant standards about personal planning referred to throughout this guidance.

Health and Social Care Standard

1.15 My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices.

The key message to consider is how effective personal planning enhances the quality of daily life for people experiencing care.

What are the key principles?

The guide supports the development of personal plan approaches. These contribute to improving people's experiences by making sure the plan facilitates high quality, safe and compassionate care. Planned care and support should promote people's rights, choices and individual needs and wishes. It does this through key principles of being included, promoting positive outcomes and defining the personal planning approach through learning for improvement.

Being included: Personal planning involves listening carefully to people experiencing care and having good conversations, including others that may be important, for instance families and carers. This involvement helps to promote people's rights, needs and choices through a clear and accessible written and visual plan. The plan should demonstrate people's needs, preferences, strengths, wishes and what matters to them, if possible, with a shared understanding between the person and others who may be relevant. There are many benefits to having an effective personal plan, which include:

- valuable information sharing
- consistency of approach across staff teams
- an underpinning assessment of need and risk
- a resulting informed assessment about required staffing arrangements.

Promoting positive outcomes: Personal planning can support the development of personal outcomes over time. It is crucial that this is done within the context of relationships and good conversations with people experiencing care as these can be critical in promoting a sense of identity, establishing hope, and enabling people who experience care to actively shape their own support. Recording this and demonstrating when outcomes have been met can promote increased health, wellbeing, and self-esteem. The quality of these recordings, and the language used within them, can be measured through quality assurance.

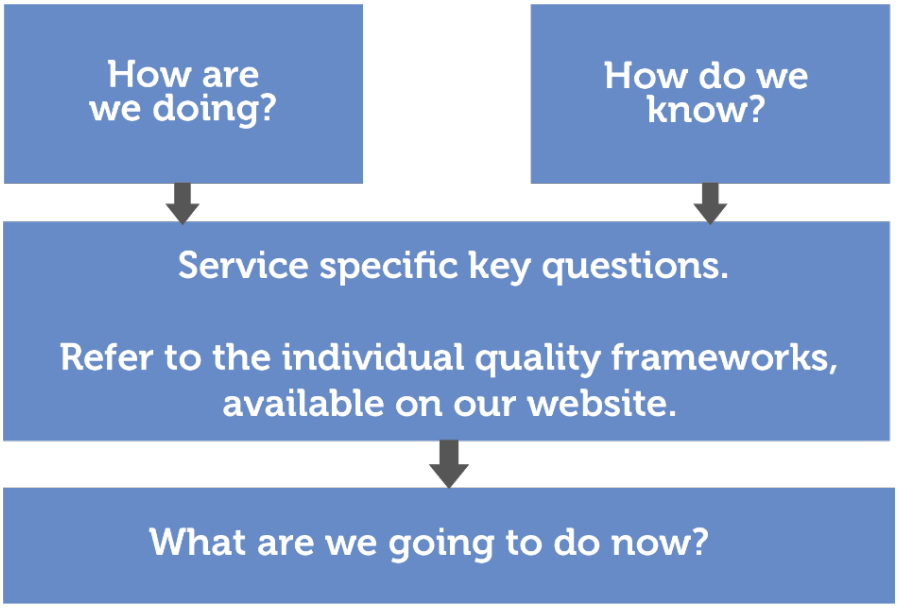
Learning for improvement: Personal planning requires a high level of skill and total commitment from everyone involved, especially staff. It can be useful to consider this as part of individuals' ongoing learning and development needs.

Self-evaluation

It is important to remember that whilst we have a role to support improvement, the primary responsibility for improving services lies with the organisations that provide them. We recognise that external scrutiny can also be a catalyst for improvement where it influences behaviour and culture of providers, leading to improvements in the way that services are delivered.

The quality frameworks have a primary purpose to support staff in services to self-evaluate their performance. The same framework is used by inspectors to evaluate outcomes for people. These evaluations provide independent assurance about the quality of care and support that people experience.

Self-evaluation is a core part of assuring quality and supporting improvement. The process of self-evaluation, as part of wider quality assurance approaches, requires a cycle of activity based round answering three questions:



How are we doing? This is the key to knowing whether you are doing the right things and that, as result, people are experiencing high quality, safe and compassionate care and support that meets their needs, rights and choices.

How do we know? Answering the question 'how we are doing' must be done based on robust evidence. The quality indicators, along with the views of people experiencing care and support and their carers can help you to evaluate how you are doing. You should also take into account performance data collected nationally or by your service.

What are we going to do now? Understanding how well your service is performing should help you see what is working well and what needs to be improved. From that, you should be able to develop plans for improvement based on effective practice, guidance, research, testing, and available improvement support.

What about GDPR?

With regard to personal plans and the requirements under GDPR we cannot give specific guidance in relation to records management. Decisions about providers' processing of personal data and document retention should be agreed at the highest level within your own organisation.

The National Records of Scotland have published a helpful guide on record keeping, which includes useful links. The National Archives also publish records management guidance on their website, which may assist when implementing internal records management processes.

If you are uncertain about setting up records management processes and implementing retention or destruction schedules, we advise that you seek legal advice, especially prior to the destruction of any records.

As a regulatory body we can advise what records will be scrutinised as part of our inspection process. We provide information about this on our website.

The Information Commissioner's Office also publishes a range of helpful toolkits for organisations. These will assist with managing the processing of personal data. This is available on their website.

What does the legislation say?

In accordance with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 2011/210, Regulation 5: Personal Plans, every person attending a registered service must have a personal plan within 28 days of them starting to use the service.

This includes people who attend services on an infrequent or irregular basis. People experiencing care and their families or representatives cannot opt out of having a personal plan.

Personal planning for children and young people

Getting it right for every child (GIRFEC)'s aim is for the consistent application of assessment of children across Scotland:

> 'Any child or young person who requires additional support should have a plan to address their needs and improve their wellbeing, summarised using the Wellbeing Indicators and My World Triangle'.

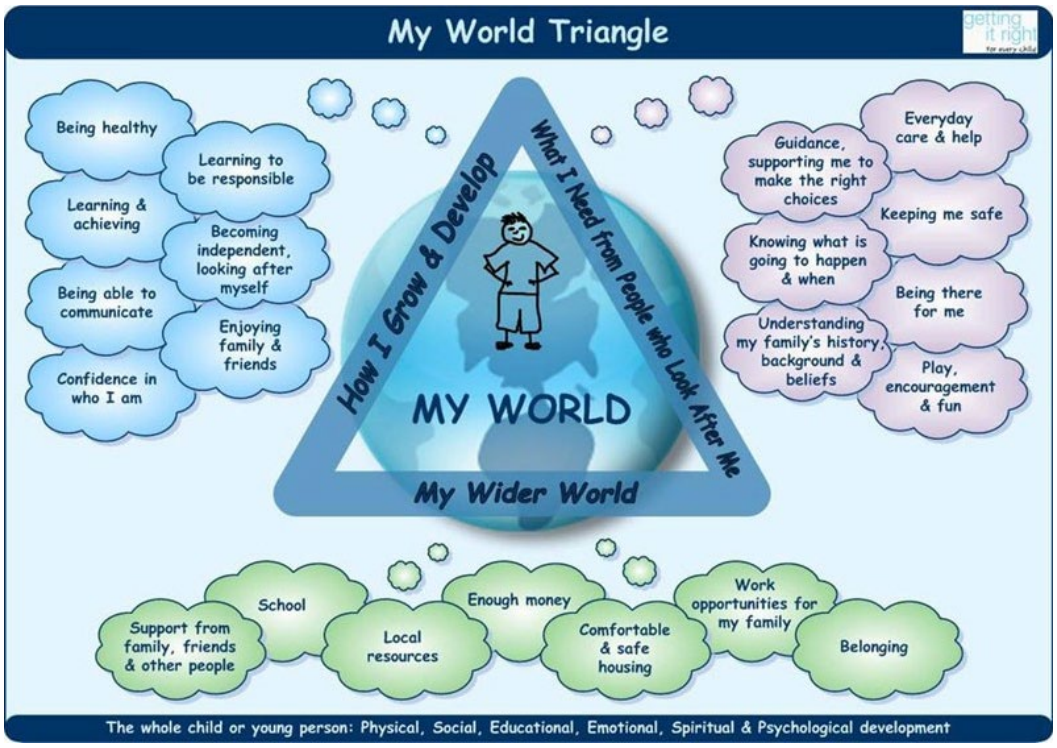


Image https://www.gov.scot/publications/shanarri/

This is called a 'child's plan' and is the responsibility of the placing authority. The child's plan should incorporate other plans, for instance, a care plan for a child looked after by the local authority. This guidance will focus on personal plans for children who are looked after or in receipt of:

- continuing care
- accessing support services
- residing in residential schools, boarding schools or school hostels.

These are also sometimes called care plans. Where a child's plan is in place, the personal plans should 'flow' from this.

GIRFEC is underpinned by the:

- United Nations Convention on the Rights of the Child (1989)
- Children's Charter
- Children and Young People (Scotland) Act 2014.

It is also founded on the aims defined in 'For Scotland's children' and 'It's everyone's job to make sure I'm alright'.

'A plan that's set-in place to help benefit your future.'

Records that all registered care services (except childminding) must keep and guidance on notification reporting also sets out some expectations around information that would normally be held in a personal plan. This will be explored in section 2.3.

The quality illustration of very good personal planning in our quality framework for care homes for children and young people and schoolcare accommodation (special residential schools) is:

> 'Children and young people lead positive, healthy, enjoyable and meaningful lives through the implementation of high quality, SMART, care planning strategies. These are underpinned by robust assessment of need and risk. They benefit from a dynamic and aspirational approach which consistently informs all aspects of care and support. The service actively seeks and enables multi-agency involvement in the planning process.'

The quality illustration of very good personal planning in our quality framework for care homes for mainstream boarding schools and school hostels is:

> 'Children and young people lead positive, healthy, enjoyable and meaningful lives through the implementation of high quality, SMART and proportionate care planning strategies based on GIRFEC principles. Their personal plans are regularly reviewed and amended in accordance with their changing needs, circumstances and desired outcomes.'

The quality illustration of very good personal planning in our quality framework for support services (not care at home) is:

> 'People and, where relevant, their families, are fully involved in developing their personal plans. People benefit from personal plans that are regularly reviewed, evaluated and updated involving relevant professionals (including independent advocacy) and take account of good practice and their own individual preferences and wishes. There is a range of methods used to ensure that people are able to lead and direct the development and review of their personal plans in a meaningful way.'

The Independent Care Review (Feb 2020) highlights the importance of listening to children and young people's voices in respect of:

- decision making and care planning
- developing and sustaining relationships
- avoiding duplication in paperwork.

All of these areas are of key relevance to the way the personal plans are designed and executed.

In 2019-2020 we made 15 requirements and 91 recommendations regarding personal planning in care homes for children and young people.

In the eight joint inspections for children and young people in need of care and protection carried out between 2018 and 2020, we found that around three quarters of the 712 children and young people who completed our surveys had been involved in agreeing their plan and two thirds had the things they wanted included in their plan. While it was encouraging to hear the majority had been involved in agreeing and contributing to their plans, further improvement is necessary to ensure that all children and young people are fully involved in developing their plans.

In our publication, 'Review of findings of joint inspections of services for children and young people 2018- 2020' we reported that improvements had been made to the quality of plans since the previous round of joint inspections of children's services. However, there remained room for improvement in the quality of plans. In the eight joint inspections over the period, we rated the quality of plans as adequate or below adequate in nearly a quarter of the 754 files that we read.

This guide contains feedback gathered during focus groups held between March and May 2019 with:

- young people
- group coordinators
- councillors
- lead young people (older care experienced young people employed by councils)
- young inspection volunteers
- residential school staff
- our inspectors from the children and young people teams.

Approximately 120 people were consulted in total. Quotes from young people who were consulted with are included throughout this document.

Being included

Personal planning involves listening carefully and have good conversations with young people who experience care, and to include others who are important such as families and cares. This involvement helps to promote young people's rights, needs and choices through a clear, accessible written and visual plan.

The plan should demonstrate young people's needs, preferences, strengths, and what matters to them, if possible, with a shared understanding between the person and relevant others. There are many benefits to having an effective personal plan which include:

- valuable information sharing
- consistency of approach across staff teams
- an underpinning assessment of need and risk
- an informed assessment about required staffing arrangements.

Based on assessment

'Why the past, not the future?'

Personal plans should 'flow' from the child's plan (see section 1). They should be based on an assessment of a young persons' history and chronology by:

- gathering and making sense of information
- considering family, peers and environmental impact on child's development
- taking a holistic approach with account of physical, psychological, sociological, and environmental factors
- previous support and intervention offered and the response to this
- measuring the child's behaviour and development against that which is neurotypical.

Health and Social Care Standards

1.13 I am assessed by a qualified person, who involves other people and professionals as required.

This provides a holistic, baseline assessment, allows us to try to understand what is going on, identify need and risk for the young person and formulate an on-going plan.

Example: Muirfield Place (Mungo Foundation)

Muirfield Place (Mungo Foundation) is a care home service for children and young people based in Kilwinning. It uses well-constructed and logically arranged personal plans which provide ease of access to the most important information relating to young people's needs, should it be required urgently, including a profile and a strong front page containing key information. The plans are rights based, evaluative, and make use of visuals to support young people's understanding. Links between families and social workers promotes participation and inclusion in young people's assessments to ensure accurate information informs care plans.

Dimensions of children's development needs include:

- safety and behavioural development
- health and emotional development
- activity and social presentation
- nurture including family and social relationships
- achievements and education
- respect and identity, ethnicity, cultural and spiritual growth
- responsibility and self-care skills
- inclusion.

The plan should provide an analysis which takes appropriate account of up-to-date knowledge, theory, and research.

These should address each of the young person's needs, and ensure that for each of these, it identifies the desired outcome and, as specifically as possible, how these are intended to be met.

Health and Social Care Standard

4.27 I experience high quality care and support because people have the necessary information and resources.

Personal plans should show an understanding and a balance of risk management, including how protective factors are likely to reduce or mitigate risk. They may also assess future potential risks when approaching transitions or changes, for example:

- when permanency is being considered
- when approaching adulthood
- when transitioning schools or care settings.

However there would still be an expectation that separate risk assessments are completed for each young person.

For more information see:

- Centre for Youth and Criminal Justice - A Guide to Youth Justice in Scotland: policy, practice and legislation
- Institute for Research and Innovation in Social Service - On Risk
- Scottish Government - Framework for Risk Assessment Management and Evaluation (FRAME) for Local Authorities and partners – incorporating Care and Risk Management Guidance.

Example: Rowantree House

Rowantree House, Balivanich, is a short break care home service for children and young people based in Uist. The service has integrated the relevant Health and Social Care Standards with associated visuals into young people's personal plans. Young people's families are fully involved in collating and creating plans that incorporate individual risk assessments and behaviour management plans to ensure that young people are kept safe.

Health and Social Care Standard

1.14 My future care and support needs are anticipated as part of my assessment.

There is an expectation that information gathering and assessment will take place at pre-admission stage to ensure that the service can meet the young person's identified needs, as detailed in our guidance document 'Matching Looked After Children and Young People: Admissions Guidance for Residential Services'. Personal plans should be further informed by ongoing assessment once the young person has moved in.

User friendly design

Services should ensure that all documentation that evidences statutory obligations, such as reviews, is available to all young people. They need to be relevant to young people, in language and format they can understand and that makes sense.

'When diversity is used, it makes it better for everyone.'

The front page of the personal plan is extremely important to set the right tone. It should be child friendly, appealing and inviting, with more graphics and less writing, for instance a profile page with a picture of the young person, age, likes.

Health and Social Care Standard

1.9 I am recognised as an expert in my own experiences, needs and wishes.

Example: The Mallard, CrossReach

The Mallard, CrossReach, is a short-break service for children, young people and their families based in Glasgow. It uses visuals and nurturing language to present each young person as a fully rounded person in their personal plans including areas like:

- what makes me happy
- what people appreciate about me
- bedtime routines
- profile page.

Personal plans should be well structured and organised, laid out in a simple way, and not overly lengthy. You should use language and terminology which is easy to read and follow, use plain language instead of jargon and, where possible, be understood by the person the plan describes.

'What is written in the personal plan, makes the young person sound horrid'

However, plans also need to be thorough and detailed enough to support professionals to meet and promote the person's needs, and support protecting them from risk of harm.

They should be asset based, focused on achievements, ambitions, positives and celebrating success, rather than deficit based, and contain no more information than is necessary. They should clearly state the unique personality, talents, and interests of the young person and set out how the adults will support them to develop these further. It is important to use sensitive language which does not stigmatise the young person, whilst still being honest. The language should not be patronising, professional or formal, or focused purely on negatives. Staff should consider if the young person would be okay reading about themselves in this way.

Example: Youth Activity Programme Scotland

Youth Activity Programme Scotland is a programme by the National Deaf Children's Society, based in Glasgow. They provide a support service for children and young people, and they aim for their personal plans to be child centred. The front page starts with a photo of the young person, followed by an opportunity for the young person to describe themselves in three words and detail their likes, dislikes, and hobbies.

Young people are also encouraged to share information about themselves by sending in photos, videos, stories, or any other format of information they would like.

Out-of-date information should not be included in personal plans. However, what should and should not be included depends primarily on what information staff need to see, as well as what young people want to be included.

Personal plans should be visually appealing, bright and colourful. However, the layout, design and structure of the plan should be carefully considered to meet the needs and preferences of the young person.

Health and Social Care Standard

1.23 My needs, as agreed in my personal plan, are fully met, and my wishes and choices are respected.

Young people may want to be involved in the design and personalisation their own plans and how their information is recorded using different styles and using their creative strengths and talents. This might be through co-creating or choosing to set this information out in:

- photograph albums
- social stories
- floor books
- folders or boxes
- a digital or electronic format where they have been involved in the design.

'Make them a game'

Personal plans should include good quality graphics and images for instance:

- photographs to explain the writing
- visuals to show likes and dislikes
- emojis to scale outcomes
- decorative borders of cartoon characters
- whatever is most relevant to the young person.

Example: Blairvadach Residential Home

Blairvadach Residential Home is a care home service for children and young people based in Helensburgh. They use a bright and appealing design and layout for their personal plans, including bubble boxes and their wellbeing web.

This enhances the quality and quantity of young people's participation in their plans and allows them to take pride in their progress.

For young people with communication differences, it may be helpful to link to a communication passport such as My Communication Passport. Consider alternative formats such as braille, audio, sign recorded video, or use the young person's first language if this is not English.

GIRFEC wellbeing indicators

The GIRFEC wellbeing indicators represent eight areas, often referred to as SHANARRI.

- Safe
- Healthy
- Active
- Nurtured
- Achieving
- Respected
- Responsible
- Included

'Why does it always have to be about SHANARRI?'

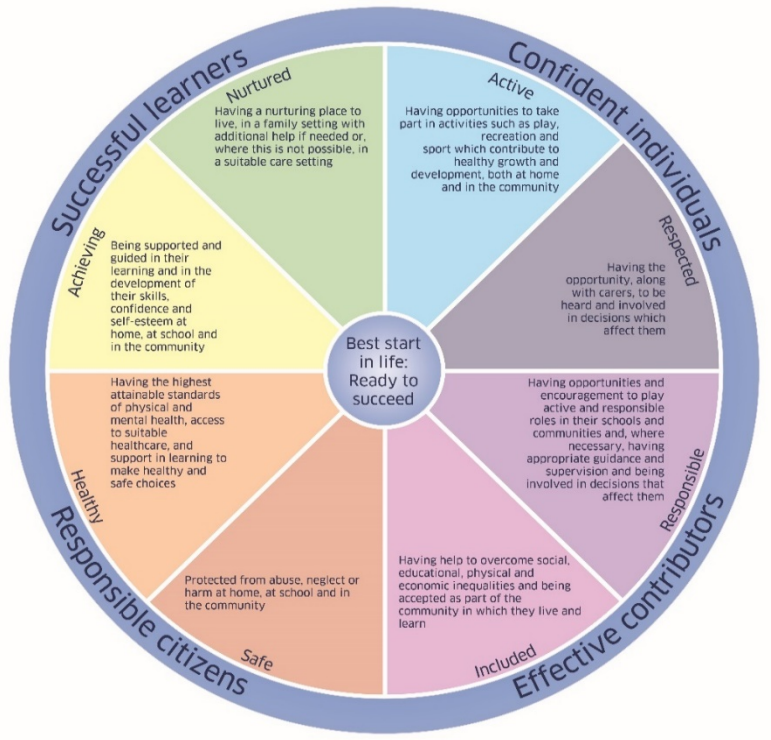


Image supplied by: https://www.gov.scot/publications/shanarri/

Health and Social Care Standard

1.15 My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices.

Example: Glenlee

Glenlee is a care home service for children and young people, provided by Care Visions, based in Govan, Glasgow.

They follow highly individualised personal plans which embrace a holistic view of young people using the GIRFEC wellbeing indicators.

The indicators can be used to identify needs and risks, describe what needs to change to improve the child or young person's wellbeing and to structure information recorded about a child and identify expected outcomes. However this must be done in a meaningful way, which is proportionate to the young person's needs, reflects a culture of nurture and presents the young person as a fully rounded person.

In a personal plan, this may include:

Safe - level of staff supervision, link to behaviour support plan, link to risk assessments, support required to travel safely.

Healthy – disabilities, medical conditions, seizure management plan, link to risk assessments, health requirements, sensory issues, physical, sexual, mental, dental health needs, medication, allergies, dietary requirements, feeding routines and level of support required, food and drink preferences, immunisation history.

Achieving – targets and aims, strategies to achieve these, success criteria.

Nurtured – important people, relevant professionals, memorable dates, contact details, family contact arrangements.

Active – hobbies, interests, favourite activities and outings, likes and dislikes, phobias and comforts.

Respected – identity, sexuality, religion and practices, fears and anxieties, specific needs relating to disability, for instance, autism spectrum condition, appropriate consents.

Responsible – ability to make choices, level of support required with independence and self-care skills, for instance, dressing, washing, teeth brushing.

Included – communication preferences, advocacy arrangements, daily routines for instance, bedtime.

Health and Social Care Standard

3.11 I know who provides my care and support on a day to day basis and what they are expected to do. If possible, I can have a say on who provides my care and support.

Example: Broomfield Crescent Residential Children's Unit

Broomfield Crescent Residential Children's Unit is a care home service for children and young people based in Balornock, Glasgow. They have structured their personal plans around the GIRFEC wellbeing indicators.

Young people are fully involved in developing their own plans. Staff work with them to review their progress towards identified outcomes through completing the assessment tool 'The Wellbeing Web'. Plans use coloured speech bubbles to display the words the young person has actually said in relation to each indicator, along with further speech bubbles entitled 'How can we make things better?', 'Who will help make things better?', and 'Desired outcomes and timescales.'

Our guidance 'Records that all registered care services (except childminding) must keep and guidance on notification reporting' also sets out some expectations around information that would normally be held in a personal plan. This includes:

- the person's name, address, and date of birth.
- the date the person started using the service.
- Next of kin of, or of any person authorised to act or consent for, the person using the service, including their name, address, telephone number and email address. If necessary, include details of their relationship with the person using the service and, where the person has an active power of attorney, type of relationship, for example, welfare or financial guardians.
- The name and address of the person's general practitioner.

Promoting positive outcomes

Personal planning supports the development of personal outcomes over time. It is crucial this is done within the context of relationships and good conversations as these can be critical in promoting a sense of identity, establishing hope, and enabling young people experiencing care to actively shape their own support. Recording and demonstrating when outcomes have been met, can promote increased health, wellbeing, and self-esteem. The quality of these recordings, and use of language within them, can be measured through quality assurance.

Outcome focused

'Personal goals, not social works' goals for me.'

Personal plans must address the young person's needs as identified in the child's plan. It should address these in some detail, indicating both the desired outcomes and the tasks agreed to achieve those outcomes. The delivery of quality day-to-day experiences is essential in driving the desired outcomes. It can be helpful to think about this in terms of three types of objective:

- Outcome objectives - in simple terms, what should the outcome look like?
- Task objectives - what needs to be done, how, who by, where and when?
- Resource objectives - what resources are needed to achieve this? For instance, staffing, staff skills, access to suitable education, psychological support, physical amenities.

Educating through Care Scotland describes outcomes as: 'The changes that happen for children / young people, their families, and carers, as a result of a service's interventions and their engagement with them, (for example, the impact, benefit, progress, or learning).'

Outcomes can help us to identify the needs of young people, increase clarity and focus on the work carried out with young people and help us to evaluate the effectiveness of the approaches and interventions we use. They can inform practice and generate reflective discussions about young people's progress. They allow us to capture progress, and prove we are making a difference to their lives.

Outcomes can provide important information for quality assurance purposes, promote relationships with commissioners and funders, and provide essential quantitative and qualitative data for future strategic commissioning of services. In school care accommodation services outcomes can support with setting joint targets, promoting the 24-hour curriculum, and enhancing communication through key teams.

The Institute for Research and Innovation in Social Services (IRISS) publication 'Leading for Outcomes: Children and Young People' describe outcomes as 'the answer to the question, 'So what difference does it make?'

There are a number of outcome frameworks available. It is of benefit for services to employ a model which is child and young person focused, and which can be used in partnership with local authorities, young people and families. A practical and tangible model can help to promote inter-disciplinary practice and reflection, and enable greater collective understanding of young people's needs, as well as effective approaches or interventions.

Health and Social Care Standard

4.14 My care and support is provided in a planned and safe way, including if there is an emergency or unexpected event

Some outcomes frameworks provide a bank of outcomes. Where this is the case, they can be adapted to ensure they are fit for purpose. Other aspects worth considering are how the outcomes link to the values of the organisation, the GIRFEC wellbeing indicators (see section 3.3), the Health and Social Care Standards, and if relevant, the Curriculum for Excellence's Four Capacities, and how they will be reported on to a variety of stakeholders.

Example: Bachlaw Intesive Support Unit

Bachlaw Intensive Support Unit is a care home service for children and young people based in Banff. They use highly individualised and outcome focussed personal plans which are regularly reviewed. Plans detail how young people are supported to achieve their goals and they include strategies to minimise any identified risk. Targets are updated to ensure they remain relevant and focussed, with all staff being a part of ongoing discussions to ensure the support provided is meaningful and consistent, and focussed on young people doing well.

Clear short and long-term goals, specific to age and ability, should be in place for each young person. These might include young people's hopes, dreams, and ambitions. A short-term goal may cover a six-month period but should be broken down further into smaller step-by-step tasks to promote achievement, possibly with weekly goals. For example, older young people may be keen to develop life skills such as budgeting, washing clothes and cooking. Outcomes should be both realistic and aspirational, while being highly individualised.

'You are the one raising me so should be teaching me!'

Example: Tremenna

Tremanna, a care home service for children and young people based in Falkirk, uses SMART goals that are individualised and meaningful to young people, with progress towards the desired goal regularly recorded and monitored. These outcomes focused personal plans underpin the commitment to support young people to progress and achieve personal goals such as:

- returning to education
- gaining qualifications
- accessing apprenticeships
- learning to drive and achieving driving certification
- engaging in skills for work programmes
- gaining employment.

Services should ensure that systems are in place to evaluate progress for all young people and these result in next steps, changes to strategy, and follow through. Progress may be tracked, for instance, symbolically or numerically, and the information gathered used for future goal setting. This would include establishing a baseline at the start of the goal setting, with regular review. Supporting evidence should be gathered throughout the period of the goal, to provide triangulation. Achievements should be recognised, and strengths or areas that young people do not require support with noted.

'You get promised so much but most of the time it isn't followed through.'

SMART principles can be used when tracking progress in achieving outcomes and used to guide setting objectives. Traditionally SMART outcomes have been classified according to the first set of definitions provided below. However, various alternatives are used and the definitions highlighted have been found to be more compatible with a personal outcomes approach and are consistent with the ethos of appreciative inquiry, and more relational approaches to care and support.

- **S** - Specific (or **Significant**)
- **M** - Measurable (or **Meaningful**)
- **A** - Attainable (or **Action-oriented**)
- **R** - Relevant (or **Rewarding**)
- **T** - Time-bound (or **Trackable**)

Reviewing in collaboration

'Advocacy should be given.'

The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 2011/210, Regulation 5(1) Personal Plans is a regulation to ensure that each person using a service has a written plan within 28 days or one month of starting to use the service, which sets out how the person's health, welfare and safety needs are to be met. Young people should be involved in the creation of the personal plan from the onset of the placement, or even before if it is a planned placement.

Services should ensure that, whenever possible, young people, parents, carers and all relevant professionals are involved in personal planning. Personal plans should be regularly reviewed and amended in accordance with young people's changing needs and circumstances. Information should be available on who will assist a young person with this, and clarify what their role will be.

Children and young people must be at the heart of plans for their care and support and are enabled to lead and direct their development, dependant on their age and stage of development. Their personal plans should clearly detail what matters to them.

Health and Social Care Standard

1.12 I am fully involved in assessing my emotional, psychological, social and physical needs at an early stage, regularly and when my needs change.

Key areas covered by the quality framework for care homes for children and young people and schoolcare accommodation (special residential schools) quality indicator 5.1 'Assessment and care planning reflects children and young people's needs and wishes', include the extent to which:

- the service uses personal plans to deliver care and support effectively
- personal plans are reviewed and updated regularly and as children and young people's circumstances, needs and desired outcomes change
- children and young people are involved in directing and leading their own care and support.

The voice of the young person must be heard throughout every personal plan, however this does not necessarily mean they should be written in the first person. If the young person is unable or unwilling to engage in their personal plan, steps must be taken to include the voices of those who know the young person best.

Example: Riggheads

Riggheads, a Care Visions care home service for children and young people based in Lockerbie, uses creative methods to involve young people in their personal plans.

Relationships with key workers and members of key teams are vital. A key worker must be identified for helping to complete and develop every plan. The worker and young person should have protected time in order to discuss and edit the plans, and to answer any questions the young person may have. A good relationship between the person drawing up the plan and the person who is the subject of the plan allows a clear exchange of information and the highest levels of honesty about the plan's content.

The personal plan should be seen as a dynamic and live document that organically grows with the young person. It should be frequently reviewed with young people on agreed and realistic dates for both staff and young people to ensure their views and wishes inform decisions; an ongoing appropriate assessment of need and risk; relevance to changing circumstances and the development of the young person; and to support children to feel proud of themselves as they change and grow. It must be reviewed at least once every six months but can be reviewed more frequently e.g. if there is a change to the young person's needs, or if the young person or someone acting on their behalf requests for it to be reviewed.

Space should be included in personal plans for young people to include their views and give feedback. There should be space available not just for the young person's guardians to sign agreement and understanding, but also the young person actually using the service.

Example: East Park

East Park is a schoolcare accommodation service and care home service for children and young people based in Maryhill, Glasgow. They recognise that in supporting young people with learning disabilities and autism spectrum disorder, robust data not only provides evidence to parents, service commissioners and to the young person themselves about their progress and achievement but, it is also integral to the development, monitoring and reviewing of an effective and successful personal plan.

To support in this process, they use a behaviour analysis tool which identifies trends in a young person's behaviour, providing an easily understood visual representation of the frequency of the behaviour and the potential causal factors / antecedents. This information helps them to consider significant setting events and to understand the function of the behaviour for the young person. This data guides the development of the individualised behaviour support plan. The trend graph ultimately provides a longitudinal view of the young person's progress over time. Their personal plan is explicitly underpinned by the GIRFEC wellbeing indicators.

It is a bright, colourful document which provides key information for and about the young person, including clear guidance on behaviour support strategies to support all staff to respond to the young person with a consistent approach. It is developed with the young person and their key family members and very much owned by them.

Accessibility and monitoring

'I am a person, not paperwork.'

There are a variety of technological solutions available which can support services with recording and monitoring the progress of personal plans. For example, these systems may be able to record previously achieved outcomes so that progress is tracked over time, or issue a reminder when plans are due for review. They also support to keep the personal plan as a live document, as it can be updated as often a required.

There should be an opportunity for the person, who is the subject of the plan, to have a copy of it in a format they choose. Young people have told us they prefer to access their personal plans electronically, for instance from their mobile phone. This allows them to look at it when it suits them and when they have ideas. They may also prefer their plan to be emailed so they can comment and to respond in this way rather than face to face which can sometimes be too difficult for some young people.

Example: Moore House

Moore House, a range of care home services for children and young people located in the central belt of Scotland, use personal plans which are meaningful, live documents, with daily and weekly plans which staff are confident to use.

Through reviewing plans against the GIRFEC wellbeing indicators, progress is identified for each young person, as well as areas where more support is needed. These areas are worked through with the young person's keyworker, or through direct support, and strategies are identified to help young people make positive choices.

Safeguarding young people is the top priority when it comes to ownership of plans. Young people should always have the option to physically own a copy of their plans, but this requires careful discussion from staff. It may be deemed appropriate in some circumstances for it to be the staff's duty to keep the personal plan safe for young people.

Health and Social Care Standard

2.17 I am fully involved in developing and reviewing my personal plan, which is always available to me.

A monthly assessment of staffing needs taking account of young people's physical, social, psychological and recreational needs and choices should inform individual young people's staffing ratios in their personal plans. See our Guidance for providers on the assessment of staffing levels for more information.

Health and Social Care Standard

4.15 I experience stability in my care and support from people who know my needs, choices and wishes, even if there are changes in the service or organisation.

Learning for improvement

Personal planning requires a high level of skill and total commitment from individuals to be able gather as much information from the young person as possible. They need to allow enough time to discuss all the options to be included in the plan. This is particularly important when working with young people who experience communication difficulties. Young people should receive full support to use suitable methods of communication to express their views and preferences, including advocacy. They may be able to express their views creatively using drawing or modelling for examples.

Example: Balnacraig

Balnacraig is a schoolcare accommodation service for children and young people based in Perth. They track monthly goals which are created with young people. Staff are committed to the process, which results in key time discussions, linked to the identified goals and young people achieving significant outcomes. Within each young person's personal plan there is a clear section on their rights. Boundaries and structures are clearly highlighted in the plans and fully discussed with the young person, which aids understanding and implementation.

Health and Social Care Standard

2.6 I am as involved as I can be in agreeing and reviewing any restrictions to my independence, control and choice.

Services should have in place a system for quality-assuring, self-evaluating, and reviewing the effectiveness of personal plans. Our '[Self-evaluation for improvement – your guide]' provides more information about this. Our quality frameworks have also been designed to be used for self-evaluation. These are available on our [website].

Managers must have an oversight and promote a collective ambition to ensure that the whole team, not just the keyworker, commit to the identified outcomes being achieved.

Staff should understand what the aims of the personal plan are. It can be useful to consider this as part of individuals' ongoing learning and development needs and this may be supported by providing training and guidance to staff on

- understanding outcomes
- engagement with young people in writing their plans
- motivational interviewing
- the elements of good plans.

Example: Kibble

Kibble, a national provider of specialist care, education, and training, have developed a guide for staff members to use when completing personal plans.

Learning for improvement toolbox

Further relevant references, which are referred to throughout this guidance document, are detailed in the toolbox below. You may also want to visit the Care Inspectorate Hub which provides lots of information to help skills and knowledge about personal planning. The Hub also has additional links to other resources, such as the Scottish Social Services Council, the Mental Welfare Commission and NHS Education for Scotland.

Toolbox

Bronfenbrenner, U: The ecology of human development. Cambridge, Massachusetts: Harvard University Press.

Records that all registered care services (except childminding) must keep and guidance on notification reporting

Matching Looked After Children and Young People: Admissions Guidance for Residential Services

A quality framework for care homes for children and young people and schoolcare accommodation (special residential schools)

A quality framework for mainstream boarding schools and school hostels

A quality framework for support services (not care at home)

Guidance for providers on the assessment of staffing levels

Self-evaluation for improvement – your guide

A Guide to Youth Justice in Scotland: policy, practice and legislation (Section 3: Theory and Methods).

Child Behaviour Checklist

Children and Young People (Scotland) Act 2014, asp 8:

Daniel, B. Wassell, S. and Gilligan, R: Child Development for Child Care and Child Protection Workers. London: Jessica Kingsley Publishers.

Educating through Care Scotland: EtCS Outcomes Framework Manual

What is Curriculum for Excellence?

My Anticipatory Care Plan

Independent Care Review: The Promise

Information Commissioner's Office: For organisations

Leading for Outcomes: Children and Young People

On Risk

Larzelere, R.E., Daly, D.L., Davis, J.L., Chmelka, M.B., and Handwerk, M.L.: Outcome Evaluation of Girls and Boys Town's Family Home Program. *Education and Treatment of Children,* 27(2), 130-149.

Miller, E. and Cook, A: Recording outcomes: The critical link between engagement and improvement. Edinburgh: Joint Improvement Team.

My Communication Passport

How to manage your information

Model Records Management Plan

Public Services Reform (Scotland) Act 2010, asp 8.

For Scotland's children

It's everyone's job to make sure I'm alright

Protecting Children and Young People: The Charter

Framework for Risk Assessment Management and Evaluation (FRAME) for Local Authorities and partners – incorporating Care and Risk Management Guidance

Health and Social Care Standards: my support, my life

National health and care standards: consultation analysis findings

Getting it right: Child's Plan

Getting it right for every child (GIRFEC): Wellbeing (SHANARRI)

The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 2011/210

Sparrow, S.S., Cicchetti, D.V, and Saulnier , C.A: Vineland-3 Adaptive Behaviour Scales – Third Edition.

United Nations Convention on the Rights of the Child:

Youth in Mind: What is the Strengths and Difficulties Questionnaire?

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- The Young Radicals
- People Achieving Change
- East Lothian Champion Board
- Dundee Champion Board
- East Dunbartonshire Champion Board
- West Dunbartonshire Champion Board
- Falkirk Champion Board
- Argyll and Bute Champion Board
- Fife Champion Board
- Stirling Champion Board
- Linn Moor Residential School.

Glossary

Empowerment	Empowerment involves: • developing a clear action plan to build an organisational culture which embraces the leadership of people who use services, their carers, the community, staff and colleagues at all levels in the organisation • working with colleagues in partner organisations to build collaborative leadership capacity and enable innovation and appropriate risk-taking across organisational boundaries • supporting professional autonomy and leadership from staff and people using the service. For more information visit the SSSC Step into leadership website.
Good conversations	Conversations about what is important to the person experiencing care and support. They are not about asking a set of questions, they are about exploring opportunities, listening, involving and sometimes answering questions. A good conversation helps to make sure people's strengths, assets, wishes, ambitions and needs all inform their personal plan. That way staff know how best to care people so that the quality of their life is enhanced by the care they receive.
Innovative practice	Health and social care practice that includes new and different ways to do things, resulting in better outcomes for people.
Key worker	A member of staff allocated to a person experiencing care. They oversee, assess, plan and evaluate care and support with the person and can be a point of contact if the person wishes to discuss or change things.
Named nurse	A nurse allocated to a person experiencing care. They oversee, assess, plan and evaluate care and support with the person and can be a point of contact if the person wishes to discuss or change things.
Personal outcomes	People's experiences resulting from an intervention, support or action. Personal outcomes are about things that matter to people. They can be positive or negative. When a person is experiencing care and support, personal outcomes should improve because of that care.

Personal plan	Planned care and support, as agreed in writing, between a person receiving care and the staff. The plan should detail how to care for someone. The daily evaluations make up the dynamic document and should be used each time care and support is delivered. While assessments, reviews and other health checks or screening are part of the personal plan, only the planned care and daily evaluations need to be accessible every day. The person receiving care, those important to them and staff caring for them should also be able to look at the other parts of the plan whenever they want to.
Proportionate approaches	This is an approach where lots of things need to be considered and used to inform actions. When applied to caring for people, it is about the least intervention possible to achieve what is important to the person. When applied to inspection, it means better performing services receive less scrutiny, so inspectors have more time to support poorer performing services.
Quality assurance	Checking the quality of a service. It involves inspection, but quality assurance should be done by managers and staff in services. An important part of quality assurance involves managers getting feedback from people experiencing care on what works well and what needs changed. Self-evaluation is an important part of quality assurance. For more information read our 'Self-evaluation for improvement – your guide'.
Risk Enablement	This is about making it possible for people to do things that might be risky, but that are important to them. This might be simple things like supporting them to make a cup of tea. It might be more complex things like supporting them to go out independently despite a physical, mental health or psychological disability. For more information read the SSSC's 'What is a risk worth taking' and our position statement on a positive approach to risk for early learning and childcare (ELC) services.
Risk management	This is about managing risk, not taking risk away altogether. For example, if a person finds handling a kettle difficult it might be about using adaptations to help them pour the boiling water. It could include using technology, for example, if a person has difficulty remembering how to get home after a walk, a device that tracks where they are can help staff to support them from a distance, rather than always having to be with them. For more information read the SSSC's 'What is a risk worth taking'

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