



# Community Living Transition Planning Toolkit

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TRANSFORMING LIVES

*Programme to Implement the Recommendations of the*

*Value for Money and Policy Review of the Disability Services in Ireland'*

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## About this Toolkit

In 2011 the “Time to Move on from Congregated Settings – A Strategy for Community Inclusion” report was published and adopted as national policy. This report identified that over 4,000 people with disabilities in Ireland were living in congregated type settings, defined as **“where ten or more people reside in a single living unit or are campus based.”**

The National Time To Move On Subgroup<sup>1</sup> develops resources to help service providers and their staff to plan the transition of people with disabilities into the community with person-centred supports. Collectively these resources are referred to as the Implementation Framework, which currently includes:

1. Project Action Planning Templates
2. Communications Plan Stakeholder Mapping Tool
3. Communications Key messages
4. HSE Housing Option Guidance Document for Service Providers
5. Community Living Transition Planning toolkit

The Community Living Transition Planning (CLTP) Toolkit was first developed in 2013. Since this time, a number of reports and other documents have been published that impact the disability landscape, namely:

- Aras Attracta Review Group Reports 2016
- Peoples Needs Defining Change: Health Service Change Guide 2018
- National Framework for Person Centred Planning in Services for Persons with a Disability
- Quality Framework: Supporting Persons with a Disability to achieve Personal outcomes 2018

An outline of the key messages of each of these documents is included in *Appendix 1*.

This CLTP toolkit has been reviewed and updated to reflect the recommendations and best practice guidelines in these documents. This review also reflects the learning that service providers and staff working at all levels across the HSE and the Voluntary Sector have shared, based on the journeys they have made in supporting people to transition.

October 2018

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<sup>1</sup> The Time To Move on Subgroup is a national working group established under the Transforming Lives programme that has responsibility for implementing the initiatives which underpin and enable a new model for residential support in the mainstream community, where people with disabilities are supported to live ordinary lives in ordinary places. This is a multi-stakeholder, cross-departmental group that drives the implementation of the policy and provides support and oversight at a national level.

# 1 Community Living Transition Planning (CLPT) Toolkit Overview

A transition can be defined as ***the process of moving from one state or stage to another***<sup>2</sup>. Moving to a new home is significant for anybody as it is a process with many steps that requires detailed forward planning. For a person coming out of a congregated setting, moving to a new home in the community often provides the opportunity to live a very different life with more independence, choice and control.

The Community Living Transition Planning (CLPT) Toolkit aims to guide service providers through the process of supporting each person to develop their plan to move into the community. It will equip service providers with an understanding of what is required to support people to transition successfully to their new homes but will not be prescriptive.

The CLPT Toolkit will support providers to consider:

- Good practice in transition planning
- The influence of the organisation (service provider) in the process
- Who the key stakeholders are in the transition process
- The components required in the transition planning process to ensure that each person is fully supported and assisted to have a successful and sustainable move into the community

## Key Message McCoy Report (Aras Attracta):

*The transition to community life will entail a fundamental change in culture, from learned dependence to personal choice and calculate risk-taking, from staff controlling people's lives to workers supporting individuals to live the life of their choosing, from people having limited options to having the same options as others living in the community.*

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<sup>2</sup> Collins English Dictionary Essential Edition 2006

## 2 Good Practice

Before commencing the process of transition planning each organisation should consider their readiness to support good transition planning.

Service providers and those leading the transition process may wish to review the four stages as outlined in this toolkit which will underpin the transition process in their service and for the individuals they are supporting.

In particular, services might consider the following:

- The person centred planning tool or approach to be used. See *Guide Note 1* below and *Appendix 2* for more details on person centred approaches and tools.
- The change management model and project tools to be used to underpin the process. See *Appendix 3* for details of change management models and *Appendix 4* for project tools.
- How to meet the communication or other specific support needs of the people who will be transitioning, to ensure they participate fully in the process.
- The need for support and / or training in:
  - Person centred planning
  - Change management
  - Communication & engagement processes

## Guide Note 1: Person Centred Planning Approaches & Theory

It will be a matter for each service to determine and agree which theory/ approach informs the practice in their area. It is strongly recommended that the transition planning process in each service is underpinned by a recognised approach to person centred planning and that staff are adequately trained and supported in the approach being followed.

There are many different tools and approaches available, such as:

- PATH – Planning Alternative Tomorrows with Hope\*
- All About Me- Person Centred Plan (PATH based approach)
- MAPS MacGill Action Planning System: Making Action Plans\*
- Personal Futures Planning\*
- Essential Lifestyle planning (ELP)\*
- Person Centred Thinking Tools\*
- Community Circles\*
- Personal Outcome Measures
- Social Role Valorisation (SRV: Theory of Practice)\*
- The Discovery Process (SRV based approach)\*
- Supported Self Directed Living (SRV based approach)

### Guidance from the National Person -Centred Planning Framework:

*Person-centredness is part of an overall approach to enable person-centred cultures that benefit all individuals. Person-centred planning supports and enables a person to make informed choices about how they want to live their life, now and in the future. It supports the person to identify their dreams, wishes and goals, and what is required to make those possible.*

All of the approaches and tools above marked \* are discussed in more detail in the National Framework for Person Centred Planning and a brief outline extracted from this report is included in *Appendix 2: Person Centred Planning* along with links to other PCP approaches, theories and associated tools .

### 3 Organisational Influence

Whilst the transition process should be directed by the person, who is supported by a Transition Co-ordinator, it must be acknowledged that this usually happens within the landscape of the service provider organisation and not in isolation of these structures.

Where service providers focus on key success factors this supports and underpins effective transition planning within that organisation. Three key success factors that have been identified are as follows:

#### 3.1 Leadership

Clear and supportive leadership and management support for organisation change is essential to deliver successful transitions. Effective leadership can be seen where there is:

- A shared vision that is promoted and driven from the top down
- Protected time for leadership and implementation at all levels
- A culture that fosters person centred planning and positive risk management
- A proactive approach to the development of clinical governance arrangements , appropriate policies, procedures, protocols and guidelines, such as :
  - medication management
  - safeguarding protocols
- Proactive workforce planning, such as :
  - Reviewing rosters to support and enable new ways of working
  - Establishing appropriate reporting relationships
  - Up skilling /training and supporting staff development to transition to new ways of working

#### ***Guidance from the National Person Centred Planning Framework***

*Valuing the importance of good person-centred practice at all levels within the organisation, along with experienced staff as role models on how to undertake this process effectively, can encourage and enable change from traditional practice patterns*

It has to be recognised that whilst any change process will face challenges, the transition to the community represents a paradigm shift for many of the stakeholders and strong leadership is critical to supporting this process. At a senior level, leaders need to support and resource the learning and development plans that will target the education, training and skill development needed to deliver and sustain the change. This can be specific to staff taking on new roles, changes in work practices as well as providing support to enable and facilitate the letting go of 'old ways' and practices. The



use of coaching and mentoring alongside training initiatives can help to embed new practice and support a change in culture and model. It can also involve working with families and other stakeholders through forums and focus groups.

Service providers need to invest in and fully support the Community Transition Co-ordinators and the Project Team to enable them to work effectively. Steps include:

- Establishing a Project Team (see Key Stakeholders)
- Ensuring the Project Team has protected time and a defined remit around the transitioning agenda. There should be a clear reporting and working relationship between the team, the management structure and the staff working in the service. This ensures the team can support the transition planning process unhindered by the day to day activity of the organisation or service, whilst remaining closely connected to the person and the frontline staff.
- Transition Coordinators need protected time to work with people in a more intensive way to lead the design and delivery of the transition plans.
- Transition Coordinators must be supported by a project team to enable effective coordination, ensure management commitment, support peer learning and help all stakeholders to be person-centred.

### 3.2 Keeping it Local

This approach enables service providers to adapt to the challenges that arise with local decision making and support local responses that allows for a flexible approach that can effectively address local issues. This would include:

- Finding and enabling local solutions, to maximise opportunity for staff on the ground who are best placed to support solutions
- Ensuring person centred planning is built into decision making at every level
- Managing transition lead in:
  - On-going skill building for residents pre and post transition
  - Managing expectations re staffing
- Effective local community mapping to support transitions
- Developing local support networks
- Developing links with Local Government / HSE Estates/ Estate Agents / Housing Associations

### 3.3 Communication

Communication is the bedrock that must underpin the transition process from start to finish. Good communication and engagement will build trust with the people moving, their families, staff and communities and will support the process. To be effective and positively influence the transition process, communication and engagement needs to be well planned and managed, targeted, clear, meaningful, time-sensitive and must be a two-way exchange – both reciprocal and responsive.

All communication has to be actively managed with all stakeholders and at all stages of the process. There is clear evidence that communication strategies have enhanced and supported the transition process, but also other examples where poor practice has significantly undermined and derailed plans.

When communication lacks focus or clarity, is impersonal, poorly targeted or mistimed it is ineffective at best and in the worst case scenario it will be detrimental and actually hinder progress.

#### 3.3.1 Tools to Support Stakeholder Mapping and Communication & Engagement

There are many tools and resources available to support service providers to map their stakeholders and guide them through the process of developing a communication and engagement plan. It is recommended that at an early stage work is done to scope out the stakeholders, as this supports the development of a comprehensive and well informed communication and engagement strategy.

The tools available can support a team to identify and map the various stakeholders and capture their level of interest and influence on the project. The tools also encourage a team to consider the best approach to communicating and engaging with all the stakeholders. More detailed information and links to all of these tools, is provided in *Appendix 6: Communication & Stakeholder Mapping tools*.

#### 3.3.2 Key Messages

To support the implementation of the *Time to Move On from Congregated Settings* policy a number of key messages have been developed specifically for use in communication and engagement processes to support the implementation of the policy and transition processes.

Critically when engaging with the stakeholders, it is important that the messages are tailored to the audience

**.....for and about the Person transitioning**

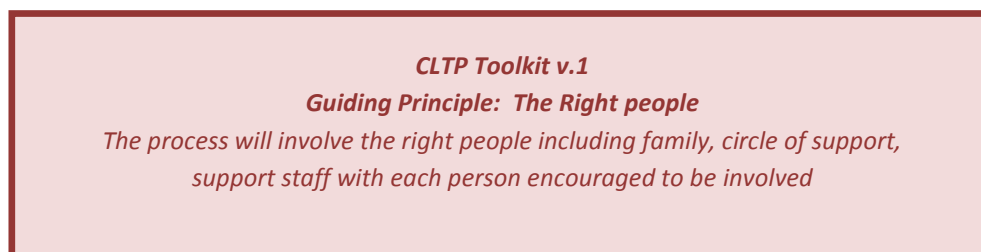
**.....for and about families and other stakeholders**

**....staff perspectives, citizenship and life in the community**

Further information on developing key messages and links to the Key Messages document are given in *Appendix 6 Communication and Stakeholder Mapping & Analysis tools*.

## 4 Key Stakeholders in the Transition Process

There are a number of key people and stakeholders which impact on the success of any transition.



### 4.1 The Person

The most important person in any transition plan is the person who is moving. Throughout the process of transition planning, all stakeholders need to continually be mindful that the person is supported to be central in the process at all times in terms of the engagement, discussions, and activity and decision-making, and remaining true to the adage, “nothing about us, without us”.

Throughout the engagements that will take place as the transition plan is progressing, it is essential that the person is kept at the centre and that all communication is sensitive to the person’s wishes and preferences. Considerations in this regard might include, the location of meetings, the timing of meetings, the format of meetings/discussions, the communication method, the non-disclosure or sharing of particular information and attention as to who the information is shared with.

*For the Person:*

- Communication is at a pace that the person can engage with
- The communication methods are tailored to the needs of the person
- The person has an up to date and portable communication passport which is accessible at all times
- Staff are supported to get to know the person and their means of communication to ensure staff recognise and understand the persons communication methods
- The transition plan recognises the person’s preferred communication method and ensures that it is continued and fully supported when the person is transitioning

### 4.2 Individuals significant to the Person

There are also those that, depending on the person transitioning, will be considered as significant stakeholders in the transition process, namely family members, close friends, advocates and in many cases the staff who currently support the person and who will be involved post transition. In

addition to this, family groups and associations linked to particular services and wider social circles can also be a priority for engagement where they are actively involved and interested in the life of the person with a disability or their family.

### 4.3 Other Stakeholders

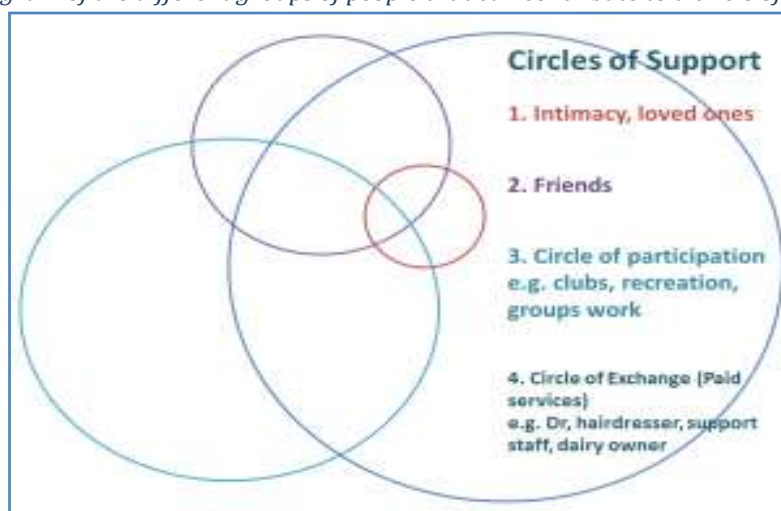
Many other stakeholders may need to be informed or involved in the transition plan process. For each of these stakeholders the timing, method of communication and the content of any message/engagement will be important.

### 4.4 Circle of Support

A circle of support for each person provides a firm basis for the development of a person centred transition plan. The circle involves a group of people coming together to help formulate, promote and support the goals of the person with a disability. The circle acts as a community of friendship and support with the person at the centre. It is a means of providing practical advice, problem solving and generating creative ideas to contribute positively to the person’s life.<sup>3</sup>

The circle of support for the person transitioning will bring together advocates, family, friends, staff, associates, service providers, acquaintances, employers, teachers, neighbours and the local community who know the person in different ways, see Figure 1 below.

Figure 1: Venn diagram of the different groups of people that can contribute to a circle of support



To the greatest extent possible, each person’s circle of support will be unique to them and will reflect their personal connections. Ideally a person will only be involved in one individual’s circle of support. Initially in congregated settings this may be challenging, particularly if the person being supported has few family members or friends and little social connection outside of the setting at

<sup>3</sup> Resourcing Families Circles of Support 2015 Family Advocacy an Independent NSW advocacy

the start of the process. In these circumstances, it is important to ensure that where an individual may be part of the circle of support for more than one resident, that this is manageable from a time and commitment perspective and that the overall composition of each circle remains unique in order to avoid any conflict of interest.

Circles will help bring people closer together and help actively plan to bring more people into the person's life and increase their participation in their communities. This can be done in an informal way or in a formal way by way of a meeting or more informally over a meal.

See *Appendix 3: Additional Resources*, for links to this and other resources that provide guidance on establishing and supporting the development of circles of support and collaboration with families and personal networks.

## 4.5 Transition Coordinator<sup>4</sup>

This is the person who will engage with the person, work to understand the person's aspirations and support needs, develop a transition plan, work and collaborate to deliver on the plan. The Transition Coordinator will work (supported by the Project Team)...

....*With the individual to:*

- Build a relationship with the person to establish support network/circles of support with them that includes family (where appropriate), natural and unpaid supports and advocates.
- Build capacity in supporting the person with a disability to transition to community living with appropriate levels of support.
- Build capacity to support the person with a disability to integrate into their community. Establish and maintain networks and connections with the person and the community in which they will be living.
- Develop, implement and evolve the transition plan with the person and key stakeholders to ensure that adequate preparation is made for the transition.
- Facilitate people to move to their own homes in a planned, phased and coordinated manner

....*With staff to:*

- Provide leadership to the staff working in new community houses with regard to implementing a social care model of support during and after the move.
- Work with the support staff to enable each person to settle and embed into a meaningful and connected life in the community, in line with the person's wishes and preference.

**CLTP Toolkit v.1**  
**Guiding Principle: Vision**  
*In ensuring that the persons will and preference is met, all of the people involved will need to work collaboratively to support the person to meet their vision, building in innovative problem solving along the way.*

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<sup>4</sup> The role of Community Transition Co-Ordinator described here is also known by other names. Some services refer to these posts as the Key worker, Discovery Co-ordinator, Social Care Worker, Community Connector etc

An example of a generic job specification for a Community Transition Co-Ordinator is included in *Appendix 4*.

## 4.6 Transition Project Team

It is recommended that service providers identify and put in place a project team that supports the transition planning and delivery process in each location. There are aspects to each person's transition journey that will require a service response and the *Time to Move on Project Action Plan* document, recommends that a lead person is identified to manage issues that fall under the heading of:

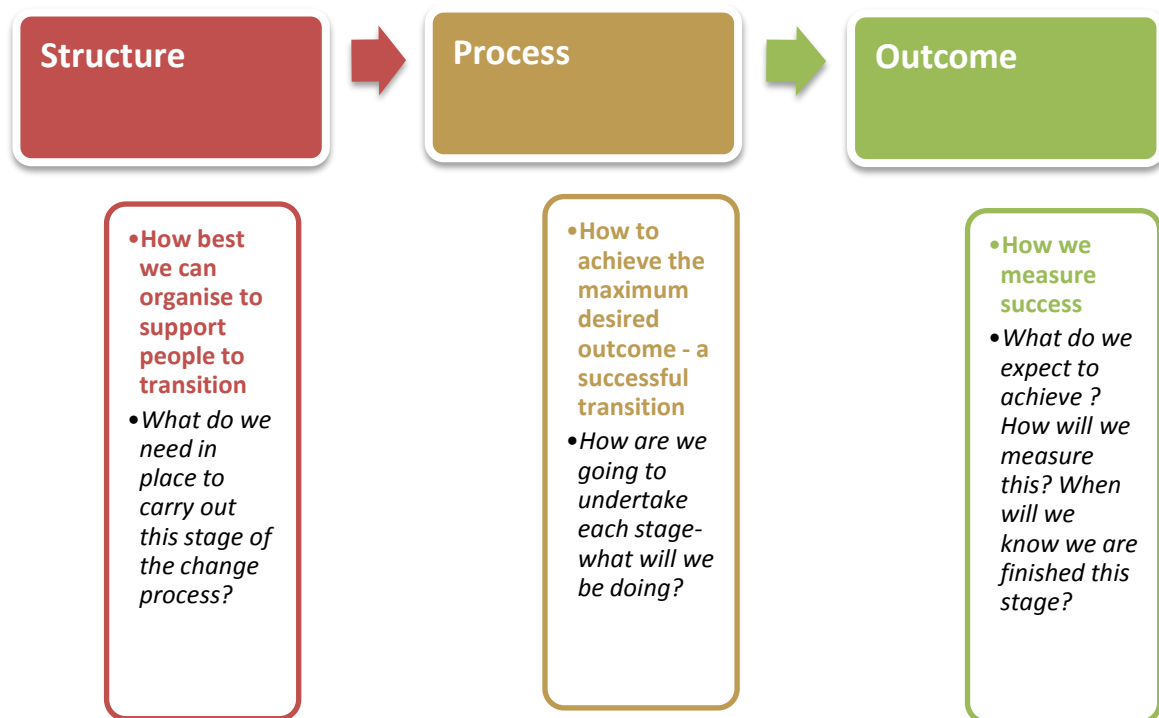
- Governance & Leadership
- Communication
- Housing Acquisition
- Finance
- Individual Assessments\*
- Transition Planning\*
- Community Inclusion
- Workforce planning

Work will be needed at a local level to define individual team roles, team objectives, key individual responsibilities and reporting relationships etc. An example of the potential responsibilities and tasks that might be assigned to the project team members is provided in the Work Plan breakdown in the *Time to Move On Project Action Plan* document. See *Appendix 5: Supporting Project Tools* for more detailed information on this and links to the document.

## 5 CLTP Layout

The layout of the CLTP Toolkit follows the Donabedian model<sup>5</sup>, which is a three step approach as noted in Figure 2 below.

Figure 2: Donabedian's Three Step model



This approach helps to provide a clear pathway for each of the stages in the CLTP, as well as supporting the evaluation of the process undertaken at the end of each stage through outcome indicators, which can inform improvement measures.

This will support the service or team to evaluate and learn from their process and approach to transition planning whilst also measuring the outcomes achieved. The **Outcomes** section in each stage identifies outputs and outcome predictors that represent best practice in relation to person centred planning i.e. completion of a documented plan, support in place for person's preferred communication method. This approach acknowledges that it can be a challenge to define measurable quality of life outcomes for the individual transitioning in circumstances where their personal goals may change over time.

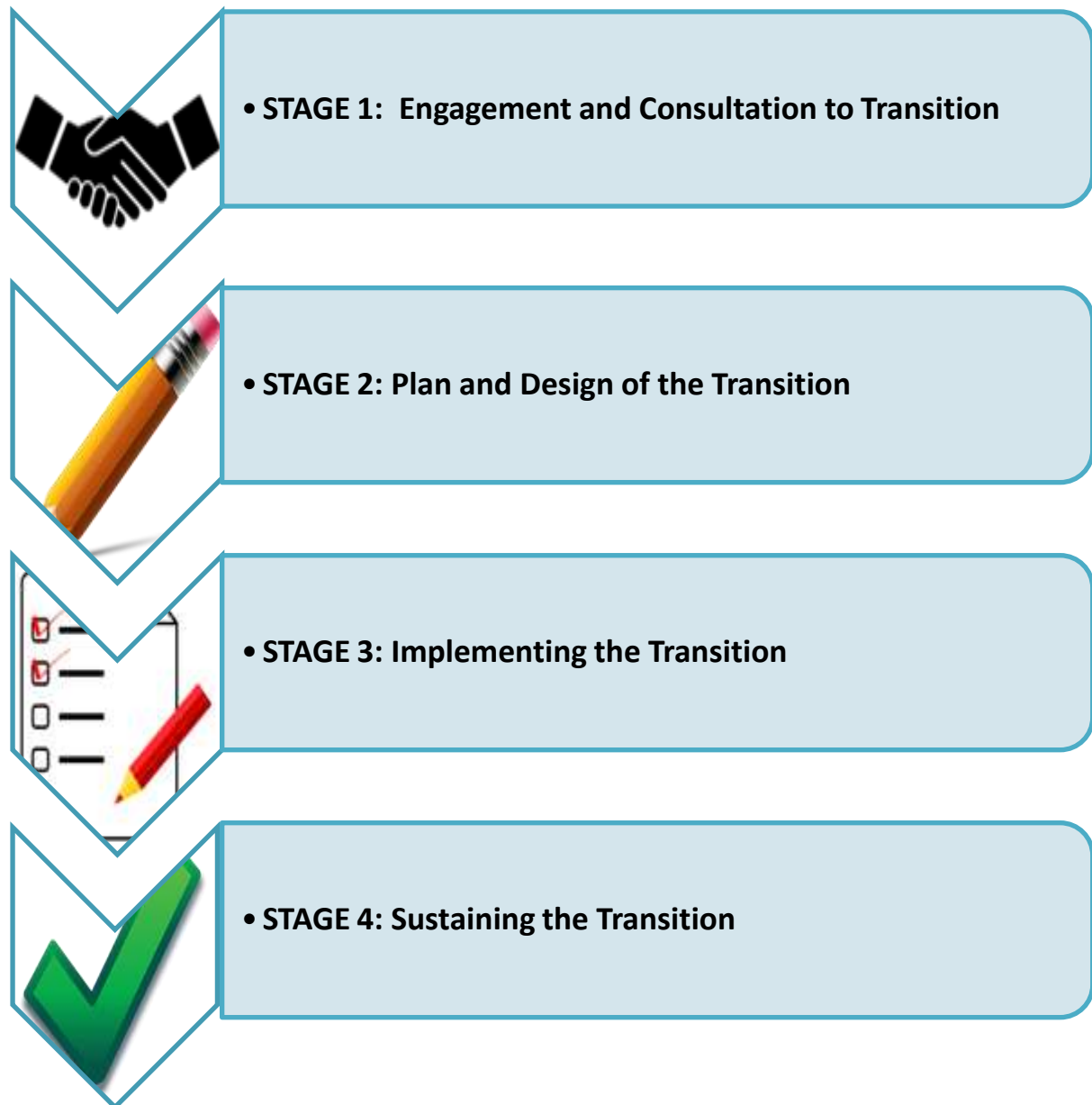
To this we have added indicative timeframes.

<sup>5</sup> Written by the ACT Academy for their Quality, Service Improvement and Redesign suite of programmes NHS Improvement

## 6 Stages of the Transition Planning Process

As with any change process, there are a number of key stages in the transition planning process, that need to be given due attention. In the CLTP toolkit these are identified as shown in Figure 3 below:

*Figure 3: Stages on the Transition Planning Process*





## STAGE 1: Engagement and Consultation

Early and on-going engagement enables people to make a real investment in the change, to develop a shared sense of purpose and to agree achievable outcomes. Effective targeted engagement and communication must be on-going throughout all the stages of the transition planning process to ensure that the plan can continue to be developed and adjusted to match the person's needs and wishes and support their personal goals to be realised.

In this initial stage, the focus is on enabling the transition process to be initiated. Where there is already a culture and practice of person centred planning, this can be easily built upon, but in other cases more intensive work will be required to develop the appropriate engagement and communication process for and around each person.

It is essential that the person, their families and the other key stakeholders are supported to understand what is expected in the process. To ensure this is clear to everyone involved, it is recommended that key principles are stated and agreed that underpin the transition planning process and are fully aligned to the key messages. An example of an agreed set of key principles is given below:

***Key Message from the  
McCoy Report (Aras  
Attracta)***

*What will determine the  
success of community  
settings:*

*The involvement of the  
person in all aspects of the  
move, including deciding  
where they will live, and who  
they will share their home  
with.*

## Structure

The key structural components that need to be in place to enable effective engagement and consultation to be undertaken in Stage 1:

- The Transition Co-ordinator for the person is in post
- A project team is identified and in post to support the overall transition plan.
- An agreed PCP planning tool/approach is in place which will enable a structured approach to building a picture of the hopes and dreams, will and preference of each person for their transition.
- Significant groundwork will have been completed to assess and map stakeholders and ensure that all significant opportunities and concerns have been identified and are being actively managed where appropriate.

## Process

The Transition Co-ordinator or equivalent person that will lead out on the following actions to progress this stage:

- Arrange meeting(s) with the person who will be transitioning to build trust and a relationship that is the first step towards creating the safety and space to support change.
- Arrange access to supports that will optimise each person's capacity to communicate
- Meet with family, friends, advocates and support staff who can provide insights.
- Develop and establish a circle of support around the person, drawing together individuals who can contribute positively to support the person transitioning
- Building on the initial groundwork, explore and map the wider stakeholders.
- Working with the person and through the circle of support, explore all the aspects of the person's life and consider how to capture future goals. For example:
  - Introduce the person to possibilities not currently available in their setting
  - Consider past interests and aspects of their life before moving to the congregated setting
- Engage and lead regular meetings to review the persons existing PCP and begin the process of re-focussing on the development of a transition plan, ensuring that key relevant information and personal goals from the PCP are identified and incorporated into the transition plan

## Outcomes

The following outputs and outcome indicators can be used as a guide to ensure the progress made under Stage 1 supports best practice in transition planning:

- The most effective communication method for supporting the person is established and enabled from an early stage
- A circle of support is in place that can effectively to support the person. The circle will have agreed principles, a clear statement of purpose and set ground rules.
- A clearly defined process for capturing the will and preference of the person is in place.
- An understanding of the person's initial will and preference that is emerging.
- The initial views and capacity of the circle of support and wider stakeholders to support the person's transition
- Preliminary work is completed to outline what is needed pre-transition to build capacity and support the person to move:
  - Practical support– additional care supports, new technology, access to Assisted Technology
  - Personal resourcing – transport, cooking, personal safety, finances
- There is an understanding of the current services and supports that are in place around the person and what will need to continue post- transition.

- Additional assessments required informing the transition planning process or support required for the person to participate fully is identified and organised.
- Any additional assessments that might be required to support the actual transition (as opposed to the planning element noted above), is identified.
- All necessary permissions and protocols to share and protect information are in place.

## Timeframes

The time allocated for this stage of the transition planning process could be in the region of 4 months once the Transition Co-ordinator is in post. Within the overall timeframe, it may be useful to identify a number of mid-stage milestones with target dates. This can be helpful in keeping focus and demonstrating progress, particularly when they are a number of activities underway simultaneously or where overall timeframes are long. Having a documented work plan or Gantt chart can be a useful way to plot and track progress against milestones. *See Appendix 5: Supporting Project Tools* for more information on these.

## STAGE 2: Plan and Design the Transition Plan

As noted in Stage 1, where there is a Person Centred Plan already in place for an individual, this can provide the backbone of the Transition Plan. The planning and design of each person's Transition Plan should be a deliberate but smooth extension of the PCP process. However, where the practice of person centred planning is not well developed, the process of transition planning will need to bridge a wider gap, in order to ensure that the transition plan is person centred and reflects the will and preference of the individual.

Developing a transition plan will include identifying the strengths and challenges associated with the person's transition and detailing the essential supports required. The plan will identify what supports are needed for the person to enjoy an "ordinary life in an ordinary place", who needs to be involved and what needs to be done to make it happen. Caution must be taken to ensure that the process of developing a transition plan does not give rise to unrealistic expectations as to when a transition will occur and what might be possible, being mindful at all times to manages a person's expectations. .

### Structure

The key structural components that need to be in place to enable the effective planning and design of each person's Transition plan:

- The Transition Co-ordinator (or equivalent role) is in post.
- The circle of support for the person is in place.
- Person Centred Planning Meetings are being held. Regularly. These need to be co-ordinated and scheduled. There should be an agreement in place that clarifies the "meeting ground rules", purpose of the meetings, membership, meeting venues, roles at meetings ( minute taker, chair, timekeeper etc.), regularity of meetings, attendance etc. This will ensure the meetings are focussed and effective, run smoothly, are purposeful and lead to actions and outcomes.
- A template for the development of a transition plan is in place that aligns to the PCP planning tool/approach agreed and in use.

**CLTP Toolkit v.1**  
**Guiding Principle:**  
*Every part of the transition plan will be in line with the persons will and preference, and will be ensure that appropriate supports are provided.*

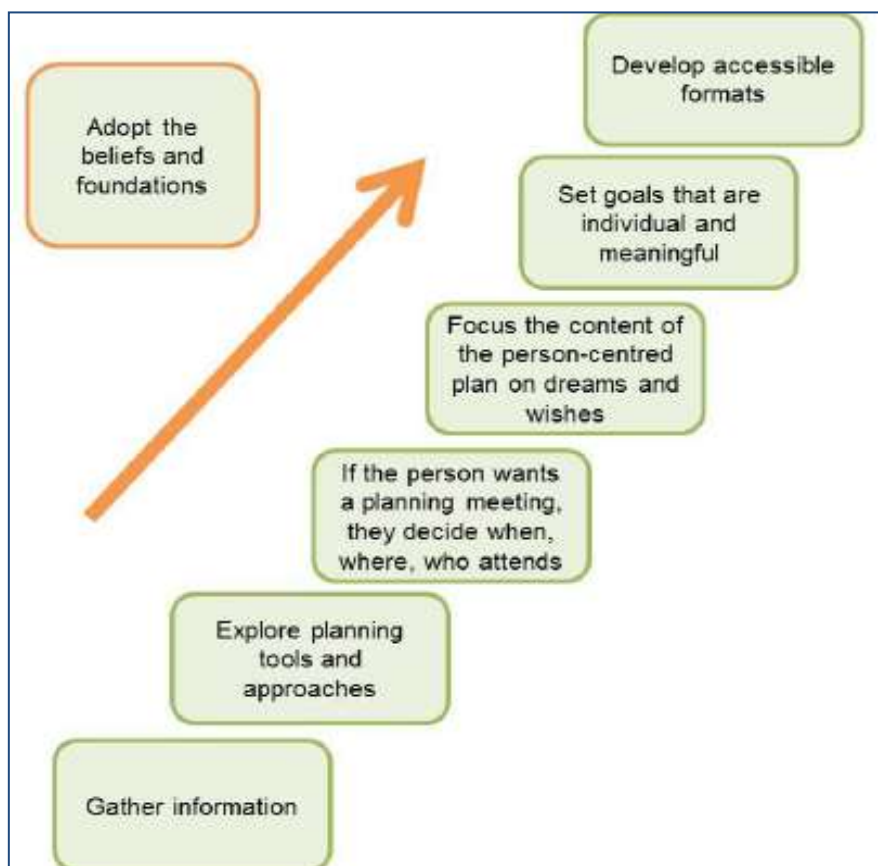
## Process

The person who is transitioning should lead the process of planning and design with the support and guidance of the Transition Co-ordinator at all times. The person transitioning must be supported to decide who will be involved and the extent of the other people’s involvement in the development of their plan.

Co-design is an open and collective approach to care planning where multiple stakeholders, particularly the person, families, frontline staff and people from diverse fields, are included as equal partners in the plan design process.<sup>6</sup> It is important to ensure that where there is a co-design approach, it is fully in keeping with the will and preference of the individual, so that there is no compromise on a person’s goals and the influence of the other stakeholders is to enhance the plan to achieve these goals not to hinder them.

The National Person Centred Planning Framework identifies the process of design and planning, as “putting a Person Centred plan together”, which is outlined in Figure 4 below.

Figure 4: “Putting a Person Centred Plan together”



<sup>6</sup> HSE Change Guide – Peoples Needs Defining Change

The format and structure of the Transition Plan will vary depending on the Person Centred Plan tool used and to ensure it supports the each person to aid communication and understanding.

There are a number of common “building blocks” that will be identified in any Transition Plan

- The Person’s dreams & vision
- Their network of family, friends and supporters
- Clarity and support in decision making and governance
- Opportunities to ‘imagine better’ and explore new alternatives
- Their plan for participation, contribution and community engagement
- The practical plan including resources required to support community living
- Identifying a place to live that’s home – where, with whom & how
- Partnerships and shared responsibilities
- Safeguards

**CLTP Toolkit v.1**  
**Principle: Transition Plans**  
*Transition plans must be comprehensive and include all key elements that are vital in ensuring that the person is set up for a successful and*

**CLTP Toolkit v.1**  
**Guiding Principle: Partnerships & Funding**  
*Any transition plan will need to identify resources and funding required to support transitions. This may include funding of supports, day programmes and specialist equipment. New partnerships will also need to be considered with community services, housing bodies, local councils.*

Regardless of the tool used, it is important that in each person’s transition plan the following is identified:

- Evidence to show that the goals and outcomes are in line with the person’s will and preference
- Information on the current status of
  - the person’s capacity and skills
  - the current resources and supports around the person
- Gaps that need to be addressed to support the transition relating to
  - the person’s capacity and skills
  - the resources and supports around the person
- Any critical dependencies for the implementation of the plan. This could be training, funding, access to property, access to specialist’s assessments or therapeutic supports etc.

**CLTP Toolkit v.1 Principle: Risk Assessment**  
*There needs to be a comprehensive understanding of the risk factors associated with a move to the community that need to be addressed pre-transition. (This may include physical limitations/ behaviours that challenge) This assessment will include good risk analysis and an exploration of intentional safeguards.*

## Outcomes

The following outputs and outcome indicators can be used as a guide to ensure Stage 2, the design and plan of the Transition plan is in line with best practice:

- The Person's Transition Plan will be documented.
- It will be presented in a person centred way and in a format that is accessible to the individual.
- It will include sufficient detail to cover all areas identified for inclusion under the nine building blocks (see previous page).
- The plan will consider a number of phases in the transition process and reflect how the goals and outcomes of the person are reflected and managed during these, such as
  - Planning to move – work to support the person to move before the move
  - Settling in after the move – work to support routines and reduce anxiety
  - On-going longer term capacity building

## Timeframes

An initial plan should be available 3 weeks after last planning meeting / consultation/ assessment.

## STAGE 3: Implementing the plan

To effectively enable each person to transition there should be a documented transition plan in place that is accessible to the person moving, reflects their wishes and preference and identifies the agreed goals and outcomes to be achieved in the transition.

In order to “*make this happen*”, an **action plan** must be developed that identifies the activities and tasks that need to be undertaken to support the transition to progress. The action plan will identify the step-by-step process to be followed. Each person’s transition plan will continue to be the ‘live’ document that is regularly reviewed and updated throughout the implementation stage, so that any changes necessary can be identified and acted upon.

On-going care must be taken throughout the implementation stage to manage any changes that arise and ensure that the expectations of the person moving and the other significant stakeholders are managed effectively.

### Structure

The key structural components that will support best practice in the implementation of the transition plan:

- Person’s transition plan is in place, documented and accessible.
- The Transition Co-ordinator (or equivalent role) is in post.
- The circle of support for the person is in place.
- Transition implementation meetings are being held.

### Process

An action plan is drawn up to identify the activities and steps that need to be undertaken to bring effect to the person’s transition plan

#### 6.1 Leading the Development of the Action plan

Effective leadership and clear communication throughout the implementation process is essential as there may be a range of people involved or contributing to various aspects of the action plan. It will be important to have clarity over who is co-ordinating the plan, oversight of the progress when actions are interdependent and can direct and manage any changes.

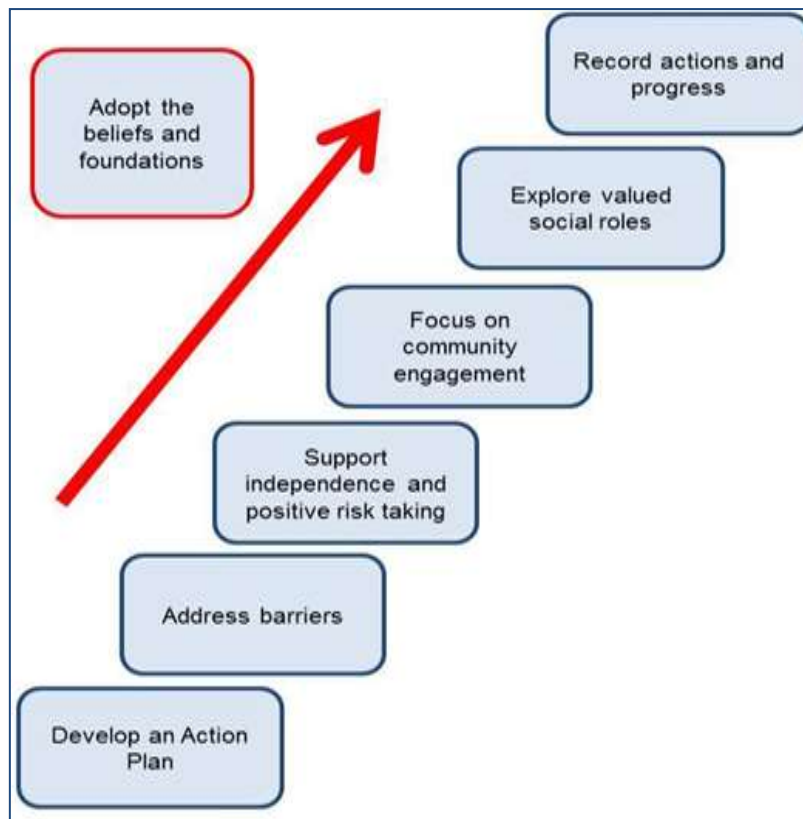
One person should be identified to co-ordinate and lead the development of the action plan that will plot the transition process for each person. Transition Co-ordinators can take on this role with support from their Project Team.



## 6.2 Putting the Transition Plan into Action

The National Person Centred Planning Framework identifies the process of “putting a person centred plan into action”, which is outlined in Figure 5 below.

Figure 5: “Putting a Person Centred Plan into Action”



In Guide Note 2 an overview on structuring an action plan is given. Further information and some examples of action plan formats are also provided in *Appendix 7: Action Plan Approaches*.

## Guide Note 2: Action Plans

### Structuring the Action plan

Each person's transition plan should form the basis for the action plan. The Transition Co-ordinator will work in collaboration with the person, the project team and circle of support, to draw up the action plan. This does not have to follow any particular format or layout, but care should be taken to ensure it is accessible to the person transitioning. *Appendix 7: Example Action Plans* includes three examples of action plan formats that can be used.

Regardless of the format and structure of the action plan, it is essential that the Transition Co-ordinator leading the development of the plan is working in close collaboration with the person moving, the Project Team, the service team (local management and staff) and the circle of support. Where a plan is developed without this collaboration, there is a much greater risk that critical dependencies and issues will be overlooked that might negatively impact the transition process at a later point.

### Timeframes & Action Owner

Careful consideration is needed when developing the action plan with regard to the setting of target timeframes and the assignment of responsibility for the completion of actions.

Where timeframes are set too short, this can lead to a lack of trust and momentum if participants and stakeholders perceive a process is failing or falling behind. Where timeframes are too long, it can lead to a lack of action, as there is no incentive to complete the task when the deadline is considered far away and a lack of confidence in the process. Another flaw can be vague timelines i.e. using "January 2019" rather than "10<sup>th</sup> January 2019" which clearly shows when in the month the action is expected to be completed. Ensuring all actions and tasks have specific deadlines, prevents any confusion and protects against unintended project slippage. Where particular actions and tasks will take time to complete, for instance "Action: Secure one additional carer for support by day", it can be useful to break the action down into smaller parts that allow progress to be overseen and managed, for instance:

- Agree role of person transitioning in selection process
- Draw up job spec, advert etc.
- Submit business case for funding /reconfiguration etc.
- Secure funding
- Commence recruitment process /expression of interest .....etc. . . .

Another factor to consider in the setting of timeframes is the sequencing of different tasks, and in particularly how changes or delays to some actions might create difficulty or have a knock-on effect in other areas. For example, if a member of the project team is responsible for developing policies specifically for the new home, it is possible that some of these will be contingent on where the house will be, who will be living there and the supports that will be in place, so finalising the policies may need to be staggered accordingly.

### 6.3 Implementing the Action plan

A clear and agreed process needs to be in place to drive the implementation of the action plan. This may be led by a member of the Project Team when there are known resource dependencies that are outside of the scope of the Transition Co-ordinator. It is recommended that Transition Implementation Meetings are scheduled and held regularly to review the action plan and track progress and any new issues that might arise.

**CLTP Toolkit v.1**  
**Guiding Principle: Implementation & Review**

*The Transition Plan must be actioned with carefully consideration given to ensure that the key components are delivered as required. It must also be flexible to ensure that any additional challenges/opportunities can be included in the plan.*

### 6.4 Transition Implementation Meetings

These meetings will involve the Person, their support staff, the Transition Co-ordinator and at various times key members of the project teams and circle of support. The meetings will ensure effective communication across the key stakeholders involved in the implementation of the plan to optimise the co-ordination of activities. Maintaining communication with all stakeholders through the meetings will ensure that any adjustments to the plan or timeframes do not undermine the process or erode trust.

Timeframes must be closely managed and monitored and may need to be adjusted in response to the changing needs or wishes of the person or other developments, such as decisions around resources or the availability of housing.

**CLTP Toolkit v.1**  
**Guiding Principle: Vision**

*In ensuring that the persons will and preference is met, all of the people involved will need to work collaboratively to support the person to meet their vision, building in innovative problem solving along the way.*

Similarly, actions that relate to the strategies in place to support the person’s move should be reviewed regularly to ensure that they continue to be appropriate and sufficient to meet the person’s needs. The Transition Co-ordinator has a pivotal role in this regard, working with the circle of support, staff team and project team to enhance the understanding of the person’s strengths and vulnerabilities and the strategies that are in place to support them, which will promote independence and learning and help minimise anxiety.

Where the plan is dependent on resources or other factors that are outside the control of the Transition Co-ordinator or Project Team, the implementation process may need to be managed on a phased basis. The use of a dependency log, risk log and issue log can be effective to track the impact of these factors and support the Transition Co-ordinator and Project Team to escalate these

for attention and to communicate with the stakeholders. See *Appendix 6: Supporting Project Tools* for details of these logs.

## Outcomes

The following outputs and outcome indicators can be used as a guide to ensure the implementation stage is in line with best practice in transition planning:

- Clear action plan and implementation strategy
- The person transitioning is actively involved in the process
- Milestones are in place to capture incremental progress in line with the goals and personal outcomes set out in the transition plan
- On-going revisions of the plan are in line with the person's wishes
- Completion of identified defined actions such as skills development, opening a bank account, selecting furniture, joining a local club etc. (Some of these will be linked to personal outcomes but others will be organisational outcome predictors of best practice).

## Timeframes

The process of developing an initial action plan should be completed within 6 weeks .

## STAGE 4: Sustaining the transition

Once the person has physically moved into their new home, the final stage of the transition process begins. Each person should be supported to experience this at their own pace and in a way that meets their needs. Every person will go through a period of adjustment as they begin to settle into their new home and the local community and this can be a significantly different journey from person to person.

For some individuals, there will be changes in the level of support to be co-ordinated and managed during the “settling in” period, in order to enable and encourage capacity building and participation. In some cases, one to one support may be required to enable the person to engage in the community, whilst in other cases a person may benefit from increased time spent alone or with a reduced level of staff support or supervision to enable them to develop greater independence at home or out in the community.

### Structure

The key structural components that will support best practice in sustaining a transition:

- Transition Co-ordinator remains in place after the transition
- Transition Plan, Action plan and Person Centred Plan remains in place
- Process for formal and informal review at regular intervals
- PCP meetings
- New home
- Circle of support – continues to be involved and may be widened to include new friendships
- Paid and unpaid supports

### Process

The Transition Co-ordinator has a critical role in ensuring that work continues with the person, the staff supporting them in their new home and the circle of support to keep “moving forward”, so that the person is supported to explore and enjoy new opportunities and discover what an “good life” means for them in their new home and community. The Transition Coordinator will support the person for a period of time, beyond the actual event of physically moving home. This will provide continuity until the person has settled and adjusted to their new home and life.

To help ensure the initial success of the move and build on this to make the transition sustainable, there should be a seamless shift in focus away from the implementation of the action plan, which will be nearing completion and towards the revision and renewal of the person centred plan focussing on the new home and community.

An important part of this process is to review the actions identified in the implementation plan and ensure they have been comprehensively completed or are being actively addressed. It is

anticipated that some of the actions by their nature will not have been completed, but in all cases it is important to ensure that there is follow-through on all actions so as not to undermine the final stage of the transition process. Examples would include:

- Incomplete capacity building to enable the person to engage in the community; however this can continue on the ground over time
- Failure to fully negotiate and agree change in staff roles , leading to gaps in service delivery and cover for key responsibilities
- Failure to train and support staff to promote and embed a person centred approach which results in the traditional service-led practice prevailing in the community.
- Delay in supporting the person to establish their financial arrangements that will enable them to access their own resources (with or without support) in order to participate in the community.

Once the person has moved the focus changes to working with the person to settle into their new home and developing their involvement in their new community. This should be co-ordinated and managed through the Person Centred Planning process.

The PCP meetings which will have continued throughout the transition process should now be “bedded down” in the service supporting the person in their home. The Transition Co-Ordinator should step back from leading the PCP process but continue to work closely with the support staff working in the person’s home and engage with their day service and community supports, where these are in place.

A key worker from the staff team supporting the person can lead the PCP process going forward. This person may be from the residential or day services or a range of professional backgrounds. It is important that the staff member has a genuine interest and connection to the person and is appropriately skilled and enabled by the service to lead the PCP process for that person.

## Outcomes

The following outputs and outcome indicators can be used as a guide to ensure the final stage of the process is supporting best practice in transition planning and sustainability:

- The person has moved to their new home, with all of the necessary arrangements –personal, financial, legal, staffing supports, adaptations in place
- The person is comfortable in their physical environment
- The person is being supported to do as much as they can for themselves
- All goals in the person’s transition plan have been reviewed and anything outstanding is reflected in their person centred plan
- The person centred plan is up to date and reflects the person’s current will, preference and goals where possible
- The person is living an ordinary life and engaging with their local community in line with their personal goals

## Timeframes

The final time lines in the transition involve the move to the new home and the process of settling in. Whilst 6 -12 months might be considered a reasonable timeframe to allow each person to settle, it is a particularly individual process and will need to be managed as such.

*“Oh my God, well it’s lovely; yes it’s lovely to have your own home, your own place; you know, my own place I mean where you can come and go, where I can get up when I like, and go out and come home and go to bed when I like, do the things you want to do without some telling you do this or do that or you shouldn’t do this or you can’t do that; eat this; wait there; get up; look at the time it is, you should be in bed long ago; all that sort of thing, just telling you and you have to do it when they say”*

***Rosaleen,  
who moved to her new home after spending 50 years in a  
congregated setting***

# Appendices



## Appendix 1: Key Documentation & Reports informing this CLPT

### 1a Aras Attracta Swinford Review Group - McCoy Report

In December 2014 the Áras Attracta Swinford Review Group was established, comprised of specialists in the fields of intellectual disability, the protection of vulnerable people, and change management and supported by experts in the areas of disability, ageing, and social research.

The findings of the Review Group are presented over a series of reports:

**“What matters most”**, sets out the findings of the Review Group in relation to Áras Attracta itself. It includes recommendations relating to Áras Attracta management, actions for the HSE at a national level, and a plan to guide all managers of congregated settings as they move towards decongregation.



**“Time for action”**, deals with the wider system of service provision for people with a disability, and proposes a range of actions to inform national policy across government departments that emerged from a national process of consultation with stakeholders involved in disability services and the wider public

**“Start listening to us”**, is a documented record of the lived experiences of people with intellectual disability and how they perceive the support they receive.



**“Key Messages”** is the Expert Group report that summarises the context, captures the main challenges and identifies the key recommendations both for the Aras Attracta campus and the wider disability residential sector. In respect of the transition to community living, the Key Messages report notes the following:

### ***On The challenge of moving to community living***

*Moving from a congregated setting to a community setting is a major challenge for any service provider and will require a simple, clear and explicit vision that describes what the new reality will look like. It will also require strong leadership and total commitment from all senior management to help realise this vision – there can be no ‘sitting on the fence’ by senior management. The challenge is to create a new kind of service that is tailored to each person’s needs and priorities. The management should engage with all stakeholders to articulate this vision for the future, and the values that will underpin the new service. The values should reflect a commitment to support a meaningful life, community participation, individual empowerment and respect for human rights. The transition to community life will entail a fundamental change in culture, from learned dependence to personal choice and calculated risk-taking; from staff controlling people’s lives to workers supporting individuals to live the life of their choosing; from people having limited options to having the same options as others living in that community, this includes healthcare needs being accessed through primary care centres and community services. Such a fundamental change will involve:*

- *A steep learning curve for senior management (this will involve opportunities to visit de-congregated sites, to meet with the leaders of successful transition to community settings, and to learn about the management of organisational change).*
- *Sharing the learning with all levels of the organisation and with people supported and their families.*
- *Identifying leaders at all levels in the organisation that is ready, willing and able to lead the change.*
- *Constant communication with all stakeholders (newsletters, websites, Facebook, Twitter, meetings, and so on).*
- *Formalised arrangements for regular consultation with the people supported and their families, with staff, and with funders.*
- *Fostering the independent voice of the people supported by the service, through self-advocacy training, speak-up groups, house forums, and so on.*
- *Supporting those individuals who already want to move to a community setting, through the process of transition into the community.*
- *Sharing the successes as they occur with all stakeholders, and learning from the challenges that arise.*
- *Ensuring that large-scale institutionalised living is not replaced with small scale institutionalised living.*

The Key Messages report goes on to consider what will determine the success of community living and notes:

*The success of the move from the congregated setting to a community setting will be determined by a number of factors:*

- *The involvement of the person in all aspects of the move, including deciding where they will live, and who they will share their home with.*

- *The commitment of all staff and management in each setting to prepare people for the transition to community living. This preparation will focus on empowering each person to make everyday choices, to speak up for themselves, and to express preferences.*
- *The HSE's engagement with housing bodies (local authorities, NAMA, voluntary housing associations) and landlords and developers, to ensure a variety of housing options for people in suitable community locations.*
- *In identifying suitable locations, the focus will be on local facilities (closeness to shops, churches, GPs, education, sports and leisure facilities, active community groups, opportunities for part-time employment, closeness to family members, access to public transport, friendly neighbours, and so on) and personal choice.*
- *Engagement with education providers to explore, facilitate and promote learning opportunities. Focus on preparing the local community for the transition.*
- *As far as practical, the person will choose their own support staff.*
- *A transition team will have responsibility for coordinating the transition from living in the congregated setting to living in the person's chosen community location.*

***“A ‘roadmap’ setting out the vision for the future model of service at Áras Attracta”*** outlines how the service aims to enable residents

to make this transition to community living and support them in their choices about where they live, who they live with and how they spend their time. Informed by the Review, the Roadmap is designed to support the consultation and engagement with residents, their families and advocates to guarantee their voices are heard and their will and preference respected. It also aims to support the consultation and engagement with staff, unions and other stakeholders whilst the final development plan for Áras Attracta is agreed and implemented. The roadmap acknowledges that there needs to be on-going improvement of services at Áras

Attracta, while working towards the transition to community living, ensuring the resident's voices are heard and that they are at the heart of everything we do. Key themes in the roadmap include:



- Leadership and Governance
- Implementing the 'Social care Model' of support
- Opening new community and transition houses
- Promoting the Residents voices, Enhancing Advocacy support and the communication with families through family forums
- Staff training and new approaches
- Investment in staffing
- Implementation and Change teams
- Transition planning processes and timelines

<https://www.hse.ie/eng/services/news/media/pressrel/arasattractaindependentreview.html>

## 1b National Framework for Person-Centred Planning in Services for Persons with a Disability

The HSE is due to publish the National Framework for Person-Centred Planning in Services for Persons with a Disability shortly.

The Framework sets out to support individuals, teams and organisations to foster the beliefs and foundations of person-centredness and person-centred planning.

The Framework aims to assist organisations to identify areas for improvement, to promote a consistent standard of practice, and to embed self-evaluation and reflective practice into their person-centred planning policies.

Within the Framework the themes of person centeredness, person centred planning and personal support plans are defined and discussed. The Framework goes on to consider the impact of organisational culture, structure and processes on person centred planning with particular reference to communication, support for staff, collaborative working, advocacy, risk taking and managing resources.

The Framework defines and discusses the key elements in person centred planning under the headings:

- Getting ready to do a plan
- Putting a plan together
- Putting a plan into action
- Finding out if a plan is working

*Once published, the Framework will be available on the HSE website.*



In May 2018 the *People's Needs Defining Change – Health Services Change Guide* was published. It aims to guide and support staff to become change leaders in health and social care services. It draws together the collective learning from practitioners, leaders, service users and staff and combines this with evidence into a coherent and integrated approach to leading change. It aims to strengthen the people and culture focus and complement all of the other service, quality and culture change programmes that are currently making progress toward the delivery of person-centred care.

The Change Guide is a resource that can be applied at all levels to support managers and staff, and it provides practical assistance to define, design and deliver change through the use of guidance, templates and resources that can be adapted and applied to a local context.

The Change guide specifically recognises that people are at the centre of all of our initiatives and provides guidance on working with Service Users, Families, Citizens, Communities and Staff to understand their needs better when undertaking change.



There is an extensive range of essential templates included in the Guide that can be used to support staff and teams working to deliver change, such as:

- Influence-Interest Mapping Grid (for use with stakeholders )
- Stakeholder Mapping and Analysis
- Engagement and Communication plan
- Defining Personal Values
- Personal Readiness for Change
- Cultural Web exercise
- Team diagnostic
- People and Culture Change Platform-Readiness Factors

<https://www.hse.ie/eng/staff/resources/changeguide/>

## 1d Quality Framework: Supporting Persons with Disabilities to achieve Personal Outcomes

The focus on personal outcomes is an essential part of the recommended service delivery framework under the Transforming Lives Programme<sup>7</sup>.

Following research and consultation by the National Disability Authority, including literature on outcome measurement and experiences from other jurisdictions, the Department of Health and the HSE approved nine outcome domains for Irish disability services for adults. These reflect widely recognised aspects of quality of life that are important to all people and include connections with family, friends and community, see Figure A1.1 below.



Figure A1.1: The Nine Quality of Life Domains

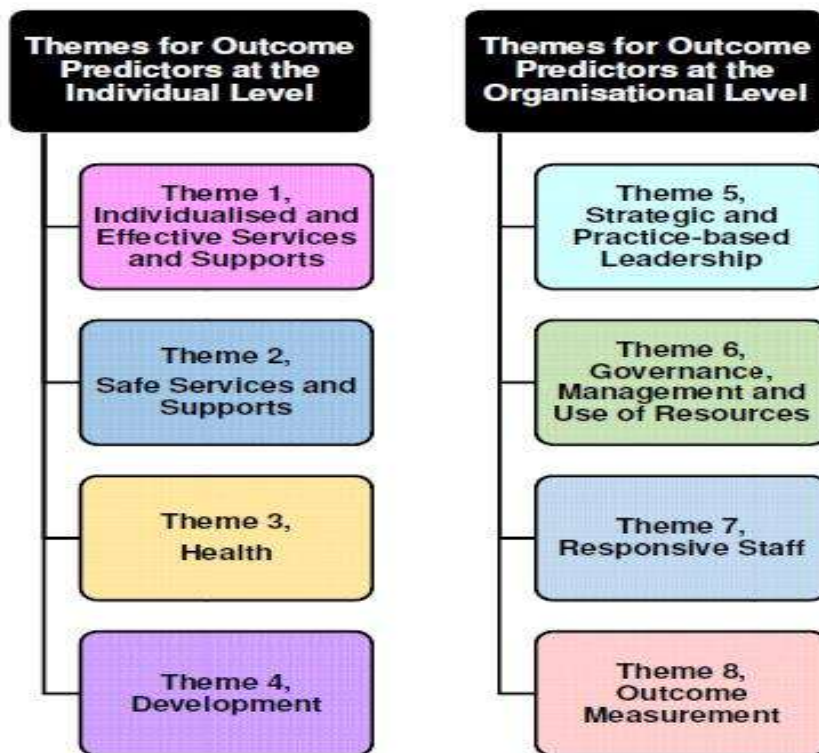
The persons who use disability services:

1. Are living in their own home in the community
2. Are exercising choice and control in their everyday lives
3. Are participating in social and civic life
4. Have meaningful personal relationships
5. Have opportunities for personal development and fulfilment of aspirations
6. Have a job or other valued social roles
7. Are enjoying a good quality of life and well-being
8. Are achieving best possible health
9. Are safe, secure and free from abuse

<sup>7</sup> The Transforming Lives Programme is driving the implementation of the recommendations of the Department of Health's 2012 Value for Money and Policy Review report and national disability policy to deliver person-centred models of service. The Programme aims to ensure that people with disabilities are supported to make choices about their lives which are available to everyone else in society.

The Quality Framework identifies outcome predictors for the individual and organisation that support the measurement and evaluation of activities and practice that are known to support positive quality of life outcomes under the nine domains. These outcome predictors are captured under eight themes that are aligned to the HIQA Outcome Framework themes. This approach was taken as these themes are familiar to all residential disability service providers. The eight themes are captured in Figure A1.2 below.

*Figure A1.2: Quality Framework-: Outcome Predictor Themes that support the achievement of personal outcomes*



## Appendix 2: Person Centred Planning.

The following extract from the National Person Centred planning Framework provides a brief overview of person centred planning approaches and theories:

### Planning Tools

#### PATH (Planning Alternative Tomorrows With Hope),

Developed by Jack Pearpoint, John O'Brien and Marsha Forest; "begins with the end in mind". It is a creative planning tool that uses both process and graphic facilitation to create a shared vision of a positive future for individuals, families, teams and whole organisations. The process focuses on ideals, values, passions, and dreams. PATH draws on people's ability to visualize different futures and to plan backwards from a future vision or dream, and tell stories about how that vision can come into being. It starts with the person's future dream, compares this with what their life is like now and produces an action plan to help that person to achieve their dream. Each session will be led by two trained facilitators - a process facilitator who guides people through the stages and ensures that the person is at the centre throughout, and a graphic facilitator who creates a large graphic record of each of the steps in the PATH. PATH can work really well for a person who has developed a vision of what they would like to do. It is a very results-oriented process, excellent for team building, and has been used to mediate conflicts.

#### MAPS (McGill Action Planning System aka Making Action Plans),

Developed by Jack Pearpoint, John O'Brien and Marsha Forest; asks eight guiding questions from which a team works together to assist individuals to define their dream and build a plan to achieve it. Key questions address the individual's history, dream, nightmare, strengths and needs. The process culminates with a plan of action. MAPS gathers information for planning based on the personal history of a person. The individual and those who have known him or her contribute information by telling stories about significant events. The background map created helps the group to understand the life experience of the focus person and his or her family. Participants gain a greater appreciation of the individual as a whole person, with a broad range of experiences, struggles, and achievements. The positive experiences point out opportunities upon which the group can build; the problems and barriers encountered give the group a greater sense of the effort required to make good things happen. The map helps to celebrate the accomplishments and to show how opportunities in the present are often a result of experiences and actions in the past. MAPS is a creative planning tool that also uses both process and graphic facilitation. The MAPS sessions are also led by two trained facilitators - a process facilitator and a graphic facilitator.

#### Personal Futures Planning,

Developed by Beth Mount and John O'Brien; provides a way of helping to describe the person's life now and look at what they would like in the future. It contains a series of six tasks designed to help find capacities in individuals, identify options in their communities, and develop supports and services that will meet each individual's strengths and needs. It helps people to build on areas of



their life that are working well now and to move towards their desired future. It is useful when people need to learn more about the person's life (unlike PATH, which assumes this knowledge) and to create a vision for the future (unlike Essential Lifestyle Planning that focuses on getting a lifestyle which works for the person now). It will not provide the detail about what the person requires on a day-to-day basis in the way that Essential Lifestyle Planning does, but provides an excellent overview from which areas of concern can be considered. The quality of the planning depends more on the skill of the facilitator than on choosing the 'right' style.

### Essential Lifestyle Planning (ELP),

Developed by Michael Smull and Susan Burke-Harrison; to support people who were moving out of institutions into their communities. ELP set out to ensure learning about what is important to people and what supports they need was captured and used. An essential lifestyle plan focuses on what is important to someone now and balances this with things like keeping the person healthy, happy and safe. Plans are written in plain and clear language and focus on enabling the person to achieve what is important to them and on how to provide the support to do this. An essential lifestyle plan should always have an action plan and it is vital that the plan changes and grows with the person - it is a living document.

### Person-Centred Thinking Tools,

Can support people to think about a number of key questions. The information is then gathered to co-produce their plan. A range of people should be involved in the planning process, but the person being supported should always be at the heart of the process. Person-centred thinking tools and skills provide a practical framework you can use day-to-day to help people to have more choice and control in their life. Each person-centred thinking tool provides the basis for actions and further information about what is important to people and how they want to be supported. Key questions include:

- o What is important to you?
- o What do you want to change?
- o How will you arrange your support?
- o How will you spend your money?
- o How will you manage your support?
- o How will you stay in control?
- o What will you do next?

## Planning approaches

### Community Circles;

Is a way of bringing people together around an individual with the support of a trained facilitator. Community Circles support the person to achieve an outcome or change that they would like to see happen in their life. The facilitator's role is to structure the Circle's meetings, and turn aspirations and ideas into action. The Community Circles process uses person-centred practices to enable conversations that lead to actions that make a positive difference.

### Social Role Valorisation

Is a Theory of Practice that is extremely useful for making positive changes in the lives of people disadvantaged because of their status in society.

It is based on the theory that the more social roles a person has, the better the chances of having access to the good things of life. The good things of life are universal across society and cultures, and are the typical things that most of us enjoy such as family, friends, a meaningful day, home, safety and security, the opportunity to develop, belonging, respect, ordinary social life, good health, access to community places, and having a say.

### The Discovery Process;

Developed by Hope Leet Dittmeier, discovery is an approach which engages with the person to obtain and gain a deeper knowledge, insight and understanding of the person. The Discovery process can look at all aspects of a person's life, dreams, wishes and preferences. It is an individualised journey of learning with and about the person, supporting them to gain knowledge and experience through family and community engagement and inclusion, and building circles of support. The Discovery Process is based on Social Role Valorisation Theory.

**“Bringing the Good life to Life”** This website developed by the Community Resource Unit Ltd in Australia includes many resources that support and guide the reader in relation to person centred planning, social role exploration, community inclusion. <http://thegoodlife.cru.org.au/>

**STEPS To Independence** is a guidebook that provides an opportunity for individuals with an intellectual disability to determine how prepared they are for semi-independent living. It provides a holistic tool to help someone with their goal of living independently with supports by starting the conversation, identifying current skills, determining skill areas for improvement (where more learning can happen), and next steps to focus on.

<https://connectability.ca/2014/06/24/steps-to-independence-2/>

**MyCompass** This is a web based secure tool designed to help people with disabilities and their supports to chart a course towards all the things that make life great. It's a planning and case management tool, a better log note system and a secure way for people served to keep in touch with their guardians, family and support workers. <https://www.mycompassplanning.com>

**In Control Scotland** This organisation was formed to promote the development of self directed support and individual budgets. Their mission is the transformation of social care into a system of self directed support so that people get more control over their support and their lives and they are able to fulfil their roles as citizens. They promote and support the development of a sustainable system of self-directed support in Scotland. There is a range of resources and advice on their website <http://in-controlscotland.org/>

**Radical Visions** provides practical assistance to fellow citizens, families, organisations and wider society to promote and exercise the values of inclusion. It is part of a network and movement for change, and the challenge of orthodoxy to develop approaches to Person Centred Planning, Self-Directed Support, and Organisational Change and Development.

<http://radicalvisions.wpengine.com/>

**Enabling Good Lives:** The EGL approach adopted in New Zealand is led by disabled people and their families, giving them greater choice and control over their support and their lives. This is one resource in the National Office of Disability Issues(ODI) overall Disability Strategy.

[www.odi.govt.nz/guidance-and-resources/enabling-good-lives-overview-presentation/](http://www.odi.govt.nz/guidance-and-resources/enabling-good-lives-overview-presentation/)

## Appendix 3: Additional Resources

### Change Management Planning Tools

There are a wide range of change management models and tools available. Below is a small sample of the models currently available and widely used. The examples given have been selected on the basis that they take different approaches and demonstrate a range of methods to managing a change project.

#### 30, 60, 90- day cycles of change

The 30/60/90-day cycle tool is a way of helping to identify, prioritise and implement actions and will enable you to break actions down into manageable chunks. It will allow you to maintain flexibility and help define clear and specific objectives with a clear timescale.<sup>8</sup>

In using the 30/60/90-day cycle tool

- *While the objective of each cycle should be achievable in the timeframe specified, it should also result in a clear step beyond the place where you began*
- *Spend time purposefully anticipating what you will do next. You are not bound by this thinking, but if you have not given it any thought you risk wasting the momentum you have created*<sup>9</sup>

Further information:

<https://improvement.nhs.uk/documents/2083/30-60-90-day-cycles.pdf>

#### Plan, Do, Study, Act

Plan-Do-Study-Act (PDSA) [182] is shorthand for testing a change in the real work setting – by planning it, trying it, observing the results, and acting on what is learned. This is the method adapted for action-orientated learning. This approach empowers staff to run small scale test cycles, to share their ideas regularly, to determine if the change is a better way of doing things and to see first-hand if additional improvements could be recommended.

Simple models, such as the Plan-Do-Study-Act Model have merit in terms of introducing the concept of change cycles with defined phases, but they fail to support the real-life complexity of delivering change, which may not follow the prescribed sequence of events. More complex organisational development (OD) models have emerged that facilitate these complexities and a number of these are noted below.

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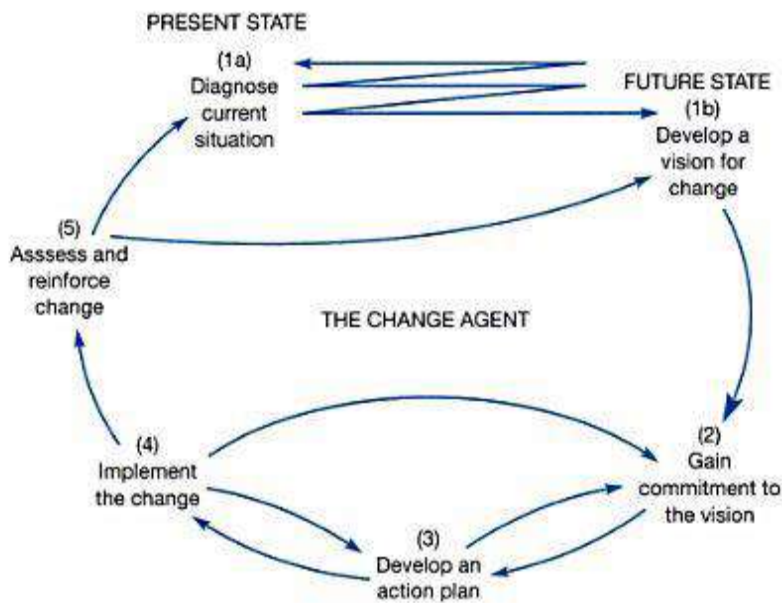
<sup>8</sup> From the ACT Academy for their Quality, Service Improvement and Redesign tools 30/30/90 day cycles

<sup>9</sup> Adapted from page 103 Leading Large Scale Change: A Practical Guide NHS England

## Senior and Swailes Organisational Development Model

The senior and Swailes OD Model is a change model that focuses on facilitation and renewal at all levels in an organisation. This model identifies five stages in a cycle with strong linkage back and forth across the model. This reflects that change is a dynamic process requiring continual reassessment and adaptation to move forward. The model is shown in Figure A3.1 below, followed by an overview of the stages.

Figure A3.1: Senior and Swailes OD Model



### Stage 1a and 1b: Present and Future State

The first stage is the diagnosis of the “Present State” and the development of a “Future State”. These are presented as steps within one stage to reflect their symbiosis

### Stage 2: Gain Commitment

The second stage identifies the need to gain commitment for the change. This recognises the challenge in moving a vision out into an organisation and securing buy-in and commitment from stakeholders to ensure the change will be supported, delivered and sustained.

### Stage 3: Develop an Action Plan

The third stage concerns the development of an action plan. Senior and Swailes identify this as the beginning of the transition but also the continuation of gaining commitment, through the involvement of people in the planning process.

### Stage 4: Implementing the Change

The implementation of the action plan is the focus of stage four. Senior and Swailes recognise that the methodology of change implementation varies significantly depending on the focus of the change. They reference the importance of orchestrating short-term wins which will build motivation and confidence in the proposed.

### Stage 5: Assess and Reinforce Change

In the final stage effective assessment will determine the extent to which the change has been achieved as planned and whether the service has realised the planned “Future State”. Equally, reinforcement is needed to ensure the sustainability of change through the consolidation of activities, behaviours, structural and process changes. This stage links back to the first stage, recognising that change is on-going and that once the future state has been achieved, the process of developing a vision for the future begins again.

## The HSE Change Model

The HSE Change model from 2008 is a four stage approach: initiation, planning, implementation and mainstreaming. This model has merit and is well supported by a change management toolkit and detailed literature. Similar to the Senior and Swailes model, it is a cyclic model that recognises the need for movement between the stages to support organisational change, see Figure A3.2.

Figure A3.2: HSE Change Management Model



## Person- Centred Change Management Resources

Leading Large Scale Change: A Practical Guide NHS England <https://www.england.nhs.uk/wp-content/uploads/2017/09/practical-guide-large-scale-change-april-2018-sml.pdf>

**Enabling Good Lives:** The EGL approach adopted in New Zealand is led by disabled people and their families, giving them greater choice and control over their support and their lives. This is one resource in the National Office of Disability Issues(ODI) overall Disability Strategy.  
[www.odi.govt.nz/guidance-and-resources/enabling-good-lives-overview-presentation/](http://www.odi.govt.nz/guidance-and-resources/enabling-good-lives-overview-presentation/)

Big Plans: A guide for meaningfully engaging people with learning disabilities in the development of their plans <https://www.scie.org.uk/social-work/named-social-worker/engage>

Guidance on the Development of a Personal Plan HSE Quality Improvement May 2018

Person-centred care for people with learning disabilities Webinar recording: 6 December 2017.  
Webinar about what it takes to deliver truly person-centred care for people with learning disabilities  
<https://www.scie.org.uk/social-work/named-social-worker/person-centred-care-people-learning-disabilities>

A New Way Home A personalised approach to leaving institutions.  
<https://www.centreforwelfarereform.org/uploads/attachment/596/a-new-way-home.pdf>

Circles of Support Manual for getting started <https://www.ric.org.au/learn-about/building-support-networks/circles-of-support/>

<https://www.communitycatalysts.co.uk/stories/general/>

Multi Me is a secure social platform and online person centred planning toolkit created for people with learning disabilities and their Circles of Support – but they do charge

Circles Network is a UK wide voluntary organisation renowned for building inclusive communities on the foundations of justice, advocacy, empowerment and friendships

<http://circlesnetwork.org.uk/>

<https://www.community-circles.co.uk/>

Foundation for People with Learning Disabilities UK: <https://www.mentalhealth.org.uk/learning-disabilities/a-to-z/c/circles-support-and-circles-friends>

Easy Read Guide : <https://www.mentalhealth.org.uk/sites/default/files/a-guide-to-circles-of-support.pdf>

Niki's story: <https://www.challengingbehaviour.org.uk/cbf-articles/your-stories/enduring-circles.html>

Facilitating Niki's circle - <https://www.challengingbehaviour.org.uk/cbf-articles/your-stories/facilitating-a-circle.html>

Circles of Support – A comprehensive guide to assist people with a disability, their families and carers, along with voluntary and community support organisations, to start their own Circle of Support or build on an already existing one. <https://www.inclusiondesignlab.org.au/what-weve-learnt/circles-of-support/>

It's my choice <https://www.inclusiondesignlab.org.au/what-weve-learnt/choice/>

Seven approaches to connect with your community [https://www.inclusiondesignlab.org.au/wp-content/uploads/woocommerce\\_uploads/2015/10/Seven-Approaches-web-version.pdf](https://www.inclusiondesignlab.org.au/wp-content/uploads/woocommerce_uploads/2015/10/Seven-Approaches-web-version.pdf)

The “Bringing the Good Life to Life” website from the Community Resource Unit Ltd, include resources on including others and the role of family and friends in supporting the good life

<http://thegoodlife.cru.org.au/including-others/>



## Appendix 4: Example Transition Co-ordinator Job Specification

Below is an example job specification for a Community Transition Co-Ordinator. In this example, the service is using the SRV approach to person centred planning to underpin their transition programme, which is reflected in the spec.

<p><b>Purpose of the Post</b></p>	<p>The Community Transition Coordinator will have a key role in managing the transition of residents from an institutional/ congregated setting to new homes in the community.</p> <p>This is a significant change in the lives of the residents and their families and these roles will be critical in ensuring that it is a success. In addition the post holder will also have a key role in ensuring that the model of service provided in the new community houses is person centred and based on a social model of support, and is in line with the principles of social role valorisation (SRV) and supporting self-directed lives (SSDL).</p>
<p><b>Principal Duties and Responsibilities</b></p>	<p><b>Transition to New Service</b></p> <ul style="list-style-type: none"> <li>• To facilitate people to move from a congregated setting, to their own homes in community settings in a planned, phased and coordinated manner.</li> <li>• To develop and implement detailed transition plans for each individual with key stakeholders, most importantly the residents, to ensure that adequate preparation is made with and on behalf of the person so that the transition process, the actual move and settling into their new home will be a success.</li> <li>• To work with Project Manager, Unit Managers and Director of Services in a collaborative ways to ensure that smooth transition to the new service.</li> <li>• To be part of the Time to Move on Implementation Team</li> </ul> <p><b>Managing Critical Relationships</b></p> <ul style="list-style-type: none"> <li>• To meet with and establish a mutual relationship of trust with residents and their families</li> <li>• Build a relationship with each resident to establish a support network and circles of support with each person that includes family (where appropriate), natural and unpaid supports and advocates.</li> <li>• Establish and maintain networks and connections with the person and the community in which they will be living.</li> <li>• To attend supervision and performance development reviews on a regular basis.</li> </ul> <p><b>Implementation of New Model of Service Delivery</b></p> <ul style="list-style-type: none"> <li>• Using Social Role Valorisation and Supporting Self Directed Lives theory, explore and identify residents interests, abilities and support then in developing valued social roles.</li> <li>• Establish links with Primary Care Teams and to support each person to source a GP, Dentist and pharmacist etc. of their choice in the community as appropriate.</li> <li>• Provide leadership to staff in new community houses on implementing social model of support during and after the move.</li> </ul>
<p><b>Eligibility Criteria</b> <b>Qualifications</b></p>	<p>Each candidate must, at the latest date for receipt of completed application forms for the post must possess:</p>

<b>and/ or experience</b>	<ul style="list-style-type: none"> <li>• Two years experience in working and supporting people with disabilities;</li> <li>• Social care, healthcare or nursing qualification</li> </ul>
<b>Post Specific Requirements</b>	<p>As this post will involve travel, access to suitable personal transport to allow the proper discharge of the duties of the post is a requirement for this post.</p> <p>A full clean drivers licence is required</p>
<b>Skills, competencies and/or knowledge</b>	<p><b>Clinical Knowledge</b></p> <ul style="list-style-type: none"> <li>• Demonstrate an understanding of relevant national standards for Disability services;</li> <li>• Demonstrate an understanding of safeguarding and service user protection;</li> <li>• Demonstrate a knowledge of Social Role Valorisation and Supporting Self Directed Lives Theory and how this can inform service delivery and development;</li> <li>• Demonstrate the ability to facilitate and implement a person centred plan</li> </ul> <p><b>Interpersonal &amp; Communication Skills</b></p> <ul style="list-style-type: none"> <li>• Demonstrate effective interpersonal &amp; communication skill, with both resident, and the ability to present complex information in a clear and concise manner, which can be clearly understood by all;</li> <li>• Demonstrate the ability to form links with other groups and the wider community;</li> <li>• Demonstrate a capacity to build therapeutic relationships with service users', families and staff.</li> </ul> <p><b>Organisational Skills</b></p> <ul style="list-style-type: none"> <li>• Demonstrate effective time management skills and ability to manage competing priorities;</li> <li>• Demonstrate an ability to use IT applications such as word, powerpoint and excel</li> </ul> <p><b>Motivation</b></p> <ul style="list-style-type: none"> <li>• Demonstrate the ability to motivate oneself;</li> <li>• Demonstrate resilience &amp; flexibility;</li> <li>• Demonstrate an ability to work effectively in a changing environment.</li> </ul> <p><b>Leadership &amp; Team working</b></p> <ul style="list-style-type: none"> <li>• Demonstrate the ability to work on own initiative and work as part of a multi-disciplinary team.</li> <li>• Demonstrate an ability to lead a change programme and engage positively with other staff.</li> <li>• Demonstrate a commitment to the principles of rights based person centred services and is keen to accept the challenges involved in the ongoing delivery of such services.</li> </ul>

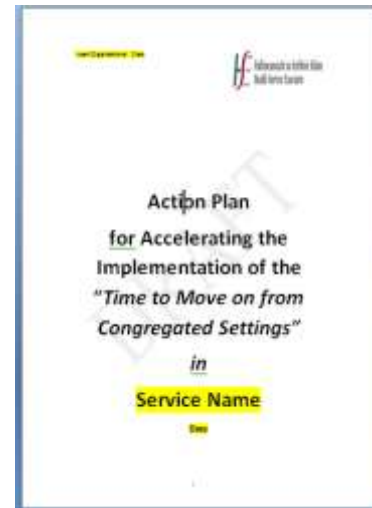
## Appendix 5: Supporting Project Tools

### 5a Time to Move On Project Action Plan Documentation

A Project Action Plan template is available to support priority sites to develop their Action Plans for the transitioning of individuals from congregated settings. [www.hse.ie/timetomoveon/](http://www.hse.ie/timetomoveon/)

This resource is focused on:

- Supporting service providers to deliver a plan that can be implemented and used as an on-going project management tool to track and manage project progress
- Informing and guiding organisations on the key work streams required as part of a change project to successfully support people moving to the community
- Supporting providers with the reconfiguration of resources and enable the identification of transitional resource requirements
- Supporting providers to develop plans for part of a service or a group of individuals in the context of operating a larger congregated setting.



The Action plan document suite is a number of pre-populated and formatted documents that providers can adapt and amend to create a service-specific plan. In the context of supporting person-centred transition planning, the following components may be useful:

- High Level Project Scope Statement
- Guidance on development and population of 8 defined work streams. Work plan templates to define tasks and assign roles, responsibilities and timeframes for every task under each work stream
  - Leadership, Governance, Strategy & Planning
  - Communications
  - Finances
  - Individual planning
  - Housing
  - Transition
  - Workforce planning/ HR/Training
  - Community Services (Inclusion)
- Project Tools to support management of the Risks, Issues and Dependencies through tracking logs

## 5a.1 Project Scope Statement

The project scope statement tool can be useful to guide the initial development of a transition plan.

<b>Project Name:</b>	
<b>Project Lead/Manager:</b>	

<b>Project Justification:</b>	<i>e.g. This project is to support the transition of XXXX from a congregated setting, to a home in the community in line with the Time to Move on and New Directions policies of the Transforming Lives programme</i>
<b>Project Description:</b>	
<b>Project Objectives:</b>	
<b>Project Outcomes:</b>	
<b>Project stages, Deliverables and timelines</b>	

<b>Critical dependencies</b>	
<b>Assumptions</b>	
<b>Risks</b>	
<b>Approach to delivering the project:</b>	<i>How the project will undertake its work. e.g. establishing project team, workshops etc</i>
<b>In Scope of project:</b>	<i>Example : reconfiguration and delivery of day supports in keeping with new Directions model</i>
<b>Outside of Scope of Project:</b>	<i>Example: Project plan excludes Centre X on the service campus, which will be subject of a separate project action plan X residents accessing day supports in the residential setting will not be subject to individuals planning processes</i>
<b>Project Team Members:</b>	

**Project Scope Statement: Project Management Work streams**

<b>Work stream Name</b> <i>(examples given below)</i>	<b>Assigned Lead Person</b>
<i>Workforce Planning</i>	
<i>Finance</i>	
<i>Communication Planning</i>	
<i>Housing Acquisition</i>	
<i>Individual Assessments</i>	
<i>Governance/ Planning oversight</i>	
<i>Community Services</i>	
<i>Transition Planning</i>	

## 5a.2 Work stream Plan

An example of a work stream plan is given below. This identifies the first work stream heading and an example list of the individual tasks included under this heading. This would be repeated under each of the work stream headings. A full list is included in the Project Action Plan template document.

<i>Work stream1 : Leadership &amp; Governance</i>			
<b>Deliverable</b>	<b>Key Actions/KPI</b>	<b>Task Owner</b>	<b>Date Due</b>
Identify Clear Mission Statement re policy  Clear visions and “Statement of Purpose” for overall services and specific centres	<ul style="list-style-type: none"> <li>• Agreed organisational decision on decongregation</li> <li>• Agreed theory of practice (vision, values, beliefs, assumptions, purview, principles, agreed approach)</li> </ul>		
Identify Implementation Team	Governance /oversight group in place		
Identify Project Manager	Personnel in place to undertake the work		
Identify Communications Manager	Personnel in place to undertake the work		
Agree Workstreams	Workstreams defined and captured in project scope document		
Agree deliverables for each Workstreams	TOR and tasks defined for each workstream		
Appoint workstream leads			

### 5a.3 Project logs

A word document version of each of the logs identified below is included and is available in the Time To Move On Action plan accessible at [www.hse.ie/timetomoveon/](http://www.hse.ie/timetomoveon/)

#### Dependency log

A Dependency Log following the format below can be a useful tool to track issues that are critical to project success. As noted below these are considered the “show stoppers”, issues that will critically impact the progress of a project.

### Project .....: Dependency Log

Critical Dependencies “show-stoppers”					
Dependency	Actions required	Agreed with Dependency Owner (y/n)	Agreed Delivery Date:	Dependency Owner	

#### Risk Log

This should be used to record any risks that are identified as a potential or known risk to the implementation of the project. This supports and enables the team to monitor, track or escalate these risks before they become an issue that impacts on the progress of the project.

### Project ..... Risk Analysis Log

Risk Analysis								
No	Risk	Date Raised	Raised By	Probability	Impact	RAG Status Red/Amber/Green	Risk Owner	Mitigation / Resolution

### Issues Log

This should be used to record any issues which arise during detailed implementation planning to ensure they are monitored and resolved.

## Project.....ISSUES Log

Inventory of open issues from project

Ref No	Heading	Issue	Action required	Responsible	Date raised

### Project Plan Tracking Document

This tool can be used to track all the tasks identified to support the action plan and using the RAG status ( Red - Amber - Green), it provides a quick overview of where the project is on target and where issues might be arising, as tasks are behind schedule or overdue.

A word document version of this is available for use in the Project Action plan document on the webpage [www.hse.ie/timetomoveon/](http://www.hse.ie/timetomoveon/)

Project Plan Task List					
Task Ref	Task Description	Named Person	Date Due	Status	Comment
Workstream 1 Governance					
Deliverable 1. Overall Project management					
1.2	Identify Implementation Team	J.A.	Date		Completed. Members identified and org. chart completed
1.3	Agree Terms of reference for Team	J.A.	Date		In draft, to be agreed at next meeting
1.4	Set Schedule of meetings / engagement to support project action plan development	S.O'M.	Date		Agenda item for next meeting
1.5	Develop risk register for all project moves	S. O'M	Date		Risk Log to be commenced at next meeting



## Gantt Chart

Where a project involves several activities running simultaneously, it can be useful to develop a Gantt chart, which identifies the individual actions with target delivery dates against the overall project timeline. This provides a visual overview of the workload at all stages, which is beneficial in ensuring a manageable distribution of tasks. It also facilitates ongoing monitoring to ensure that deadline slippage is avoided. An example of a Gantt Chart is given below in Figure A5.1 below.

Figure A7.1 Gantt Chart template

### Example Gantt chart

Activity/Task	Completion dates										
	30/09/13	15/10/13	31/10/13	15/11/13	30/11/13	15/12/13	31/12/13	31/1/14	28/2/14	31/3/14	14/4/13
Action 1	■	■	■	■	■	■	■	■	■	■	
Action 2	■	■									
Action 3			■								
Action 4			■								
Action 5			■								
Action 6				■							
Action 7						■		■			
Action 8					■		■				
Action 9						■		■			
Action 10								■	■		
Action 11			■		■		■				
Action 12									■	■	
Action 13									■	■	
Action 14									■	■	■

There are many websites that provide Gantt chart templates for free including [www.teamgantt.com](http://www.teamgantt.com) and [www.smartsheet.com](http://www.smartsheet.com)

## Appendix 6: Communications and Stakeholder Mapping & Analysis tools

### 6a Time to Move on Communication Stakeholder Mapping tool

This tool provides a resource that service providers can use as a starting point to identify all the potential stakeholders that they may need to consider. The mapping tool includes a comprehensive list of the potential stakeholders and then poses the questions Who?, What?, How?, When? and What if? (see Figure A6.1 below), in order to prompt the service to consider the appropriate communication and engagement strategy for the stakeholders as part of an overall comprehensive communication plan, in order to prevent issues of poor or un-coordinated communication arising.

Figure A6.1: Communication Stakeholder Mapping Tool Headings

WHO?		WHAT?		HOW?	WHEN?	WHAT IF?
Target Audience	Who Delivers the Message	What is the purpose of the Communication?	What is the content of the message?	What is the Recommended Communication method?	When is the best time?	Dependencies

### 6b HSE Change Guide Engagement and Communication Plan tool

There is also a tool available on the HSE Change guide that takes a similar approach but explores the development of a communication and engagement plan in more detail. The key guidelines in the tool are not specific to the transition planning process, but as generic queries they are equally as valid Under each heading Who (Audience)? Why? What? How? When? and Who (Responsibility)? There are a number of prompts that will support service providers to explore these areas thoroughly. See Figure A6.2 below.

Figure A6.2: HSE Change Guide Engagement and Communication Plan tool

Who? Audience	Why? Purpose/change outcomes	What? Content and focus	How? Method and impact <sup>a</sup>	When? Frequency/timeline	Who? Responsibility
<p>(see stakeholder mapping and analysis)</p> <p><b>Identify who you are communicating and engaging with</b></p> <ul style="list-style-type: none"> <li>Individuals</li> <li>Groups</li> <li>Evolving networks and coalitions for change.</li> </ul> <p>(Note: The identification of the different individuals and groups you are communicating with, i.e. your target audience, will influence your decisions regarding each of the questions in the columns to the right.)</p> <p>See Section 2: People's Needs Defining Change</p>	<p>Clarify the purpose of engagement and communication, i.e. to inform, consult, involve, collaborate or co-produce?</p> <p>Identify the 'purpose of the change' and associated 'outcomes': why is the 'change outcome' a reason for me to get involved? Is there a compelling vision for change? How will the change outcome inspire people to engage?</p> <p>(Note: The purpose of communication/engagement will determine the content and focus – see column to the right.)</p>	<p>Consider what will assist you to connect with people and help them to engage – how will you frame your message?</p> <p>Take into account what your 'audience' already knows.</p> <p>What do people need to know?</p> <p>What key focus/messages do you want to give?</p> <p>What issues are people already dealing with that will impact on their capacity to engage?</p>	<p>Consider how individuals or groups are currently engaged – what is working well? Utilise existing opportunities to communicate and engage.</p> <p>Identify the most appropriate method or means of communication, or engagement.</p> <p>Be clear on how people can get involved or get more information.</p> <p>Use the potential of social media to reach wider audiences and diverse groups.</p> <p>Address challenges to communication and engagement – tailor your message/language to meet the needs of particular groups.</p> <p>Consider accessibility issues for people with particular communication needs.</p> <p>Consider access including venue location and facilities for engagement events.</p>	<p>Consider the best time to share information and engage. Are there other competing issues that you need to be aware of?</p> <p>Be clear on frequency of communication.</p> <p>In setting timelines for a response be specific and open to feedback on what is realistic.</p> <p>How will ongoing communication and engagement be managed so that it is not a 'once-off' event?</p>	<p>Clarify and assign responsibility for communication – this may be an individual or group.</p> <p>Who is best placed to deliver the message? How can these individuals be supported in their role?</p> <p>Encourage personal responsibility for sharing information through networks and different media. Recognise that 'we all have the power to be change agents.'</p> <p>Clarify responsibility for engagement. How can this be shared? How can service users/citizens be involved?</p>

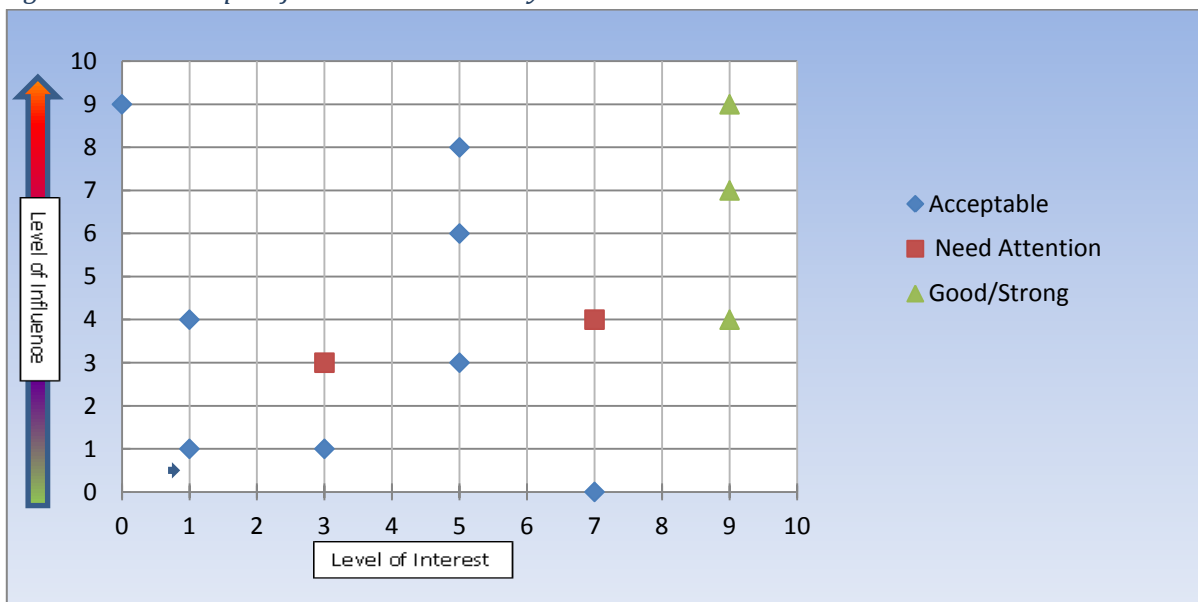
## 6c Stakeholder Influence & Interest Tools

There are a range of tools that can be used to chart and assess the level of **interest** and **influence** that the different stakeholders have at a particular point in the process, which can be an effective way of identifying areas of concern which will inform the communication and engagement plan. Where transition planning is only starting in a service or there is a lack of clarity around the views and position of different stakeholders or their inter-relationship with others, this tool will be particularly useful to guide the service through the process of mapping the stakeholders so that the plan for communication and engagement is well informed.

This tool can be very useful to indicate where influence and interest is linked to both formal and informal structures and networks. It can be the case that opinion leaders, the ‘go to’ people locally or other local stakeholders may have as much impact as those in senior management positions, high ranking professionals or those with access to resources.

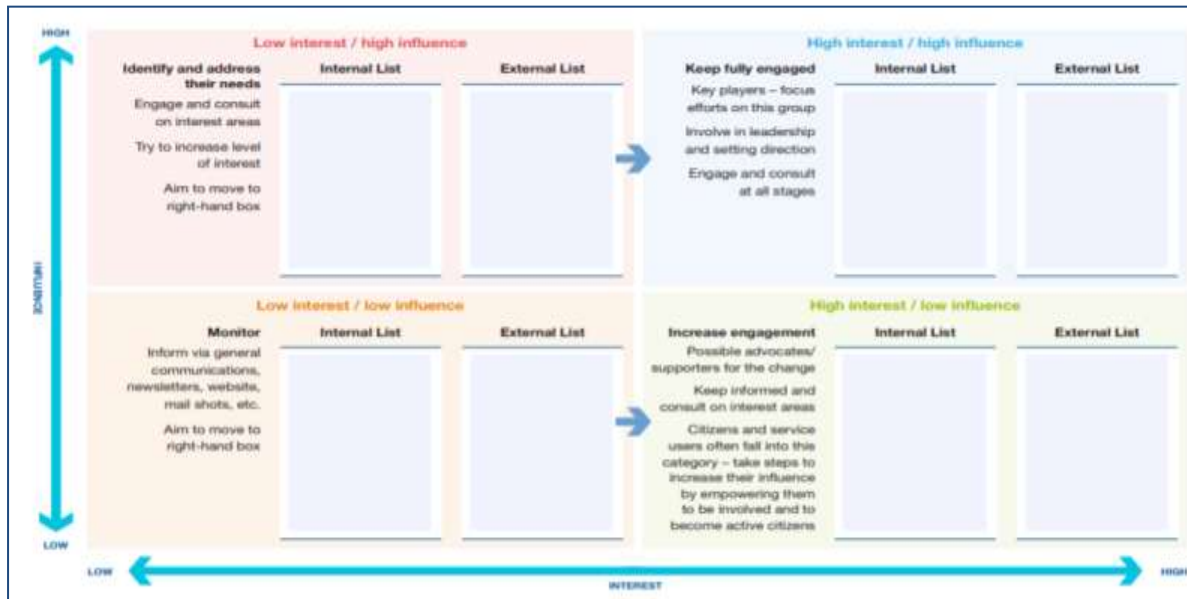
There are many versions of this tool available and the example at Figure A6.3 below, is a simple variation where the stakeholders are plotted on a chart depending on their level of influence and interest. The tool can then be used by an individual or group to determine whether each stakeholder is “*in the right place*” or whether action is needed to manage their level of influence and interest. It is often useful to do this exercise as a group, as each individual will bring their own perspective of the impact of others to the process and these views can vary widely.

Figure A6.3: Example of a Stakeholder Analysis Tool



In Figure A6.4 below, another variation of a Stakeholder Influence & Interest tool is identified, that uses a grid format to map the level of interest and influence. This is a less dynamic approach, as it does not question where a stakeholder currently sits in the map, but it does group the stakeholders and identify the type of actions that might be needed to manage stakeholders at the different levels.

Figure A6.4: Interest and Influence Mapping Grid from HSE Change Guide



This template is accessible on the Change Guide webpage at <https://www.hse.ie/eng/staff/resources/changeguide/resources/template-611-interest-influence-mapping-grid.pdf>

### 6d Detailed Stakeholder Analysis Tool

This is taken from the Defining Peoples Needs- Change Guide and is complemented further by a detailed stakeholder analysis tool that explores for the key stakeholders:

- identify their level of accountability for the change
- levels of readiness to embrace the change
- levels of interdependency
- explore how stakeholders can assist and influence the change
- identify how best engagement and communication can be progressed

In Figure A6.5 below the key areas considered in this tool are listed

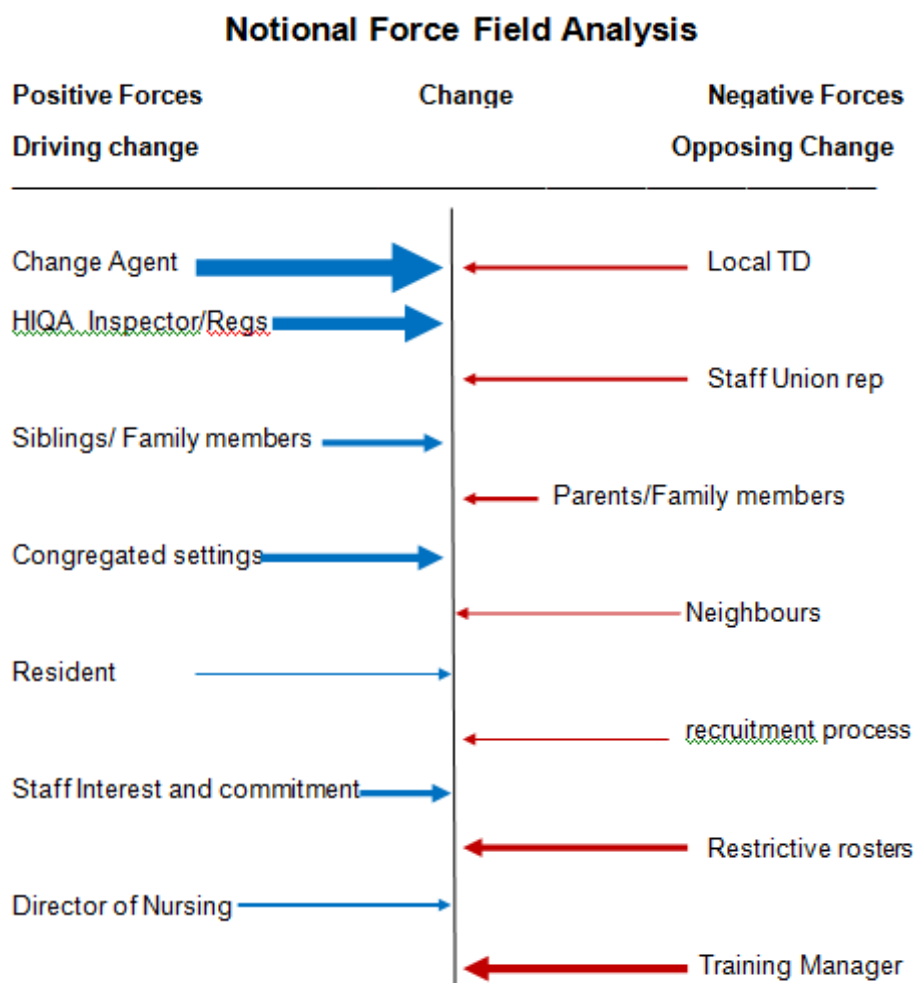
Figure A6.5: HSE Change Guide: Stakeholder Analysis and Mapping tool headings

Stakeholder name (individual/group)	Accountability for the change	Personal/team interests and readiness	Interdependency	Assist and influence the change	Engagement and communication
	What key actions are you responsible for individually or as part of a team?	Identify people's interest in the change. Identify hopes and concerns regarding the change at personal or team level. What factors would make it difficult for individuals or groups to 'get on board'? What would help?	Consider services that need to work together to achieve the change required. How might a change in one service/team impact upon other services/teams (ripple effect)? What changes are required in other parts of the organisation or service to enable this particular service to change/operate effectively?	Identify ways individuals or groups could assist and support the change process. Who influences them most? Who do they influence?	Consult with people on how best to engage and communicate with them. Outline engagement processes. Outline communication processes. Agree, review and update at agreed intervals.

## 6e Force Field Analysis

The force field analysis pioneered by Lewin in 1953, aims to capture the forces working positively and negatively around a proposed change, to identify how to drive the change forward by realigning the forces. The analysis is inclusive of all forces, with the stakeholders, systems, structures, processes, cultural influences and the change agent reflected. Using this analysis highlights the stakeholders and processes that can or need to be leveraged to bring about the change, which can inform the communication strategy. An example of a force field analysis is included in Figure A6.6 below

Figure A6.6: Force Field Analysis Example



Key messages should be revised and tailored for each specific audience, to ensure that the focus of the message, language and medium used are appropriate and effective. For individuals and their families, messages should be in plain English. Some examples of revised and tailored key messages are as follows:

#### ....for and about the Person transitioning

- Each person has the right to live independently\* and be included in the community.  
*\*“To live independently” means to live the life they choose, where they exercise real and meaningful choice. People can be supported to live independently; it does not mean they live without support*
- Each person will be supported to understand their rights and entitlements in the process.
- Each person will be supported to understand, communicate and express their will and preferences.
- Each person will have their needs assessed and communicated in a person centred plan.
- Each person will be supported to exercise real choice over where they live.
- The right of each person to decide on where and with whom they live will be respected.

#### ...for and about families and other stakeholders

- All stakeholders, including persons with disabilities, will be supported to understand the policy, why it is important, how and when it is likely to affect them, and how they can be involved.
- Parents, siblings, family members and friends are acknowledged as important in this process and their views will be considered in the planning process.
- There will be dedicated work with the individual/ families/ guardians to ensure that the concerns and hopes of all key stakeholders are heard and that these will be taken into account at all times.

#### ....staff perspectives, citizenship and life in the community

- The views of the staff supporting people will also be recognised and considered.
- The welfare and personal safety of each person moving to the community will be a key consideration in the planning process.
- Supports in the community will be organised before each person’s move.
- It is about “ordinary lives in ordinary places”.
- The terms *moving on* and *community inclusion* should be used in communications.
- Upholding the principles expressed in the UN Convention on the Rights of Persons with Disabilities.
- Recognising the value of people with disabilities as valued members of society and their local communities.

The Key Messages document developed for the *Time To Move On* policy are available on the [www.hse.ie/timetomoveon/](http://www.hse.ie/timetomoveon/) webpage.

## Appendix 7: Examples of Action Plan Approaches

### 7a Building Blocks Approach

An action plan can follow the headings in the person’s transition plan. Based on the building blocks identified in Stage 2, this would lead to an action plan that is structured as follows:

Actions & Tasks that:

1. Support the goals and outcomes identified under Dreams & Vision
2. Support the goals and outcomes in relation to the network of family, friends and supporters
3. Clarify & Support the person in decision making
4. Ensure governance
5. Support and enable opportunities to ‘imagine better lives’ and explore new alternatives
6. Deliver the plan for participation, contribution and community engagement
7. Address the resources required to support community living
8. Deliver a place to live that’s called home
9. Support partnerships and shared responsibilities
10. Support safeguarding

### 7b “Statement of Actions” Approach

The action plan can be structured from the perspective of the person moving, called a “Statement of Actions” approach. In this approach, the actions and tasks are grouped together and linked to the process from the person’s viewpoint as follows:

**Statement of Actions....**  
What must happen so I am ready to move  
What must happen to support me to move  
What must happen to help me settle into my new home  
What will happen once I am settled in my new home

Under each of these “**Statement of actions**” the specific actions, tasks and dependencies can be identified in relation to directly supporting the person as well as the many other aspects that need to be addressed to enable the person to transition.

Figure A7.1 below gives an example of tasks identified to meet the action statement “**What must happen so I am ready to move**”. In this examples these are divided into actions and tasks relating to

**the person transitioning** and concerned with **making the home**, the **support service** and the **resource implications**, but many more groups could also be included .

Figure 7.1: Example of a preliminary action plan scope for the first phase “What must happen so I am ready to move”

What must happen so I am ready to move	
In relation to:	Tasks (examples) :
<b>The Person</b>	<ul style="list-style-type: none"> <li>• Learning new skills- e.g. make a cup of tea, use a washing machine, take a bus</li> <li>• Spend time together with my potential new housemates</li> <li>• Go grocery shopping</li> <li>• Learn to use a Smartphone or tablet</li> </ul>
<b>Making my home</b>	<ul style="list-style-type: none"> <li>• Securing funding for the home</li> <li>• Securing the location</li> <li>• Planning any adaptation works</li> <li>• Assistive Technology, Aids and Appliances for daily living</li> <li>• Bedding- care needs and person centred</li> <li>• Decorating- to support visual impairment or those with sensory needs</li> </ul>
<b>My support service</b>	<ul style="list-style-type: none"> <li>• Risk Assessments</li> <li>• Changes in roles and responsibilities, team configuration and reporting relationships</li> <li>• Changes in service boundaries</li> <li>• Changes in working conditions</li> <li>• Work Practises and job specifications</li> </ul>
<b>Circle of support and my community</b>	<ul style="list-style-type: none"> <li>• Connecting with neighbours and community groups</li> <li>• Exploring opportunities for a social valued role or paid employment</li> <li>• Unpaid volunteers</li> </ul>
<b>Service Resources</b>	<ul style="list-style-type: none"> <li>• Funding for support staff</li> <li>• Access to mainstream support services</li> <li>• Changes to my day service support</li> </ul>
<b>Personal Resources</b>	<ul style="list-style-type: none"> <li>• Managing my money</li> <li>• Budgeting</li> <li>• Bank accounts</li> </ul>

### 7c Project Action Plan Approach

The project action plan approach takes the eight work streams from the Project Action Plan (See Appendix 5) and uses these as headings to capture the actions. It is important to ensure that if this approach is taken, that attention is paid to ensuring the person remains central to the transition plan and transition process and that service priorities and activity do not take over.



