This is the 10th briefing paper to be issued on the Monitoring and Review of Supporting People.

**INTRODUCTION**

The aim of housing support services funded through Supporting People (SP) is:

- To assist vulnerable people achieve or maintain a tenancy or other independent tenure, or
- To help them move on to live independently.

One of the primary tools for delivering the housing support service and to achieve these aims is the Support Plan. Under Supporting People greater emphasis is being placed on the quality of support planning and the involvement of service users.

The Quality Assessment Framework, (QAF), places significant emphasis on the accurate assessment of need and individual planning as being important steps in the process of ensuring that service users receive a service that reflects their needs. To date, the QAF has consisted of four core objectives. From June 2005, a revised version of the QAF has been introduced, with the number of core objectives increasing to six, with needs assessment and support planning now being assessed separately, to reflect the importance of this aspect of housing support provision.

This briefing paper focuses on support planning and review processes in relation to the delivery of the housing support service.
Core objective 1 of the QAF prescribes that:

“Service users have support plans based on up-to-date assessments of need. Processes place users’ views at the centre, are managed by skilled staff and involve carers and/or other professionals if service users wish”

The priority given to support planning is based on the premise that all supported housing services should have a clear purpose. The delivery of the service should be planned in a way that suits the needs of the individual and reflects their aspirations.

**Individual support planning is:**

- A snapshot of how someone wants to live today, serving as a blueprint for how to support someone tomorrow
- A way of organising and communicating what is important to an individual in “user friendly”, plain language
- A way of identifying how they are going to achieve their individual goals and checking on progress towards these goals.
- A flexible process that can be used in combination with other person centred planning processes
- A way of making sure that the person is heard regardless of the complexity of his or her needs

The range of needs of people using SP services are varied and disparate. Subsequently the range of services included in the programme varies greatly in their shape and focus. Therefore there is no support plan format that is appropriate for every type of service to every client group. There are however some fundamental principles to guide the support planning process.
PRINCIPLES TO GUIDE THE SUPPORT PLANNING PROCESS

Clear aims and objectives
The Support Plan should reflect the overarching aims of the specific housing support service. It should reflect the nature of the housing support offered and the needs of the specific client group. With the service user, agree specific steps and goals they will take to reach their overall aim, and how you are going to help and support them to reach these. Individual goals should be framed so that they are understandable to the service user and be achievable within their capacity. Clearly identify who is going to complete the tasks or steps (including those to be taken by the service user), and set a realistic time limit.

*For example, a night shelter providing short-term support is likely to address the emergency accommodation needs of the service user, with the secondary aim of helping the individual secure more permanent accommodation. The support plan is likely to focus on a small number of immediate needs and tasks. In a crisis situation it is likely that the worker is going to be more proactive, particularly in the initial stages. In contrast, the support plan in a sheltered housing scheme will reflect the more settled, long-term nature of the service and the help required to enable the service user to sustain their tenancy. The tasks and responsibilities are more likely to be supportive to the service user so that they can continue to exercise as much autonomy and control as possible.*

Empowering the individual
Each support plan should acknowledge the specific requirements, of the individual, and recognise their strengths as well as areas were they need support.

In order for support planning to be effective the service user should have a sense of ownership. This sense of ownership should be promoted by their full involvement in identifying their needs and measures required to address these needs. It could also be promoted by features like the service user writing and / or holding their own support plan.

Personal safety needs of the individual should be considered. While it may not always be necessary for service users to hold copies of their own support plans, best practice suggests that it should be the user’s decision. It is the role of the support provider to facilitate the service user’s choice.

Involving the service user
The most effective way of empowering the individual service user is by involving them at every step. Where possible you should encourage and support the service user to identify and set their own goals and tasks and in reviewing the action plan and agreeing next steps. For support planning to
work effectively, mutual commitment from the service user and the support worker to work together is essential. With participation a person will take more ownership and responsibility for decisions that are made.

Providers often find it difficult to encourage service users to become involved. Barriers to participation can be reduced by adopting the following:

- Explain the process of support planning clearly
- Describe its purpose
- Recognise the user’s current situation e.g. does he/she have needs around financial security or housing that need to be met before other considerations?
- Be aware of any cultural, social & racial issues
- Overcome any anxiety or tension that support planning is an institutional tool that the person doesn’t need
- Avoid jargon and use acceptable language, e.g. some people may prefer the term “individual plan” to “support plan”
- Use other means to establish preferences and dislikes when a person has communication difficulties e.g. facilitated communication, video, audio, and graphics.
- Describe any restrictions on choice and freedom imposed by a specialist programme
- Meet at a venue where the person feels comfortable
- Set objectives that are SMART (Specific, Measurable, Achievable, Realistic, and Time related)
- Give the person a copy of the plan or discuss and agree where copies are to be kept
- Explain and discuss confidentiality and agree who has access to the plan
- Review the plan on a regular basis, record achievements and agree new goals
Any individual support plan should follow five stages:

1. Make an initial assessment of need
2. Develop a support plan
3. Put the plan into action
4. Review of progress and reassessment of needs, within a regular, specified time
5. Set new goals and tasks

This is a cyclical process that should be ongoing for as long as the client continues to use the service.

1. **Assessing Individual Need in Relation to the Service Available.**

The assessment aims to identify the needs and aspirations of the service user and should form the basis for establishing the support action plan. The initial needs assessment should begin within a short period (1 or 2 days) of the person being accepted/admitted to the service.

As previously stated, each stage of the planning process, should reflect the overall aims of the service.

*As an example, the following might be discussed with a person being admitted to a direct access hostel:*

- Safety, security, health and well being
- Managing money, benefits and entitlements
- Ability to manage daily living tasks
- Support on emotional and personal issues
- Education, employment and training
- Practical issues
- Permanent accommodation needs

The needs assessment process is addressed in greater detail in Briefing Paper 11.

2. **Planning the Support and Action to be taken**

The support action plan should be completed following the assessment of need, ideally within a few days of any assessment meeting(s) or sooner if the nature of the service dictates. The action plan should reflect the same areas
as discussed and identified in the assessment, i.e. there should be clear links between the two stages.

**Objectives should be SMART:**
- **Specific** – about what objective the service user wants to achieve
- **Measurable** – you can measure if you / they are meeting the objective
- **Achievable** – within the individuals capacity and the time scale
- **Realistic** – within the resources available
- **Time limited** – how long will it take to achieve the objective

**A format for the plan might include:**
- The issue or need identified and the individuals goal in respect of this issue
- The task and action to be taken to achieve the goal
- The target date for completing the action
- The person/s responsible (including the service user themselves)
- Additional comments

**In general the following good practice is recommended to providers of supported housing services.**
- Support plans should reflect the aims of the particular housing support service
- The areas for goal setting should reflect the areas of support available within that service (e.g. maintaining the safety of the building, daily living skills, help with budgeting etc.)
- The person receiving support should set their own objectives with the support and guidance of his or her support worker
- Where possible and if appropriate the service user should write his or her own support plan
- The service user has the right and choice to share his or her plan with whomever they choose

**3. Putting the Plan into Action**
Actions should include those to be taken by the service user as well as the worker or the agency. Therefore consideration needs to be given to the capacity of the service user and the resources and support they will need to successfully achieve the tasks. These requirements should be recorded on the plan.
4. Reviewing Progress

The review is the time to assess how things are going and identify next steps in the support plan. In short term services the review should be carried out, at least, on a monthly basis. In permanent services the interval between reviews will depend on the level of vulnerability and needs of the service users. It should also be made clear that service users can ask for more regular or frequent meetings to discuss their needs and particular issues. Also that a review should take place if there are significant changes to the individual’s needs.

The review should become the main tool to record progress on the issues being addressed. It should reflect the same areas as the assessment and support action plan.

5. Agreeing Next Steps

For special needs clients in particular the first set of (SMART) objectives are likely to be small and achievable steps. The next set of agreed actions should build on successes and achievements to take next steps toward the overall aim. There might also be learning from goals that were not achieved. Maybe they were unclear or not realistic the first time, or perhaps the service user’s needs have changed. The review presents the opportunity to reframe or refocus the aims or try different ways to achieve the goal.
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<th>CHECKLIST</th>
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<td><strong>Assessment</strong></td>
<td>Clear aims and objectives for the service</td>
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<td>Explain the support planning process to the service user.</td>
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<td>Engage the service user in the process&quot;</td>
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<td>With the service user assess their needs in relation to the</td>
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<td>Identify strengths as well as needs</td>
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<td>Identify inhibiting factors and enabling factors.</td>
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<td>Agree with the service user how and where the support</td>
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<td>plan is to be stored.</td>
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<td>A formal risk assessment process should be included as part of the</td>
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<td>support plan</td>
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<td><strong>Support / Action Planning</strong></td>
<td>Identify the service users' priorities.</td>
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<td>What is the solution or goal?</td>
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<td>Identify the action needed to achieve the goal.</td>
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<td>Who will take the action (including the service user)</td>
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<td>Identify the time needed to achieve the goal</td>
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<td>Agree date for review</td>
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<td><strong>Implementation</strong></td>
<td>Take appropriate action based on the goals identified.</td>
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<td>Support the service user in completing their part of the tasks.</td>
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<td>Keep progress under review and adjust in the light of developments or</td>
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<td>new information.</td>
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<td><strong>Review the Plan</strong></td>
<td>Formally assess progress</td>
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<td>Identify blocks and supports</td>
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<td>Record progress</td>
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<td>Reassess – have needs changed?</td>
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<td><strong>Next Steps</strong></td>
<td>Set new goals, timescales, and responsibilities.</td>
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<td>Identify possible solutions to blocks</td>
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<td>Sign and date new plan</td>
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<td>Set next review date</td>
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WHAT CAN PROVIDERS DO TO PREPARE?

Policy and procedure development

Any organisation that does not have support planning in place should consider developing a policy statement and procedure as part of managing their SP contract/s.

The policy should outline the aims and principles of the organisation’s approach to support planning. The procedure should outline the practice, style and methods to be followed by staff in implementing and reviewing individual support plans.

The format of support planning should reflect the SP eligible housing support tasks carried out by the service.

It is possible that policy and procedures around service user involvement and participation need to be updated to reflect the support planning process.

Preparation for QAF

Core objective 1.2 in the QAF specifies the standards associated with support planning. There is also a comprehensive list of evidence requirements that demonstrate the standards are being achieved. SP providers are encouraged to acknowledge these in developing or adapting the organisation’s policy and procedures in relation to support planning.

Staff awareness and training

It is imperative that staff involved in the process of support planning are competent and have the necessary skills to deliver this process with the requisite care and diligence.

In this context it may be necessary to revisit training needs assessments for staff and to tailor training and development plans accordingly.
The SP team have produced this briefing paper to assist you in developing the support planning process. In addition you can contact the SP team at supportingpeople@nihe.gov.uk or visit the Supporting People section of the Northern Ireland Housing Executive’s (NIHE) website at www.nihe.gov.uk.

Further support can be obtained from CHNI: contact Bernie Heery at 71366363 or e mail Bernie-sp@utninternet.com

The following documents produced by the ODPM and available on the SP kweb (www.spkweb.org.uk) will assist in understanding the accreditation process:

(1) Monitoring and Review of Supporting People Services – An Overview
(2) Monitoring and Review of Supporting People Services – Using the Quality Assessment Framework

Other briefings produced by the SP team include:

(1) Supporting People: Briefing paper number 1 Monitoring and Review of Supporting People services
(2) Supporting People: Briefing paper number 2 The Quality Assessment Framework
(3) Supporting People: Briefing paper number 3 The Accreditation Process
(4) Supporting People: Briefing paper number 4 Contract Monitoring
(5) Supporting People: Briefing paper number 6 Security, Health & Safety
(6) Supporting People: Briefing paper number 7 Access and Diversity
(7) Supporting People: Briefing paper number 8 Protection from Abuse
(8) Supporting People: Briefing paper number 9
Complaints

(9) Supporting People: Briefing paper number 11
Needs & Risk Assessment