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Working on person-centred planning

From amber to green light?

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Abstract This article reviews the practice and policy based literature on person-centred planning in learning disability services in England. Its aim is to identify the implications for the workforce in practice. The analysis found that implementation is often described as partial or slow and characterizes reasons for this at a number of levels, including the slow pace of change in service culture and power relations, immutable funding structures, services' inflexible infrastructures, high levels of staff turnover and lack of training, inexperience among service management, inadequate staff supervision, and ambiguity among some stakeholders. Little substantial critique exists of the model itself. Analysis of the literature further reveals that the implementation of person-centred planning in practice is assisted by policy encouragement, service development and investment, favourable case reports and personal accounts, practitioner enthusiasm and positive evaluations. This article explores these to consider what facilitates the adoption of new elements of practice.

Keywords evaluation; learning disability; person-centred planning; professional practice; social care; *Valuing People*

Introduction

During the last decade the development of person-centred planning (PCP) for individuals with learning disabilities emerged as a policy goal in England. Person-centred planning refers to a number of explicit methods that provide a framework for people who use social care services to design their own services to meet their current needs and desires, and move towards future goals (Stalker and Campbell, 1998; as summarized in

Dowling et al., 2006). It responded to a number of critiques of services, particularly that people have routinely been expected to fit into existing services (Maudslay, 2002; Sanderson, 2000) and have often been thought of as passive recipients of care with no role to play in the organization or planning of their support packages (Rose, 2003). Stainton (2002) has claimed that the 'needs of the disabled' have been determined without reference to any particular person in the erroneous belief that disability related needs are universally, rather than individually, determined. PCP builds on previous models of planning and change and has particularly been associated with the inclusion movement (Sanderson et al., 2006).

Services continue to evolve in England following the impetus of the White Paper *Valuing People* (Department of Health, 2001a). Many changes are evident (CSCI, 2004) and further are planned (Department of Health, 2006). Rose (2003) identifies a shift in attitudes towards greater respect and equality among providers for service users. Moves to the greater individualization of organizations have led to increasingly personalized services. However, progress towards the widespread implementation of PCP has been portrayed as evolutionary (Robertson et al., 2005) despite its potential to improve people's life chances. While it has on occasion become an idiom commonly used to describe the way services operate (see Jarvis, 2001), it is not the case that it has been fully adopted or implemented across social care (Cambridge and Carnaby, 2005).

This article draws on a recent literature review, which assessed the barriers and bridges to person-centred planning in adult social care. The review was funded by The Joseph Rowntree Foundation and carried out by a team at King's College London over a 4 month period in 2005 (Dowling et al., 2006). Following a brief discussion of the methods used to carry out the review, the article discusses the findings, namely the factors that impede or promote the implementation of PCP within social care services for people with learning disabilities. Factors that appear to be causally linked to implementation difficulties are problems in adapting funding and service structures, staffing deficits, and ambiguity about the approach or desire to change. Analysis of the literature also identified that the implementation of PCP is being assisted by policy encouragement, service development investment, case reports and personal accounts, practitioner enthusiasm and positive evaluations. Thus the article explores factors that seem to be positive drivers in practitioners' and services' adoption of person-centred planning.

Methods

This scoping review was conducted through a review of the literature and by consultation with a team of user consultants, who were paid for their work. These two methods were integrated and mutually informative, but for ease of description and clarity they are described separately here.

Literature review

Criteria for considering papers for this review Since this was an integrative review seeking clarity and consensus, rather than a systematic review, a broad approach was adopted regarding the inclusion of papers. If they focused on PCP, by way of either empirical work, opinion, evaluation or review, and in so doing drew attention to existing barriers or bridges to its implementation, then they were included.

Search strategy for identification of studies The general structure of the search strategy was:

- (person-centred planning or synonyms)
- ‘or’
- MeSH terms were added using the OR operator depending on the thesaurus for each database
- ‘and’
- specific user group or synonyms (e.g. learning disability and synonyms or older people and synonyms; this was repeated for a wide range of social care user groups).

The following electronic databases were searched: Assia, Amed, Age Info, Age Line, Care Data, Best Practice, Cochrane, Cinahl, King’s Fund and PsycINFO. A forward citation search using Web of Science was carried out on papers which were included in the study. In addition, searches were made for materials originating in the voluntary sector, professional and governmental organizations, using the websites of the (then) Modernization Agency, the National Council for Voluntary Organizations and the National Electronic Library for Learning Disability (BILD). Internet searches using Google as a search engine were also made and these identified a number of websites concerned with person-centred planning, which were screened for relevance to issues of interest to this review. Finally, journals that produced a significant number of references were hand searched, and reference lists were checked for relevant citations.

Study selection Titles and abstracts of studies identified were read on screen by the study’s researcher (SD). These were assessed against the broad inclusion criteria (described above) and those clearly outside this were rejected. Those studies that seemed likely to inform the reviews questions were retrieved in hard copy and a sample of these were read by the other members of the research team. The studies identified were discussed in detail before a final decision as to whether to include them was taken.

Data management Citations were stored using Reference Manager. The researcher (SD) extracted data using preprepared data charts. These had been piloted to ensure their reliability in extracting relevant data.

Data extraction and analysis Papers included in the final review (Dowling et al., 2006) were read and data were extracted using a framework method. Eight analytical charts were created, each focusing on a particular theme. These included: general information, antecedents to person-centred planning, contextual and structural issues, process in implementation, issues for service users and their families, factors relevant to particular populations, issues for frontline staff and finally outcomes and evidence of good practice. Each chart was divided into a number of subthemes and data from papers were entered into the charts. This method enabled a clear view of the range of data and also facilitated comparison of contrasting and common factors. Salient and recurrent themes were drawn out of the charts and appraised in relation to the research questions.

Working with user consultants

User consultants were recruited as members of the research team. They represented Impact, a mental health user consultancy; Paradigm, a learning disability user consultancy; Better Government for Older People; as well as one independent user consultant in disability. User consultants were regarded as essential to the research process; they contributed to three defined and important stages of the project, namely, study design, data extraction, data analysis and preparation of the study report. Additionally, the consultants were asked to advise on literature sources they were aware of, in particular those where voices of users were reported in relation to person-centred planning. Work with the user consultant from Paradigm enabled the researchers to produce an accessible version of the project's findings (for copies of this please contact the authors).

Findings

It was immediately apparent that publications about learning disability services and their staff dominated the literature. Those publications discussing services for older people (particularly people with dementia), mental health services for adults of working age, and services for people with physical disabilities, were in a minority and are not included in this article unless they are relevant. From the publications covering learning disability services, a number of themes emerged which identified factors that encourage or impede the implementation of PCP in practice. These are reported on and discussed in the subsections below.

Inhibiting factors

The slow pace of change The legacy of past organizational structures, work practices and modes of service delivery may impact on whether the implementation of PCP can be comprehensively achieved or simply tacked onto existing structures and service models. Government policy recommends a collaborative and inclusive approach to service delivery within social care. In May 2004 (quoted in Wistow, 2004), Stephen Ladyman (then Parliamentary Under Secretary of State for Community) announced a new 'vision' for social care, stating that services should be 'person-centred, proactive and seamless'. Moreover, the consultation paper on the social care Green Paper in England states that adult social care should be based on the principle 'that everyone in society has a positive contribution to make to that society and ... should have the right to control their own lives' (Department of Health, 2005a). While it is clear that person-centred care lies at the heart of current policy, the principles underlying person-centred planning have been emerging also in policy documents since the publication of the White Paper *Caring People: Community Care in the Next Decade and Beyond* (Department of Health, 1989), which promoted independence and choice in the development of individualized services. Nowhere has this become more evident than in the White Paper on learning disability, *Valuing People* (Department of Health, 2001a).

Some see little evidence of widespread implementation of PCP in social care services, beyond the policy agenda (Rose, 2003). For instance, ideas of user involvement and person-centred planning are only partially included in some mainstream services (Truman and Raine, 2002). Others draw attention to the limited evidence base (Mansell and Beadle-Brown, 2004a; 2004b), which had not demonstrated significant improvement in outcomes before the policy was adopted and promulgated so widely. Mansell and Beadle-Brown (2004a) warn against focusing on training for PCP without real changes in resources; in their view it can be a 'displacement activity', with more attention on planning than on action.

The scale of the task outlined in policy documents is ambitious and PCP is just one of a series of imperatives, not just in learning disability services, but in social care and community health (Cabinet Office, 2005;

Department of Health, 2006). Modernization, reconfiguration, and a range of policy goals affect frontline workers and their managers alike.

Practice levels Some contradictions have been identified between policy and practice guidelines, thus increasing complexity in implementation. This is illustrated within services for people with learning disabilities, where the inspectorate (National Commission for Care Standards, now Commission for Social Care Inspection) states that no one with a learning disability can be 'supervised' by someone who is untrained or has not been subject to a criminal record bureau check (Todd, 2002). This may be read as in conflict with the 'informal supports' encouraged within person-centred planning protocols. However, Magito-McLaughlin et al. (2002) note that compliance with regulations and the establishment of broad systems that impose rigorous standards of care may take priority over individually desired outcomes or social inclusion.

Immutable funding structures

Resources Social care services have inherited a resource system based on an outdated mode of service delivery. Routledge and Gitsham (2004) argue that to deliver person-centred services requires a change in how resources are managed and allocated, particularly in relation to authorizing, contracting and paying for services (also see Emerson and Stancliffe, 2004). Mansell and Beadle-Brown (2004a) consider that greater resources are needed to provide small-scale community services, where person-centred services can be nurtured. However, while Routledge and Gitsham (2004) identify the need for strategic investment in services, they also highlight a poor balance between listening to what is important to people and deciding how resources are allocated.

Mansell and Beadle-Brown (2004b) report that resource constraints undermine the ability of service providers to turn person-centred planning into action. For instance, a lack of resources in a particular area may affect the kinds of choices available to people. Similarly, if there is not enough appropriate housing this is likely to limit people's aspirations for alternative housing in their plans (Coyle and Maloney, 1999).

Many argue that there needs to be a restructuring of funding arrangements in order to give more control to consumers and thus facilitate person-centred services (Emerson and Stancliffe, 2004; Felce, 2004). Funding should be allocated on an assessment of individual requirements rather than on a notional whole service basis (Mansell and Beadle-Brown, 2004a). Importantly, the larger resource issue has been taken up by the Association of Directors of Social Services in England (ADSS, 2005). This makes a strong case that even existing levels of services cannot be sustained in light of the expected growth in number of people requiring support and greater numbers having substantial needs that are no longer being met by the NHS.

Service infrastructure

The structure and organization of services appear from the literature to be a key factor in the delivery of person-centred services. The ways in which services are organized, routine practices as well as strategies for multi-agency working and access to mainstream as well as specialist services, all affect opportunities to implement person-centred planning.

Inter/multi-agency working Inter-agency or multi-agency collaboration is regarded as conducive to the realization of person-centred plans (Amado and McBride, 2002). Towell and Sanderson (2004) recommend multi-agency engagement at a personal, service and local authority level to engage individuals, staff and managers, and the local community in strategies to promote and support person-centred planning. Rose (2003) states that inter-agency collaboration solely at managerial level is unlikely to result in changes for frontline workers or service users. Rather it is multilevel engagement that may promote person-centred planning. However, in practice, as the ADSS (2005) report confirms, there appears to be a withdrawal from leaning disabilities services by the NHS and the 'knockon' effects of one part of the pubic services making decisions about resources or responsibilities for another are not generally appreciated at planning stage.

Staffing issues

The literature observes that the role of frontline workers is crucial to the successful realization of PCP but identifies a number of issues of capacity, ability and service systems which may present obstacles to this.

Staff turnover Flexible support, developed collaboratively, built on people's abilities, ambitions and hopes for the future, and based on principles of choice, empowerment and inclusion, are some of the factors that enable a person-centred approach (Magito-McLaughlin et al., 2002; Sanderson, 2000).

Attention to an individual's background, experience and personal attributes is essential to person-centred planning. However, traditional service models cater for large numbers of people, an effective barrier to individualized support. Large homes or day centre environments make it impossible for frontline staff to pay attention to people as individuals. 'These factors have the potential to compromise the integrity of the individualised supports' required within the PCP model (Magito-McLaughlin et al., 2002).

Time Practitioners need time to do PCP well (Emerson and Stancliffe, 2004); however, Felce (2004) points out that the time needed is not accounted for in the resources invested. Thus there is likely to be a strain on resources in terms of the time needed to create individual plans for each service user (Emerson and Stancliffe, 2004) and to work with PCP facilitators. Enough time and adequate levels of staffing are necessary to support person-centred planning.

Skills Limited training for frontline staff on PCP is consistently stated (Coyle and Maloney, 1999; Mansell and Beadle-Brown, 2004a; Ward, 1999), although Fitzpatrick (2006) reports the development of a higher education certificate in person-centred approaches. Mansell and Beadle-Brown attribute skills deficits among many frontline workers mainly to inadequate training (see also Emerson and Hatton, 1994; Perry and Felce, 2003). Limited skills may impede adopting a person-centred approach and act as a barrier to its implementation (Cambridge et al., 2001). Training for staff is reported as crucial, but it is also suggested that existing skills and abilities (often highly developed, for example in communication and listening: see Todd, 2002) should be acknowledged and developed (Sanderson, 2003). This raises the question of whether current problems in developing good practice, building staff confidence for example, present barriers to PCP (Parley, 2001).

Role of managers The significance of management support to enable staff teams to adopt a person-centred approach is widely accepted. For example, Kleunen and Wilner (2000) report that frontline workers often are denied opportunities to be involved in care planning or other decision-making activities; compounding their difficulties in providing adequate support to promote PCP. Some staff state that they are often unsure of what managers expect from them, and think it difficult to separate person-centred planning from previous planning initiatives that have declined into obscurity (Parley, 2001).

Practice dilemmas According to some commentators, service users' choices may be at odds with the choices and expectations of professionals (Kilbane and Thompson, 2004) or in conflict with professional training or personal beliefs of staff (Todd, 2002). Surrendering control over what happens in someone's life is reported as being difficult for many professionals; and raises issues for policy and planning around risk (see Department of Health, 2005b).

Service culture It is widely argued that the culture of services is a major factor in shaping how they are planned and delivered (Brooker, 2004; Duffy, 2004; Emerson and Stancliffe, 2004; Mansell and Beadle-Brown, 2004a; 2004b; Parley, 2001; Sanderson, 2000; 2003; Stalker and Campbell, 1998; Towell and Sanderson, 2004). Todd (2002) notes that PCP represents a culture shift for most agencies. Some (Emerson and Stancliffe, 2004; Towell and Sanderson, 2004) argue that power should be vested in individuals, facilitating choice and the potential for inclusion and self-determination (Parley, 2001). Cultural changes are described as 'whole service changes', affecting not just the way that services are delivered but also practice and managerial style (Sanderson, 2003). However, Mansell and Beadle-Brown (2004a) maintain that until person-centred planning is given legal backing in the UK, it will be hard for service users to challenge providers who do not deliver personalized services.

While the principles of PCP provoke little criticism, some writers highlight possible internal inconsistencies and contradictions. Its central values reflect wider social trends towards a focus on individuality and an emphasis on the importance of promoting independence and autonomy. Moreover, the language of person-centred planning implies a 'community' base that is atypical of much modern social life; this raises questions about the feasibility or ease of implementation of the concept into practice.

Service users and their families

Service users increasingly say that they would like to take part in planning the way that services are constructed and delivery (Wistow, 2004); however, Truman and Raine (2002) report that service users often believe that their influence is limited. While the degree of disability, illness or complexity of need should not be regarded as a barrier to person-centred services (Maudslay, 2002), more complex needs present greater challenges. For instance, a network of informal support is regarded as central to achieving a person-centred plan. This may be more difficult for those who have encountered obstacles in developing sustainable friendships or relationships outside their immediate family or network of paid carers (Sanderson, 2000). However, the focus of PCP is on an individual's strengths and capabilities, while attention to (dis)ability is reminiscent of outmoded models of care (Sanderson, 2000). There is a common over-reliance on verbal communication, and practitioners can misjudge levels of an individual's understanding or often have low expectations of those with learning disabilities; this could impact negatively on the options that are made available to them (Routledge and Gitsham, 2004). For many people with learning disabilities the reality of choice is new, and the choices that people make may be influenced by the limits of their personal experience (Coyle and Maloney, 1999), which may be further shaped by staff not facilitating the process. The result can be a narrow vision of opportunity (Todd, 2002).

Relationships between service users and staff The introduction of PCP reportedly alters relationships between support staff and service users, from a situation where professionals take decisions about people's lives to one where decision making is shared with individuals and people who care about them (Sanderson, 2000). Such positive relationships are needed to make person-centred planning a possibility, but some writers claim they depend upon adequate supervision and staff support to encourage positive relations between staff and service users and to reduce the risk of harmful relationships developing.

However, Hubert's (2004) study of 30 families identifies the lack of opportunity for many people from minority ethnic backgrounds to access services in the first place, identifying how lack of awareness about available services, inaccessible information and familial social isolation combine to limit the use of services by people from minority ethnic groups.

Involving families The inclusion of family members and friends is a key component of PCP (Maudslay, 2002), and a basic challenge lies in figuring out how best to encourage their participation (Sanderson, 2000). Felce (2004) cautions against informal support networks masking a lack of investment in formal support structures, where family and friends provide support to bolster inadequate staffing levels; he argues that this may deplete family enthusiasm. Sanderson (2000) states that service providers should work positively with families; practice that stereotypes them as 'over-protective' or 'disinterested' undermines positive working relations.

Supportive factors

Policy encouragement Government commitment to self-determination, participation and contribution to society is vigorously repeated (Department of Health, 2005b) and the rhetoric if not the substance of it is generally accepted by potentially critical audiences (e.g. Morris, 2005). There is broad recognition of the need to improve the life chances of disabled people (Prime Minister's Strategy Unit, 2005) and to address the problems of multiple, separate and overlapping assessments (Social Exclusion Unit, 2005). *Valuing People* (Department of Health, 2001) remains a singularly important policy statement for people with learning disabilities, as well as other strategies on social care and public services more generally. Thus policy encouragement behind PCP is substantial and from the 'top', which uses regulatory frameworks to monitor progress. All the 12 councils inspected by the CSCI (2004, p. 16) are reported as having started PCP, with progress accelerated when a coordinator had been appointed.

Direct payments, whereby people receive money to buy their own support, instead of just receiving care services, enable people to have more choice and control over their lives and to make decisions about their support in line with the principles of PCP. Mansell and Beadle-Brown (2004a) consider that further takeup of direct payments will encourage more PCP (Department of Health, 2005b). Local authorities report that these are being well received and appear to provide value for money for public services (ADSS, 2005).

The 'In Control' pilot programmes in six UK local authorities have developed a 'resource allocation system' which enables local authorities to establish how much funding is needed for each individual and thus addresses some of the resource problems identified. While this benefits local authorities as they can plan their finances more effectively, the schemes are reported as encouraging greater creativity and community inclusion in service design (Duffy, 2004; Sanderson Associates, 2006). Access to funding streams beyond the Department of Health will enable such innovations to make further use of public funding to support disabled people. Government commitment to extending these pilots under individual budget schemes provides further opportunities for the principles of PCP to be adopted (Department of Health, 2005b; 2006).

Use of specialist and mainstream services

Policies or care pathways within generic services, which enable people who have commonly received support through specialist services to gain access to mainstream provision, promote greater choice and encourage inclusion (O'Brien, 2004). Towell and Sanderson (2004) recommend that those working in specialist services should learn how to work with and to negotiate access to mainstream services (also see O'Brien, 2004) as part of PCP implementation.

Service development and investment: championing PCP

We have some information from the literature about the communities of influence that group round the gradual adoption of PCP. Much of this relates to the rolling out of *Valuing People*. This White Paper was not followed by legislation, but its implementation was a policy goal and so guidance was produced for social and health communities (Department of Health, 2002) stating that PCP was to be given high priority. As part of central government assistance, a Learning Disability Task Force was set up by the Department of Health with its own Director of Implementation. A Learning

Disability Development Fund, while small, was the vehicle for providing some seedcorn monies to rolling out PCP. Such a model is similar to the other modernization approaches of national service frameworks in mental health where service expectations were set out with a process of local implementation that both monitored and developed local services and professional practice. At regional level, a series of *Valuing People* support team advisers undertook service development work. At local authority level, partnership boards were given responsibilities for embedding the aspirations of *Valuing People* into local services and communities.

We have some evidence from those working at national and regional levels of influence about the approach they took in respect of PCP. Routledge et al. (2002) have outlined the development of the guidance that was issued around PCP, namely local authority Circular LAC(2001). They describe how this guidance consisted of a process of consultation with experts on PCP, the involvement of key statutory organizations, and engagement of people seen as influential in learning disability services. They outline the rationale for production of the guidance, and report how they countered criticisms that this might over-professionalize the approach by acknowledging that there was a need to influence it positively.

Routledge et al. (2002) describe the three phases of their support. As our review of the literature demonstrates, much of the material they initiated forms the basis for informing the practice community since production of material for a range of practitioners was a key task. This work includes the development of training resources, sharing learning through discussion materials, numerous articles in the professional press and journals, story telling, conference presentations, and the production of the guidance itself. With hindsight this may appear logical and unproblematic; however, the authors acknowledge that at times it was not easy: 'As facilitators we often felt like lone evangelists.' Their legacy, as our review shows, is a wealth of material available for a wide range of readerships, mainly in social care but also in housing (e.g. Jarvis, 2001) and health (e.g. Bailey et al., no date, on incorporating health action plans within PCP). Locally, partnership boards have been working at increasing the numbers of and training facilitators to enable people to take part in their own PCP.

Relevant, accessible training and information for families are reported as helping them to offer informal support (Coyle and Maloney, 1999). While Routledge and Gitsham (2004) note that staff training often takes priority, Sanderson (2000) notes that more courses are directed at families, advocates and self-advocates. This highly developed pattern of implementation may account for O'Brien and Towell's (2003) observation that increasing numbers of people have heard about PCP.

Case reports and personal accounts

The literature reveals that another important thread of raising the profile of PCP has been the use of qualitative data, or simple reports and personal accounts. The situation is little changed from that observed by Rudkin and Rowe (1999) in their systematic review of lifestyle planning for adults with learning disabilities, where they note the paucity of outcome data but the almost superfluity of description, overview and anecdote. Since their review, little has changed. Testimony and commentary are used to illustrate the positives of the approach, to convey human interest and to counter possible resistance. For example, Duffy (2004) notes that some families would like to have more control in the planning and delivery of services and that they are not generally opposed to the idea. Some stories give ideas of the potential for PCP to be used in services that are underdeveloped, such as those for people from black or minority ethnic groups, e.g. Imran's story reported by Routledge and Sanderson (2000). Illustrative case examples continue to be used, and those in Table 1 are fairly representative of the benefits identified and the identification of what made them possible.

The accounts in Table 1 share a number of characteristics. Although interpreted by PCP champions in the main, they seem authentic in their details and reflection of individuals. The inference is that practitioners will be able to identify with the people described. Aspirations are generally achievable. Most are young adults. The staff involved are not necessarily highly trained professionals; indeed these are often noticeable by their absence. More recently, some service users have provided their own experiences (Clark et al., 2005).

Table 1 **Illustrations of person-centred planning**

- John in Oxfordshire lives in a group home where practitioners devised a combination of essential lifestyle planning (a form of PCP) and active support. This helps improve his quality of life and reduces his anxiety, enabling things that were important to him to get done through a better process of recording and monitoring (Sanderson et al., 2002).
- Peter shares a house with three other men and wants to move and have a holiday. He is a member of the local People First group and is supported by a student nurse who brings together a group to support him in his wish to have a place of his own (Sanderson Associates, 2006).
- In Oldham, the stories of Karen, Diane, Imran and Liam are used to illustrate the variety of living options available to people so their needs are better acknowledged (Routledge and Sanderson, 2000).
- Ken has severe learning disabilities and a hearing impairment. He has been moved to a bungalow complex and staff wanted to know if he was happy with this. They developed a process that allowed them to ascertain his views and create a personal profile. The work was documented and shared (Bradshaw, 2005).
- A young man living in a residential home with four others, involves practitioners as facilitators of his first PCP meeting (Mendora and Ledger, 2005).

Practitioner enthusiasm

Many staff admit their own enthusiasm for the values of PCP. Kilbane and Thompson (2004, p. 28), for example, comment that for colleagues and themselves PCP has 'visceral rightness' and that 'it feels as if the concept expresses all we have ever aspired to in our professional practice'. Osgood (2003) recalls how in the early days many practitioners 'flocked to conferences and seminars' on the subject of PCP. A number of informal support structures for practitioners have emerged from the literature, many of them recommended by staff themselves as useful support mechanisms. These include working with other staff teams to share problems and discuss solutions (Stalker and Campbell, 1998). Routledge and Sanderson (2000) describe work in Oldham undertaken by an implementation group of change agents and their incremental development of practice change.

While no one claims that training is sufficient in PCP, training has expanded (Department of Health, 2001; 2002). The idea that practitioners need to be listened to is attractive and communities of practice can be a way of providing support to those who may not feel generally valued in their work. Sanderson's (2003) view that PCP needs person-centred teams, which can mirror relationships with users within staff settings, conveys some of this enthusiasm.

Positive evaluations

While Rudkin and Rowe (1999) detect few statistical findings of significance, Mansell and Beadle-Brown (2004a) note that evidence is thin and Osgood (2003) points to a reliance on anecdotes rather than outcomes. This state of affairs has been changed recently by the arrival of the major evaluation of PCP (Robertson et al., 2005). This evaluation states that PCP has 'a positive benefit on the life experience of people with learning disabilities' and is 'associated with benefits in the areas of community involvement, contact with friends, contact with family, choice' (2005, p. ii). The researchers observe that PCP's impact varies across areas of life, individuals and contexts. It appears not to make much difference to the inclusivity of social networks, employment, physical activity or medication use. Indeed, in some areas of life there seem to be negative consequences in terms of affecting people's risks, their physical health, emotional and behavioural needs. At the time of writing it is too early to assess the impact of this study in terms of whether it will be taken up as a further lever for the introduction of PCP; however, the 'traffic lights' are at green in terms of saying that the outcomes of PCP are improvements in wellbeing and that practitioners should move ahead. Driving evidence into practice and local care pathways is not a simple linear model, of course, but PCP could become both an indicator of good practice and a performance indicator.

Conclusion

Several factors, many inherited from previous models of service delivery, appear to present barriers to the implementation of person-centred planning. While there is evidence of change in service organizations and approaches to practice, these seem partial and restricted to some rather than all providers. Cambridge and Carnaby (2005, p. 230) suggest that one of the strongest inhibiting factors is the distance between those who use services and those who work in them, at whatever level.

The culture of a service can be regarded as governing the underlying guiding principles that affect the way in which it is run and how support is delivered to service users. It steers the development of relationships between users and providers and is often evident in the way that frontline staff interact with users. A service culture that embraces ideas of empowerment and inclusion, is open to possibilities, willing to take risks and think outside traditional planning models, is therefore likely to facilitate person-centred planning. The literature demonstrates that the process of implementing PCP has much in common with other initiatives that seek to become mainstream practice. The CSCI's (2004) consultation on the barriers to direct payments, for example, identifies a number of the same barriers reviewed above, and suggests that workforce requirements, ranging from practicalities to attitudinal change, are among the routes to further take up of direct payments. Likewise, person-centred planning to some extent depends on community and social networks that are supportive. Both direct payments and PCP need to address wider social barriers.

Enthusiasm for person-centred planning among groups of self-advocates and service users is high (Cambridge and Carnaby, 2005). This article argues that the championing of PCP by a core group with influence and inspiration has played a major role in the acceptance of PCP in practice in England. This reflects the often overlooked contribution of networks of professionals and managers who diffuse innovation laterally in the public sector (Hartley, 2005). Their activity is generally reflected in the literature, and it was clearly evident throughout the study in the work with user consultants, other advisers and advocates. The next stage of evidence looks set to be informed by a more substantial evidence base. In light of this and of people's more explicit rights to plan their own lives and work towards fulfilling their own goals, person-centred planning may be sustained in the new world of adult social care and be part of its development for people with learning disabilities.

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