Lancashire Transforming Care Partnership

Learning Disability Development Day

6Th June 2016

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Samlesbury Hotel, Preston, PR5 0UL

The purpose of this event is to hold workshops to develop the following areas:

Community Service Specification
Interventions around placement breakdown
Workforce
Finance developing pooled budget

This event is open to:

Service users, Providers, Local Authorities, Commissioners, Finance and
All those involved in Learning disability care

Please come and help us shape the services of the future

BOOK YOUR PLACE

To book your place, please contact: Linzi Gill

By Telephone: - 01772 214085 or By Email: - Linzi.Gill@nhs.net

Lunch and refreshments will be provided

Please advise of any special dietary requirements or access requirements when you book your place.

There were 120 attendees at the event from the following organisations:-

Action on hearing Loss

Affinity Supporting People Limited

Affinity Trust

Alternative Futures Group

Autism Initiatives

Berkeley House Specialist Rehabilitation & Care Centre

Blackburn with Darwen Borough Council

Blackpool Council

Blackpool Teaching Hospital NHS Foundation Trust

Calderstones Partnership NHS Foundation Trust

Calico Homes

Consensus Support

Copper beech homecare

Creative Support

Cross roads care

Cumbria County Council

Dance Syndrome

East Lancs CCG

Edgar Street residential Home

Empowerment Charity

Freedom Care and Support

Future Direction

Fylde and Wyre Learning disability team

GS Social Care Solutions Ltd

Guardian Homecare

Halo Housing

Healey Care Limited

Health Education England

HFT

Hyndburn BC

Lancashire County Council

Lancashire Care Foundation Trust

Lifeways Community Care Ltd

Living Ambitions

Mersey Care

Midlands and Lancashire Commissioning Support Unit

Mosaic Community Care

National Autistic Society

Next Stage

NHS Chorley and South Ribble CCG

NHS East Lancashire CCG

NHS England

NHS Lancashire North CCG

NHS Fylde and Wyre CCG

North West Community Services

Northern Healthcare

Ormerod Trust

Oxen Barn

Pendle Support

Potens

Prestige Nursing

Preston Learning Disability and Autism Team LCC

Progress housing group

React

Rockmount Northwest

Routes Healthcare Limited

Safe hands care

SAIL

Select Support Partnerships

Shaw Healthcare

Skills for care

SM Care

Spire Preston

The Disabilities Trust

Thera North

Turning Point Learning Disability Business Unit

Unique Personalised Support (UBU)

Voice ability

Warren Hub -Day time support service

West Lancashire Council

Outcomes from the event

Community Service Specification Workshop

Provision of health Facilitation/links with primary care services/teams

- Access Healthcare, record keeping, information sharing
- Annual health checks – but need to be promoted with families and GP's
- Assessment target (18 weeks) is a Health target – an agreed Health/ Social care assessment timescale is needed
- Can mental health & LD work together
- Change/ make clear – Ensure care navigation e.g. for role – crisis situation essential. Health /social -> sign posting – duty system / hub
- CLDT include all psychology – SALT, CPNN, and OT – physio etc. LD services working alongside mental health services. Joint Team approach
- Clear capacity – health/education/social care
- Co-location – social workers, community health, therapy, forensic support, health
- Current Health & Social Care Team organised with different boundaries – some negotiation needed between Health & Social Care at an early stage to agree consistent boundaries.
- Doesn't mention health watch – should it? Enter views for example
- Draft spec can inform clear thresholds and criteria for truly integrated working across health and social care and voluntary/3rd sector
- Funding – needs to be realistic – joint funding SS/Health
- Good access to main stream health care
- Health action plans – hospitals need to recognise and have a uniform one
- Health checks referred to (but only "encourage")
- Hourly rate to be consistent and realistic between health and social services
- Include and recognise the work the team does to validate who has on LD for GPS so they know who needs health assessments
- Interdependencies with mental health services need to be strengthened. Team needs to support other mainstream services expertise / advice
- L/D nurse to deliver health care injection
- Lack of integration between health and social care
- Lack of recognition that people with LD have mental health issues
- Life cause pathway of health care
- Mental health LD protocol in place but not used properly
- Mental health practitioners with LD skills
- Mental Health service which have a responsibility
- More details about roles and responsibilities to manage health/ Ed/ Social care through transition
- More emphasis on how the physical health agenda and PMLD agenda will be made – what indicators/measure?
- Multi-disciplinary health and social care expertise available
- Need buy in from GP's re physical health checks
- Need more health needs support from adults during transition from school to community services

- Needs more detail re: linking LD psychiatry & Mental Health – managing mental health needs in the community – via community MH Teams. CMHT's often reluctant to 'take on' PWLD, but multi-disciplinary working & assessment needed when the person has been discharged from Section
- Needs to strengthen team's role in relation to personal health budgets/ integrated personal commissioning
- Not specific enough about how services deliver health improvements i.e. targets
- Not training other professionals need to be clearer it it's just healthy intervention then say so
- Recognition that support hours for activities and community support are a preventive strategy and will stop deterioration of mental health and behaviours
- Reflect there are people with LD who aren't challenging and aren't offending but need physical and psychological health support form specialist LD services
- Spec is multi-disciplinary not separating health and social care
- Spec needs to say what they need to do for general population to health promote crisis contingency
- Training for health needs around the individual
- Where are peoples O.T needs best met from – SS or health. Sometimes individuals on both lists from SS + health. Need to prevent people falling through gaps in services.
- Will there be a link to hospital/ general health care to educate and get them on board
- Wording around health check and HAPS is woolly and should be strengthened.

PBS element of the service

- What is meant by the PBS service? Is it a separate team/service or part of the LD team? Clearly state what it is and does. Who is responsible?
- An agreed framework for PBS/PI Restrictive practices – not sure how
- Confusion around PBS/ PI. Restrictive support practice for providers
- Consider having mechanism for mainstream health professionals e.g. GP to be able to access advice and support. GPs are not specialists and don't always respond in a least restrictive way e.g. recently a GP under pressure from a family member prescribes lorazepam for "outbursts". A successful PBS plan was in place which the family did not adhere to. If GP was better supported perhaps he'd have stood up to the family and advocated for the PBS plan.
- Good – PBS, Life course approach, Prevention and early intervention, Family / carer involvement
- PBS – good emphasis on 'quality of life' and reliance on PBS prior to 'crisis'
- PBS + Crisis response plans – how will these work within all the different frameworks/ models currently in use?
- PBS element is positive and is helpful in working with non-statutory providers – needs to be well understood and well resourced
- People with autism who do not have LD will not have access to the community LD Team. Will this exclude them from accessing the expertise that this team has in relation to PBS and functional analysis?
- Reword challenging behaviour – to behaviours that challenge (move towards PBS) Not to look at one size that fits all. Needs more reference to co-production. Should we consider a step up step down service – within the package? Contingency plans need to be included within the personal budget
- Specification –PBS - Need more attention on communication

- The PBS emphasis is very routine – need detail about how it will be kept "live" when a person is placed in their new home – e.g. support for family, shared lives or providers about how to use the PBS every day so that behavioural crisis's are averted (not just responded to)
- People with autism who do not have LD will not have access to the community LD Team. Will this exclude them from accessing the expertise that this team has in relation to PBS and functional analysis?
- Reword challenging behaviour – to behaviours that challenge (move towards PBS) Not to look at one size that fits all. Needs more reference to co-production. Should we consider a step up step down service – within the package? Contingency plans need to be included within the personal budget
- Specification –PBS - Need more attention on communication

Provision of training (as a preventative service)

- Clarification – medical training not provided by ets
- Lack of training for providers – mainly due to lack of funding
- Need a network for sharing support options and training- flat in Blackpool that other providers can use – "Healey Care Ltd", ready next spring
- Need specific training on single elements for IPCs and PHB's rather than using a full package unnecessarily
- Not training other professionals need to be clearer it's just healthy intervention then say so
- Prioritisation of own agency training - mandatory – so no availability for integrated training
- Specify financial support for specialist provisions e.g. transition costs, additional training and preparation
- Training and consultancy of the services e.g. police, probation, children's
- Training and development of staff – capacity to train support teams – managing vacancies
- Training and open working with other services, e.g. police need awareness of LD and be able to deal with situations without criminalising
- Training for health needs around the individual

Roles of Social Workers and input into statutory processes e.g. DOLS

- "Exclusion" section needs to be checked by a legal expert
- Build into spec for providers re: crisis/ complex cases: - contingency plan, increased staffing needed for the crisis period, better contracting processes to ensure the complexity of the client is recognised.
- CLDT include all Psy- psychology – SALT, CPNN, and OT – physios etc. LD services working alongside mental health services. Joint Team approach
- Co-location – social workers, community health, therapy, forensic support, health

- Covers legal and operational partnership
- DOLS application taking too long – ensure timelines are monitored and escalation process are in place.
- DOLS work – completing capacity assessments in partnership social worker and SALT within adult community learning disability and autism team – not clear around who does what?
- Governance – addressing structures, processes, communication strategies
- Lack of understanding from CCG and CSU around legal frameworks, policy, legislation
- Legal compliance multi agency working
- More robust reference & arrangements re: DOLS application etc.
- Need case manager – more social workers named to a person for more continuity of care
- Need specific LD social workers not generic. Prevents understanding of risks.
- Social workers need to respond in a timelier manner. Could be utilised in a more effective way. Use support workers
- Social workers part of an integrated team
- Variation in response to social workers and changing approach
- Where access to full MDT i.e. Include –OT, physio and SALT

Pathways

- All age but – all the way through the document, reference is made to Adult CLDT referral criteria, pathways etc. – This needs to be amended. Needs strong reference to education services & link with EHCP's etc.
- Clarity on local pathways'. Is this going to be the same everywhere? I.e. will there be an option for diagnosis if people don't have one?
- Clear care pathways/crisis v escalation – role and responsibilities re: relapse prevention, crisis plans, crisis contingency plans – are these to be Q indicators
- How is the capacity of the professionals involved being considered – are there enough professionals to meet demand and deliver the spec, when services are so stretched – will need clear pathways with timescales and outcomes to avoid drift
- If commissioning different providers /care pathways for e.g. Forensic services – need very clear pathways/criteria etc., or service users will fall between criteria
- Need clear safeguarding pathways across all areas that outlines who can do what and the timescales – avoids delays
- Need to specify a pathway and from this identify what skill and competencies are needed at each point of the pathway to inform self-care skills and competencies and workforce skills competencies
- Roles and pathways as appendix

Forensic support

- As an example it refers to forensic support then forensic support team within community spec or separate spec
- Co-location – social workers, community health, therapy, forensic support, health

- Forensic support – what will it look like?
- How are current plans to develop forensic support services being steamed lined with this service spec. Danger of people with challenging behaviour who could be seen in the community moving to specialist service
- If commissioning different providers /care pathways for e.g. Forensic services – need very clear pathways/criteria etc., or service users will fall between criteria
- Investment to skill up private providers to be able to support individuals with complex forensic needs
- Joint working/working alongside forensic services to skill up community staff (not forensic 'hit squad')
- People don't understand how forensic services can help and support
- Where does the current forensic support service fit into this? There is reference to links but maybe need more clearly defined pathway

Mental health

- Can mental health & LD work together
- CLDT include all Psy- psychology – SALT, CPNN, OT – physio etc. LD services working alongside mental health services. Joint Team approach
- Interdependencies with mental health services need to be strengthened. Team needs to support other mainstream services expertise / advice
- Lack of recognition that people with LD have mental health issues
- Mental health access
- Mental health LD protocol in place but not used properly
- Mental health practitioners with LD skills
- Needs more detail re: linking LD psychiatry & Mental Health – managing mental health needs in the community – via community MH Teams. CMHT's often reluctant to 'take on' PWLD, but multi-disciplinary working & assessment needed when the person has been discharged from Section
- Recognition that support hours for activities and community support are a preventive strategy and will stop deterioration of mental health and behaviours

Hospitals

- Do we view children going to residential special school like the same as adults going into hospital? Nearest hospital provision for children is Northumberland and Sheffield
- Blackburn and Burnley hospitals have a liaison nurse. What is in place in other hospitals? Does it work better?
- Health action plans – hospitals need to recognise and have a uniform one
- Need a better understanding towards PWS from police, hospital staff
- Nothing about Hospital Liaison Nurses working in General Hospitals – supporting 'reasonable adjustments' & good person-centred care
- Will there be a link to hospital/ general health care to educate and get them on board

MDT

- Attempts to create parity across the districts MDT for all people using services
- Co-located MDT – social work/ nurse teams
- Define roles, responsibilities and accountability of members of MDT (include support team members)
- Good range of professionals on MDT
- Inconsistency of MDT's spec more specific
- Like focus on MDT approach
- Make up of MDT – ok. FSS pathway. Elements of works 5/6/7. CPA – all system
- MDT – maintain skills. Having the time to attend and the budget – staff finance themselves
- Point 7 access: via integrated specialist MDT 24/7
- Support workers in all MDT
- Team of people in the MDT looks great
- The MDT could include an "expert by experience" this model exists in some MH services
- Want full MDT teams
- Where access to full MDT i.e. Include –OT, physio and SALT

Safeguarding Concerns

- Heading dedicated to safeguarding and expectations in relation to co-operation
- Need clear safeguarding pathways across all areas that outlines who can do what and the timescales – avoids delays
- Reference to safeguarding 24/7
- Safeguarding – clear protocol to avoid delays
- Safeguarding reference not clear (diff local authority have diff process criteria)
- There is no reference to Safeguarding Procedures
- Through spec safeguarding is good reporting in

Transition

- Good it is an all age spec – could smooth out transition bumps
- Great to see all-age! Hopefully remove the artificial barriers at transition points and ensure equitable services provision for CYP and adults and assist families to adjust from school placements to community provision
- More details about roles and responsibilities to manage health/ Ed/ Social care through transition
- Need more health needs support from adults during transition from school to community services
- Need to include transitions in this service
- Specify financial support for specialist provisions e.g. transition costs, additional training and preparation
- Transition from child and adult service more explicit – how will it work/be funded?

Comments on the Service Spec

- Add to section 3.1 – The service will support users to be the best they can be for themselves by promoting and using support approaches that are safe and appropriate and help service users learn new skills and contribute to their own betterment
- Blackburn and Burnley hospitals have a liaison nurse. What is in place in other hospitals? Does it work better?
- Focus on prevention work in the community teams which would require extra funding and resources
- How are current plans to develop forensic support services being steamed lined with this service spec. Danger of people with challenging behaviour who could be seen in the community moving to specialist service
- If commissioning different providers /care pathways for e.g. Forensic services – need very clear pathways/criteria etc., or service users will fall between criteria
- Joint working/working alongside forensic services to skill up community staff (not forensic 'hit squad')
- Mention choice of accommodation in the outcomes and how it is going to be achieved if they are not part of the multi-disciplinary team.
- P11 unclear
- P8 other PBS – what does this refer to?
- People taking responsibility for Court of Protection and Ministry of Justice issues with transforming
- care
- Pg. 9 – life course pathway – seamless. Needs to be clear what this means
- Population covered – narrowed down (LD & autism), page 2, adult and children not explicit enough
- The term service and team is not used consistently throughout the document
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- Who makes the decision re: the LD service being "best placed" to provide a service to someone without an LD? (pg. 9 & 10)

Interventions around placement breakdown Workshop

Crisis Response Definition/Responsibilities

Mental Health

- Access to specialist mental health support (and beds if needed) from mental health NOT LD services
- Appropriately resources MD mental health teams, adequate psychiatry to provide safe RC cover
- Educating people themselves about their mental health issues and the carers around them

- Emotional crisis – where does this fit in – it's not mental health crisis but impacts on all the categories
- Ensure mental health professionals understand LD – diagnosis, culturally excluded
- Expertise of autism – rather than mental health needs
- False distinction – can you distinguish between challenging behaviour and mental health.
- LD liaison nurse in mental health services
- LD nurses not having mental health training
- Mental health access – not that easy for LD specific
- Specialist mental health beds
- Crisis occurs sometimes due to physical health care need. Pain or discomfort can result in challenging behaviour which results in potential breakdown of placement

Challenging Behaviour

- Locality old model now de-commissioned but worked well:- had challenging behaviour teams, with crisis bed, full behavioural assessment, local service, 24hr on call provision, identified care support and transition
- Respite support – challenging behaviour
- Social care crisis/MH need/Challenging behaviour – can't break it down (not useful)
- Specific teams, challenging behaviour teams
- Staff changes can provoke anxieties and result in placement breakdown due to MH crisis and challenging behaviour
- Support for providers – training in challenging behaviour
- Support for psychological needs to avoid mental or challenging behaviour crisis

Forensic

- Facility to recall re; statutory requirement (forensic section)
- Forensic crisis
- Improved cross working. Sharing skills – not being limited by boundaries e.g. Some have forensic experience and some done

Care

- Direct support staff and monitor health care e.g. 'anticipatory health care tool', training, maintaining skills/workforce
- Need to ensure carers get support they need under Care Act
- Ensure that all families are aware of 'peace of mind for carers' and can sign up to this as contingency if there is a social crisis
- Breakdown boundaries of services, mainstream/health &social care in spec – re: exclusion criteria
- Networks for paid carers and family
- Contingency plan written up: - share with care workers (nurses/social worker), share with commissioners. Access to additional funding for support away from home for max 7 days

- Good informed and person centred 'risk assessment' to inform current care plan, renewed, knowledge/skills required, advocacy required
- Emergency duty teams – social care. Emergency duty out of hours needed for health
- Linked nurses to complex care providers
- Crisis occurs sometimes due to physical health care need. Pain or discomfort can result in challenging behaviour which results in potential breakdown of placement
- Using care plans creatively to enable flexible care and support
- Locality old model now de-commissioned but worked well:- had challenging behaviour teams, with crisis bed, full behavioural assessment, local service, 24hr on call provision, identified care support and transition
- Carer's crisis - What happens when carer dies/becomes ill. Pre-bereavement counselling services could be further developed to prepare people for family bereavement to help avert crisis
- Compatibility – social care contracts needs to be in place, capacity to sign agreements
- Social care remodelling team going in and reducing staffing 1:1 hours
- Housing – environmental changes, road safety (location), eviction, housing and care provider being one in the same doesn't work
- What type of emergency care accommodation?
- Social care crisis/MH need/Challenging behaviour – can't break it down (not useful)
- Time out/short breaks – individual approaches, shared care options
- Short break being used as emergency care
- Family carers having an understanding of PBS through training and education
- Regular dialogue and communication with housing providers – relationship maintenance is important to prevent placement breakdown, especially where the person has a small (or no) package of care e.g. person with autism
- Shared lives – good service to take over carer's role and offer respite. These services need to be developed further
- LD person in acute general hospital, reported that individual had surgery and as the ward staff couldn't provide care for the person with LD, they were discharged early and the small scale provider struggled to provide additional support to this person. Could have been avoided if staff from provider had gone into hospital to support the individual
- Somewhere to go to tell me what help I can get – care navigator
- Care planning not maintained with MDT. Cases are closed and then new referrals are required. Need better links back into the services?
- Good care planning/assessment information to inform providers and knowledge of other people involved in care
- Effective appropriately resources care – co-ordination for individuals with complex needs
- Care plan around crisis, triggers and what to do – contingency budget
- Educating people themselves about their mental health issues and the carers around them
- Respite being flexible re "trashed environment" need somewhere people can go 'care navigator
- Need: - MH/LD care co-ordinator, someone with MH background specialising in MH and LD
- Share information "share to Care"
- Link with crisis care concordat and unscheduled care action plan

- Care co-ordinator role for people with LD
- Ability to respond to crisis in care that may not be seen as crisis, e.g. elderly carers has urgent medical appointment and need care at short notice to cover them

Support

- Accept that crisis will happen in MH and LD – put the client in the middle, stop blame, work quickly, identify most appropriate team member to support
- 4 tier system: - prevention plan, clinical advice, respite, intervention and support and crisis/bed space
- Access to specialist mental health support (and beds if needed) from mental health NOT LD services
- Acute therapy service- intensive support
- Asperger's specialist service needed – long term, low level support not crisis not reflected in spec
- Assistant psychologist employed by providers but supported by the community team. This helps to maintain the service user in the community (used in Scotland)
- Circles of support
- Clear community support /family networks
- Commission more supported living
- Commissioners can only commission specific activities to support the placement which, when resources are limited, is a limited range of supports
- Contingency plan written up: - share with care workers (nurses/social worker), share with commissioners. Access to additional funding for support away from home for max 7 days
- Defining crisis – person centred and urgent support
- Early input into families to support them and all being on board with decisions
- Early support planning/crisis planning/HAP/risk assessment, PCP to ensure up to date information is in place
- Families don't like support going in
- Faster response from support services
- Floating support
- FSS support
- Funding for contingency support
- Good knowledge of individual service users and how to put things back together to support the individual through the transition
- Housing is a key issue in this – supported living is crucial
- LD support should be provided when in mainstream placements to support other services – needs commissioning
- Monitoring review support
- Not easy to get support due to different criteria (MH, autism, LD)
- Opportunity to share support and staff costs
- Outreach support
- PBS team to regularly review/assess and support
- Prevention needs to be first line of support

- Provider knowledge of offender support and MOJ restriction
- Psychiatric support availability is variable and can take time
- Resettlement: - good plans, good support, additional support to providers, flexible funding, contingencies, care co-ordination
- Risk register – proactive manage and provide support
- Role in developing locality provision: - housing support, workforce, service redesign
- Skilled workforce – confident, competent, supported
- Social care/social worker support
- Spec to include provision to provide support to providers to increase staff skills and improve quality
- Specialist agency support
- Specialist community behavioural support/support services
- Speed of response – intervention direct support 48hrs as a maximum, decision making
- Stronger link with police/prisons to ensure effective support/management
- Support for providers – training in challenging behaviour and mental health
- Support for psychological needs to avoid mental or challenging behaviour crisis
- Support worker often left dealing with crisis
- Then they can allocate and support across these types of crisis. Focus on the model rather than the category they need to be able to support
- Thinking about community support networks/drop ins/points of contact across providers
- Utilise other models of support

CTR

- CTR process – works if done proactively
- Blue light CTR's should be done for all including MH

Risk Management

- Adequate staff training – PBS/Risk Assessment/DOLs/Legislation
- Early support planning/crisis planning/HAP/risk assessment, PCP to ensure up to date information is in place
- Good informed and person centred 'risk assessment' to inform current care plan, renewed, knowledge/skills required, advocacy required
- Good strategies/PBS plans and risk assessments that are contemporary
- GP – high risk patients need to be guaranteed an appointment by Flagging on system
- Need to ensure providers understand the risk system and can work with system
- Need to standardise risk assessments and social networks need training to achieve the level required to undertake the risk assessments
- Needs to be more flexible response which is less risk-averse
- Positive risk management
- Risk profiles for all assessments and anyone at level 2 risk at least 6 weekly interventions
- Risk registers for CCG's
- Risk too high to hold in community
- Safeguarding issues – risk of harm to others

- Spec missing that some people do need secure service:- too risky, too restrictive to provide in the community
- Temporary accommodation when the person enters a crisis (would apply to social crisis, MH or CB) in a safe environment –"shared risk"

Urgent Care

- Ability to respond to crisis in care that may not be seen as crisis, e.g. elderly carers has urgent medical appointment and need care at short notice to cover them
- Access to crisis/urgent response across Pan Lancashire
- Defining crisis – person centred and urgent support
- Urgent respite
- Urgent response psychiatry

Police Involvement

- Bespoke packages to help police respond appropriately
- Bridge between hospital and police intervention e.g. crisis team or setting
- Campaign of intimidation against the person is picked up by police
- Developing good relationships with police liaison officers, prisons emergency services
- Including police and other relevant teams in – in education use of health passports
- Issues affecting the name/address are linked together on police register – each move of property damage or assault seen as separate crime
- More training with police, they are not always happy to be used
- People with LD in crisis get admitted to acute psychiatric ward or police cell. Frightening for people with LD. GM commissioning more specialist services for LD with mental health problems
- Social crisis can be an issue in the neighbourhood e.g. hate crime, mate crime; we need police on board possibly an LD Liaison role.

Cause

- Lack of standardisation causes issues for providers even safeguarding has different systems and creates delays
- Remodelling – cutting packages because they are working
- Safeguarding within the property. Bullying may cause major breakdown

Co-ordinate

- Write into spec re need to cover co –coordinator role at times of leave sickness etc.

Workforce Workshop

Induction and Training

- Standardised training for PI across Physical intervention – governance framework
- Access to bespoke training based around individual needs and then agreeing monitoring of competencies
- Accessible training diminishing
- An understanding of what good training looks like is needed
- Autism training
- Backfill for training
- Challenging client group training needed and this needs to be funded
- Clinical type training – diabetes, epilepsy
- Community nurses should provide health training e.g. diabetes, stoma care, prescribing requirements
- Consider some community base support training – maybe shared across providers
- Control and positive risk training
- Cost of providing care package will increase in order to allow staff to be trained -i.e. double costs to cover shifts for staff on training
- CQC essential standards provide guidance on essential training
- Equity across different community teams in Lancs – not all teams have access to OT, SALT etc.
- Establish training consortiums- share resources, supplies, support, bench mark up, experience/knowledge/skills
- Extra training and responsibilities expected at a time of reduced funding
- Face to face training as a minimum
- Frontline staff and assertiveness training
- Governance to oversee training
- Improved sensory knowledge – basic training
- Invest in staff to retain- provide good induction and offer additional training and support
- It would be helpful to have more support and guidance (from anyone – social care, health, education, providers) to enable us as providers to support experts by experience or self-advocates to deliver skills in providing training. Training provided by people with lived experience is very powerful
- Legal training
- Less online training
- Levels in strategy – need to drive up and monitor organisations access to training identified in strategy
- Limited opportunity for small providers to “piggy back” on larger providers training sessions
- Mental health awareness
- Navigator and facilitator roles – link nurses to community homes
- Need community team expertise for specialism – important in transition periods
- Need to capture children and ensure PBS is used early to prevent escalation. Family training will be most effective
- Need to recognise in commissioning that staff in treatment care services need much more training and shadowing and providers can afford to fund these without help
- Nurse prescriber CB/PBS training
- Person specific training

- Plans created around the care plan based on individuals needs and then a training plan to meet the needs
- Prioritising training
- Providers mandatory training responsibility
- Providers that will do shorter specific training needs
- Pyramid of training/competencies – graded
- Quality assurance and inspection regime for providers who will not provide sufficient/quality training
- Regular supervision and training plans
- Release time for training
- Resilience training for care staff
- Standard to training and managing quality
- Standardised training for physical intervention
- Team leader/managers training
- Time it takes for new staff to do essential training prior to taking up posts
- Training around identifying risk and carrying out risk assessment
- Training for providers to support offenders
- Training in ABC charts or recording systems
- Training is provided for families from smaller providers
- Training needs for people with LD – different life in the community
- Training on PBS is very variable and there is a gap between degree level and basic managing of violence/aggression/breakaway training
- Training progression
- Using expensive accredited training , providers can cause issues for smaller providers as they become less cost effective
- Values bases training
- Where there is a need for providers to train staff to have an enhanced skill set (whether statutory team assists with this training or not) there is an issue about commissioners paying a standard rate per hour – leaves you with a mix of staff burn out and staff leaving for easier jobs with better money
- With autism now being part of the community teams responsibilities – how will the team be able to manage additional demand?

Skills and Qualifications

- Apprenticeships – no life skills, not confident with a challenging service user
- Baseline set of qualifications – skills set
- Commissioners need LD skills
- Counselling skills for support staff
- Determine what qualifications positive behavioural practitioners need
- Establish training consortiums- share resources, supplies, support, bench mark up, experience/knowledge/skills
- Importance of matching hobbies and interests(as well as skills) so people enjoy their job – better retention
- Managers have been taken off hands on shifts by many providers to keep hourly rates down. This means staff has less access to observation, mentoring and coaching to develop skills on the job.
- Providers could share skills/resources
- Providers want value based staff – not just qualifications or written staff, respect/dignity
- Skills required – IAPT

- Skills to undertake sensory processing, assessments and interventions
- Support and guidance from social care, health, education, providers to enable us as providers to support experts by experience or self-advocates developing skills in provider training.
- What are the expectations for £13.38 per hour? – Skills/knowledge

Supervisions

- Access to supervision commissioned as part of the total cost of the package
- Good leadership
- Incentives – terms and conditions, values/supervision/appraisal
- Leadership –instill values and is critical
- Leadership training
- MD team working – will need support to make work leadership
- Regular supervision and training plans
- Supervisions and appraisals – giving time to off load, to feedback. Supervisors to be well trained to offer supervision

Pay/Salary

- Agree on hourly wage/ finance not enough
- Can services deliver support at £13.38 per hour? – How does this affect people using SDS?
- Current holiday pay and sleep in arrangements (changed recently by case law). Not finically viable for providers (especially smaller providers to absorb additional costs related to paying the hourly rate at night).
- DBS payments
- Different levels of pay for specialist/challenging packages
- Do people/carers want to do this work for the living wage
- Getting good quality staff to enter the sector due to pay and pressure of the role
- Increased pay (retention)
- Pay and sleep payments
- Providers having to pay a premium to work with more complex/challenging behaviour in order to recruit
- Quality checks “NHSE” – how to employ and value with valid wage, not volunteer
- Staff sickness – duty of care but no pay

Positive Behaviour Support

- Access to specialist support, to support staff to stay in their role e.g. a psychologist attends monthly meeting with staff supporting complex people to reflex, learn, support each other and regroup, discuss new approaches, review PBS plans/risk assessments. Helps staff to be resilient and recover after a crisis incident
- All professional gap areas – PBS/OT/SALT,CB
- Autism – no LD translating forensic risk into community PCP/PBS/ plans
- Competence around PBS in different staff/teams
- Full PBS packages not always needed:- certain elements are more useful
- LD specific training, formalised PBS training – Legal training
- Need to capture children and ensure PBS is used early to prevent escalation. Family training will be most effective

- PBS needs to be specific for the cohort that requires it. Don't waste time and money making all staff
- PBS trained – they will not use the knowledge
- Statutory services and LD specific training (awareness training) formalised PBS training.
- Training on PBS is very variable and there is a gap between degree level and basic managing of violence/aggression/breakaway training

Finance/Funding concerns

- Access to supervision commissioned as part of the total cost of the package
- Costs for accreditation
- Costs for 2 x train/trainer
- Resource and cost burden to achieve certificates competence
- Some providers use agency staff which cost more. Risk to staffing budgets and the overall package of care if agency staff used regularly
- Current holiday pay and sleep in arrangements (changed recently by case law) not financially viable for providers especially smaller providers to absorb additional costs related to paying the hourly rate at night.
- Cost of providing care package will increase in order to allow staff to be trained -i.e. double costs to cover shifts for staff on training
- Using expensive accredited training , providers can cause issues for smaller providers as they become less cost effective
- Transition cost absorbed by provider – does this affect quality. Discrepancies between expectations of children's/adults services. Too many professionals involved – lacks consistency
- Funding – making staff free to attend
- Reduction/ stop in funding for the diploma? Providers especially small ones will not be able to pick this up
- Competitive funding processes will prevent providers being able to work collaboratively (LCC situation?)
- Extra training and responsibilities expected at a time of reduced funding
- Transition funding

Commissioner Concerns

- Better relationship between commissioners and providers
- Commissioners – outcomes and standards, thankyou's and well done
- Commissioners and providers having proper discussions/communication
- Commissioners are no longer specific LD – need to have subject matter experience
- Tolerance and trust between commissioners and providers – service reviews rather than contract monitoring

Recruitment and Retention

- Burn out/lose staff – retention
- Easier services may lose support to move complex services due to recruitment/sickness issues
- Family feedback can increase retention
- How does this affect people using SDS? Gap in recruitment

- Importance of matching hobbies and interests(as well as skills) so people enjoy their job – better retention
- Key to recruitment is:- right staff, right values, ensure families are involved in recruitment (or individuals)
- National campaign for support worker recruitment
- NHS retention
- Paying staff minimum wage makes recruitment very difficult
- Physical retention on quality checks – north, central and east Lancs different approaches to PIQC, needs to be uniform, single and collaborative
- Recruitment 2 stage
- Recruitment days
- Recruitment issues can be geographical – full time in Burnley is easy, part time may be an issue
- Rolling recruitment program
- Staff expectations at point following recruitment – impacts on retention
- Staff retention in some providers is poor
- Target recruitment
- User involvement in recruitment