

a) Providing respite and short breaks to people with a learning disability and/or autism

overcomplicated especially for supported living

unrealistic funding/cost implications

CQC

Is it sustainable

Provider portal and forums

Lack of communication

Short term

- Dementia carers
- Reinstating his normality to share the load
- Can be ½ day activity
- Evenings
- Prep for young person to get used to care homes
- Carer/parent needs should be met to support them and reduce stress
- Routine –keeping the time table set
- Person centred – fits their needs
- Individual and can meet needs – ie the things/activities they want to join or learn about
- Respite fear and anxiety – make it what they want
- Available when needed – set entitlement but people choose when they use it
- New workers in respite will identify different opportunities – need to be able to share good ideas and communicate with other providers
- Making it a positive sell – managing them – how do you measure the two and the impact
- How does a choice of package work for both individual and business
- Respite image needs to be improved – fun activities
- Taster sessions for an evening gives them the opportunity to build confidence
- Regular and structured

Consistency of support care having enough LD people support hours commissioned to be able to sustain the service and staff

Making sure person centred plans – robust care and support plan

Communication passport

Transition home from hospital/residential/supported living

Can be disruptive within a home setting, potential to open 'respite only' service, compatibility, multi-functional support is John Shipman style respite

Shared lives respite carers

Specialist service access people's own homes (autism respite)

Continuity of care and support

General consensus from other people living in the home about having a respite bed

More information around what respite means for individuals

A bed in a service or going away i.e hotel accommodation

Routines – if someone is in an unfamiliar environment/staff etc – will this potentially trigger certain behaviours

Damage to property

Different information from families and professionals can be conflicting

Transitions planning/assessment etc

Is there an incentive? ie holding cost to keep respite beds open and staff waiting – costly to keep bed open and to have respite user in place

Continuity for schedule respite so routine can be continued with service user

Collaborating with relative and other MDT ie OT and BI

Homecare services can be providing respite in home – short breaks –who pays?

Info on how many people/needs/availability

Block purchase

Recruitment/ open beds

On the spot purchasing

Compatibility of clients/customers

LA to audit how many services and types – geographical information

Agree fees

Placement reviews (28 days+)/short term placements

Early intervention

Working with service users to establish need

Carers moving into customers homes whilst parents/family away

Person centred approach

A variety of options ie specialist services

Referral to carer support groups

Ad hoc services

Invest in shared lives

Action planning

b) Innovative models of care

volunteering in lieu of support hrs/care

employability – providers (lack of)

building better opportunities

realistic opportunities for education / training / employability

Personal care – matching staff to people we support

O'brien's 5

Block fund – OCS

Day services – choice especially for complex needs

National minimum standard for person centred plan

Little or no mention of support need – is low medium or high via brokerage system, day centres which can lead to further problems and unsuitable placements

Equal care standards for all

Drop-in centres “KNOW THEIR RIGHTS”

Fundamental standards know their rights

Advocacy – cutbacks

Connections – community people

Sense of self – ordinary citizen giving back

Money from education used for transition in social care fund alternative education (not classroom/school)

Early planning for transitions

Managing parents expectations

Funding belongs to individual not family, education/communication with families – signposting (less of a minefield)

Funding assessment PIP overwhelming for people, better support for people - DWP, peoples money has been stopped – going into crisis, send families away provide ‘respite hours’ at home

Expanding on the services you already provide

Creativity

Access to employment

Early assessments – nurses not in services

GP visits

LA willing to fund clinical loads?

Criteria ABC

Easily accessible information for staff

Closer working relations

Better review process

Continuity of workers

More innovation in contracts

Flexibility with budget

Continuity of support

Better relations with NCC & communication

c) Provider market training need specific to today's learning

lack of information regarding 'free' training

current training not applicable

manual/booklet could be offered to providers

training portal / blog forums

technology training

specific conditions – individual specialist; telling people as well by the person with the condition; co-production; educating providers

outcomes training – how to develop/identify/signpost for progression

care planning – specialist role; for example: outstanding providers to share best practice

technology to support the individual; to create the information and update plans; train family to use the system

service user training sessions – when the service users can access the information that they need to but what about training the SU to know their rights and responsibilities

Healthy eating, diabetes training manager, mental capacity training, DOLS, autism training, PADA, PBS, PBM, PCPAS Training

Specific health topics and LD syndrome

- Epilepsy
- Diabetes
- Prader willie
- Etc
- Behaviour issues
- PDA

- Autism

Funding training of staff

Networking between companies to share costs of training

Dip 3&5 costs

PBS training expensive

Autism

Assistive tech

Communication tools

Sharing expertise

Evidencing outcomes

Sharing courses/costs between providers – central place for information

Progression mind set “can do”

Benefits – what people are entitled to etc

Safeguarding especially for new staff

Tapping in clinical specific training

Training staff to assess daily

Outcomes training

Better awareness of training from NASS or new MDT services

Record keeping should be made mandatory and standardised

Offer master classes to share knowledge across professionals – peer to peer

Assessments:

- regular mental health reviews
- general physical health reviews
- annual health checks
- liberty protection
- Scrutiny from LA/NHS in monitoring

Opportunity to train

Free training for providers

PBS training

Networking/ cost sharing between providers

d) Issues

Inconsistency of social workers, waiting times for referrals, training on the specialist equipment, funds for specialist equipment takes a long time – grants NCC or other, assessments can be short sighted, no long term outcomes, health need, aging process, inconsistency with reassessment, FACE overview, not all the same/ enough information

Safeguarding

Standardising care planning

NGH – level of experience in communicating with LD people fails repeatedly

Care plans – lack of from LA

Separation of finances within families

Finance PB – DPS rate

Training challenge for small businesses

Who to contact for what, who's who

Late transition work

Capacity

Silo mentality – need to share more

Funding – “ssshhhh....”

Lack of reviews

Difficulties with contact / always a duty worker

Money – agreed formats information sharing, simplified payment system, paying on time

Honest discussions on training, regulations, costing models discussion with providers increasing costs

Investments for providers (3rd sector/transforming care)

Lack of communication