APPENDIX G

DETAILED PROECT LOG OF BARRIERS AND SOLUTIONS

During the project, we maintained a project log of barriers and in supervision we analysed the barriers to personalisation for people with challenging behaviour and developed hypotheses about what was causing them.

We also discussed solutions to the barriers. Most of that discussion is captured here.

THEME Barrier *Evidence*	Analysis / Hypothesis	SOLUTION
COMPETING PRIORITIES		
Although the additional project inputs were modest (PT project manager, 2 consultants), there was a distinct lack of capacity locally to make the project work well i.e. local service managers and care managers *One senior manager commented on the serious disconnect between what Directors sign their organisations up to and the realities of operational pressures. This simply leads to workers experiencing work pressures. This seemed to be something that was agreed with by others at the meeting* *A SW case was nominated to the project by others. She said she would not be able to attend meetings or spend time on the phone. She did once I had explained the value of the project. She talked about the terrific workload pressures for all workers* *SWs repeatedly cancelled (& rearranged) monthly tel calls due to other priorities. Rearranged phone calls were cancelled*	There was much change going on in both NHS and LA organisations. People constantly referred to not knowing whether their job would continue (not care managers) Project-itis (having lots of different projects all happening at the same time) affects the available time which workers and managers have to give to each one as well as the 'day-job'	If there is to be a project, it should be resourced honestly and ring-fenced so that workers can do what needs to be done rather than constantly feeling as if they are failing the project whilst having to juggle higher priority work We need to calculate what input projects will need from on all stakeholders and not make assumptions that people can participate in projects whilst doing their 'day job' whether that is service users, families, workers or managers

THEME Barrier *Evidence*	Analysis / Hypothesis	SOLUTION
Lack of SW capacity/ time due to safeguarding pressures. Safeguarding pressures overwhelming teams (conversations with all managers / SWs) *One SW said that the reality is that people with complex needs do not get attention unless there are specific risks presenting, even though their service outcomes are not as good as they could be*	A senior manager suggested there is a need to rationalise current safeguarding practice and develop clearer thresholds for team managers to apply so that alerts due to poor quality services are addressed as such rather than being treated as safeguarding. But need to balance that with intuitive sensing of the need to pursue. Potential conflict between intuitive assessment of risk and the getting it wrong	More training and support for team managers to help them develop more confidence in their judgement when deciding whether a safeguarding alert requires investigation More training and support for SWs when carrying out investigations to match time spent with the risks
Workers weighed down by bureaucratic procedures	SWs are anxious to ensure they have a complete audit trail in case challenges arise. The litigious climate is diverting workers making them focussed on the needs of their organisation (and themselves) rather than the needs of the disabled people they are serving	National paperwork set – rationalised?
PARTNERSHIP COMMISSIONING		
Lack of information sharing across agencies *- A SW planning for someone's discharge was told she was no longer free to look at people's ATU nursing notes without following the correct procedure.* *The SW was not told what the correct procedure was. The person she was assessing was non-verbal*	Some people become bogged down in the rules on information sharing and see confidentiality as an end in itself Others hide behind confidentiality if they want to block access to information for other reasons	Need for regular training and briefing reminders to workers about how information should be gathered i.e. with notification that it will be used in furthering a person's best interests in ways that are related to the purpose and context of how it was gathered – that this might mean sharing information with other agencies to enable the best outcomes
A lack of clarity at operational level in the local framework for joint commissioning for people with learning disabilities and behaviour described as challenging	Insufficient capacity in system; differing priorities; tensions in funding arrangements PCTs insufficiently equipped to provide quality case management for individuals.	Operational joint commissioning teams so that common issues can be resolved, joint solutions reached and a single market shaped

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Difficulties were experienced in setting up some local project teams between the LA and NHS – the frameworks for this were generally not in place. *One SW said in a meeting "Managers want us to stop working with 100% health funded people"* *Separate streams of commissioning between LA and NHS commissioning and within NHS separation between Continuing Healthcare and MH/LD specialist commissioning.* *Whilst people have a right to access a community care assessment, if the LA finds that their needs are continuing care, they discontinue care management responsibility.* *Also "When people are admitted to hospital, they are no longer a priority for us (LA SW)"*	Lack of commissioning expertise in PCTs. Outsourced to NHS providers and not linked to social care commissioning processes. Lack of provider support and development framework for providers provided by NHS. To what extent do they have capability in promoting non-medical model lifestyles? A regional market development role would lose the links with contracting for individual patient's outcomes and links with LAs.	Gloucestershire's joint commissioning sounds to work well: a manager employed by the local authority manages 8 care managers who do social care assessments and healthcare assessments of complex people. Cases are allocated according to the presenting information and then discussed as a team. People are assessed as to what degree of CHC funding they are entitled to (if any). The team commissions together, shaping a single marketplace for local people.
Some LAs/PCTs are in effect 'exporting' needs. In some cases they are not routinely conducting good quality reviews and ensuring a developmental or future focus *One senior manager talked about how many safeguarding referrals they have relating to out of area living people in their LA. One PCT had not reviewed one person referred for safeguarding for 7 yrs* *One psychiatrist said she had received 35 referrals of people from out of area in a month due to new providers opening up in her area (Cambridge/Peterborough)*	A commissioner can 'export' their person's needs without responsibility for the impact on the system local to the OOA service The economic relationship between safeguarding and OOA complicated as people placed by NHS or other LAs do not have to provide safeguarding response. The cost of a placement does not reflect the total cost	Need for economic model to show the full costs of OOA placements including safeguarding and DOLs

THEME Barrier *Evidence*	Analysis / Hypothesis	SOLUTION
CHC DST PROCESS & TOOL		
Planning for people whose needs could be either or both health and social care are subject to two systems of assessment and funding decisions *One area said that the needs of people with LD just do not fit the DST format and that the NHS and LA perceptions of aspects of the tool do not match up*	The inherent tension between health and social care in determining how people's services should be funded is exacerbated by the current tremendous financial pressure on both 'sides'.	Advice from a reliable source on future NHS commissioning process/structures said " *The National Commissioning Board will retain funding for high, medium and low secure services. The rest …will be devolved to Clinical Commissioning Groups whose work will be directed by the Health and Wellbeing Boards and scrutinised by Healthwatch. The relationship with LA commissioning where people are assessed as 50:50 will fall within these arrangements. <u>There will be the option to pool funds for commissioning to avoid incentives for needs to be interpreted as health or social care according to funding pressures".</u>*
CARE MANAGEMENT PRACTICE		
Many commissioners think that people need to be in a care home or hospital if they • do not have the mental capacity needed to sign a tenancy or • might need to have their house doors locked to keep them safe or • might need physical interventions from support staff to keep them safe *One area told us this in their set up meeting* *One person was removed from her home because her commissioner thought she could not have physical interventions (families work)*	This is not true. Case Law has ruled that none of these things should stop people living in their own home as long as their assessment clearly states they need to live in their own home and that they need to have doors locked and to receive physical interventions. If everyone agrees with the assessment, it is legal to local doors and provide physical interventions with very clear support plans, reviewed regularly delivered by staff who have had appropriate training about this kind of support.	If everyone who is important to that person agrees with the assessment, they can have their own private home (as a tenant or as an owner). If everyone does not agree, the Court of Protection can look into the situation and decide what is best for the person.

THEME Barrier *Evidence*	Analysis / Hypothesis	SOLUTION
Lack of clarity about what service is being commissioned and dynamic monitoring once a person is placed *One care manager was reviewing someone in an out of area placement. The project's consultant found there were no clear objectives shared between service, family and commissioner:* *"It appears from my discussions with X that the aims and objectives of the placement from the provider's perspective and from the local authority/parents are at times different. The SW found the expert advice invaluable and said "the outcomes could not be achieved without her support*" *Another care manager asked for advice on someone in a care home following many incident forms. She was shocked to learn the care home thought he should move care homes as they did not have the expertise for him.*	The consultant analysed documents and discussed plans with the OOA placement She said "*The provider is supporting the person to develop compensatory skills to help him function successfully rather than changing his long standing and persistent behaviour traits and cognitive/skill deficits. His parents appear to expect the provider to be addressing and attempting to change the difficulties that the person experiences. This leads to confusion about the interventions that are being used and the priorities are sometimes conflicting.*	External independent advice to commissioners from a behaviour analyst/ positive behavioural support specialist is beneficial in commissioning services. Not only does can advice give a clear picture of what is not working in a current placement, it can point the way for what could work in a new service or enable the current service to improve. See Annex X for a sample report to a care manager (anonymised) from a behaviour analyst/ positive behavioural support specialist
Lack of involvement of multi-disciplinary team and lack of expertise in SWs. *A newly qualified SW whose only previous experience was with physically disabled people did not involve the MDT in her assessment and clearly lacked an understanding of the nature of someone's behaviours: she offered a mother 1 hour of support each day for her adult daughter who has 3:q staff to go out. The family felt they had*	Lack of training and experience – a risk in generic services	Given pressures on workloads, an online Training module for SWs around challenging behaviour and positive behavioural support Availability of behavioural support specialist to advise workers

THEME Barrier *Evidence*	Analysis / Hypothesis	SOLUTION
*to be pleasant to ensure SW did not avoid them so did not challenge (*Families work)		
Families all struggle to get timely (or any) contact with their SWs / care managers. Families not kept informed of developments (Families work) *Examples from all families* *e.g. despite giving several weeks' notice of one family's flight details, respite care for person A not confirmed until 2pm the day before. Person still has no long term support plan or allocated SW after one year*	There appears to be it lack of prioritisation of family's communication need – why? (cont'd) 1. Do some workers regard the family as oppressive and think they overprotect their relative or 'keep them back'? 2. Are some SWs simply anti-family and projecting this onto their clients? 3. Is there a cultural/ generation gap between care managers and parents in values, attitudes and style? 4. Has the data protection act led to such individualised case management that workers think they cannot share info with families?	The person with a LD as a member of a family - agenda to be explored and promoted including family information needs – how to involve families. How to help families see that their point of view is important but needs to be balanced with advocacy point of view for individual. CM's father did SCIE module for SWs on personalisation and found it interesting. Bespoke module for families would be good.
Families not properly involved in assessments or best interest decisions *W – given notice to leave current placement. Family not involved in assessment or offered sight of it. SW new to LD. (Families work)* *Despite family warning LA that things were not going well at his care home, V given 28 days' notice to move. New SW had 3 hrs notice of the meeting to plan the move with no previous knowledge of the person. Did not tell family why notice has been given. SW asked family in meeting whether they wanted relative placed in or out of area! (Families work)*	Have people with LD become seen as individuals at the expense of being seen as detached from families? What is this driven by? Is it the data protection act i.e. because information can only ever relate to one person and workers have to be careful not to include information about other people? Or is it a symptom of a broader trend towards Individualisation in society?	Need to raise awareness of workers of family involvement as a source of enduring social capital for the individual and as providing a valid natural cultural context or point of reference for the individual which must be valued and respected Need to stop thinking of families as carers i.e. the issue of people's family relationships should not be conflated with issues to do with families as carers – this is a separate and additional issue.

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Lack of choice and control by individual	Being non-verbal is seen as not being able to contribute	Creative person-centred proxies for service user satisfaction measures to be included in service monitoring
Fragmentation of response: *one young person (S) has three SWs – a children's worker, a transitions worker and an adult worker. At a review, the adult worker had not spoken to the children's worker before and had not seen the file. One person (T) is being referred to a different team to have a person-centred plan (families work)*	Could computer based records be driving this?	Need person-centred and not internal process orientated care management
FAMILY-LED COMMISSIONING		
Families know when things are not right but not necessarily what to do about them Conversations with commissioners are not easy to access *(Families work – all families)*	Why should they? Commissioners not seeing families as key partners in planning for individuals	On-lineTraining modules for families using family experiences - how to be persistent when my son's assessment took over 10 months! - starting to think about my daughter in terms of outcomes family-commissioned support using direct payments - the value of advocacy in engaging with my brother's commissioner
Families may have low expectations of their relative's life ambitions *R's family happy with OOA placement. Think supported living not possible for her (families work)* *S's mother does not want to consider supported living for her 19 yr old daughter. Only wanted advice on choosing a local care home.(families work)*	Families might be happy with new placements if previous ones were even worse. Some families prefer apparent safety of residential care if they are not able to appreciate benefits of supported living model	Small numbers of people with complex needs so families don't necessarily meet those in similar circumstances Link families with each other to share experiences More DVD / video footage needed of supported living for people with complex needs to inspire families

THEME Barrier *Evidence*	Analysis / Hypothesis	SOLUTION
Families reluctant to ask for help in case it is seen as an inability to cope and person would be taken away from them *Mentioned in EMids network meeting July 2011*	Emphasis on safeguarding makes families reluctant to reveal they are struggling, as their inability to cope with the behaviours is interpreted as a threat to the individual rather than a gap in their support	Prevention agenda to be implemented rather than relying on reactive safeguarding responses Need for CBF training on positive behavioural support for families undertaken together with all those who all support a person
Personalisation without preparation *Z's family told to find new support provider for Z with no preparation, guidance or support (families work)*	Assumption that people understand how to assess providers	Need to think about what training and support families need to do this A printable online guide to commissioning services for families (for people with complex needs)
Families not seen as relevant to commissioning / value for money *Email from SW to highly involved sibling: "I do not believe that it is appropriate for families and carers to become embroiled in discussions between the Local Authority and care providers regarding funding arrangements but, nonetheless, you are aware that the Care Home has queried the funding for the current package, specifically for V's daily activities. … (families work)*	The SW appears to have commissioned a service without negotiating a contract before the service began. The family has been querying this before the move to the care home was made and for the four months since the move was made.	Families need to be told what level and quality of service has been contracted and given a clear role in contract and made explicit with the service provider
PERSON-CENTRED OUTCOME PLANNING		
Person-centred planning not being done so pc outcomes information not being developed. Why not? *"Takes too much time to arrange and we have high*	PCP seen as inevitably requiring large meetings	Encourage idea of virtual meetings and teams – people do not all have to be in the same place to contribute – care manager

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workloads - it is not a priority." *" We have very little admin support to help with arranging meetings"* *"Finding a date all stakeholders can make is really difficult"*		as collator of information and views through a series of processes
Lack of confidence and expertise of SWs in person-centred planning - person-centred planning seen as something that is facilitated by an expert *"I'm waiting for the pc planner to arrange person-centred planning for my clients" (several SWs)* *" Flipcharts, coloured pens, pictures and clear writing, artistic skills - all that kind of thing is not really my strength"*	This belief and the practice stops pc planning becoming embedded into routine work as there is limited or no funding for expert facilitation Workers challenged and demoralised by being expected to deliver this?	Need to simplify person-centred planning, challenging some of the assumptions of the current approach. Encourage belief that person-centred planning is a way of thinking not a particular methodology. Allow workers time to learn more about complex people so they can see support planning from the person's viewpoint. Training on co-production
Some families refuse to participate in person-centred planning meetings	Some families more comfortable with being in meetings than others (assertiveness skills). Some are intimidated by so many workers (who are used to being in meetings and forget this). Some families might feel their privacy is invaded – taking about painful private matters in large meetings	Try including families in different ways – not necessarily in big meeting format – give options and don't judge
Most of the people identified for the project had not got a recently created person-centred plan One person's family had paid for PC planning but this had no clear way of taking it forward: ambitions were unrealistic and not tracked as characteristics of achievable realities *Questions asked of all SWs and families*	It is quite likely that PCP is not being offered unless there are safeguarding or other significant risks to people, and then when there are, it is quite likely that the need for urgent action diverts workers from initiating and undertaking PC planning work.	Offer person-centred planning on a routine basis

THEME Barrier *Evidence*	Analysis / Hypothesis	SOLUTION
SWs not seeing PCP as their responsibility. PCP has not become embedded in day-to-day practice. Seen as separate from assessment – an optional loop in the planning process *"we have a team for that"* *A SW said she is newly qualified and has not had training in PCP*	Is this view because specialist workers / teams were set up. If the posts have either ended or been cut, is this seen as the end of	New initiative needed to ensure PCP is integral to assessment and support planning with training for team managers on how to inspire their workers. Need for a PCP methodology suited to a time of austerity, with short-form training for SWs and a simple guide on incorporating PCP into mainstream practice so SWs do not see PCP as a separate process e.g. co-production in MCA Best Interest decisions
SWs/care managers are not using PC planning as a driver for their work due to a lack of experience *A PCP facilitator said that many SWs have not had any experience of PCP which this has been done by day centre officers and by reviewing officers but not SWs who would be working with people who present greater risks due to their complex needs*. *W- New placement chosen by SSD with no discussion of sought outcomes or a PCP.(families work)* *Z's PCP was paid for by family: SSD do not have copy. Appears to be both capacity and capability issues in SW workforce* (families work)	SWs are not required to use outcomes – is anyone monitoring their work? I saw more than one support plan where recording of needs and outcomes was muddled with little outcomes statements – mostly needs and descriptions of what support should be provided	SWs to be monitored on their use of outcomes as the basis of their commissioning. Training for SS in developing or conceptualising outcomes needed (What is a need, what is a service or support, what is the outcome of that?)
Lack of commitment by SWs to person-centred planning *One PC planner said that some SWs regard PCP as giving away power – their style is more directive and doing to people rather than co-production*	Is this about fundamental personal values or is it a lack of awareness/inspiration?	Assuming latter, need for inspirational training which helps people to see the value of PC practice/ co-production SCIE briefing on the evidence base for co-production: http://www.scie.org.uk/publications/briefings/briefing31/

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Reactive commissioning and lack of outcomes focus when setting up a contract for service. Email from SW to sibling " *the Care Home has queried the funding for the current package, specifically for V's daily activities … To date...the Care Home has not confirmed some of the details that have been requested by my commissioning officer. Hence, V has an allocated budget but the service and support the Provider will provide within that budget remains unclear." This remained unclear 8 months on*	A lack of practice of outcomes-related commissioning	SWs need to be required to use outcomes to lead the commissioning of a service, asking the service provider specifying to propose how they will achieve the outcomes and this dialogue should form the basis of monitoring the contract (which would include any regular visitor to the person or someone who the person might visit regularly)
LENGTH OF TIME TO SET UP SUPPORTED LIVING		
Discharge from hospitals or moves from care homes where there are problems cannot wait for supported living to be developed due to the length of time it takes to set up supported living - what happens to people whilst they wait? *NHS commissioner asked for advice on what can be done about this.*	What is causing the delay? Housing>? COP? What should happen to people whilst they wait?	Develop notion of interim placements whilst people have supported living developed for them. Develop interim services using existing services or short-use buildings, with future support provider recruiting additional staff who will then be the core of a team for the person when they get their own home. LAs and NHS to share the true cost of interim placements - honest relationship with provider
People with LD / autism cannot cope with uncertainty around a crisis or change in their needs	Need to get away from the idea that. Is a disablist view.	Support to cope with change needs to be properly planned and necessary support provided.

THEME Barrier *Evidence*	Analysis / Hypothesis	SOLUTION
PARALLEL OR PARTNERSHIP PATHWAYS: HEALTHCARE MODELS & SOCIAL CARE MODELS		
Lack of availability (capacity) or limited nature of roles (capability or remit) of specialist healthcare professionals *Removal of person under MHA for 1 years from her own home when problem was lack of positive behavioural support approach (families work)* *Lack of monitoring of communication support for people in care homes (two people in the families work both use picture symbols but didn't have any)*	Is there a clash of social care and medical models? Is there a need to integrate the resources into one model of assessment, care management and monitoring or services rather than having two separate support & care/decision-making process pathways? Pressure on public sector finances funding and assessment process for continuing healthcare funding– does this drive LA and NHS to polarise their approaches?	Hounslow have psychiatrists in the social care team and they are line-managed by Social Care senior manager– what can be learned about this? How is it developing? (Have asked for feedback)
Interface between NHS Provider / Social care Provider: People's supported living services are provided by support provider organisations who might need additional resources when people are in crisis. If the LA does not provide any, they are at risk of being admitted to an ATU. The individual sits between two processes of care and support for which the resources come from different pots. When people go into inpatient care, they lose their benefits and can lose their home: if the additional input could be provided in their own home, this would not need to happen. The LA can make a saving if the person stays in hospital for a long time and altogether if they become 100% CHC. NHS staff have no control over LA budgets if they think the person needs additional support. A p*sychiatrist from Cambridge said that her letters asking for a higher level of support for people*	Medical model / social care model – service and care pathways: Do NHS crisis assessment and treatment services and associated specialist services (inpatient units and linked community teams) fit with a disability model of positive behavioural support? Mental Health treatment often cited as need for admission – but is this the best way to support someone if their home address is the best place for them in the long term and there is a need for change in their support plans not in their accommodation?	Individual Health Budgets combined with personal social care budgets – will enable better shared approaches to personalisation

THEME Barrier *Evidence*	Analysis / Hypothesis	SOLUTION
received no response		
NHS commissioned and provided specialist LD services not in tune with the social care model of LD *SCENARIO 1: P lives at home with parents. Aggression towards his father by P, though not towards people at his day and short breaks services. Parents finding life v difficult. The family is offered intervention from the NHS LD Outreach team who aim to prevent admissions to inpatient services. The parents refuse the service as they have previously not found it useful.* *SCENARIO 2: Y: lived in own home with support commissioned by the NHS. Denied access to physical interventions either due to a lack of this being in the service spec or the wrong provider being selected or – worse – the provider being told it was illegal. Removed to inpatient services. PCT pushing for long term hospital placement* *SCENARIO 3: The project team was invited to present to a provider forum. Suggested the organiser invited the NHS crisis/ inpatient services to discuss service interfaces. This was not usual practice yet there is no other forum where the services reflect on how they work together.*	Are NHS commissioned and provided specialist LD services fit-for-purpose in relation to people with challenging behaviour i.e. do they promote the social care agenda and supported living? What is the basis of the typical NHS crisis/outreach team's approach - the underpinning model? What are they being asked to do by commissioners? Is there a service specification or just a number of face-to-face contacts in the whole of the provider's contract – a line on a spreadsheet? Do the teams deploy positive behavioural support? Do they rely on reactive strategies? Do inpatient services offer positive behavioural support? How do they do this despite what we hear about high staff turnover and use of agency staff? Do LD specialist services offer a model of support which does not fit with the philosophy and direction of the personalisation agenda?	Providers need to routinely talk to NHS specialist services – developmental dialogue – how do we work together? Do our models complement each other? The two sets of providers then need to advise together re funding/service model for individual people with the LA or NHS commissioner. It would be good to identify an area where the NHS specialist services work closely with commissioning. This seems to be the case in Glos. Any others?
LEGAL FRAMEWORKS – MHA . COP		
Needing a tenancy signed by the CoP will burden care managers / adult social care commissioners,	Are CoP applications increasing? Is it possible that the needs of people with LD are	LA have powers to make a Best Interest Decision provided all are in agreement

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disrupt the payment of housing benefit and potentially delay arrgts *Someone in one area had been waiting 9 months to be discharged due to COP delay – their home was ready for them*	becoming too legalised Recent messages from the COP sound as if reason is prevailing	
A belief that people without capacity need to go to CoP to have security of tenure *In one area an experienced SW believed supported living was not possible for someone unable to sign a tenancy without COP*	Only if the person having a tenancy is a matter disputed by those around him and therefore needs to go to CoP. – otherwise no need for CoP	As above
A continued lack of clarity on DoLs policy for people without capacity for whom supported living would be a Best Interest Decision option of choice *In one area an experienced SW believed supported living was not possible for someone as they need DoL to be safe.*	Caselaw has shown that as long as receiving physical interventions and having doors locked is in a person's assessment of need, providing a service with these features in a person's own home is lawful without recourse to the CoP.	Relationship between MHA and MCA needs further exploration e.g. use of CTOs (related to medical model within social care model)Develop the policy through practice – advocates and providers to shape. Practitioner guidance needed
THE COST OF PERSONALISATION		
The high costs of services encourages continued use of residential care even through people suspect that although 2:1 is commissioned, this is not actually delivered. *discussions with various workers and senior managers*	Commissioners believe that people need 2:1 yet 2:1 staffing could lead to staff relating to one another rather than the person, escalating/provoking negative behaviours. Although the principle of delivering higher quality staff on a 1:1 basis (more trained) moving from a service which relies on 2:1 to one which delivers safely 1:1 would be a massive change in provider culture and practice	RADICAL CHANGE IN COMMISSIONING Implementing this thinking would lead to radical change in commissioning services, improving service quality and virtually halving costs. We should develop a QIPP proposal e.g. for how Sarah would work with providers to help them achieve that change: Sarah would need to work with them over a 2 year period, with intensive training and support at first, moving to mentoring and monitoring. See project plan in email
Cap on Direct Payments – so that people having Direct Payments cannot afford to commission their	Peter believes this is something to do with In Control	Needs to be clarified as LAs have a duty to meet assessed needs and cap on

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own service		hourly rates perhaps goes against this requirement?
R's mother believes barrier to supported living in their affluent area is care worker shortage as pay is too low.	Needs testing before assumptions accepted on this	
LACK OF UNDERSTANDING OF CHALLENGING BEHAVIOUR		
If the person's behaviour presents too much of a challenge, supported living providers not prepared to offer a service. Yet their behaviour is likely to be arising from their current situation which needs to change *One area reported that a person being secluded in an ATU was regarded as too high a risk by a provider and that they would not take him until he stopped being secluded.* *Another person in an ATU was said to be having an unsettled period, yet we knew from another source that there were severe staffing shortages at that time – no link was made by the worker between the two*	Living on an inpatient unit where only reactive support is provided due to understaffing and the use of agency staff; where the other people there are all disturbed; where the environment is not the person's settled home must surely trigger people's behaviour Use of inpatient units for people with challenging behaviour needs to decrease	More training in understanding challenging behaviour is needed for ATUs which can be dominated by a mental health model, and also for support providers who want to develop services for people with challenging behaviour Inpatient units need to use proactive behavioural support plans for each person with a transparent system to track when these are not being put in place due to a lack of staff – this way it can be seen what potential there is for the person to respond to positive behavioural support.
People's challenging behaviour when they have high levels of support continues to be seen as an individual character trait rather than a form of communication *Workers cited high numbers of incident forms as evidence that the person is not yet ready to leave where they are*	High numbers of incident forms probably indicate that the person is not well supported in their current arrangements	Positive Behavioural Support Training needed for all commissioners so they understand challenging behaviour and what building the right support for someone means – not just 2:1