

**Personal Care Task Group Meeting  
26<sup>th</sup> October  
Chudleigh Town Hall**

<b>Present:</b> Caroline Lee (CL)	LINK Facilitator
Michael Johnson (MJ)	LINK Volunteer
Pam Hogan (PH)	Minute Taker (LINK)
Jill Perry (JP)	Community Engagement Worker (LINK South Hams and Teignbridge)
Robin Corser-Langford (R C-L)	So Out in the South West
George Alfred-Husband (G A-H)	LINK Chair
Andrew Kemp (AK)	MS Society
Nick Cape (NC)	South Hams CVS
Liz Gilbert (LG)	Individual/Mid Devon Carers UK
Jane Hansford (JH)	Carer South Hams
Sarah Roe (SR)	Newton and Noss Mayo Carers Support Group
Liz Hitchins	Individual
Denise Brabin	DCC
Paul Collinge	DCC
Richard Newcombe	Newcare

**Welcome and apologies: received from Wendy Lloyd and Audrey Campbell**

**Monthly Update and Discussion**

**8. Minutes of the previous meeting held 23 09 09**

**8.1. Matters arising**

**8.2. Re 4.1. CL apologised for the lack of feedback on her meeting with Denise Brabin. Her understanding was that DCC do not monitor contracts with people who pay full costs. The CQC is their first port of call. The Personalisation Agenda also means people can vote with their feet. This is something to consider at this meeting.**

**9. Update and discussion prior to the arrival of Denise Brabin, Paul Collinge and Richard Newcombe, covering: The problem of services not being available, particularly in rural areas, to provide care even if a budget has been provided. The Personalisation agenda has attracted a lot of government funding. What proportion will be used to address the additional needs of rural carers? Specifically:**

**9.1. The issue of unpaid travel time and the difficulty in recruiting enough carers**

**9.1.1. Why not subsidise agencies in rural areas?**

**9.1.2. Is this something we can work with commissioners on? Can we influence this?**

**9.1.3. Concern that nothing has changed in the last 3 years since the last report - what influence does this Task Group have? The issues are known: can anything be done about them? How can we move forward; make progress?**

- 9.1.4.** The importance of awareness raising with the commissioner.  
This meeting opens up new possibilities for effective involvement.
- 9.1.5.** The direct route to information on people's views on services and how they are affected through the South West Alliance of Neurological Organisations (SWANO). Concern over apparent lack of action from DCC over procurement complaints. In house services are good but bought in services have gone down and down.
- 9.1.6.** The need for good quality case studies on lack of provision, carers arriving late or not turning up at all - important as evidence.
- 9.1.7.** The mistaken assumption that people find it easy to complain. Often the opposite because of a fear that they will not get the services they need.
- 9.1.8.** The important role LINK has in raising issues anonymously, feeding directly in to the Health and Social Care Scrutiny Committee, to Councillors and at Ministerial level if necessary.
- 9.1.9.** Concern over forthcoming changes in Health and Social Care, specifically in the diminishing role of the care manager. Many people don't have the energy to source carers and do all the organisation themselves. The majority of those consulted through the MS Society wanted support with the Personalisation agenda. An advocate is a possible solution.
- 9.1.10.** The need for information to be such a part of the local community that people automatically know where to go for information. DCC feels like such a huge lumbering organisation, it's not accessible.

(Part Two) Meeting of LINK Devon Personal Care Task Group and Commissioners and Providers of Personal Care Services in Devon, 26 October 2009

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**10. Discussion with Denise Brabin, Paul Collinge and Richard Newcombe.**

10.1. CL summarised the aim of the discussion, i.e. to explore how this task group can work with commissioners and service providers to influence and improve personal care services across the county. The main points arising included:

10.2. **How to improve the situation in rural areas:** DB - we don't want rural areas to have a second class service but the issues are difficult to deal with. It would be helpful to understand the issues, add to hot spots we know about and to supplement contract monitoring currently being introduced to assess time-keeping.

10.3. **ACTION** Task group to provide information about areas where services are not functioning as well as they could be i.e. "hotspots" where service could be improved, particularly in South Devon/South Hams. CL reminded the group that LINK has to retain an interest for the whole of Devon. NC to liaise with complex care team in South Hams to enable this to happen.

**11. How to improve the supply of carers and reduce time it takes to get started.**

11.1. DB & RN - So difficult to attract people into the profession. Constantly advertising but struggle to get and retain staff. It's challenging work, anti-social hours. International staff have made a big difference but traditionally stay for short time then return home. Not just a rural problem. In Exeter cannot take on any new work in the 7am-11am slot.

11.2. PC - Do we need to look at the way we're contracting? May be people we've contracted for 8am who could wait.

**12. How to deal with disincentives e.g. - No pay for travel time (district nurses are paid) and lack of career structure**

12.1. RN - Nurses are salaried. Our staff are paid hourly and work in short units of time - av. 30 minutes. A small group are salaried and can cover rural areas. We're trying to work more co-operatively, reducing the number of providers covering the same area. All staff are NVQ trained but there is a lack of advancement possibilities because of the nature of the job. 2 tier. 300 staff and 13 managers - who also do hands-on.

**13. Perceived lack of government support. Given their policy of keeping people in their own homes they should lead on workforce development.**

13.1. RN - Every morning 200 out supporting people in their own homes. They wouldn't have received that service 10 years ago. But we haven't managed to raise their profile.

**14. Carers are very much appreciated but problems are often with the organisation.**

14.1. RN - Two of the main issues, punctuality and too many different carers, result from the sheer complexity of the task. Enormous number of visits, short units, the need to divert carers in response to changing needs/urgent situations. Accept there's room to improvement in communicating when we're running late but we get a huge volume of calls every morning - carers, referrals, clients - some just needing to talk. Emotional health has big impact on how long people remain at home.

14.2. **ACTION** - GAH & RN to look at potential to develop a Befriending service in Newton Abbot. Identifying isolated clients who might benefit from support and linking to volunteer befrienders.

**15. What additional help is available for rural areas?**

15.1. DB - We're seeking to amend pricing to encourage providers to undertake rural work with an enhanced package and rates for rural areas - urban areas will be reduced.

15.2. PC - we need to address some unpalatable facts. If we continue to provide services as we are now we can't address the challenges you are raising - it will cost 4 times as much by 2015. We have to have a conversation about how to get best value and service - perhaps thinking of different models of provision, taking the hard decision to move capacity into community services. Possibilities:

15.3. invest more in prevention, delaying/reducing demand for intensive services.

15.4. focus on reablement enabling people to stay in their own homes for longer

15.5. shift from residential to own-home/community care

15.6. ensure variety of support services available for Personalisation Budget spend

15.7. Now is the right time to be thinking about what services should look like for the future. How do we make Personalisation work?

16. How can inadequate respite care be addressed to enable people to stay in their own homes for longer? Two issues:

16.1. Change in regulations meaning many respite care providers have had to cease because they're no longer able to offer personal care

16.2. There is a need to look at the availability of residential pre-bookable care.

17. There is potential to involve communities through the Parish Plan - involving everyone at an early stage. Do they want to stay in their own homes? How can they be supported; perhaps by the community itself? How can the community become energised to take services forward in collaboration with the L.A?

18. Conclusions:

18.1. This task group has a role to play in developing personal care services through:

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| <p>18.1.1. Rebuilding connections with and working effectively alongside,</p> <p>18.1.2. commissioners and providers. inputting ideas and suggestions on a regular basis</p> <p>18.1.3. contributing to the debate on the hard decisions that need to be taken quickly</p> <p>18.1.4. articulating the experiences of those who receive services to provide a fresh perspective on whether or not they actually deliver what people need - a reality check.</p> <p>18.1.5. contributing to the conversation on what domiciliary care should look like in the future</p> <p>18.1.6. exploring local pilot projects, such as the befriending scheme in South Hams</p> <p>18.1.7. bringing representatives from the statutory, voluntary and independent sectors together to agree targets and develop action plans.</p> <p>18.1.8. contributing creative/ innovative solutions, for example in addressing ageism</p> |
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Meeting Closed