

Service Review

Adults Social Care

Comments from mailbox and Ward meetings

Ref	Date	Comment
SR131002e	24.6.13	<p>Last week I was reading the above subject e-mails you sent to us and have some concerns about the information. In part of the e-mail it said that consideration was being given to put Specialist Care Services into a local enterprise scheme. I have been working for BCC for 21 years and wish to remain a BCC employee till retirement. When I read about the consideration it did not go very well with me.</p> <p>Please could you give me further information and clarification about this and how it may effect me and my standing with BCC. Personally I feel that the services for adults and communities should continue as they are but with minor changes if possible and nothing too major.</p>
SR131005e	7.7.13	<p>I am writing to respond to the service review and green paper on proposed avenues for money saving at the council for 2014-15.</p> <p>I am responding in particular at this moment, on adults and communities but would like to do so on the other areas mentioned in due course.</p> <p>I will try to aim to answer your main question which is "How can we continue to provide essential services to residents and guide the city through such difficult times, whilst supporting greater fairness and future prosperity?" in my response:</p> <p>I would firstly like to point out that once again in public consultations, which I believe this too is, people with Autism are not specifically mentioned (i.e. page 2 of 7 of Adults and Communities Green Paper Review). Would this not make it unlawful under Sections 149(1)(b) Equality Act 2010 and 149(3) which states that: "</p> <p>(3)Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need toâ€</p> <p>(a)remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;</p> <p>(b)take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;</p> <p>(c)encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low".</p> <p>Had I not had mental health difficulties too, as mentioned on page two of the green paper, I may not have submitted this response to you. This does need to be addressed asap especially for points (3)(b) and (c) mentioned above.</p> <p>I would hope that by individual budgets on page 3 of 7 you would also cover</p>

Direct Payments as they are in statute compared to the former, due to legislation from 1996 to the current Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009 and corresponding Statutory Guidance.

I am quoting the following from the paper and then shall answer the corresponding questions you have listed:

"1. Consistency between children's services and adult services - to ensure "whole life" approach and a more seamless transition from one service to the next.

2. Integrating and aligning our services with the NHS. This has been progressing for some years, but this year will mark the start of a major leap forward towards a joined up approach³.

3. Radically changing the way we deliver specialist care services, such as day centres and home care

4. Working more closely with local communities and recognising the role that we all play in supporting our neighbours, friends and relatives.

A "whole life" approach to disability and mental health.

We are considering developing services for children with disabilities which span their lifetime. We cannot accept that dependence is an outcome for so many young people. This will look at incentives to providers to promote earlier planning and independence. The plan will include identifying employment opportunities and creative thinking about removing barriers to individuals living in their own home.

We are working with the NHS to create a single plan for older people in the city.

We want to improve the care management of frail elderly people, across health and care. This will mean better planning for very frail people already in care homes, so that increasing needs at the end of life can be met in the care home, not by transfer to hospital. The Plan will pave the way for better multi agency working for people outside hospital. It will give older people and their families the confidence that they will be cared for appropriately, in their own home. It will also look at providing a more coordinated response to a whole range of events from falls, to strokes, to intermediate care and end of life.

A radical new approach to specialist care services.

We are considering establishing a social enterprise to enable specialist care services to trade outside the council. There are potential gains from this operating model and could save the council around £2.5m in three years.

Offering more choice and using resources better.

We are considering ceasing council owned residential provision for short breaks for people with disabilities and their carers and replacing it with individual budgets. This offers potentially greater choice and a more effective use of the resources we currently spend. Carer support continues to be funded to the same level."

In regards to your questions:

Q1. Do we reduce the reliance on residential care? Residential care is very expensive, both for individuals and public services. There are some people who will always require care. By virtue of birth, or through disabilities acquired through life, some citizens will need the Council to make arrangements to meet their needs in ways that are dignified and safe. For some people this includes residential care. But most people would prefer to remain in their own homes as part of the wider community for as long as possible.

Answer for Q1. - No, as there are many people who require residential care albeit for short to long term due to respite, health and social care reasons. With direct payments and their current non statutory individual budgets counterparts, no more than four weeks can generally be spent on respite care (e.g. in care home etc) therefore the council will still be required to provide funding for this, unless the current Care Bill in parliament will allow direct payments and soon to be individual/personal budgets etc can be spent for a longer time period and for such care to be continued for a periods less than four weeks apart. Maybe shared lives is something the council should consider as it might be suitable for **some** people (e.g. young adults aged 18-35). It would also help the council intergrate the two directorates better as it desires too.

I also welcome whole life approach to disability and mental health but for independence I do hope it does not mean that people are forced to have enablement services which can be too structured and not personalised for individuals (e.g. six sessions over six weeks and you're supposed to be enabled and independent by the end of it). This might work for some people including those not able to voice their concerns and dislikes but not for others like younger adults etc.

Q2. Are our communities able to support us to live in our own homes?

Not everyone who is currently in the care system needs to be there. Birmingham is placing too many people, with all types of needs, in residential and nursing care. This is a reflection upon the current quality of housing, community and employment options.

Answer for Q2. - Who determines who is supposed to be in the care system? By the way, it shouldn't be referred to as the "care system" as it sounds too familiar to what under 18 years old sometimes have to go through as looked after children etc. Though coming on the point, people should be able to stay in their homes for as long as possible, by support of wardens and practical support in the home under Section 2 Chronically Sick and Disabled Persons Act 1970 (CSDPA). People also who have serious mental health difficulties like Dementia and require support but not necessarily as formal patients under the Mental Health Act 1989/2007 or under the Mental Capacity Act 2005; as a measure to get them the support they need as some hospitals won't take patients unless detained due to lack of beds or aftercare being given through nursing/residential homes when with a bit more imagination they could be supported at home. The CQC, HMIC and HMP have all looked into this matter at the moment. There will always be some people that this is not possible, but the far majority can for at least some period of time before they need residential care.

Q3. Can my community help me to live in my own home?

We need to promote more mutual support amongst people, families and communities. This will involve communities in Districts and neighbourhoods taking some responsibility for people with care needs where they live, by providing practical support to their health and well-being and challenging service delivery practice in health and social care.

Answer for Q3. - Yes people should be helped by people within their community but not for the directorate for adults and communities to save money not to help people in need, when they or their support cannot give or want to give.

Q4. Can my community support vulnerable younger adults to live a community life?

We are developing a joined up working with Children's Services to encourage lower levels of dependency and reduce the costs of overall care in the longer term. The review has modelled a potential saving that this approach could achieve. Although these are small numbers each year, and not a high proportion of each Directorate's work, there are clear correlations between higher care costs and younger adults.

Answer for Q4. - We require more info on what the two directorates are developing in order to reduce "dependency" on the adults directorate and at this stage cannot comment more.

Q5. Do our social workers need to work differently?

For over the last decade, social work has become more of a process. Some of that is positive and has created the basis of some high quality, skilled work. Some has been at the expense of promoting a social model - ensuring that people are supported and enabled to live their lives in a network of family and community life. Social work will now have to champion people's rights, to push and advocate for housing, meaningful activity and jobs, inclusion in community life and strengthening the circles of support offered by family and friends. We will work with people as equals in developing personalised care, but we will challenge people to have aspirations, and to match needs with their potential.

Answer for Q5. - Social workers need to go back to the traditional route of helping people and not being button pushers for which their association and the new College of Social Work are trying to do. It would also enable them to provide social work advice and support as required to those who need under Section 2 CSDPA 1970.

Q6. Do you have any examples from your own experience of problems that could be solved by joining our services up better?

We have mentioned examples of situations where current services may lead to duplication, overlaps or gaps in provision and cause unnecessary anxiety and confusion. Do you have any personal examples of this?

Answer for Q6. - Merging the two social services directorates into one so can have cradle to grave support people need, and joining care leavers and staying put support with adult services.

SR131006e	10.7.13	<p><i>OPEN LETTER to be sent to Cllr Albert Bore, Leader of BCC, Peter Hay, Strategic Director of Adults and Communities Directorate and Steve Wise (Finance Director)</i></p> <p>Dear Salma (former Respect leader and former Birmingham councillor, Salma Yaqoob on BBC1 'Question Time', 6 June 2013 that prompted this)</p> <p><u><i>REPORT ON MY EXIT FROM THE WORLD OF WORK AFTER 35 YEARS WITH SOCIAL SERVICES IN SANDWELL AND BIRMINGHAM</i></u></p> <p>or, <i>How Central and Local Government Waste our Money - but, they certainly don't mean to, of course!</i></p> <p>Greater minds than mine have struggled for years with the intractable problem of delay upon delays in social care and health. Here is my analysis of the problem, with suggestions at the close.</p> <p>Your "bed blocking" (We refer to delayed discharges or, in the case of enablement packages waiting to go over to long-term, we use the word, 'over-stayers' - see, also note 1, below) is nothing to do with cuts in the budget for Social Care, as I think you said on last week's programme. Rather, it is to do with my colleagues and I taking hours over following the assessment process that is now seen as an essential service in its own right. It has become an end in itself, rather than a means to an end of a safe, swift and correct discharge plan as soon as the patient is medically fit for discharge. The assessments are an obligation, and should be given to the elder, even though it is the elder and his/her family (and, sometimes, other professionals) who have given us all the information. The outcome (a safe, sensible and swift discharge) has become less important than the assessment. Hence, many weeks sometimes go by after the patient is fit for discharge, rather than days, before the bed is unblocked and can be used for someone else. I have spent hours working through the assessments only for the patient to die before the assessment paperwork could lead to the safe and good outcome (the transfer to a hospice, in the case I am thinking of). All my hours of research and writing was wasted! The hospice or care home would then want to do their own assessment, anyway and the assessment and conclusion by the manager of the home always trumps the social worker's decision and hours of work put into the assessment, anyway!</p> <p>MORE REASONS FOR YET MORE DELAYS TO THE DELAYED DISCHARGES AND OVER-STAYERS:</p> <p>The assessment process means far too much writing and typing to prevent legal challenges that have never come, in my experience - and they are normally only read by my line manager who has to authorise them.</p> <p>For me, the purpose of the assessment is this: What can she, the elder, do and not do. What does she struggle with and need help with. What support is she getting, who does what, can a professional carer take some of the pressure from the family carer(s) or, are any needs not being met because of the absence of any family or friend? From my experience, whether or not our elder gets the help from us, does not depend on the eligibility band but the opinion/judgment of the social worker and her line manager. To meet genuine need and that we can help with, we make the assessment meet substantial or critical band. The whole lengthy, laborious process really is irrelevant!</p>
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The emphasis on lengthy assessment writing is disproportionate, I think, for a one to four calls a day care package or, for admission to a care home. In addition, I don't think you need three years full-time, intensive training or, to have to write thirty pages in one assessment that takes hours to research, prepare and type up with, occasionally, five other assessments to complete as well. This is all OTT, unnecessary and irresponsible, even if we were **not** living in a supposed age of austerity.

The assessment tally is:

Contact assessment - 6 pages

Carer's assessment - 17 pages

Capacity assessment - 4 pages

Assessment Questionnaire - over 30 pages and twelve sections

Specialist assessments- indeterminate

Financial assessment - 16 pages

The main assessment, in twelve sections, was originally called the Self-Assessment Questionnaire because the elder or his/her carer was meant to complete it with the social worker adding his/her comments in the appropriate boxes in ten out of twelve sections of over thirty pages. Some of the assessments have to be copied and passed on to other professionals and/or the elder or his/her family. This is all extremely lengthy and takes many hours - and, all for just one person languishing in a hospital bed desperate to get home with a care package where the carer might call no more than four times a day! If I was that person, I would not wait for the lengthy and laborious assessment to be written. I would simply set things up myself, if doctor told me that I was fit for discharge and there was nothing more they could do for me.

The way the six assessments are presented for printing is wasteful. It is far better, I think, to select, copy and paste into a Word document and to send or e-mail that.

There then comes the support plan that really *is* important, is read and must be followed by the carers delivering the care package. And must be reviewed to ensure the carers are genuinely needed. Even so, it is the elder and/or his family carer who know the most about what is or is not wanted and what needs to be done by the carers. However, the social worker must be vigilant to ensure that the tasks really cannot be done by the elder and that the professional carer is genuinely needed. Those going private, as I was with my dad who was over the threshold of £23,250, sort out their own care packages without six assessments and one support plan.

Therefore, the financial assessment must be given top priority in case the elder has savings of more than the £23,250. In that case, we should not be doing the other assessments. We should be advising them to fix up their own care packages and care homes.

It is a most inefficient and unproductive way of doing assessments when the computer does not even automatically give you the correct eligibility banding and RAS amount as numbers and letters are entered, as we laboriously work through the ten sections out of twelve that we have to do. This is what computers are very good at doing but the software was not programmed to do it! This is very poor, if not scandalous. The whole thing is a tedious rigmarole

that brings longer delays and longer waiting lists - and, serves no useful purpose, whatsoever. It is a waste of taxpayers' money **and** gives them a poorer service. Quite astonishing incompetence but, true!

All the letters and numbers we play around with reminded the facilitator at one training course I went to this year, as like playing the children's game of battleships. How very true!

Wasteful and a poor service because, sometimes, the eligibility band and the RAS amount have no bearing on what we do to meet genuine need. The substantial band is when "there is, or will be, an inability to carry out the majority of personal care or domestic routines". In practice, this is far too strict and cannot possibly be adhered to. What happens is that we negotiate with the elder and his/her family to get the right care package to support them all. We sometimes make up the eligibility band and the RAS sum in order to get the money for the package that everyone knows is essential for a safe discharge from hospital or for a long-term package to take over from the enablement package. Rigging the assessment is unethical, unprofessional but, sometimes, **has** to be done. But, **really**, what an idiotic waste of our time and of taxpayers' money going through this whole, lengthy process of pretence in the assessment questionnaire. It takes unnecessary hours and contributes to Salma Yaqoob's bed blocking.

In my experience, reading the up to date case recordings and the carers comments in the communication book are far more helpful than the assessment questionnaire that is not up to date, especially when elders are recovering from a hospital operation.

There is one new initiative after another to try and deal with the chronic problem of delayed discharges and of over-stayers. Interim care (Note 4) was thought up to get patients off the ward. Intermediate care (Note 6) was devised to also help in this area. Next, enablement came into being as a way to make more efficient use of our in-house home care teams. Each new initiative means yet another referral form for social workers to complete. Interim care and intermediate care simply postpone a final decision and both make for yet more work for social workers in completing forms. There are interim care social workers, too - and, therefore, it is inefficient and actually creates delays. Yet, all we need is patients, family and ward staff working together to decide whether it is back home (with or without a care package) or, into residential care home or care home with nursing.

Are all these teams really necessary?:

Peripatetic Hospital Discharge Team

Hospital Post Discharge Team

Main hosp sw teams in the hospitals

Intermediate hosp social work team

Interim care social workers

Central Adult Support Planning Team

and there are more, outside the hospitals, in the Adults and Communities Directorate

Even the excellent, hospital 2012 scheme of enablement and the short hospital assessment on two checklists must be followed by the full ten section, 30 page assessment for my colleagues and I (on the Hospital Post Discharge team) to do, if the elder still needs care staff, beyond the maximum six weeks enablement, to

maintain her independence. Two lots of assessments for one person for one discharge. Plus a possible five other assessments! Even a new name is found, "over-stayers" to describe those waiting for social workers like me to transfer elders from short term enablement carers to the long term private sector agencies. However, the enablement initiative is a good one in that it works to reduce dependency on those who have the potential to become more independent on discharge. The only problem is that it includes those over the savings threshold of £23,250 - and, they pay nothing to the city council for the enablement carers, despite enablement carers costing the city council three times what the council pays the private sector (a total of £36 per hour for the city council carers is scandalous). Our in-house enablement carers nearly always get good reports but the above cost is prohibitive at this time of urgent financial savings. I would suggest, get the definitely more efficient and economical private sector to do the excellent enablement initiative. Privatise in-house home care.

The first 27 years of my 35 years in social work was far more sensible and worthwhile. The really big misuse of taxpayers' money started with the disastrous advent of Individual Budgets and the Single Assessment Process in the last decade. It did away with the excellent assessment and social work reports, care plans and review forms we were using up until then. There was no need for any change that made life so much more complicated and so very costly. The only change that **was** essential was to go electronic.

SUMMARY AND SUGGESTIONS

An immense amount of work is expected for every elder, even for a small care package of one morning call a day. This is very inefficient, unproductive and wasteful of government money and of finite resources. It is also a further turn of the screw on the catastrophe of us humans deliberately enhancing the greenhouse effect from all this unnecessary frenetic activity. Research has shown that social workers are now spending 80 to 90% of their time in front of their computers. (Note 1a)

A maximum possibility of six assessments, even for an elder who needs only one call a day. This is absurd. Even the one main assessment takes far too long to complete and is out of all proportion to the final end result, **and** when providers do their own assessments, anyway!

The eligibility banding and the RAS score were a nice idea in theory and were meant to make social work less subjective and more objective and scientific. However, in practice, both are irrelevant and all the time spent on working them out is wasted time, is more inefficiency and a waste of taxpayers' money.

"BCC must make £340m savings by 2017" Birmingham Post 13 June 2013 (Note 2)

Social Services is certainly ripe for reform, in my opinion. Perhaps, just hand it over, lock stock and barrel to the private sector to see what they can do. We've done it in Birmingham with very nearly all the care homes. Four new care centres are left. How do they compare in value for money with the private sector care homes?

The very least that I think must be done is to emphasise on the website and in our literature that elders are better off going private if they have savings of more than £23,250. Social care must concentrate on those Birmingham citizens who

have less than the threshold. Therefore, the financial assessment must come first, in the hope that the other five assessments will not, then, have to be done. A short financial section in the full assessment is now included but it is right at the very end. It should be at the beginning of the full assessment questionnaire. Or, why not a seventh, financial summary assessment?!

Press the Secretary of State to abolish Individual Budgets and Direct Payments for over 65s who are not already on them. DPs are much more time consuming for social workers and others to set up. Attendance Allowance is meant to pay for personal care and is similar to Individual Budgets. Therefore, it is all more unnecessary expense for the taxpayer. I do worry about how the Direct Payments money is being spent and the extra trouble in monitoring/auditing how the money is being spent. I fear that the auditing may not be very effective and, therefore, there is abuse of the system. Keep it for physical disability cases but, certainly not for over 65s ('elders' in this document).

If we want to save £340 m by 2017 (note 2), I think it is essential that not even one assessment is even begun for anyone with savings over £23,250 in Birmingham. The social worker must signpost them immediately to the private sector.

There are far too many managers and nearly all of them fail to help us to get the work done on the shop floor. I have two managers supervising me - one supervises my cases and the other supervises my professional development and training. Wasteful doubling up. Some of us call the Professional Development Review or PDR, the Pointless Distracting Rigmarole, for that is what we think the initial letters should stand for. The PDR is what the second supervisor supervises, as well as the shocking sickness absence record (Note 3) of employees who are all younger than me and who should be at or near the peak of their good health and strength. To be fair, my first supervisor who is very good in every way (Note 3a), still does some actual social work and so keeps her hand in. However, the previous managerial hierarchy was perfectly adequate (only one supervisor) and should never have been abolished - yet, more expense for the poor, beleaguered Brummie taxpayer.

140 managers, as I read in one work e-mail is far too many. Every manager should spend a full one month every year (and without taking any annual leave in that month) doing the real social work on the hospital wards and out in people's homes, to keep in touch with how their decisions as managers work out in practice.

Scrap the Shining Stars organisation in the directorate. This is a self-congratulatory process that is out of place after what I have highlighted, here. I have never dreamed of nominating anyone. I would refuse to take part in the process if anyone, jokingly, whispered the thought of nominating me.

In summary of the summary. Too many long-winded assessments, that are too lengthy and make for an inefficient and pointless process. Pointless because care agencies and care homes do their own assessments. Our assessments are so long they may not get read. Certainly, a summary assessment must be written for the senior manager who holds the budget. Pointless because the eligibility band and the Individual Budget amount that the assessment questionnaire come up with, too often bear no relation to what we decide after talking with elders, their families and others who know the situation which, with

observation, is what assessment is all about. Too many managers in too many meetings and only the most junior managers keeping their hand in by assessment and support plan writing. Far too much waste and inefficiency. Please, just hand over everything; lock stock and barrel, to the private sector for friendly competition with co-operation.

NOTES

1

On 6 June 2013 on BBC 1, 'Question Time', David Dimbleby said to Salma Yaqoob, "You're in the NHS business yourself" that she did not deny and, mentioned that her husband is a GP.

Salma said, " ... but (the government) make huge cuts to the Social Care budgets in the local authority ... The local authority ability and capability to do that (move elderly patients on from hospital beds) is now being slashed."

1a

I love using computers and love writing but even I think that all this writing, recording and copying/pasting of material is far too much! The turnover of cases/patients is far too slow/low and, I have concluded, that is down to the convoluted, inefficient social work system of working.

2

Sir Albert's 'dialogue' on how to make £340m cuts

With at least £340 million of savings needed by 2017 and increasing burdens on social services, Sir Albert Bore has warned that the council will need 'to do things very differently' if services are to be maintained. 13 June 2013

3

12.4 days/employee/year on top of generous annual leave and a dozen other kinds of leave, too - a grand total of 13 kinds, I have counted on the attendance record card!

3a

Mandy Lewis, Senior Practitioner Delivery, for the sake of this compliment going in her Professional Development Review.

4

Interim care is residential or nursing care free of charge and free of top up for six weeks. Used to free expensive NHS beds when, for example, "family have concerns regarding her returning home and the period in interim will help ascertain her long term care needs and where these will be best met." There is a team of interim care social workers. Yet more social workers and yet another team!

5

Enablement care is up to six weeks of a care package that is free for the elder who has this help. A short assessment is written to more quickly free up hospital beds. The carers understand that they must only do what the elder cannot do for her/himself. The carer should also enable greater independence and work to work herself out of a job. This is all excellent but it does mean for each hospital discharge, the patient has two assessments (a short and a full) from two social workers. (Doubling up of work and workers.) Unless, they go self-funding after the enablement carers have finished. In which case, only the

		<p>short assessment is written. But, then, why is BCC money used to pay for the six weeks care package when the patient had savings over the £23,250 mark and should, really, have gone private straightaway to save the city council's budget? All professional carers should be working to enable their elders to become more independent. This should be standard good practice.</p> <p>6</p> <p>Intermediate care is further enablement from physios and OTs in the enablement unit at the Kenrick care centre, owned and managed by the directorate. I think, it is certainly much cheaper and, better in other ways, for this work to take place in the elders' homes, to where they will need to return, anyway! Many come from West Heath Hospital to free up those beds. Yet, the hospital majors on rehabilitation, the medical term for the social care term of enablement. So, some elders get the process twice and still not in their own homes. More doubling up. More waste.</p>
SR131007e	10.7.13	<p>In terms of the overall approach to service reviews . I think there may be some logistical mileage and therefore financial mileage in a wider look at services across BCC and the local CCGs in terms of movement of goods and services to people's homes and to public service properties.</p> <p>I believe there is a range of solutions currently adopted for all organisations in terms of delivery of items to homes and premises , whether community equipment , Telecare , medicines , post , bloods and results , continence products , school equipment , records , decontaminated waste, receipt and distribution etc etc , and I'm sure many more</p> <p>It appears that all organisations tend to do their own thing but would assume by trying to bring some of this together logistically we could not only make it more efficient and effective with sharing resources but may also have an environmental impact by working together to make less journeys and perhaps eventually looking at the types of vehicles that are used. Some of this "work" (although may be limited) may be able to be carried more locally by other sectors also.</p> <p>It just appears to me that if we organised ourselves better or in a more coordinated manner in terms of logistics we could make a difference and hopefully lean out the process that could give us some financial savings - but realising that this may need cross sector involvement rather than just BCC and would not be a quick fix</p>
SR134009w	10.7.13	<p>Any cut to services for people with dementia or Alzheimer's would be detrimental not only to their health and well being but would also create greater costs to the health service in the long run. Many people who were cared for in residential care were 'stabilised' by the continuity in care that they received and any change to that care caused by a cut in funding would have a dramatic effect and warrant additional resources in the long run. Joint working with the health service was the way forward.</p> <p>There was a 'hidden', hard to reach community of carers etc whose comments needed to be fed into the dialogue, therefore ways of reaching them needed to be addressed.</p> <p>Reductions in budgets meant reductions in staff and the care services could not cope with further reductions in staff numbers which were usually low paid</p>

		<p>women. This would have a two fold effect – on the level of service that could be provided to vulnerable people and the employees and their families. Staff at day and residential centres needed to be kept up to date with the situation.</p> <p>There was concern that budget cuts to adult care would lead to people having IT equipment in their own homes rather than receiving residential care but that this could lead to isolation and other problems.</p> <p>All service users needed to be involved in decisions taken around Centres and facilities that they used. However not all people liked attending Centres, especially young people and therefore their views on all aspects of the adult care services should be sought as they understood the situation better than anyone else. This might mean finding ways of contacting those that did not attend Day Centres etc so that a truly representative opinion was included in the dialogue.</p> <p>Full use should be made of Birmingham – Making it Real as co-production was a vital tool.</p>
SR131008e	12.7.13	<p>concerned there is always a lot of talk still about looking at other authorities for best practice - we must have some of this internally and have we done enough to seek this out before we move on elsewhere ?</p> <p>also on a number of occasions when talking to social care staff - the point has been made that "if we could only set up our own business we can make this work better than the private sector" but of course they lack the tools and experience to do this . Would it be worth looking at support for these staff to set up more local social enterprises or similar and to create a network of local provision where we use the expertise we have already in the council ?</p>
SR131009e	12.7.13	<p>Adults and Communities</p> <p>I think care in the home is laudable but in many cases impracticable. The attendance of carers who have limited time, trying to rush the elderly who cannot move quickly leads to insufficient care being undertaken. This I have had experience of in connection with a neighbour who has carers in first thing in the morning and evening, ostensibly to get him up and put him to bed, to ensure that he has medication and eye drops. It was impossible, it takes him nearly 2 hours to get ready and medication was not being taken on time which led to a further deterioration in his condition. He has now moved into a home for respite care whilst he recovers from two cataract operations. He also has Parkinsons disease. Whilst he would love to be at home, he needs someone to badger him to take his medication on time, get him food, get him dressed, get him bathed etc., etc., Only a carer living in 24/7 would be able to do that. The residential home provides that.</p> <p>Reliance on neighbours, family and community. With social mobility as it is, the gentleman above has a son who lives in Northants, therefore he cannot rely on his son to see to his daily needs. Other neighbours are either nearly as infirm as he is or they are at work. Again no use to him. Some of us don't fall into that bracket but have no vocation whatsoever as nurses. I am happy to shop but we would both feel totally uncomfortable if I had to tend to his personal needs. Therefore I think it is a bit much asking the 'community' to take over social care function.</p> <p>I believe there is a website starting up for mycareinbirmingham which may be a useful one stop shop. However ringing social services on behalf of my husband</p>

		to find out a simple thing of where to return an attendance allowance form proved impossible. I realise that this is local government giving central government information but surely the two relevant areas can assist each other?
SR134002w	17.7.13	<p>BCC could promote a better sense of community spirit and community cohesion by mandating street parties – which would in turn enable communities to take a more active role in preventative work.</p> <p>There are wider issues about asking the community to take on more responsibility with regards to dealing with people’s physical and mental health needs. (Partially answered, by noting it’s about preventing isolation which impacts on health, etc.)</p> <p>We live in a litigious society, and the voluntary sector needs a protective framework before taking on more responsibility.</p> <p>BCC needs to be more flexible in terms of the support it can provide to communities.</p>
SR134004w	23.7.13	<p>People need to *feel* part of a community to contribute - this is often easiest in smaller, more homogenous housing areas (e.g. sheltered accommodation.) We need to be careful how areas are planned/allocated - e.g. Supporting People was doing amazing things with sheltered accommodation for older people, but then there was pressure to also have substance mis-users and homeless people in the same residences and the older folk couldn't cope (bonding vs. bridging social capital!)</p> <p>We need to be realistic - most people will not be willing to give (or receive) intimate personal care from a random neighbour</p> <p>Significant concern about any privatisation of care services - concern at profit motive being predominant. Reassured by other models (e.g. co-ops, third sector).</p> <p>Support for moves to provide social and medical care at home rather than in residential / hospital settings - but need assurance that the care will actually happen and be high quality (ie vulnerable people won't just be left).</p>
SR134005w	24.7.13	<p>Residential Care</p> <ul style="list-style-type: none"> – Discussed move away from residential provision for younger people with disabilities/LD. They endorsed the idea of helping people to become more independent and not necessarily spending the rest of their life in residential care. However, the point was made that the providers should be paid by results (i.e. that they could prove that the individual was living independently/safely/ good quality of life on a sustained level). Not be rewarded for just ‘getting people out’ as it were. – Will the changes proposed disadvantage small providers? <p>Personal Budgets</p> <ul style="list-style-type: none"> – What happens if people misuse the PB, e.g. spend it all on drink? – Who pays for substance substitution? Is it BCC or Health? Whose responsibility is it?

		<p>Community Doing More</p> <ul style="list-style-type: none">– Discussed what the limits of what the community can/will and cannot/will not do. Will look in on someone and do a bit of shopping, but not wash/dress.– If the community helps out, do they need a CRB check?– There will be fear of litigation from the community. There are a lot of risks involved. You might do the wrong thing. You might say the wrong thing and cause problems/harm/end up in trouble yourself.– What about insurance? – If we are expecting/asking the community to do more, we need to make sure the infrastructure is in place to do that, e.g. fast tracking CRB checks, block purchasing insurance, logistical support – Time Banking was suggested as an option to pursue for this.– Selly Oak “Live at Home Scheme” was also suggested. (Keeping a look-out and checking up on an old person in your vicinity).
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