Local Account 2017/18
'How we served you'

This is Sutton Council's Seventh Annual Local Account of its Adult Social Services.
This account sets out how our Adult Social Services performed in 2017/18. The priorities for 2017/18 were:-

☆ **Promote the independence of older adults as set out in the "Sutton Plan".**
A project to improve the speed of installation of community alarms and telecare was implemented ensuring that no patients were delayed in Hospital waiting for installation.

☆ **To increase integration across health and adult social services including the development of joint commissioning approaches.**
Statutory partners worked throughout the winter to agree a formal alliance 'Sutton Health and Care at Home', which came into being on 01 April 2018.

Deliver sustainable services in the context of financial austerity.

☆ Adults delivered planned savings and a balanced budget in the face of increased demand for care and support services.

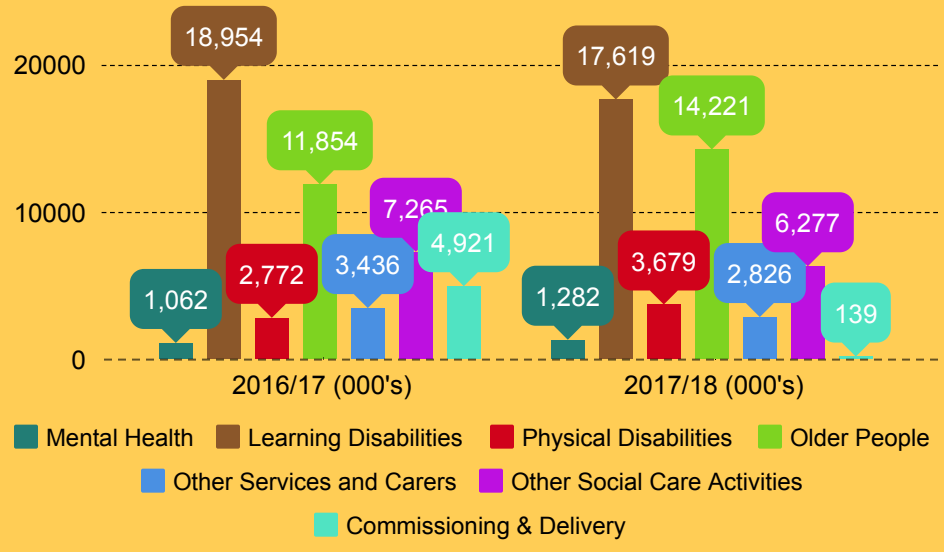
☆ **To extend the independence of borough residents through prevention, early intervention and reablement services.**

Sutton's START Reablement Team, provided support to 1900 older and disabled people, with 70% not requiring long term care. This is around 400 more residents than in the previous year.

☆ **Develop and implement a new Carers' strategy.**

A Joint Carer's Strategy was developed with Sutton CCG. This will be finalised through the Councils new Outcome Based Commissioning Programme and implemented thereafter in 2019/20.

Finances 2017/18

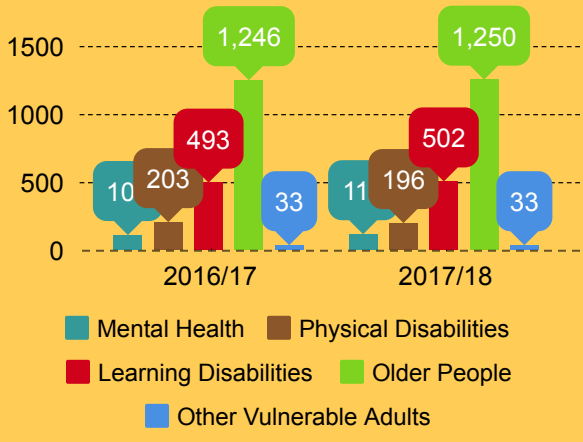


Since 2010 the Council has had to continually deliver on-going savings in response to the Government's policy aimed at reducing the Public Sector deficit, mainly through reductions in public expenditure. To date the Council has made savings of £75.4 million and of this total Adult Social Services has contributed a saving of £16.1 million. The total expenditure for Adult Social Services in 2017/18 was £46.0 million compared to £50.6 million in 2016/17. It is important to note that the required 2017/18 Adult Social Services savings target was achieved with no negative impact on front-line services

How we supported our residents

Adult Social Services received a total of 3,403 requests for support. Most of these people were provided with information and advice and/or received a referral to services in the community. The Council supported 2095 people in 2017/18 with a Long Term Support service. The breakdown of this number can be found below:

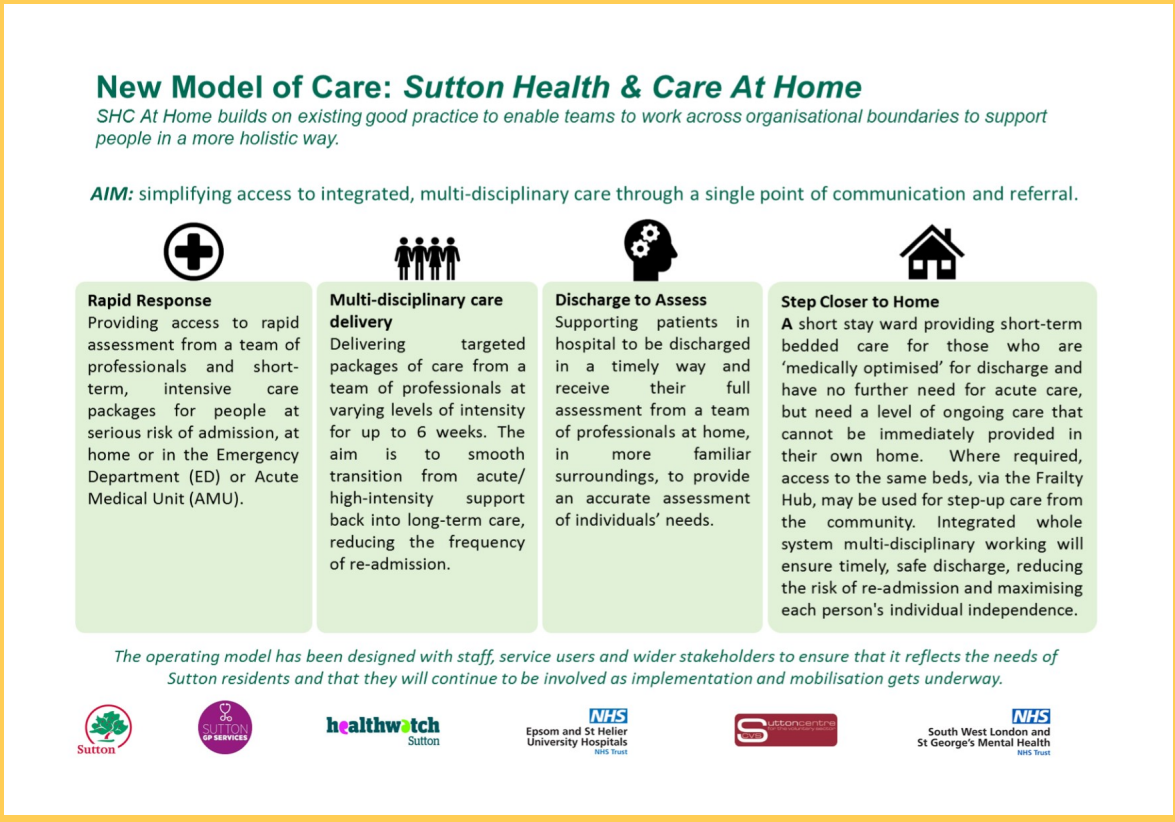
Long Term Support



Working with Health Partners

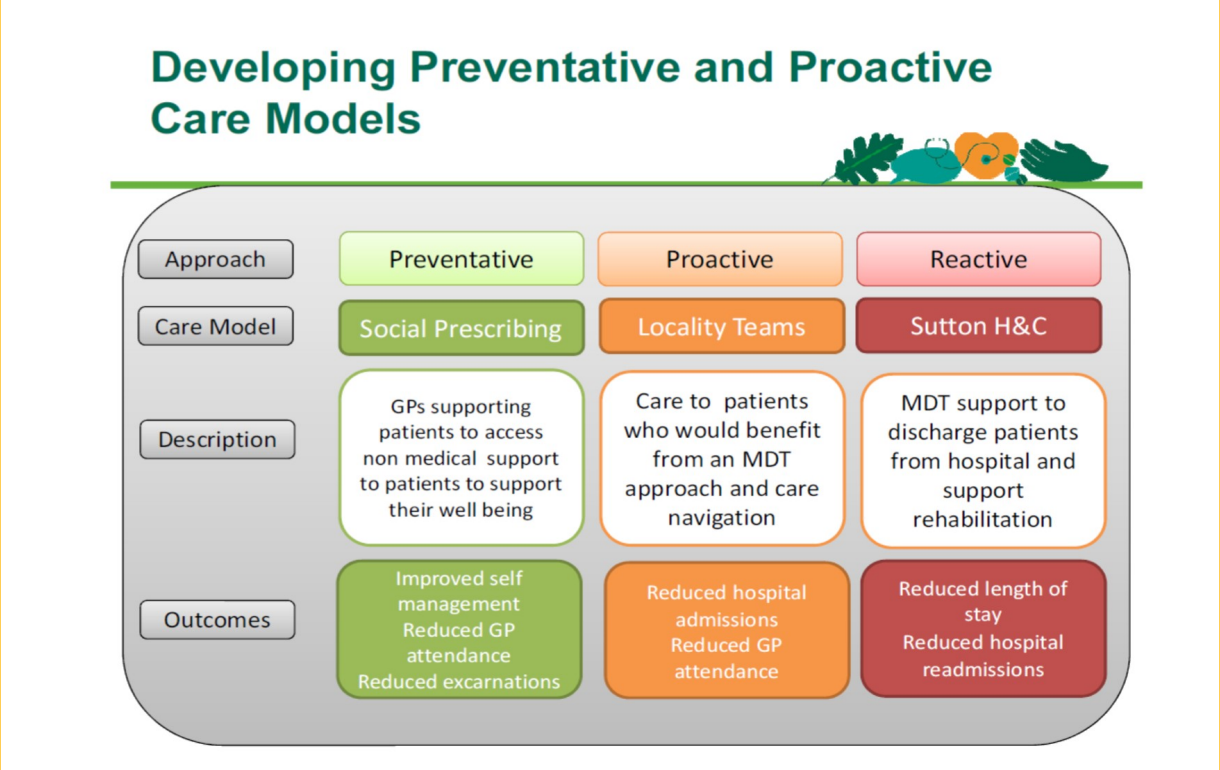
Sutton Health and Care at Home - Reactive Model

Throughout winter (2017) leaders in the Sutton Health and Social Care system have collectively been working to deliver a partner alliance around improving reactive and urgent care.
On 1st April 2018 partner organisations; LB Sutton, Sutton CCG, St. Helier Hospital Trust, South West London and St.Georges Mental Health NHS Trust and the Sutton GP federation, in collaboration formed Sutton Health and Care (SHC) at Home service, hosted by St.Helier Hospital.
This service will deliver responsive integrated care at home and wherever possible make access to multi-disciplinary care easier through a single point of access.



Sutton Health and Care Preventative and Proactive Care Models

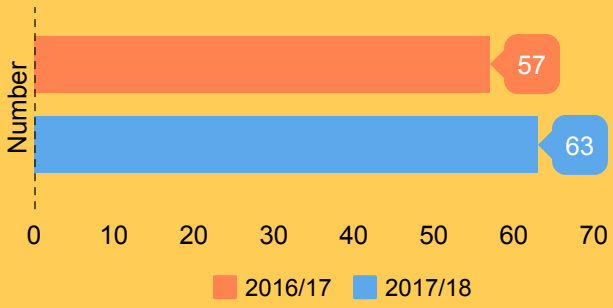
There are a further two models of care being developed called the 'Preventative' and 'Proactive' Models. The Preventative model will enable GPs to support patients to access non medical care in the community. The Proactive model will help deliver multi-disciplinary care in the community to help reduce hospital admission and GP attendance.



Performance

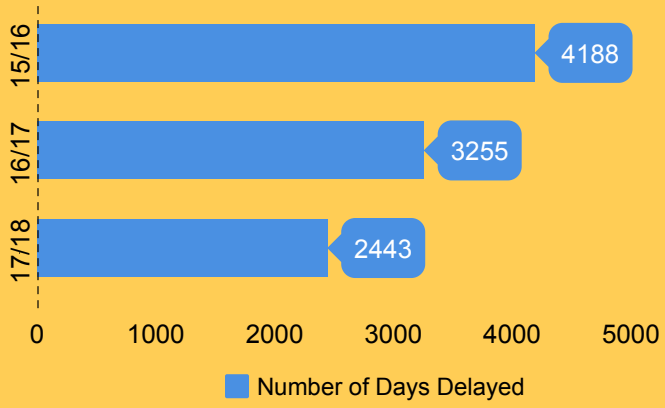
Sutton Council has an Adult Social Services Performance Report. In this Local Account, we provide a brief summary below of our performance:

Permanent Admissions of Older People



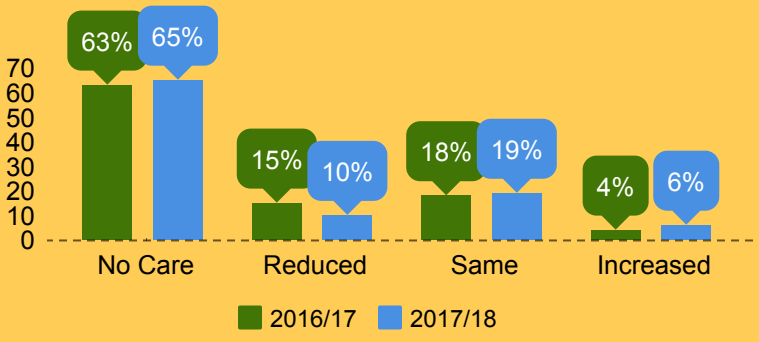
In 2017/18, there were 63 permanent admissions made to a nursing and residential care home compared to 57 admissions in 2016/17. Sutton's performance is better than the nationally monitored Better Care Fund target of 70 for 2017/18 and is better than the England average. The performance suggests that Sutton residents are able to be supported in the community for a longer period of time.

Delayed Transfers of Care



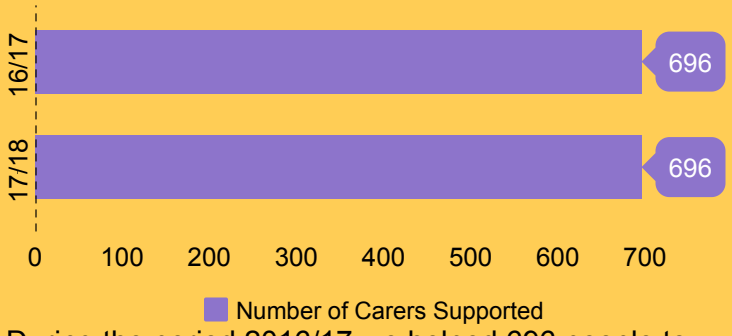
This performance measures the number of bed days that people were delayed whilst awaiting a hospital discharge from 2015/16 until 2017/18. Our aim is for people to return home as soon as they are medically fit for discharge.This helps those people keep fitter and avoid getting hospital acquired infections. A key achievement is having reduced our number of hospital bed days delayed from over 4,000 days in 2015/16 to just under 2,500 days in 2017/18.

START Reablement Service



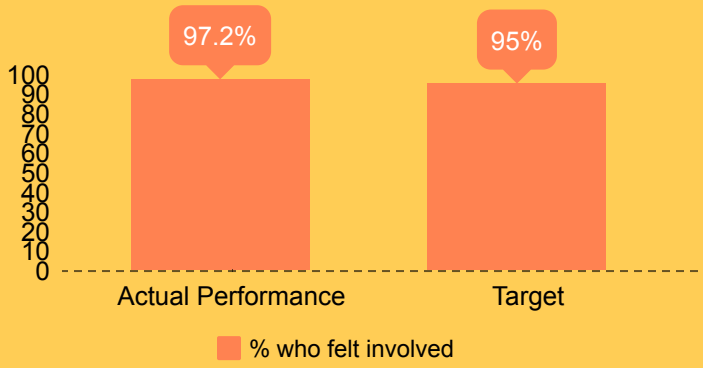
The START Reablement Service aims to support people to retain their independence and in the financial year 2017/18 received over 1,400 referrals for support. Over 65% of those individuals who completed a reablement programme did not require any long term support services following the START intervention and a further 10% saw a reduction in the ongoing support they required at the conclusion of the service.

Supporting Carers



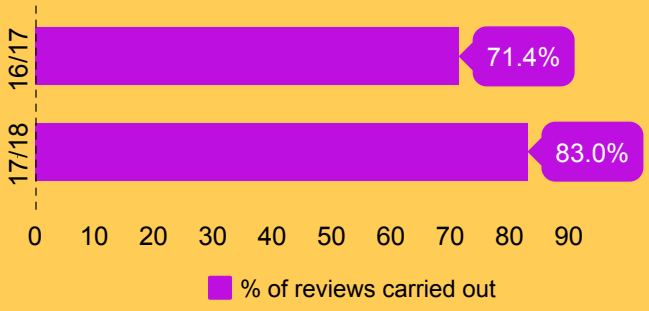
During the period 2016/17 we helped 696 people to continue in their caring role. In 2017/18 we again supported 696 carers. Performance on carers assessments was 45.5% in 2016/17 against a target of 40%. This has improved to 51.9% in 2017/18 against a target of 50%.Support was provided to carers by means of a direct payment, provision of universal services, information and advice or through signposting to other agencies.

Making Safeguarding Personal



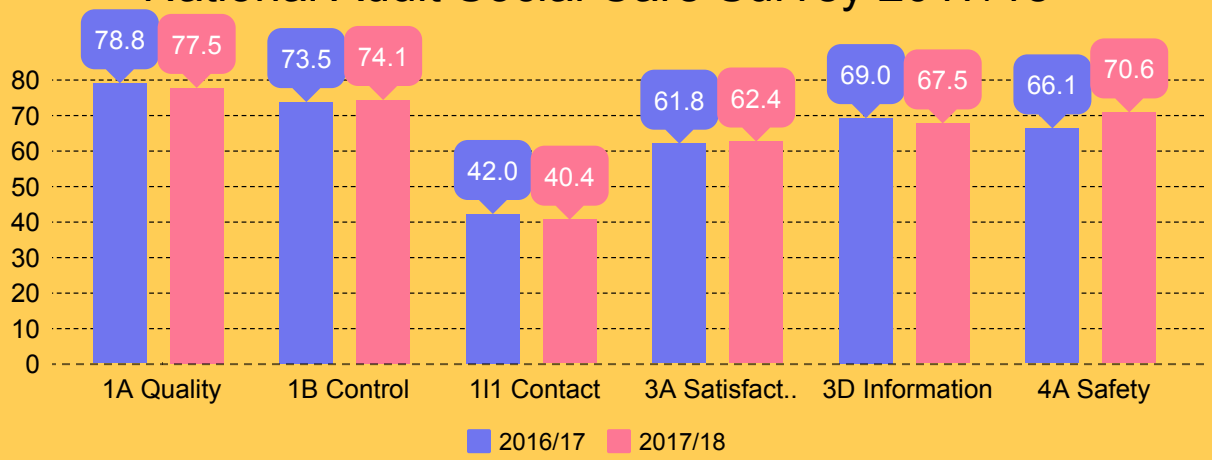
This performance measure indicates the percentage of clients, or their representatives, who felt that they were fully involved in the safeguarding process. The aim of this measure is to help people to be safer by adopting a personalised approach to the safeguarding of vulnerable adults.

% of Service Users Reviewed



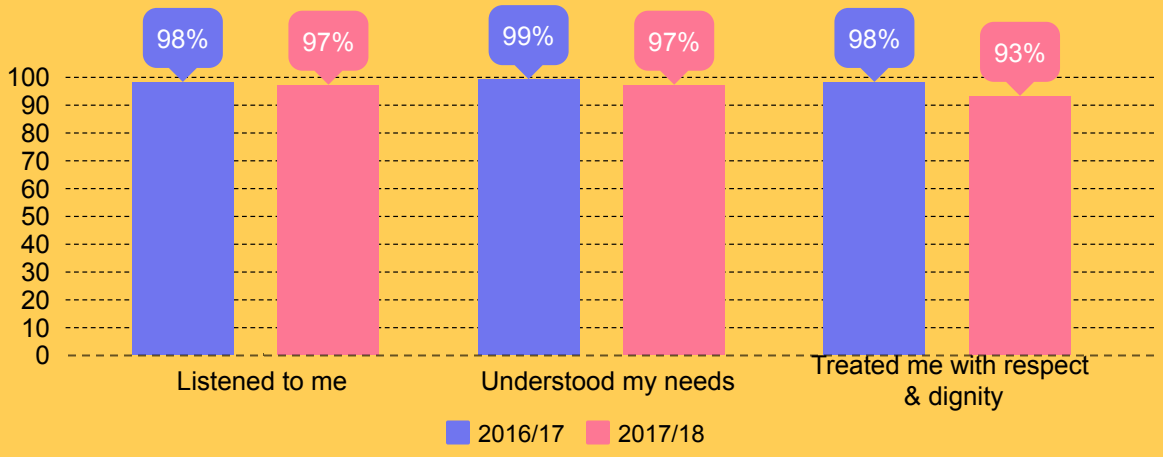
Between April 2017 and March 2018 there were 1,300 reviews of service users undertaken, which represented 83.0% of the entire review cohort for this period. The review target for 2017/18 was set at 72.5% and this target was further increased in 2018/19 to 78%. However, it is our intention to continue to improve on our current performance.

National Adult Social Care Survey 2017/18



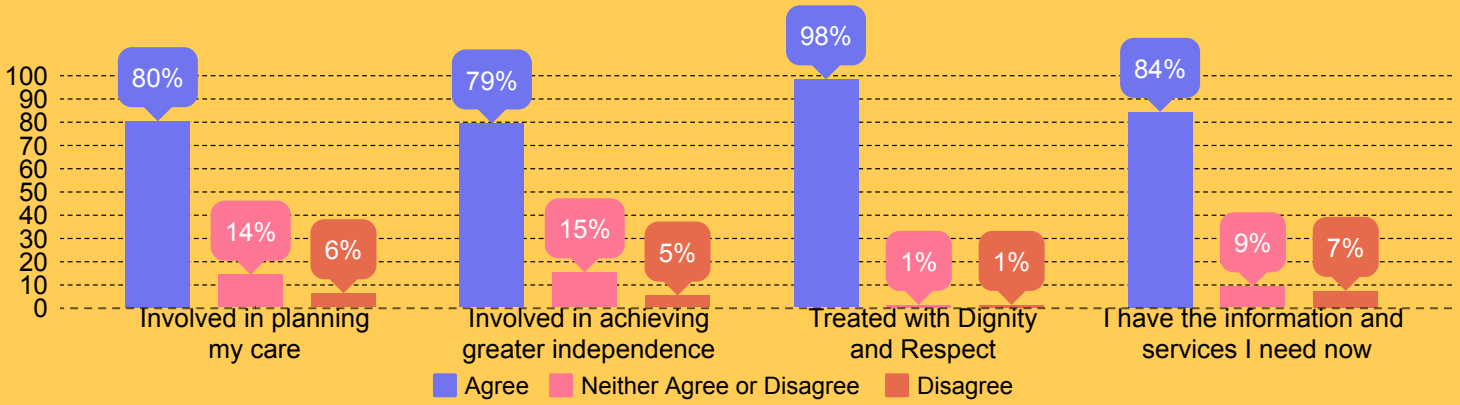
The National Adult Social Care Survey is a survey of service users conducted by all local authorities in January and February every year.
The full NHS Digital report can be accessed via this link: https://digital.nhs.uk/catalogue/PUB30102
934 questionnaires were sent to service users in Sutton of which 353 were completed and returned achieving a response rate of just under 40%.Generally we have maintained our position in a time of continued financial austerity. Improvements to provision of Information and Advice (3D) will continue to be supported through the retendering of Sutton's corporate information and advice service contract, Advice Link Partnership Sutton (ALPs).
Overall there has been an increase seen in the proportion of people who are satisfied with Adult Social Services (3A) and those who feel safe in their homes (4A).

The Sutton Adult Social Services User Experience Survey 2017/18



The Sutton Adult Social Services User Experience Survey provides an understanding of our service users experience of accessing Adult Social Services and of their satisfaction with how they were treated by us. In 2017/18 386 people completed the survey, an increase of 41% from the previous year. The survey looks at their experience of the assessment process. The survey continues to show high levels of overall satisfaction with Adult Social Services throughout 2017/18, largely maintaining our position as compared to the previous year (2016/17). The ability of staff to listen to people, understanding their needs and treating people with dignity and respect were rated most highly by the people who completed the survey again this year.

Sutton's START Reablement Service Customer Survey 2017/18



The START Reablement Customer survey provides an opportunity for service users to give us confidential feedback on the services they received during their reablement. This feedback helps us to continue to monitor and improve our services. The survey results in 2017/18 continue to show high levels of satisfaction with the START service. People felt strongly that they were treated with dignity and respect, fully involved in the planning of their care and provided with the information and support they required.

Highlights of the year

Annual Reviews of Services Users in Receipt of Long Term Care
In the period 2017/18 the Council achieved a review rate for Long Term Support Service Users of 83% which was significantly above the annual target which had been set at 72.5%

Delayed Transfers of Care
A 'delayed transfer of care' occurs when a patient is medically fit to be discharged from hospital, even though they may have rehabilitation or other social care needs, but is still occupying a bed.
Delays can occur when patients are waiting for care to be arranged to enable them to be discharged back home or to a residential or nursing home.
A key achievement for Sutton was reducing our number of delayed hospital bed days from over 4,000 days in 2015/16 to just under 2,500 days in 2017/18.

Admiral Nurses
Admiral Nurses play a unique caring role by working across different parts of the health and social services system, so the needs of unpaid carers and people with dementia can be addressed in a coordinated way. In 2017/18 Admiral Nurses supported 266 Sutton families. There is a case study at the end of this document that illustrates this good work.

Summary of our priorities in 2018/19

To continue to further develop the Sutton Health and Care at Home service with the next steps being to develop the Preventative and Proactive models of care.

The decision to transform Adult Social Services was taken following an external review of Adult Services in 2016. This is to ensure we provide excellent service to vulnerable people to help them to retain their independence and well-being and eliminate waiting times.
This change will also ensure that we are operating as cost effectively as possible given the financial pressures that the Council and the People Directorate are facing.
A key priority in 2018/19 is to implement and embed changes to the structure of Adult Social Services into multi-disciplinary teams and continue to strengthen integrated working with Health.

We will continue to improve our Customer care by becoming more efficient and effective in responding to customers who contact us. The transformation of Adult Social Services will enable us to achieve this.

A joint Learning Disability Strategy and Commissioning Framework was developed with Sutton Clinical Commissioning Group (CCG) and agreed in December 2017.
The aim of this strategy is to set out how children, young people and adults with learning disabilities and their families can be supported to improve their quality of life and outcomes, whilst also managing the decreasing financial resources available to Sutton Council and Sutton CCG.
This strategy will be delivered via a new joint Learning Disability programme with the CCG which has also been agreed.

Continuing Health Care is a package of care for people who are assessed as having significant ongoing healthcare needs.
With an increase in demand from people with more complex needs, we will ensure that people receive the correct support they require through Continuing Health Care.

We will improve the service we provide to carers. We intend to work with carers to improve the way we assess and support them. We will develop information and advice and more localised and integrated interventions to help sustain carers wellbeing.

We will develop Adult Social Care to be more businesslike with improved efficiency and provide more responsive interventions and early help. We will provide an enhanced information and advice service including developing a high street presence for equipment assessment and provision. This will provide improved outcomes for the clients and carers.

Admiral Nurse Service Case Study

Andrew and Sarah have been married for 60 years and have two adult children living at home with severe learning disabilities, Paul and Daniel. Andrew was diagnosed with vascular dementia by the memory clinic. Sarah was the main carer for all three members of the family. The GP referred Sarah to the Admiral Nurse Service due to concerns around Sarah coping at home with increased caring responsibilities. The GP was also concerned Sarah was neglecting her own health care needs. This was a complex situation.

The Admiral Nurse observed Sarah wasn't managing in terms of supporting all three family members. Sarah's two sons required a lot of attention which meant she wasn't fully able to meet Andrew's needs. It was also clear Sarah wasn't looking after herself, she looked unkempt and admitted she didn't have time to cook for herself. Sarah also had a limited understanding as to the level of support Andrew needed comparing his needs to her sons who she had looked after for over 50 years.

The Admiral Nurse arranged for a social worker to attend and begin looking at the son's support and worked with Sarah to help her understand the difference between a learning disability and dementia. This was done over a number of visits as Sarah was very entrenched in her ideas about how to care for her husband.

The Admiral Nurse worked with the social worker and got a care package arranged for Andrew which included day centre support. The Admiral Nurse also referred all the family members back to the GP for physical health checks, which led to one of the sons being diagnosed with a chest infection which was having an impact on his behaviour towards his dad.

Over the course of the intervention, Daniel and Paul engaged well with their new carers, Andrew had a care package of his own and Sarah was supported to achieve a better understanding of dementia. Sarah now has regular breaks from her caring role for the first time since her children were born. Due to the complexities of this case the Admiral Nurse reviews on a two monthly basis.