SURREY
COUNTY COUNCIL

ADULT & COMMUNITY CARE SERVICES PERFORMANCE REPORT

Runnymede Local Committee
23rd January 2004

KEY ISSUE:

This report describes the progress Adults & Community Care Services have made over the last year, particularly in implementing People First and the Joint Review. The report provides an analysis of the current performance of services in relation to the national Social Services Star Rating system and performance measures. It also sets this analysis in the context of service activity at a borough-wide level, outlining key developments achieved or planned since the inception of the recent People First changes.

SUMMARY:

This interim report focuses on Surrey Adult and Community Care Service's performance for the year up to Sept 2003 against national Performance Assessment Frameworks and Best Value performance measures for social care. It provides contextual data and explanations at a local level where possible. It will give an outline of the results of the Joint Review and focus on specific borough issues.

OFFICER RECOMMENDATIONS:

The Committee is asked to:

1. **Note and comment upon the performance of North Surrey's Adult and Community Care Service and the work that is being undertaken to provide monitoring information that is available for Runnymede**

2. **Note and comment upon the service changes made and planned for the Adult and Community Care Service in light of the People First re-organisation.**

3. **Recognise the resource implications associated with improved performance.**

4. **Recommend improvements that can be made to Local Performance reports to facilitate discussions on services for adults and local needs.**

1. INTRODUCTION AND BACKGROUND

The last report that was presented to the Local Committee from Adults and Community care on 1st August 2003 was a partnership working report; this report is an update from the performance report presented to the Local Committee 10th December 2002.

1.1. JOINT REVIEW RESULTS

Independent inspectors were impressed by improvements in our social care services and have commented that they have never seen so much progress made in such a short time! They have also stated that they believe it is sustainable. . Partly as a result of the Joint Review findings, but also through the Social Services Inspectorate (SSI) analysis of our performance indicators, the rating for the County's social services has been increased from one star to two stars.

The Social Services Inspectorate (SSI) found that for vulnerable adults most people in Surrey were being well served, and services showed excellent prospects for improvement. A year ago the SSI thought the prospects for our care services were uncertain, and we were only providing services to some people.

Officially we are now in the top 17 adult social care services in the country out of 150 authorities. This is in spite of trying to purchase services in a difficult market and delivering excellent services where we are still having difficulties in recruiting staff. There are the challenges of continuing to deliver our core standards agenda, and the budget and high cost of services in Surrey are ever present problems.

1.2. NORTH SURREY HEALTH AND SOCIAL CARE IMPROVEMENT PLAN.

The Health and Social Care Improvement Plan (HSCIP) will include targets for those groups of people previously included in the Surrey Community Care Plan, the PCT's Health Improvement Plan and the Modernisation Plan and which are not covered within the current three year LDP. It is intended that the HSCIP will be appended to the Local Delivery Plan.

The Health and Social Care Partnership Group has developed the HSCIP with direction and agreement from the Health Improvement Sub Committee of the Professional Executive Committee of North Surrey PCT. This plan reflects the priorities identified by the local community and those of the PCT, Adults and Community Care, and the Boroughs. The plan will inform partnership funding and influence areas of service development in line with existing priorities.

All the health and social care needs and proposed actions within this plan have been identified by the local planning forums, staff and the wider local community through a consultation exercise from June to July of 2003.
The second consultation phase has now taken place and was an opportunity for partner organisations to view the needs identified through the first consultation, consider current services in relation to the needs identified and consider how these needs can be addressed.

This document has been circulated to the local planning forums, voluntary organisations and local community groups to ensure it is a correct summary of the issues that they have identified and to ask these groups to prioritise the issues that have been raised. These will be agreed jointly with partner organisation and local planning forums at the Health Improvement Sub Committee meeting on January 29th 2004. The Health Improvement Sub Committee will be responsible for developing an action plan and monitoring performance.

1.3. BETTER GOVERNMENT FOR OLDER PEOPLE

The aim of Surrey 50+ is to improve service outcomes for older people by ensuring they are given the opportunity to be engaged at every stage of planning, developing and monitoring services including transport, education, environment, community safety as well as health and social care. Surrey 50+ reflects Surrey County Council's commitment to becoming an exemplar of modern local democracy through better engagement with the people of Surrey in the decision making process.

The Surrey 50+ partnership programme is supported by a multi-agency Steering Group, including representatives from Surrey County Council, Districts and Boroughs as well as the voluntary sector and Primary Care Trusts.

Mary Foster has been appointed as Network Manager for Surrey 50+ and she will be working in partnership with Boroughs, Districts and Primary Care Trusts and other organisations, to develop the network.

Initially a Surrey Wide 50+ advisory group of people over 50 representing each of the District and Borough Areas will be set up to work alongside the Steering Group. This group will also link into the South East Older People's Advisory Group which is part of the national Better Government for Older People initiative.

The 50+ partnership will promote good practice in engagement with older people and offer advice and support to public service organisations that wish to engage with older people.

Mary is based in the North Surrey Area Management Team and her telephone number is 0208 541 8594, or e-mail on mary.foster@surreycc.gov,.uk

2. NORTH SURREY ADULTS AND COMMUNITY CARE

2.1. General

From 11th Dec 2003 The Area Management Team for North Surrey Adults and Community Care will be moving to Phoenix House which is attached to Bournewood House on the St Peters hospital site. This is viewed by all as a positive move to facilitate closer working relations between Adults and Community Care and North Surrey PCT.

2.2. Benefits and Charging

This team is responsible for the financial assessment of service users, and was previously centrally based in Kingston. County-wide approx. 9,000 service users are financially assessed and pay approx £25 million per annum in charges.

Following a change in legislation and a consequent review of the provision of these services, it was decided that:

- the financial assessment of services should be localised.
- the specialist staff who provide this service would therefore transfer to be based within the geographic areas they serve.
- these staff would also provide benefits advice and support to all service users who may be charged.
- this new benefits and charging service would be provided directly to service users and their relatives/representatives by specialist staff.

This changed and extended service will be much more customer focused and will offer service users a better quality and more comprehensive service delivered face-to-face by specialist trained staff. It is an

exciting development, which will lead to benefits and charging advice being provided in a more effective and timely way.

These radical and far-reaching changes necessitate accommodation, recruitment, training, business process, IT system and procedural changes before staff can move into their Area teams. Part of that work is now completed and the North Surrey Benefits and Charging Team will move to Heritage House at Chertsey in early January as a first step towards delivering this new service.

North Area has also taken responsibility for the county lead role in developing these services.

2.3. Adult Protection

North Surrey Local Adult Protection Group was formed in January 2003 and is made up of representatives of vulnerable people, the statutory, voluntary and independent sectors. The emphasis of the group is on raising local awareness of adult protection issues, promoting joint working and ensuring the focus is maintained on vulnerable people who are at risk of abuse.

Key priorities for this group for the coming year include:

- Awareness training for front-line staff
- Carer representation on the local group
- Information sharing between agencies to protect vulnerable people from abuse
- Public awareness through events and publicity materials
- Reviewing the quality of work undertaken in this area and learning lessons from local research
- Ensuring that agencies work in partnership where abuse is identified
- Ensuring that each agency has a robust reporting and recording procedure for adult protection concerns
- Reviewing 'Protecting Vulnerable Adults: Surrey Multi Agency Procedures' April 2001
- Linking up with related and overlapping strategies which have an impact on vulnerable people

2.4. Supporting People

The Government announced the Supporting People Grant for 2003/04 in September: representing nearly £20m countywide. This is a good settlement for the county this year, in that it is sufficient to meet our contractual commitments for sheltered and supported housing contracts and, therefore, safeguards all existing services. However, the Government did NOT announce funding for April 2004 and beyond. Instead, they have announced an Independent Review to establish why the Supporting People Grant nationally (£1.8 billion) is over double that anticipated a couple of years ago. The reviewers will complete their work in December 2003, after which we will hear our grant announcement for 2004/05.

There are two main strands of work now taking place in respect of Supporting People:

1. The commencement of the service review process. All services have to be reviewed between now and April 2006. We have to consider whether a service is "strategically relevant". We also have to look at the quality of the service and at whether it offers value for money. As part of the review process we contact key stakeholders, including statutory partners and service users.

2. In Runnymede, we are currently reviewing the Home Improvement Service.

3. The development of the 5-year Supporting People Strategy. The Supporting People Team is currently pulling together the 5-year strategy on behalf of the Commissioning Body, in consultation with all the stakeholders. The 5-year strategy builds upon the Shadow Strategy, which was produced a year ago and endorsed by all the statutory partners. A great deal of research is taking place, together with consultation events, to try and correctly identify the key strategic

priorities for Surrey. The Commissioning Body (which represents all the statutory partners in Surrey, will then decide upon its strategic priorities.

The full strategy does not need to be submitted until November 2004. However, an interim document must be submitted by 1st March 2004 to inform the Government's Spending Review 2004. The Committee should be aware that Supporting People Teams are required to review all existing schemes rigorously, to ensure that they meet strategic targets and offer value for money. It is likely that in time funding will have to be moved from one scheme to another to meet strategic targets.

In terms of new supported housing developments, there are serious concerns because of the lack of clarity about how the planning of capital expenditure and revenue expenditure (for support services) is dovetailed together. This means that it is very difficult to get new schemes off the ground. The borough housing department and the Supporting People Team share concerns about this and are seeking to lobby effectively via the Regional Housing Forum.

2.5. Learning Disabilities

The North Surrey area provides assistance to 540 people with a learning disability and their families. Using a range of service models including home based care packages, employment, day care programmes and residential care options the service seeks to maximise each person's opportunities to experience as independent a life style as is possible.

The challenge of improving local service options and providing increased choice remains a live issue for the service. Significant numbers of people continue to be placed out of the area in costly long-term placements, and short-term break options are severely limited. We are developing with our borough colleagues and local housing associations a housing strategy that will provide focus for the development of future accommodation options. The Runnymede Accommodation Referral Panel chaired by the Borough Council has a key role to play in providing information to achieve growth of local provision.

The same challenge to improve applies to local day service provision at Fernleigh under the leadership of Carole Daines. The commitment of users, their families, and staff to change the service to a more local person-centred provision has been high. The results have included the increasing numbers of people in employment and adult education classes, the Burview Hall group, and the one to one work of a member of staff employed to work in the evenings and weekends. We aim to continue and move further forward with this change programme during the coming year.

Improving leisure opportunities has been secured using a service level agreement with One-to-One a Spelthorne based charity. Within this they will employ an activities coordinator to enhance their current service delivery by concentrating on people from the Runnymede area.

Since the last report the complement of care managers providing the assessment and care planning function of our service has continued to grow. A permanent manager, Madhavi Lata, took up her post in early December. We believe that this group will deliver ongoing care management to each person known to our service in the near future. This continuity of worker involvement is important as we seek to find more and more appropriate outcomes for each person that we work with.

2.6. Carers

n Runnymede there were 7,024 carers identified through the 2001 Census and of these 1,089 provide more than 50 hours a week unpaid care. About 1 in 8 of the workforce in Runnymede will combine caring with paid work.

These carers save the nation an estimated £65m a year (source: "Without us …? Calculating the Value of Carers Support" – Carers UK and Institute of Actuaries 2002).

Support for carers has been developed over the past five years through Joint Carers Strategies. Initially Runnymede was part of the West Surrey Joint Carers Strategy. There are now Carers Strategy Groups linked to each of the five PCTs and Adult Social Care boundaries. Carers are equal stakeholders to Health, Social Care and District/Borough Councils.

Key Areas of Work:

Key areas of work undertaken as a result of jointly agreed priorities in the Carers Strategy include:

- Carers Breaks services commissioned from voluntary organisations
- Funding the Runnymede Care Attendant scheme
- An independent Carers Support Scheme
- An independent Young Carers project which supports Young Carers in Woking as part of a service offered throughout Surrey. Work is undertaken in schools in Runnymede with additional funding from Learning and Skills Council
- A County-wide Carers and Employment project part funded by the European Social Fund which was highlighted as an example of good practice in the Government's National Carers Strategy

- A carers website www.carersnet.org.uk has a wide range of information for carers. It also includes "Care Radio", the world's first digital radio station for carers

- Joint work with "Rethink" (formerly NSF) to develop specialist support for carers of people with significant mental health problems.
- A Carers Breaks Voucher Scheme developed with involvement of carers (with a specific budget for Runnymede in 2004/5)
- A scheme for direct payments to give carers a break.

- Work to ensure that the needs of carers are central to Hospital Discharge procedures
- Joint work with Health to improve identification of carers with a view to ensure that carers' health needs are properly recognised.

Carers Strategy Groups are charged with monitoring progress in implementation. The latest version of the Joint Action Plan together with comments on progress are available on www.carersnet.org.uk.

3. PERFORMANCE INDICATORS

As a result of the radical re-organisation of Surrey Social Services as part of the People First changes, there has been a very significant impact upon data collection processes. This re-organisation has entailed a wholesale re-structuring of how service & financial data is collated, so as to reflect the new Area-based management arrangements. The process has also been complicated by the migration of electronic user records from one database (SSID) to another (SWIFT), with associated technical, data quality and staff training issues.

Whilst the Joint Reviewers complimented Adults & Community Care Services on the quality of its current performance and financial management information, they recognised that this was achieved at some cost, notably in staff time, with complex and disjointed systems hampering staff efforts at providing timely & accurate data. Although considerable efforts are being made to develop more efficient (i.e. a fully integrated financial & service database) and responsive systems (e.g. capable of providing linked financial and service data at county, area, borough & ward levels), remedial efforts are proving to be much more onerous than originally predicted.

Priority has had to be given to developing effective Area-based information in order that the services & associated budgets can be managed appropriately. However, progress is being made with developing

more local information following the refinement of a tool which automatically assigns correct postcodes to each electronically recorded address on SWIFT. This will allow us to aggregate anonymised service information into ward and borough and district categories and, in future, facilitate the production of local reports for Local Committees as planned.

We have to report a large number of performance indicators and for this report we have selected those that will be of most relevance to the Local Committee to give an indication of what we have achieved with the money allocated to us from the council tax. . We report these performance indicators to the County using a performance wheel with the headings: Operations, Customers, Staff and Resources, and summarise the principal points below.

3.1. Operations

3.1.1.Core Standards (Appendix I)

We measure our performance according to the impact on the key areas of Our Customers, Our People, Operations and Resources. The base set of standards that monitor our operations are known as the Core Standards. It is this process that the Joint Review inspectors were impressed with as a process of performance management.

3.2. Customers

3.2.1 Intensive Home Care Usage (Appendix II)

Whilst the overall number of home care users (2830) has declined by 63 since September 2002, a 2% reduction, the number of users in receipt of intensive home care (more than 10 hours per week has grown rapidly over the same period, with a 35% increase (220 more users). This reflects the significantly increased investment in these services made by the County Council as part of the 2003/4 Service Development Plan as well as being the product of various initiatives designed to build capacity (e.g. with specialist home care teams for older people with dementia, improved recruitment & retention packages). It also reflects changes in practice whereby more intensive packages of care have been agreed to avert hospital admissions or support discharges. With such a rapid increase in clientele it is probable that the planned target figure of 880 users will be achieved before March 2004.

3.2.2 Delayed Transfers of Care/ Reimbursement (Appendix III)

The numbers of older Surrey residents waiting in acute hospitals for both health and social care reasons fell by 61 during the twelve months between the beginning of October 2002 and end of September 2003. This represents a 32% reduction, 8% better than the South East Region as a whole. The numbers of older people delayed for social care reasons alone has continued to fall. At the end of September 2003, there were 62 older people delayed in acute hospitals for social care reasons (e.g. awaiting a care home placement) compared with 71 at the end of June and 85 at the end of March (a fall of 27% in six months). The numbers of older people delayed in both community and acute hospitals for social care reasons also fell during this period, from 134 at the end of March, to 118 at the end of June and to 109 at the end of September (a fall of 19% in six months).

The improved performance is attributable to a number of factors, the most significant of which is the substantially increased investment in services for older people made by Surrey County Council in 2003/04, assisted by the development of a wide range of joint and innovative intermediate care services.

As a result of increased County Council investment, 35% more older people across the county now receive an intensive home care service, compared with September 2002. The expansion of intensive home care services has enabled 220 more older people to remain supported within their own homes,

thereby reducing the prospects of these users with high levels of need being admitted to institutional forms of care.
Although emphasis continues to be placed upon supporting people at home, it has proved necessary to increase the number of specialist residential care and nursing home placements made during the first six months of 2003 /4 by 16% principally in order to assist those whose care needs preclude them from returning home following a hospital admission.

3.3. Resources

3.3.1 Adults helped to live at home

Our service aims to increase numbers of those helped to live at home. We are developing new services that are reflected within our development plan. These include increased homecare, a rapid response team with the mental health services, and increased rehabilitation.

3.3.2 Direct payments

Direct Payments are cash payments made to people eligible to receive community care services from Surrey County Council. Payments are made in lieu of the local authority either directly providing or commissioning community care or carers act services. This provision gives individuals greater choice, flexibility and autonomy to arrange services to meet their needs in more creative and user sensitive ways.

In April 2003 the government placed a statutory duty on local authorities to provide direct payments to all people who were entitled to receive them and chose to meet their care needs through this route. Direct payments are potentially available to adults within all care groups, carers, parents of disabled children and young people aged 16/17.

Surrey County Council is committed to significantly increasing the number of people receiving direct payments as well as increasing the variety of services purchased with them, to this end SCC currently has a Public Service Agreement with the government to achieve 400 adults in receipt of direct payments by 1 April 2004 and we are on track to meet this target. Locally in North Surrey as a whole we were providing direct payments to 60 people including 3 carers as at the end of the September 2003 and we expect this figure to steadily increase.

3.3.3 Market Difficulties

70% of all placements are made within the agreed fee structure. However, we have difficulty in placing older people with mental health problems and as a result our budget continues to be under considerable pressure.

We do however have most difficulties in finding placements for those older people with mental health support needs and this continues to put our budget under considerable pressure.

3.4. Staff

3.4.1 Staff Vacancies

Overall vacancies stand at 4%, which along with Mid Area is the best in the County. This exceeds the minimum standard for top quartile authorities in Surrey's comparator group (6.6%). Mid has the second lowest % of care manager vacancies (8%) in the county and with North has best proportion of filled Community Care (Home Care) Assistant posts. Residential social worker vacancies have reduced substantially also, falling from 16% in June to 3% in September. With the exception of certain residential

and day care establishments sickness rates are reducing, notably in the front line teams. However, we still have difficulty in recruiting qualified staff, care managers, and occupational therapists.

3.5. Local Demographics (Appendix IV, V, VI)

Of the 921 (IQA figure on 23rd December) open cases in Runnymede currently 56 remain to be allocated and 64 are being held on duty. This is a significant improvement and we aim to complete the process of allocation once we have recruited to our 2 vacant care management posts. The process of getting cases allocated has been helped by the recruitment of Community Support Workers to assist the care management process.

Open Cases Allocated and Unallocated (Appendix IV)

Ethnicity Records (Appendix V)

Open cases by client group and district (Appendix VI)

4. RUNNYMEDE

Brockhurst Residential Home for Older People in Ottershaw does not meet the requirements of current care standards.

We are reviewing our provision for older people (physically frail and those with functional or organic mental illness) in North Surrey – with North Surrey Primary Care Trust and North West Surrey Mental Health Trust.

We are envisaging a new facility, which will be an expert resource – a 'Teaching Care Home', which will accommodate a number of older people, train and develop care staff, and provide a model for best practice.

We have commissioned a consultancy firm to help us with an option appraisal. They will report their findings in February 2004.

4.1. Partnership Service Developments In Runnymede

a) A Joint Fire Safety Project
Adults and Community Care have enabled the Fire Service to purchase 10 year smoke alarms, this has enabled the start of a partnership project to expand those projects already working in Elmbridge and Spelthorne, with the aim of identifying people over the age of 65 in Runnymede who need a smoke alarm or additional fire safety measures.

District nurses, home care assistants and the voluntary sector will undertake a basic fire risk assessment, using a simple tick-box form. Where a need is identified the householder will be able to get a smoke alarm installed by the fire service or Age Concern's special handyman, and more detailed fire safety advice from officers from Runnymede's fire stations. The Fire Service is laying on the training for the home care visitors and the scheme will have the further advantage of closer integration between health and social care services.

b) Community Stroke Co-ordinator
Adults & Community Care are working with other partners to provide a service for people who have suffered from strokes throughout North Surrey area, a community stroke co-ordinator has been recruited funded jointly from Partnership Funding and Adults and Community Care to co-ordinate community services and provide information, to liaise with local stroke groups and provide training. The Co-ordinator is based at Whitelodge

5. CONSULTATIONS

5.1. Better Care Higher Standards Charter

This is in draft and out for consultation. This charter has been produced by Surrey County Council, the five Primary Care Trusts, and the eleven Borough and District Councils in partnership with Surrey Users Network, Action for Carers (Surrey) and Surrey Community Action.

It is written to give information to users and carers on the standards they can expect when they receive long term care, assistance and support from the providers of social care, health and housing, in Surrey. The production of this charter is a government requirement.

The consultation period ends on 13th February 2004 and the final charter will be published in April 2004. We are also planning to produce in April:

- A summary leaflet which will be made widely available – the feedback form asks you for information on where this should be made available
- A longer charter giving additional information, for example, on how the standards will be monitored. This will be available on the Surrey County Council website and others.

6. INVEST TO SAVE

National research suggests up to a third of pensioners entitled to Income Support and Council Tax Benefit fail to claim, while the figure for those who do not claim Attendance Allowance, despite being eligible, is thought to be between 40% and 60%. A tenth of pensioners entitled to Housing Benefit don't claim. The figures in Surrey are amongst the lowest in the country.

The county is planning to fund a very significant campaign with the support of partners, in order to provide a step change in the level of benefit claims.

The benefits take-up campaign will play an important role in the Council's policy of promoting self-reliance in Surrey communities. The extra cash available to pensioners enables them to spend more on such things as food, clothing, heating and travel, which in turn boosts their health and quality of life.

The plan is to involve voluntary organisations, the health service, district and borough councils and the Department for Work and Pensions, who will work with the County Council's benefits advisers. Where possible people can be visited in their own homes and given assistance with form-filling. There will also be a telephone advice service and publicity to help raise people's awareness of their possible entitlement.

7. FINANCIAL IMPLICATIONS

North Area is projecting an underspend of £123k on a budget of £36,181m for direct services at year end as at 30th November. Although this is a satisfactory position there are a number of key factors within this which make this situation concerning.

1. There is an overspend on services for people with physical and sensory disabilities of £317k. This budget was over committed from the beginning of the year and due to the low turnover within this care group and the high cost of placements it has been managed on an emergency basis only.
2. In order to cover the overspend on physical disabilities this year and because of the concern about next years budget there has been a slowing down of the development programme for older people and fewer services being available for Older People. Resources are tight and there continues to be an emergency contingency only for residential placements in Spelthorne for the remainder of the year. There continues to be a number of older people in residential care who are reaching their limits of capital funds and where the department has a legal obligation to pick up the funding. This too impacts on the budget.
3. There is continuing pressure on the older people fee ceilings. It is particularly difficult to place older people with mental health problems within our fee ceilings. This affects the level of resources available and our ability to meet targets.

8. EQUALITIES IMPLICATIONS

This report sets out some of the performance indictors being developed and implemented in the borough to meet the diverse needs of clients and staff. For example, the report highlights how older people; people with sensory, physical, cognitive and learning difficulties are being provided with support to enable independence in the community. It also outlines how support is being provided to reduce inappropriate admissions into hospital.

This report has been unable to provide a breakdown of take up of services based on the ethnicity of clients. It is anticipated that future reports will inform the committee on this so that there is greater clarity on how the needs of the diverse borough are served.

9. SELF RELIANCE IMPLICATIONS

Surrey County Council has a policy to promote both individual and community self reliance throughout Surrey. By working together with other statutory and voluntary partners we can coordinate and target county services towards the most deprived neighbourhoods and towards people who are most disadvantaged and at risk. As well as bringing direct benefits to individuals and communities e.g. by helping to break dependency cycles, promoting self reliance and improving the quality of life it is a cost effective way of channelling services to those who are in most in need of them.

The Local Director in each area has the responsibility for identifying and coordinating self reliance initiatives and Adult & Community Care works closely with Carolyn Rowe to ensure that they are aware of our core services and helping to identify particular areas of social deprivation. Whilst North Surrey has not been identified as one of the first wave self-reliance target areas the Chertsey St Ann's ward has been identified locally as one where particular pro-active support and intervention would be justified.

10. CRIME AND DISORDER IMPLICATIONS

We are working with colleagues in the police service and trading standards to try to prevent the incidences of distraction burglary.

11. CONCLUSIONS

Adults & Community Care Services are committed to working closely with Local Committees and Districts. Area Directors are the County representatives on PCTs and are facilitating links between health planning and community strategies.

There is recognition of financial pressures that constrain service delivery. High profile issues such as delayed transfers of care will continue to be a high priority and in the meantime, efforts are being made to ensure innovative, value-for-money alternative services are developed.

Report by:

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BACKGROUND PAPERS:	

Appendix I Core Standards

CORE STANDARDS MONITORING –North Surrey

September 2003
(Balanced Scorecard)

OBJECTIVES		MEASURES	Teams	SCTs	Rnymd/ (St. P Hosp) SCT	Spelthn/ Wybrdge SCT	N CST
Customers			**11.1. Targets %**	County Average %	**Aug fig. In italics %**	**Aug fig. In italics %**	**Aug fig. In italics %**
To be responsive to Users and Carers.	**1.**	**Decisions to undertake assessments are made within 24hrs of the first contact**	**95%**	**98** *91*	**100** *100*	**91** *100*	**na**
	2.	**Assessments begin within 48hrs of the first contact**	**80%**	**84** *77*	**92** *100*	**95** *100*	**na**
	3.	**Assessments are completed within 4 weeks of first contact**	**80%**	**79** *82*	**96** *100*	**64** *73*	**na**
	4.	**After assessment, services are provided within 4 weeks**	**70%**	**87** *82*	**71** *100*	**91** *100*	**na**
	5.	**Either Carers are offered an assessment of their needs, or if not the record will show why**	**95%**	**76** *64*	**83** *100*	**95** *73*	**35**
	6.	**All cases receiving a service have a named worker responsible for care co-ordn.**	**90%**	**97** *100*	**100** *100*	**100** *100*	**na**
	7.	**Care Plans for Users in receipt of a service are reviewed annually**	**75%**	**89** *90*	**100** *100*	**100** *88*	**35**

People (Staff and Members)				County Average %	**Aug fig. In italics %**	**Aug fig. In italics %**	**Aug fig. In italics %**
To promote a supportive environment with a shared purpose	**1.**	**The fraction of staff due to have supervision, over those who have actually had it, during the month**	**80%**	**80** *82*	**100** *100*	**80** *92*	**100**
	2.	**The fraction of staff who had an appraisal in the last 12 months, over the total number of staff to be appraised**	**90%**	**45** *57*	**100** *100*	**3** *0*	**45**
	3.	**The fraction of appraisals done this month which include objectives that support service strategies, over the total number done**	**65%**	**29** *70*	**na** *na*	**3** *0*	**9**

	4.	**The fraction of appraisals conducted this month, where the development needs of people are included, over the total number done**	**70%**	**10** *57*	**na** *Na*	**3** *0*	**9**

Operations			**Targets**	County Average %	**Aug fig. in italics %**	**Aug fig. in italics %**	**Aug fig. in italics %**
To establish efficient Systems and Processes that support service objectives	**1.**	**Referrers and Users receive confirmation of eligibility decisions**	**85%**	**79** 82	**79** 44	**50** 79	**na**
	2.	**Referrers and Users receive confirmation of proposed actions**	**85%**	**80** 82	**88** 72	**50** 79	**na**
	3.	**People with high and complex needs are referred for full assessment**	**100%**	**96** 97	**100** 100	**95** 100	**na**
	4.	**The record shows Users receive a copy of their assessment(s), care plan and reviews**	**90%**	**83** 83	**96** 81	**79** 60	**45**
	5.	**Staff systematically record the ethnicity of users**	**90%**	**91** 96	**100** 100	**86** 93	**na**
	6.	**The new 'model file' format is maintained**	**80%**	**95** 92	**79** 89	**100** 100	**na**
	7.	**All records are dated and signed by the originator**	**70%**	**94** 95	**100** 100	**91** 87	**40**

Resources				County Average %	**Aug fig. in italics %**	**Aug fig. in italics %**	**Aug fig. in italics %**
To optimise the use of human and financial resources for the benefit of users	**1.**	**The record shows Managers have 'signed off' initial assessments, full assessments, care plans and reviews**	**85%**	**73** 73	**96** 100	**73** 80	**na**
	2.	**The Care Plan states the anticipated outcome of each service investment**	**60%**	**87** 90	**100** 100	**94** 90	**65**
	3.	**Care Plan shows evidence of user preference**	**70%**	**71** 97	**100** 100	**95** 93	**55**
	4.	**The Care Plan shows evidence of why the use of direct payments is / isn't appropriate**	**70%**	**47** 23	**100** 60	**58** 50	**0**
	5.	**Cost benefit awareness is demonstrated in care planning**	**60%**	**87** 78	**92** 100	**94** 80	**5**

	6.	**The fraction of staff, for whom a workload management system is applied, over all staff**	**50%**	**39** 50	**52** 100	**27** 100	**100**
	7.	**Community equipment is provided within 7 days of assessment**	**60%**	**30** 25	**13** na	**na** Na	**na**

Appendix II Key Performance Indicators -Intensive Home Care Usage

AMT 5	**Numbers of People Helped with Intensive Home Care** as at 15th September 2003 (June 2003 figures in brackets) Source: HH1 / PRISM & In-house

	North	Surrey Total
Population 65 years & over (pre-2001 census projection) # Population 65 years & over (2001 Census)	35,908 N/a	**170,992** **172,389**
% older population (pre-Census projection)	21%	100%
Total home care households receiving home care services September 02 HH1 figures =2804 households	609 (569)	**2806+** **(2413)**
% home care users	22% (23%)	100% (100%)
Total households receiving intensive home care services (December 2002 figure in brackets – the last full audit of home care usage) **SCA Target 2003/4**	218 (175) **189**	**829** **(670)** **773** **September 02 HH1 figure = 613**
% households receiving intensive home care	26%	100%
Users receiving intensive home care* Households receiving intensive home care services / 1000 65 years & over - PAF C28 (December 2002 figure in brackets – the last full audit of home care usage)	6.1 (4.9)	**4.8** **(3.9)** September 02 HH1 figure = 3.6 SCC target 2003/4 = **5.1**

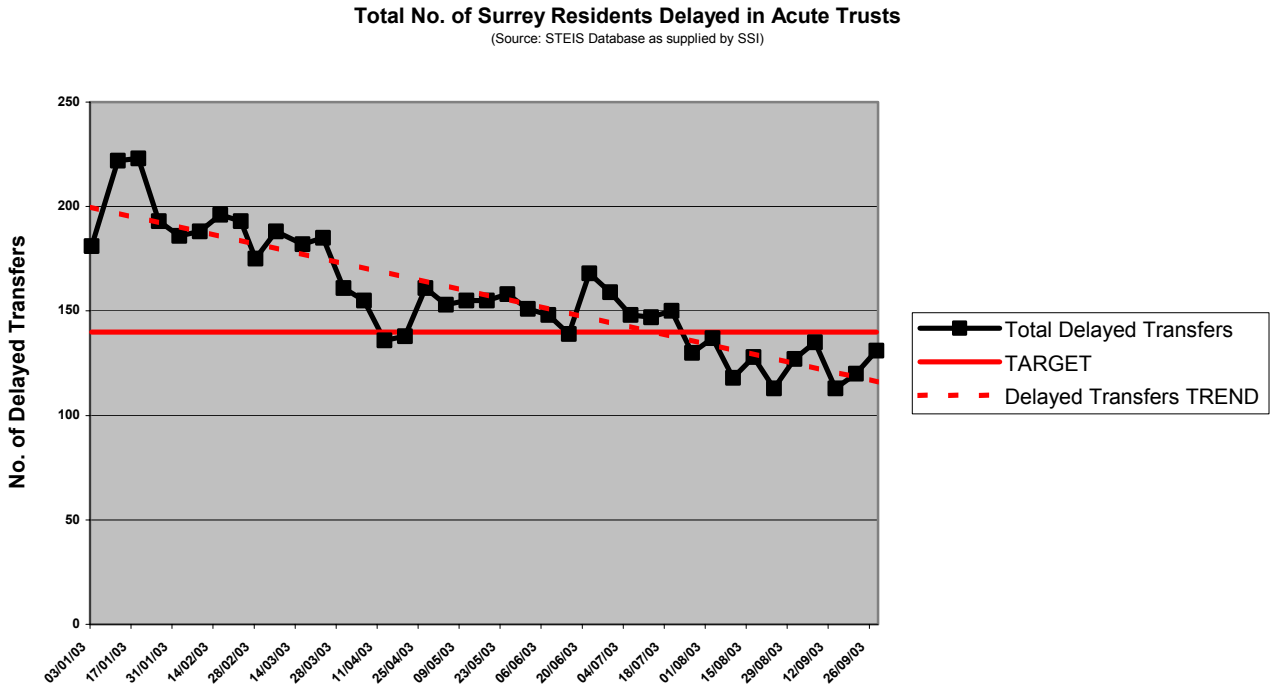
# Area population figures based on 1991 Census projections. These will be updated once ward- based data for 2002 Census a released.
$ includes 2 MH users + 2830 users & excludes 11 households of other user groups (eg Mental Health)

Trends

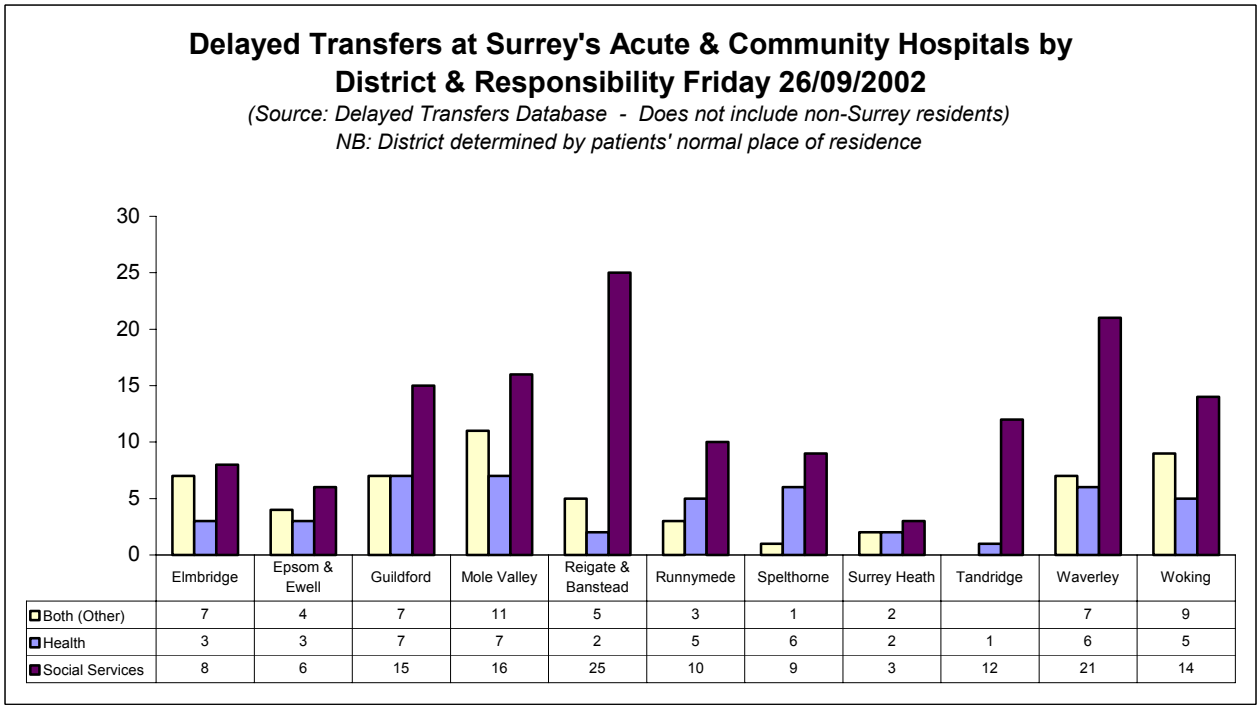
- If Direct Payments users in receipt of 10 hours or more personal assistance, were to be included within this cohort, numbers would be increased by over 100.
- 80% of current users receive at least 5 hours of home care each week.
- Surrey will need to increase its clientele by at least 850 (over 100%) to meet the top quartile rating for comparable authorities.

Appendix III Key Performance Indicators - Delayed Discharges

Delayed transfers of care in acute hospitals



Delayed transfers by borough and responsibility



	Elmbridge	Epsom & Ewell	Guildford	Mole Valley	Reigate & Banstead	Runnymede	Spelthorne	Surrey Heath	Tandridge	Waverley	Woking
Both (Other)	7	4	7	11	5	3	1	2		7	9
Health	3	3	7	7	2	5	6	2	1	6	5
Social Services	8	6	15	16	25	10	9	3	12	21	14

Comparison with other authorities

Patients with delayed transfers of care in acute hospitals for health & social care reasons October 2002- September 2003

Source: SSI STEIS data

South East Councils	Oct 2002 Week Ending 6th	Jan 2003 Week Ending 5th	April 2003 Week Ending 6th	June 2003 Week Ending 29th	September 2003 Week Ending 28th	% change Oct – September
Bracknell Forest	10	14	12	7	9	-10%
Brighton and Hove	69	70	55	40	27	-61%
Buckinghamshire	70	41	29	52	34	-51%
East Sussex	101	76	84	96	88	-13%
Hampshire	148	217	203	188	190	28%
Isle of Wight	5	7	16	16	13	160%
Kent	127	114	95	119	104	-18%
Medway Towns	25	31	22	35	44	76%
Milton Keynes	22	13	12	8	6	-72%
Oxfordshire	33	41	53	51	53	61%
Portsmouth	80	20	26	31	30	-62%
Reading	18	21	30	21	19	5%
Slough	28	20	11	9	4	-86%
Southampton	22	23	47	36	42	91%
Surrey	192	202	155	159	131	-32%
West Berkshire	29	23	18	14	15	-48%
West Sussex	120	82	35	78	58	-52%
Windsor and Maidenhead	31	9	5	6	3	-90%
Wokingham	20	10	11	7	4	-80%
Regional Total	**1156**	**1034**	**919**	**973**	**874**	**-24%**

Appendix IV Number of Open Cases Allocated & Unallocated

as at 15th September 2003
Source: SWIFT / Team manual records

As at 15th September, 11,349 cases were shown on SWIFT as open to the 10 Social Care Teams, 489 more or 4.5% higher than on the 15th June (10,860). Of these, 83% were older people and 17% were users with physical or sensory disabilities. Also, it should be noted that the Deaf Services Team has a caseload of 125 users, two-thirds of whom are aged over 65 years. Surrey Association for Visual Impairment has a separate caseload, too, of 442 cases of which 80% are older people. The current SWIFT records indicate that there are 3,125 users with learning disabilities open to the five Community Services teams, 361 more or 13% higher than on the 15th June (2,764), although this increase is probably largely attributable to fuller recording of Section 28A cases.

Of the 11,349 cases currently open to Social Care Teams on SWIFT, 9,309 (82%) were shown to be allocated to a key worker, 6% more than on June 15th and 12% more than in April. 1,039 unallocated cases (7%) are awaiting an OT service only, a similar figure to that in June and April. North Surrey teams have managed to allocate 86% of their cases. Overall, this represents a very considerable improvement since September 2002, when 66% of social care team cases were unallocated.

Notes on allocation status used in the following tables

Allocated = open and unallocated pre-assessment
Unallocated = open to duty, unallocated post assessment,
Waiting OT assessment = waiting OT assessment (OT – single service only)
Notes:
Figures in brackets are as at 15th June

NORTH SURREY	**Runnymede & Ashford St. Peter's Hospital SCT**	**Spelthorne & Weybridge SCT**	**North Surrey Community Services PLD team**	Totals	
	817 (615)	1400 (998)	312 (228)	2529 (1841)	76% (65%)
Unallocated pre-assessment +	9 (39)	34 (57)	4 (5)	47 (101)	2% (4%)
Unallocated post - assessment	71 (128)	1 (264)	140 (116)	212 (508)	6% (18%)
Open to duty	53 (39)	6 (12)	312 (83)	321 (134)	10% (5%)
Waiting OT	120 (176)	60 (54)	(0) (0)	180 (230)	6% (8%)
Total	1070 (997)	1501 (1385)	768 (432)	3339 (2814)	100% (100%)

COMMUNITY MENTAL HEALTH TEAMS – West Surrey

	West Elmbridge	Guildford	Runnymede	Spelthorne
	155 (143)	**300** (285)	**332** (322)	**297** (265)
Unallocated pre assessment	**0** (0)	**1** (1)	**0** (0)	**0** (0)
Unallocated post assessment	**0** (0)	**0** (0)	**0** (0)	**0** (0)
Open to duty	**3** (1)	**10** (3)	**5** (4)	**8** (13)
Waiting OT	**0** (0)	**0** (0)	**1** (0)	**0** (0)
Total	**158** (144)	**311** (289)	**338** (326)	**305** (278)

For Community Mental Health teams, 'open to duty' means that the case is allocated to the Duty Officer in the CMHT. This may be either a health professional or a social care one. Once it is decided, post referral, that a case is eligible for a secondary mental health service it may be allocated in this way to minimise risk pending a fuller assessment and Care Programme Approach (CPA).

Numbers of Reviews Completed (AMT PI 11/ PAF D40 / BVPI 055 / Core Standards)

Source: SWIFT

1st October 2002 to 31st July 2003

Locality	Nos. of users with a review & service in period	Nos. of users with a service in period	% receiving a review	Comment
Runnymede SCT	127	405	31%	
Spelthorne & Weybridge SCT	426	847	50%	Spelthorne based staff scored 54%
North CST	225	408	55%	Runnymede based staff scored 62%
North Area	**778**	**1660**	**47%**	
Adults & Community Care Total	**4171**	**8306**	**50%**	These figures are almost certainly an undercount, as indicated by the Core Standards results, underlining the need for improvements in SWIFT data quality. CMHT data has not been included as this appears even more unrepresentative

Source: Core Standards monitoring / SWIFT

It is estimated that the new Fair Access to Care assessments & Carer assessments have increased workloads by up to 30%.

Appendix V

DATA QUALITY ISSUES

ETHNICITY RECORDS

North Surrey

Team	Total cases	Nos. cases without ethnicity category	%
Runnymede & Ashford St. Peter's Hospital SCT	1101	95	91%
Spelthorne & Weybridge SCT	1541	7	99%
North Surrey Communit Services PLD team	459	1	100%

Appendix VI

Open Cases by Client Group and District as at 15/11/03 (based on district in which team is based)

District	Team Responsible	Asylum Seekers	Dementia	Frailty and/or Temporary Illness	Learning Disability	Mental Health	Not Recorded	Other Vulnerable People	Physical & Sensory Disability & Frailty	Physical disability	Sensory Disability Dual Sensory Impairment	Sensory Disability Hearing Impairment	Sensory Disability Visual Impairment	Substance Misuse	zzz-Adult (Other)	County Wide Total
Elmbridge	East Elmbridge Community Mental Health Team				1	198	1	1	4						3	208
	West Elmbridge Community Mental Health Team					152	1		2					2	1	158
	Mid Surrey(Esher)Community Services Team				115	33	1		5			1				155
	Mole Valley And Esher Social Care Team(Esher)		47	12	5	26	15	72	116	232	1	3	7		1	537
	North Surrey(Weybridge)Community Services Team				86	3										89
	Spelthorne And Weybridge Social Care Team (Weybridge)		50	18	1	34	6	149	105	201	2	5	7		9	587
Elmbridge Total			97	30	208	446	24	222	232	433	3	9	14	2	14	**1734**
Runnymede	Ashford And St Peters Hospital		24	15	2	20	9	23	17	71		4	2	1	3	191
	Runnymede Social Care Team		93	14	11	29	23	98	189	387	4	10	13		18	889
	Runnymede Community Mental Health Team				2	373		2	5	1						383
	North Surrey (Runnymede) Community Services Team				125		1	2	4						2	134
Runnymede Total			117	29	140	422	33	125	215	459	4	14	15	1	23	**1597**

District	Team Responsible	Asylum Seekers	Dementia	Frailty and/or Temporary Illness	Learning Disability	Not Recorded	Other Vulnerable People	Physical disability	Sensory Disability Dual Sensory Impairment	Sensory Disability Hearing Impairment	Sensory Disability Visual Impairment	Substance Misuse	zzz-Adult (Other)	County Wide Total
Spelthorne	Spelthorne Community Mental Health Team				1	238	2	1	3	1		1		247
	North Surrey(Spelthorne)Community Services Team				205	4		5	3	1	1			219
	Spelthorne And Weybridge Social Care Team (Spelthorne)		100	41	5	53	7	88	138	460	1	11	10	3	7	924
Spelthorne Total			100	41	211	295	9	94	144	462	1	12	11	3	7	**1390**
County Wide Total		13	113 7	456	2679	3735	148	1297	2188	5283	24	238	128	34	204	**17564**

* = team based within district but serving a wider / countywide area