ADULT SOCIAL CARE LOCAL ACCOUNT
A report of performance in 2010/2011
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For more information about our adult social care services, please contact the **Council’s Customer Contact Centre on:**

020 8547 5005  
or email:  
adults@rbk.kingston.gov.uk.

You can also visit:  
www.kingston.gov.uk/adult_social_care

or you can contact:  
Local HealthWatch (Pathfinder)  
enquiries@kingstonlink.org.uk  
Unit 6, Siddley House  
50 Canbury Park Road  
Kingston upon Thames  
Surrey  
KT2 6LX
Introduction

Welcome to Kingston Council’s Local Account of adult social care performance for 2010/11. We are committed to being open and transparent about what we have done to improve outcomes for our residents.

This is the first time that we have produced an account of our performance in this way and we welcome your views on its content. If there are aspects of performance that you would like to hear about in next year’s report please let us know — contact details are below.

A key measure of our success is the feedback we receive from people about their experiences of social care. Throughout 2010/2011 we found ways to hear what you had to say and we are pleased to include feedback in this report taken from surveys, user groups and evaluations.

There has been much going on in Adult Social Care over the past year and we have transformed our way of working so that people have much greater choice and control over the support they need to stay independent, safe and well.

Our new model for providing adult social care involves people much more in their assessment and support planning so that they achieve the things in life that are important to them.

We also know that people want easy access to information and advice, and our successful Kingston-i service brings together information about adult services into one place. We have also introduced a People Contact Team within the Customer Contact Centre; people can now ring one number and get their social care enquiry dealt with as quickly as possible without having to speak to a number of different people.

There are big changes taking place across the National Health Service. In Kingston we have excellent relationships with our health colleagues in NHS Kingston and we are well placed for a future where health and social care will work even closer together.

If you need support and care our aim is that you will experience a more joined-up response no matter which organisation you first come into contact with.

Our Local Account outlines the work we have done to maintain and improve adult social care services, however we know that there is still more work to be done.

Our key priorities:

We will continue to transform the way adult social care is provided by building on the work that we have already done so that our residents continue to have more choice and control. The difficult economic climate, the expected growth in the population and the greater expectations of people using services means that we have to use limited resources even more effectively and efficiently. We have adopted a ‘One Kingston’ approach with organisations across the borough, working together to provide you with the very best services.

We will:

• Work with colleagues in health and the voluntary sector to look at where we can integrate community services
• Develop community brokerage to help people make good choices about social care support from a range of providers
• Integrate commissioning across health and social care to get the best services in the most cost effective way and explore all options for service provision including social enterprises and sharing services

We hope that you find this Local Account interesting and informative.

David Smith
Director, Health and Adult Services

Sandra Berry
Chair, Local HealthWatch (Pathfinder)
Integrating Health and Social Care

We would like to take this opportunity to tell you about our work to bring adult social care and health services closer together. We believe that outcomes for people will be better if services work in a more integrated way.

Many of you will have heard about the changes that the government is proposing to the National Health Service (NHS). These proposals are currently going through parliament in a Health and Social Care Bill and many of the changes will come into place in April 2013.

Commissioning will move from primary care trusts (PCTs), which will no longer exist, to clinical commissioning groups led by GPs. Public health responsibilities will transfer to the local authority and local people will have a stronger voice and more involvement in health and social care services.

In Kingston we have made significant progress in readiness for the changes ahead:

• In 2010 our local GPs formed an interim Clinical Commissioning Group. The group has recently set out its commissioning intentions for 2012/2013. It has identified the following priorities for improving health and wellbeing, which reflect the borough-wide joint strategic needs assessment:
  • Mental Health
  • Substance Misuse
  • Integration of community health and local authority teams
  • Medicines Management
  • Management of ambulatory care sensitive conditions (primarily pneumonia and influenza) to minimise unnecessary hospital admissions
  • Urgent Care
  • Manage outpatient referrals

• We set up an interim Health & Wellbeing Board in November 2010, well ahead of the requirement to do so. The Board is made up of elected Members, GPs, Healthwatch, representatives from the voluntary sector and senior Council colleagues. From April 2013, it will have a statutory duty to make sure that health and social care work well together. It has met many times over the last year and is well placed to provide strategic leadership so that people in Kingston experience better care and support

• Our Local Involvement Network (LINK) successfully bid to become a local HealthWatch pathfinder. It will be a key way for local people to give us feedback about the quality and development of our services.

New health and education facilities on the Surbiton Hospital site

A further example of integrated working with NHS Kingston is the development of a new healthcare centre and a two-form entry primary school and nursery on the Surbiton Hospital site. The new school will open in September 2012 followed by new health facilities offering a wider range of services provided by local GP practices, in early 2013.
Kingston’s LINk/HealthWatch pathfinder – an update from Sandra Berry, Chair

During 2010-2011, members of Kingston’s LINk visited seven care homes within the Borough as part of its remit to review and monitor such facilities and provide a voice for members of the public to express their concerns. The visits provided an ideal opportunity to talk to residents about what bothers them. These were introductory visits for managers and residents to become familiar with the work of Kingston’s LINk and for LINk members to experience firsthand the workings of the care homes. Consequently no formal reports were published, though this will happen with any future visits.

During November 2010 the LINk Steering Group felt that the public consultation being conducted by RBK on proposals for new care charging arrangements was not sufficiently robust or widespread. The LINk therefore coordinated several voluntary organisations in making a case to the Council, who subsequently revised their information literature, widened the circulation and extended the consultation period.

A joint project is currently underway with Richmond LINK to find out the impact that the new charging arrangements have had upon local residents.

From June 2011, Kingston’s LINk has become Kingston’s HealthWatch Pathfinder, one of 74 LINks nationally spearheading the formation of Local HealthWatch across the country. The role is changing from one of monitoring and improvement of existing health and social care services to one of public involvement in the decision-making processes. We will be involved at the outset, helping to create and modify services being planned and commissioned by health and social care authorities. The mantra is: ‘No decisions about us without us!’
ENHANCING QUALITY OF LIFE FOR PEOPLE WITH CARE AND SUPPORT NEEDS

Personalisation

Following an intensive period of development we introduced a new way of providing adult social care in April 2011 which gives people greater choice and control over their lives. People with an ongoing need for support will receive a personal budget so that they can meet their needs in a way that best suits them. We worked with people who use our services and other key stakeholders to make these changes. A Transformation Engagement Group co-designed the public consultation, reviewed the website and commented on staff training. Over 40 people attended an engagement event in May 2010 to learn more about personalisation in Kingston and 15 out of 20 people who completed an evaluation said they felt more informed about the changes.

We have continued to deliver improved outcomes for people with a learning disability:

- We have increased the number of provider organisations in the borough from six to eight, allowing people to have a greater choice and local access to specialist providers.
- We maintained 55.9% of working-age people with a learning disability in settled accommodation as at March 2011.
- As at April 2011, 72 people with a learning disability had a personal budget which is around a fifth of the people we work with.
- We worked with the Learning Disability Parliament and their family members on a proposal for future day services. This was agreed by the Council in March 2011. Following consultation we closed the Causeway Centre as this was no longer fit for purpose, and developed more work-based activities and a drop-in centre. People who choose to do so can use their personal budgets to continue with day activities provided by the Home Farm Trust Day Centre.

- In 2010/2011, we agreed with the Learning Disability Partnership Board a range of local performance indicators that would be relevant to people and their families. We report this data on a monthly basis on our easy access web site.

CASE STUDY

Mrs W's Story

Mrs W is 96 years old and has dementia. She has lived in her house for over 72 years and has continually said that she wants to stay at home. Mrs W and her family were worried about how she could continue living at home but wanted to make sure her wishes were respected. They were also concerned about the funding of her care. The family worked with Mrs W’s Care Manager to plan how she could spend her pension, benefits and personal budget so that she could stay at home and get the most out of life. Mrs W is now living at home with all the support she needs – her Care Manager commented that this would never have happened before personalisation.
Support for Carers

In Kingston we recognise and value carers as being fundamental to strong families and stable communities. We support people to maintain a balance between their caring responsibilities and a life outside of caring.

In June 2010 we ran a week of activities for carers. Some key highlights and outcomes from the week include:

- 45 carers of people with mental health needs and their families attended a social and information BBQ
- 20 carers benefitted from a day trip out
- 20 young carers and their siblings attended the Young Carers party
- Around 80 carers attended the main event which resulted in seven referrals for increased benefits and allowances; three referrals to the Work Focused Support for Carers programme, five new referrals to Kingston Carers Network and health checks were carried out on 26 carers.

In partnership with the Kingston Carer’s Network (KCN) and Job Centre Plus we introduced subsidised holistic therapies for carers. Weekly sessions are fully booked, demonstrating their success. A book club for carers has been set up and in February 2011 we installed the Caring Matters Book Collection in Kingston Library. Around two-thirds of the books are out on loan at any one time. 103 carers received a Flexible Breaks direct payment during 2010/2011.
Mental Health & Substance Misuse Project for Carers

In Year 1, the project welcomed 61 new carers, including 19 from Black and Ethnic Minority communities. We have delivered a number of initiatives for around 120 carers of people with mental health illness, 60 dementia carers and 20 substance misuse carers during 2010/2011 including:

- Five skills workshops for carers of people with schizophrenia/psychosis
- A ten week intensive evening course in family skills and communication attended by five mental health carers.
- 15 carer information sheets produced on topics such as ‘Helping Children Understand Mental Illness’ and ‘The Rights of the Nearest Relative’
- Monthly support group and out of hours drop-in for working carers
- Outings and activities through the Wellbeing and Inclusion service of the Kingston Carers’ Network’s
- Mental health carers continued to have their say on the Trust’s new Carers’, Family & Friends Reference Group, the Mental Health Local Implementation Team (LIT) and the Carer’s Board.
- Mental health carers attended specialist advice sessions with the Kingston Carers’ Network’s new legal adviser

Mr & Mrs A

Mr & Mrs A are from a Black and Ethnic Minority background and English is not their first language. They have an adult daughter with schizophrenia and another adult daughter, M, with no mental health problems. M first contacted the Kingston Carers’ Network regarding problems the family had experienced in communicating with the professionals involved in her sister’s care. The project worker arranged a meeting between the family and the team supporting their sister/daughter, and everyone’s concerns were raised using a Family Work framework. One problem for the family had been around the difficulty the mother and father have in communicating due to English not being their first language. The meeting resulted in a commitment from their daughter’s Care Manager to ensure that suitable arrangements were made for future meetings such as care plan reviews. The care manager also agreed to regularly contact the parents to give them an opportunity to ask questions and be updated on issues (where confidentiality allowed). The meeting facilitated better communication between the family and the professionals, and the family felt more supported and better able to raise their concerns.
Supporting People Into Work

Between April 2010 and March 2011, 23 people with common mental health problems were still in employment after completing the ‘access to work’ project. A further 13 and 13 respectively went on to further job search/training and volunteering, and six were on work placements.

A further 76 people with learning disabilities were supported in paid employment and/or volunteering (49 and 27 respectively).

The work of the Aspergers service

- Five people attended a communications skills course in October 2010. All reported an increase in confidence and were able to share strategies with each other.
- Five people attended a keeping safe course attended by the Fire Brigade and Safer Neighbourhood Police. The course covered home safety and safety out and about, with recommendations being followed up by the team.
- Three people attended a preparation for work course with two of the three going on to college courses.

The Adult Social Care Survey asked people to rate their quality of life across eight areas - control, dignity, personal care, food and drink, safety, occupation, social participation and accommodation. The responses were turned into a ‘quality of life score’. Kingston scored 18.3, just above the Outer London score of 18.2.

The survey also asked people how much control they had over their daily life. In Kingston 73.8% said they had as much or adequate control over their daily life as they wanted compared to 71.1% across London.
Setting the bar: delivering high quality residential care

Top award for Amy Woodgate House

The smooth transition of Amy Woodgate House care home to its new location in Chessington in 2009 was due to the close involvement of residents and their families, many of whom contributed to the design process. Staff, along with a range of third sector organisations, including the Iris Murdoch Centre in Stirling, also got involved.

In 2010 Amy Woodgate House was recognised with an Over 50s Housing Award as ‘The most outstanding new care home for adults with dementia.’

Meeting the national standards

In September 2010 the Care Quality Commission (CQC) introduced a new method of registration for health and social care services. Registration allows people to know whether providers are meeting the essential standards of quality and safety and that they respect the dignity and rights of the people they serve.

In November 2010 the four Council resource bases for older people (Amy Woodgate House, Murray House, Newent House and Hobkirk House) along with Woodbury (a home for people with learning disabilities) had CQC checks and all were assessed as complying with all of the essential standards.
The Eden Alternative

Our four resource centres for older people use the ‘Eden Alternative’. The core principles of the Eden Alternative are about companionship, opportunities to give meaningful care to other living things, and variety and spontaneity to create a lively environment and a meaningful life. Our care homes have committed to changing the culture so that decision making is closer to residents rather than a ‘top down’ approach.

Extract from compliance review of Murray House – September 2011

‘I couldn’t wish for better’ - ‘This is the only place I wanted to consider’ - ‘I’m very happy here’. People who use the service were also positive about the staff team and comments received included, ‘I’m looked after - staff should have gold medals.’

The report also stated ‘Murray House benefits from a stable staff team, with a low vacancy rate. Any shortfalls in the staffing levels are covered by bank staff familiar with the service. These factors play a crucial role in people feeling that there is consistency and continuity of care. There is a real homely feel to Murray House with attention given to photographs of people living and working there.’
Achieving Positive Change and Reducing the Harm Caused by Substance Misuse

Significant investment has been made in drug treatment locally. The number of people engaging with treatment services has increased year on year and waiting times to access services have reduced. We have a wide range of harm reduction interventions available in Kingston and the quality of psychosocial interventions to address the underlying causes of addiction has improved. We have introduced a range of innovative peer-led services to support individual recovery journeys.

Of the people accessing treatment in Kingston in 2010-11, 86% were ‘effectively engaged’ in their treatment programme. This means they either successfully completed their treatment programme or remained engaged for at least 12 weeks. This is considered the minimum time needed to achieve a lasting effect. The number of people leaving treatment and achieving freedom from their dependence increased from 43% in 2009-10 to 49% in 2010-11 and has remained consistently higher than both the national and regional percentage of 43%.

Positive comments received from people using recovery services in Kingston include:

- ‘I am 100% in a better position’
- ‘The service helped me to control my relapses, effective for my recovery. If I didn’t have the group structure I would be bored’
- ‘It makes you look at addiction in depth’
- ‘Meeting people with the same problems and understanding staff’
- ‘The group gives me ideas, I can relate to it and it gives me a boost.’
- ‘Supportive and non-judgemental’
- ‘Getting problems out and having a confidential group’
- ‘Good, exchanging coping mechanisms’
- ‘Mixing with people and seeing the light at the end of the tunnel’

Kingston fell slightly below its target of 290 to 282 for the number of Opiate and Crack Users (OCU’s) engaged in effective treatment. The national policy focus has changed from increasing the number of people accessing treatment to increasing the number of people successfully completing treatment. In Kingston we have focused on improvement in these key areas and this has reduced the numbers of people re-presenting to services and the overall number of people accessing services.
Kingston ‘Life after Stroke’ Task Group

The ‘Life after Stroke’ Task Group oversees the use of the Department of Health stroke grant and includes members from the health, social care and the voluntary sector. This funding has been used towards a Stroke Co-ordinator and Communication Support Co-ordinator post to provide information, advice and reablement support to stroke survivors/carers. They also offer support so that stroke survivors and carers can optimise self-management in the future.

Eight stroke survivors/carers took part in a focus group in June 2010 to improve the provision of information and advice. As a result a ‘Stroke Information Handbook’ tailored for Kingston is available across the Stroke Care Pathway. The Stroke Co-ordinator has provided stroke-specific information and advice on health, social care and community services and interventions to 61 stroke survivors/carers, including 46 one-off or low intensity responses to help them maintain their independence and build networks of support.

In June 2010 the Stroke Co-ordinator attended a Black and Ethnic Minority ‘Health Day’ for five different language groups and an event in October 2010 for the Black African community to raise awareness of stroke support services, along with primary and secondary stroke prevention.

We have seen an increase in referrals to ‘Dyscover’ a voluntary organisation aphasia support group for stroke survivors with communication difficulties as well as an increase in referrals to the Stroke Association Communication Support home visiting service.

Fifteen people took part in the Communication Rehabilitation Software Project, and data demonstrates improved functional communication and improved outcomes such as the development of independence skills and decreased social isolation.

We received funding to provide ‘Bridges’ stroke self-management training to 21 Kingston adult social care workers to empower them to encourage stroke survivors to set goals to increase their independence and self management skills.

We also secured funding for training across the care pathway. The training improved the understanding of communication difficulties post-stroke to help facilitate stroke survivor’s independent access to social care, health, voluntary and private sector services (rather than relying upon the support of others). As of 31 March, three training courses have been held for 25 participants.
Live long and prosper

Public Health covers three areas – health improvement, health protection and health services. Dr Jonathan Hildebrand, Kingston’s joint Director of Public Health has recently published his public health report for Kingston 2010/11. There are many activities happening across Kingston which are helping people to lead healthier lives and preventing and/or reducing the need for future interventions from social care services including:

Falls Prevention Service

Around 625 of the estimated 7,700 older people in Kingston who fall each year will incur a fragility fracture. The consequences for many will be extensive surgery, prolonged hospital stay and subsequent rehabilitation and an ongoing loss of independence. Preventing falls is a priority and relies on a co-ordinated effort between many agencies including housing and social care services, health and voluntary organisations.

Using evidence from audits, the Joint Strategic Needs Assessment and a comprehensive review commissioned by Public Health, a number of recommendations were made to address the gaps identified. Funding was obtained to enhance the community-based falls prevention service to include risk assessment, exercise provision and home hazard assessment.

Home Energy Doctor Programme

In Kingston just over 8% of private households are thought to be in fuel poverty, affecting mainly single-person households aged 60 years and over on low incomes. A Fuel Poverty Prevention Project was developed and this targeted older people living in privately owned homes. Home visitors offer fuel assessments and guidance as well as assistance with grant applications. Since 2009, 700 older people have been visited. In 2010/2011 visits generated an average annual saving of £120 per household.
Equalities and Community Engagement Team delivers a number of projects to narrow the gap in health outcomes. Two key projects are:

- The Community Development and Health Course: this equips people with the skills to get involved in community health improvement projects and be a representative voice. Once they have graduated, people get involved in a range of community work and also support health professionals and colleagues to reach into parts of the community where voices are seldom heard.

- One Norbiton, Working Together: this local integrated services project received Cabinet Office approval in August 2010. This project is about the community having a say in deciding what is important to them and influencing key organisations in Kingston. A Community Working Group is involved in developing the project. Using evidence from existing research and analysis, eleven main themes emerged as important to local people and they are currently voting on the top three priorities.

Dementia Advisory Service

This service focuses on supporting people with early stages of dementia. We were a national demonstrator site funded by the Department of Health who are currently evaluating the outcomes. During 2010/2011 we:

- developed specialised information prescriptions and prompt cards to aid memory. 65 people with dementia received a prescription and 65 carers received information. 130 people have been signposted to relevant agencies for support and advice.

- recruited six volunteers to promote the service and assist with information provision.
Helping people to maintain their independence and stay living safely in their own homes

Re-ablement provides a short term intervention to help people regain their skills and confidence so that they can stay living safely at home. Effective re-ablement is shown to reduce the need for ongoing social care support.

As part of the wider transformation programme we introduced a period of re-ablement for all people assessed as needing support (other than in situations where a rapid response is needed or it is clear that there is no potential for re-ablement). We piloted this new approach during 2010/2011 prior to rolling out the new model of social care in April 2011. Following a period of re-ablement some people will leave the service as they will have no ongoing need. Those with ongoing needs will receive a personal budget with which to plan their support.

People leaving hospital receive a re-ablement/intermediate care package for up to six weeks. This helps to make sure that people are discharged from hospital in a timely way and that they have the support they need to regain their independence. Any decisions about longer term support can be taken when their situation is settled.

- Of the 160 people who received a re-ablement service between April and September 2011, 70 people saw a decrease in their ongoing support needs and approximately 50 had no ongoing needs for community based support.
- With respect to delayed transfers of care we exceeded our target in 2010/2011 achieving an average of 5.6 against a target of 8. (A delayed transfer of care occurs when a patient is ready for discharge from acute care, but is still occupying an acute bed. There are a number of reasons why patients might require further assessment before their discharge destination can be decided, including a lack of capability in local nursing homes, they may need a specialist placement or it may be that a patient or their family/carer needs more time to make a decision about a long-term placement).
- There was a reduction in the number of residents (all ages) in residential and nursing care placements from 594 in 2009/10 to 549 in 2010/11.
- Whilst the overall number of residents over 65 remained the same across both residential and nursing care, there was a 9% increase in the number of people aged 65 and over in residential care placements and a 10.5% decrease in the number of people aged 65 and over in nursing care placements.
- The number of supported permanent admissions during the year reduced from 175 in 2009/2010 to 112.
ENSURING THAT PEOPLE HAVE A POSITIVE EXPERIENCE OF CARE AND SUPPORT

Information, advice, advocacy and support

We want to make sure that all people, including people funding their own care and support, can easily get the information they need to make choices and have maximum control over their decisions and lives. We introduced two new services in 2011:

Kingston i

Kingston i is a partnership of local organisations working together to provide good information and choice on social care issues.

The website and telephone line launched in February 2011, hosted by Kingston Voluntary Action, makes it easier for people to find information about advice services for adults with social care needs.

Between 1 April and 16 June 2011, 419 people visited the site, which has around 500 information and advice services listed.

Adult Social Care People Contact Team

In March 2011 the Council’s Customer Contact Centre established a ‘People Contact Team’. The team handles a range of enquiries relating to Adult Social Care, Concessionary Travel and Sensory Impairment. It receives around 3000 contacts every month and consistently resolves over 80% of these during the first conversation.

The quality of service is monitored regularly and we recently achieved a Top 50 status for our Customer Contact Centre. The Top 50 is a national benchmark across both the private and public sector and is a real sign of quality within the Contact Centre industry.

Complaints and compliments

All local authorities must have a complaints procedure for people who receive an adult social care service. In April 2009 the government introduced new guidance called Listening, Responding, Improving alongside regulations removing the three stage process and previous timescales. The aim is to put things right quickly, learn from experience, improve services and prevent future problems. In addition, people are encouraged to be involved in the initial planning and resolution of their complaint.

This is working well in Kingston with a greater number of complaints being resolved at an early stage, without the need for a lengthy investigation. Of the 29 complaints received, 25 were successfully resolved without investigation.

Number of complaints and compliments in Adult Social Care

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<td>Compliments</td>
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User groups, surveys and consultations

Satisfaction survey - Kingston Carers’ Network

Kingston Carers’ Network (KCN) is an independent organisation which receives some funding from the Council. It supports unpaid carers in Kingston by providing information and advice about services, support and benefits and carers’ support groups.

Each year the Kingston Carers’ Network carries out a survey to find out what it is doing well and where it needs to improve. This year 86% of respondents were satisfied or very satisfied (68%) with the overall service received, with the remainder stating that they were neither satisfied nor dissatisfied. It received very helpful feedback about the services carers would like them to offer including IT training and health advice. The feedback will be used to look at how opportunities can be developed in the year ahead.

The Learning Disability Parliament

Kingston’s Learning Disability Parliament provides a voice for people with learning disabilities to discuss and influence the development and delivery of services. During 2010/2011 the Parliament has been involved in:

- Working with the Kingston Youth Council to visit schools to raise awareness about learning disabilities
- A new employment group to highlight the barriers to getting a job
- Advocacy/Speaking up – working with support providers to enable people to live and socialise within the wider community
- Working with health professionals to promote Annual Health Checks, Health Action Plans and Hospital Passports
- Working with the Police Safer Neighbourhood Teams to raise awareness and improve relations.

Day Services Consultation

In March 2011 we launched an exercise to get people’s views about changes to day services provided at the Crescent and Causeway Resource Centres. We heard people’s concerns about things like transport, changes in familiar location and people, and about the type of work-based activities they would like. We sent people an ‘easy read’ leaflet summarising what they had told us and our response and information about when the changes were happening.

Satisfaction with the new model of providing adult social care

Personal budgets were tested with around 70 people before being introduced more widely. This is what people told us:

- People were very satisfied with both the support they bought with their Personal Budget and from staff
- Most people (including carers) said that having a Personal Budget improved their quality of life and that it gave them more independence, choice and control
- Over half of the people involved said their health had improved
- A third said they felt safer at home
- Most said they had no worries managing their money or their support
- Almost everyone knew where to get help if they needed it
- Some people said the process was too confusing and repetitive
- They were unsure about what they could buy with their personal budget.
- Some people were worried about handling the money and employing staff

In response to what people said we launched a support service in April 2011 through the Kingston Centre for Independent Living. People can get independent support to make the most of their personal budgets.

We produced ‘Being a good employer’, a guide for people employing their own support staff with their personal budget.
In the Adult Social Care User Survey, 55.6% of people responded that they were extremely or very satisfied with the care and support services they received in Kingston (compared to 56.8% in London).

**Service user involvement in substance misuse treatment services**

The Strategic Partnership for Alcohol and Drugs (SPAD) is committed to developing meaningful service user involvement in substance misuse treatment services and has appointed a dedicated Service User Council. The Service User Council ensures that service user’s voices are heard and that their views are taken into account throughout planning and provision of services. Being a member of the Service User Council has also brought additional benefits to members as mentioned in the case study below.

**CASE STUDY**

To give you some background, I am a recovering addict with 29 months of abstinence from all drugs, including alcohol. I found a new way to live, and I maintain my recovery through working the 12 steps of Narcotics Anonymous. I am also involved with service user involvement within the Royal Borough of Kingston-Upon-Thames, for almost two years. In this time, I have taken advantage of the many training opportunities offered to me, attended meetings with members of the Clinical Commissioning Group, contributed to the Strategic Partnership for Alcohol and Drugs commissioning board meetings and gained a valuable insight about drug and alcohol services policy. As a member of the Service User Council I met with the local commissioning team to help draw up a response to the government’s Building Recovery In Communities white paper (BRIC). Two weeks ago, I had an interview with Cranston Criminal Justice Drug Intervention Program to become a volunteer substance misuse worker and was successful. I hope to find paid work in this field at some time in the near future. I am slowly rebuilding my life and becoming a productive member of society.
SAFEGUARDING ADULTS WHOSE CIRCUMSTANCES MAKE THEM VULNERABLE AND PROTECTING FROM AVOIDABLE HARM

Measuring satisfaction with safeguarding arrangements

In partnership with Kingston University we have developed questionnaires to measure service user satisfaction in the safeguarding process.

Between April 2011 and September 2011 the following feedback from five adults at risk, two people alleged to have caused harm and six carers was received:

- 80% of adults at risk, all of the people alleged to have caused harm and 75% of carers felt able to share views
- 40% of adults at risk, all of the people alleged to have caused harm and 50% of carers thought that the protection plan would help
- 60% of adults at risk and 50% and carers felt safer while 50% of people alleged to have caused harm felt more comfortable after the Safeguarding Case Conference
- 63% of carers felt the wellbeing of the adult at risk had improved
- All adults at risk and people alleged to have caused harm, along with 75% of carers, said they were overall very or fairly satisfied

In response to a question in the Adult Social Care Survey 58.3% of respondents felt as safe as they wanted to feel (compared to 57.1% in London) and 56.3% said they felt safe and secure (compared to 54.1% in London).
Keeping vulnerable adults safe

The Safeguarding Adults Partnership Board works together to make sure that there are good outcomes for adults at risk. Key areas from the Board’s 2010/2011 report are:

• Following proactive reminders, combined with improved recording, there has been a 100.5% increase in referrals from home care providers.

• Placements have not had to be suspended into any residential or nursing care homes during 2010/2011. This follows on from a significant amount of work with homes during 2009/2010. A representative of local home owners is now on the Partnership Board.

• Although there has been a significant increase in the number of alerts during the last four years the rate of increase has slowed. A 151% increase between 2008/09 (225) and 2009/10 (563) contrasts with a 9% (613) increase in 2010/11.

• More allegations have been substantiated in 2010/11 than in 09/10. It is not possible to draw firm conclusions from this increase until we have information from subsequent years. However, there has been an increase in multi-agency working in the last year which has resulted in clearer decision making.

• The Quality Assurance Group introduced an audit of alerts relating to registered providers to identify patterns. Outcomes will be reported in the 2011/2012 safeguarding report.

• The People at Risk group, created in June 2010, gives people greater involvement in improving safeguarding arrangements. The group has reviewed information and terminology and looked at service development.
Safeguarding peer review

We have commissioned the Local Government Improvement and Development agency to run a peer review of our safeguarding arrangements in February 2012. The review is a constructive and supportive process with the aim of helping councils improve. It is not an inspection and does not award any form of rating judgement or score. It is delivered from the position of a ‘critical friend’ to promote sector-led improvement.

Summary

We hope that this Local Account of our performance is informative and useful. We are committed to engaging with all people that have an interest in adult social care services and being transparent about what we are doing. We will continue to provide information to you and seek your views through the yearly Local Account and through the wide range of partnership and user groups that are in place in Kingston.

CASE STUDY

Community Learning Disability Team - Financial Abuse

This case concerned a 79 year old man with a learning disability. There was a long history of financial abuse by his ‘friend’. As part of the safeguarding process the Police became involved. Unfortunately there was not enough evidence for a conviction. The adult at risk was involved in the safeguarding process and a Mental Capacity Act assessment established that he did not have capacity to manage his finances and an appointeeship was set up with his full agreement. He was also supported to change his phone number. The outcome of the process is that he is no longer financially abused and has no further contact with the person who financially abused him.
APPENDIX A: FACTS AND FIGURES
(National Indicator Data 2010-2011)
<table>
<thead>
<tr>
<th>Indicator</th>
<th>RBK 09/10</th>
<th>RBK 10/11</th>
<th>Comparator group average* 10/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI 125 Achieving independence for older people through rehabilitation/intermediate care</td>
<td>86.8%</td>
<td>44.9%</td>
<td>84.9%</td>
</tr>
<tr>
<td>NI 127 Self reported experience of social care users (expressed as a score out of 24)</td>
<td>N/A</td>
<td>18.3</td>
<td>18.1</td>
</tr>
<tr>
<td>NI 130 Social care clients receiving self directed support (direct payments and personal budgets)</td>
<td>17.9%</td>
<td>14.0%</td>
<td>29.6%</td>
</tr>
<tr>
<td>NI 145 Adults with learning disabilities in settled accommodation</td>
<td>59.9%</td>
<td>55.9%</td>
<td>58.0%</td>
</tr>
<tr>
<td>NI 146 Adults with learning disabilities in employment</td>
<td>10.7%</td>
<td>15.2%</td>
<td>10.4%</td>
</tr>
<tr>
<td>NI149 Adults in contact with secondary mental health services in settled accommodation</td>
<td>82.3%</td>
<td>86.3%</td>
<td>79.5%</td>
</tr>
<tr>
<td>NI150 Adults in contact with secondary mental health services in employment</td>
<td>15.9%</td>
<td>15.6%</td>
<td>8.9%</td>
</tr>
</tbody>
</table>

*Comparator group information is based on the Chartered Institute of Public Finance and Accountancy (CIPFA). Each council has 15 comparator councils which share a number of similar demographic characteristics.