Croydon’s adult social care local account - annual report to residents 2014
Welcome to Croydon’s local account

What is the local account?

The local account is an opportunity for us to share information about what we have been doing throughout the year to deliver adult social care against our priorities. The report outlines the challenges we face, progress made during the year and our plans for the future. It looks at all aspects of adult social care for anyone who needs extra care and support.

It is also an important part of how we ensure we demonstrate transparency and accountability to people who use services, their carer’s, families and anyone who is interested in adult social care in the borough.

Older people in Croydon

• Croydon’s population is ageing with an estimated increase of 13% in the number of people over the age of 65 by 2020. In 2013/14 the council provided more than 5,000 residents aged 65 years and over with a care package, and of these 87% were supported to live independently through community based services.

Population aged 65+ and percentage changes projected to 2030

<table>
<thead>
<tr>
<th>Year/Age</th>
<th>2014</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged 65+</td>
<td>48,400</td>
<td>49,400</td>
<td>54,900</td>
<td>62,700</td>
<td>73,500</td>
</tr>
<tr>
<td>Percentage change</td>
<td>2%</td>
<td>13%</td>
<td>30%</td>
<td>52%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Projecting Older People’s Population Information (POPPI)

Managing domestic tasks & personal care

• The number of older people who are unable to manage at least one domestic task on their own (which refers to things such as household shopping, jobs in the kitchen and cleaning) is projected to increase significantly in the future. The number of older people who are unable to manage at least one self-care activity on their own (such as bathing, showering, dressing and taking medicines) is also projected to increase in the future.

Projections for number of people aged 65+ unable to manage at least one domestic task on their own to 2030

<table>
<thead>
<tr>
<th>Age / Year</th>
<th>2014</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged 65+</td>
<td>19,690</td>
<td>20,019</td>
<td>22,573</td>
<td>25,887</td>
<td>30,261</td>
</tr>
</tbody>
</table>

Source: Projecting Older People’s Population Information (POPPI)

Projections for number of people aged 65+ unable to manage at least one self-care activity on their own to 2030

<table>
<thead>
<tr>
<th>Age / Year</th>
<th>2012</th>
<th>2014</th>
<th>2016</th>
<th>2018</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged 65+</td>
<td>16,131</td>
<td>16,402</td>
<td>18,453</td>
<td>21,172</td>
<td>24,784</td>
</tr>
</tbody>
</table>

Source: Projecting Older People’s Population Information (POPPI)

Our mental health

• There are 38,620 people predicted to have a common mental disorder in Croydon in 2014. As Croydon’s Mental Health & Wellbeing JSNA 2012-13 highlights, age, ethnicity and deprivation all have an impact on an individual’s mental health and well-being, and the impacts of a growing population in the borough are also likely to have implications for mental health issues in the future.

• During 2013/14 a total of 975 people (aged 18 to 64) with mental health problems in Croydon received a community based care package.
People aged 18-64 predicted to have a common mental disorder projected to 2030

<table>
<thead>
<tr>
<th>Age / Year</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>38,620</td>
<td>40,142</td>
<td>41,389</td>
<td>42,369</td>
</tr>
<tr>
<td>Female</td>
<td>24,133</td>
<td>24,980</td>
<td>25,689</td>
<td>26,181</td>
</tr>
<tr>
<td>Male</td>
<td>14,488</td>
<td>15,163</td>
<td>15,700</td>
<td>16,188</td>
</tr>
</tbody>
</table>

Source: Projecting Adults Needs and Service Information (PANSI)

People with dementia

- As Croydon’s Joint Dementia Strategy 2012-15 highlights, the numbers of people diagnosed with dementia is expected to increase, approximately two thirds of people with dementia are female and the growing minority ethnic population in the borough experiences an increased propensity for dementia. The data below shows that there are an estimated 3,341 people living with dementia in Croydon in 2014 and this is projected to rise by 62% during the period 2014 to 2030.

People aged 65+ with a limiting long-term illness, by age, projected to 2030 – by those whose day-to-day activities are limited a little, and those whose day-to-day activities are limited a lot

<table>
<thead>
<tr>
<th>Year/Limitations</th>
<th>2014</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities limited ‘a little’</td>
<td>11,929</td>
<td>12,166</td>
<td>13,485</td>
<td>15,494</td>
<td>18,055</td>
</tr>
<tr>
<td>Activities limited ‘a lot’</td>
<td>10,680</td>
<td>10,903</td>
<td>12,171</td>
<td>14,109</td>
<td>16,409</td>
</tr>
</tbody>
</table>

Source: Projecting Older People’s Population Information (POPI)

People aged 65 and over predicted to have dementia, by gender, projected to 2030

<table>
<thead>
<tr>
<th>Age / Year</th>
<th>2014</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>3,341</td>
<td>3,463</td>
<td>3,914</td>
<td>4,536</td>
<td>5,417</td>
</tr>
<tr>
<td>Female</td>
<td>2,123</td>
<td>2,180</td>
<td>2,409</td>
<td>2,764</td>
<td>3,266</td>
</tr>
<tr>
<td>Male</td>
<td>1,219</td>
<td>1,283</td>
<td>1,505</td>
<td>1,771</td>
<td>2,151</td>
</tr>
</tbody>
</table>

Source: Projecting Older People’s Population Information (POPI)

People predicted to have a long standing health condition - caused by a stroke, and people who have either Type 1 or Type 2 diabetes, by age group, in Croydon projected to 2020

<table>
<thead>
<tr>
<th>Age/Year</th>
<th>Stroke (long standing health condition)</th>
<th>Diabetes (Type 1 or 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-64</td>
<td>670</td>
<td>7,252</td>
</tr>
<tr>
<td>65+</td>
<td>1,114</td>
<td>5,995</td>
</tr>
</tbody>
</table>

Source: Projecting Adults Needs and Service Information (PANSI) & Projecting Older People’s Population Information (POPI)

People with long term conditions

- It is anticipated that the number of people living with long-term health conditions will increase in the future. This refers to health problems that are present for more than a year, such as diabetes, heart disease, respiratory problems, asthma and epilepsy.

Projections for number of older people living alone in Croydon to 2030

<table>
<thead>
<tr>
<th>Age / Year</th>
<th>2014</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged 65-74</td>
<td>6,550</td>
<td>6,680</td>
<td>7,520</td>
<td>8,230</td>
<td>9,860</td>
</tr>
<tr>
<td>Aged 75+</td>
<td>11,248</td>
<td>11,377</td>
<td>12,578</td>
<td>14,885</td>
<td>17,029</td>
</tr>
</tbody>
</table>

Source: Projecting Older People’s Population Information (POPI)
People with disabilities

People with physical disabilities

- There are an estimated 22,733 adults (aged 18-64yrs) with a moderate or serious physical disability in Croydon and this is projected to rise to 24,726 by 2020.

People aged 18-64 with a moderate or serious physical disability in Croydon projected to 2030

<table>
<thead>
<tr>
<th>Age / Year</th>
<th>2014</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>17,671</td>
<td>17,932</td>
<td>19,115</td>
<td>20,029</td>
<td>20,431</td>
</tr>
<tr>
<td>Serious</td>
<td>5,062</td>
<td>5,156</td>
<td>5,611</td>
<td>5,946</td>
<td>6,050</td>
</tr>
</tbody>
</table>

Source: Projecting Adults Needs and Service Information (PANSI)

- In 2013/14 the council provided more than 1,000 physically disabled residents aged 18 to 64 with a care package and of these 96% were supported to live independently through community based services.

- It is estimated that 10,484 people (aged 18-64yrs) have a physical disability and require personal care. This can include support getting in and out of bed or a chair, dressing, washing, eating meals and use of the toilet.

People aged 18-64 with a moderate or serious personal care disability in Croydon projected to 2030

<table>
<thead>
<tr>
<th>Age / Year</th>
<th>2014</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged 18-64</td>
<td>10,484</td>
<td>10,662</td>
<td>11,511</td>
<td>12,128</td>
<td>12,324</td>
</tr>
</tbody>
</table>

Source: Projecting Adults Needs and Service Information (PANSI)

People with Learning disabilities

- There are an estimated 6,761 people (all age groups 18 years and over) with a learning disability in Croydon and this is predicted to increase to 7,183 by 2020.

- In 2013-14 the council provided 1,070 people with a learning disability with a care package (940 people aged 18 to 64 and 130 people aged 65+), and of these 76% were supported to live independently through community based services.

People predicted to have a learning disability, by age, in Croydon projected to 2030

<table>
<thead>
<tr>
<th>Age / Year</th>
<th>2014</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged 18-64</td>
<td>5,760</td>
<td>5,816</td>
<td>6,039</td>
<td>6,242</td>
<td>6,408</td>
</tr>
<tr>
<td>Aged 65+</td>
<td>1,001</td>
<td>1,022</td>
<td>1,144</td>
<td>1,306</td>
<td>1,532</td>
</tr>
</tbody>
</table>

Source: Projecting Adults Needs and Service Information (PANSI) & Projecting Older People’s Population Information (POPPI)

People predicted to have a moderate or severe learning disability, by age, in Croydon projected to 2030

<table>
<thead>
<tr>
<th>Age / Year</th>
<th>2014</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged 18-64</td>
<td>1,315</td>
<td>1,328</td>
<td>1,381</td>
<td>1,432</td>
<td>1,475</td>
</tr>
<tr>
<td>Aged 65+</td>
<td>136</td>
<td>139</td>
<td>154</td>
<td>175</td>
<td>205</td>
</tr>
</tbody>
</table>

Source: Projecting Adults Needs and Service Information (PANSI) & Projecting Older People’s Population Information (POPPI)

Substance misuse in Croydon

- There are 14,002 people aged 18-64 predicted to have alcohol dependency, and 7,963 predicted to be dependent on drugs, in Croydon in 2014. There are significant differences by gender for alcohol and drug dependency, with more than double the number of men
predicted to have an alcohol dependency, and almost double the number with a drug dependency.

**People aged 18-64 predicted to have an alcohol or drug dependency in Croydon projected to 2020**

<table>
<thead>
<tr>
<th>Age/Year</th>
<th>Alcohol dependency</th>
<th>Drugs dependency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014</td>
<td>2020</td>
</tr>
<tr>
<td>Male</td>
<td>9,996</td>
<td>5,171</td>
</tr>
<tr>
<td>Female</td>
<td>4,006</td>
<td>2,792</td>
</tr>
</tbody>
</table>

Source: Projecting Adults Needs and Service Information (PANSI)

- During 2013/14 a total of 120 people (aged 18 to 64) with substance misuse problems received a community based care package.

**Our carers**

- Croydon’s approach to supporting carers is through its Carers Strategy 2011-16. The focus for maintaining carer’s quality of life has been on providing support at the right time and in the way which best suits the individual, to help carers to continue with their caring role.

- The current carer profile, taken from Croydon’s Carers Support Centre, informs us that as of September 2014, there were 4,251 carers registered with the Croydon’s Carers Support Centre. Of the 4,251 carers 77% are in the 18-64 age band, 18% in the 65 -74 age band and 5% include carers aged over 75, 79% are female, 42% are from BME communities and 58% White.

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**Croydon Observatory – information about Croydon**

- Visit Croydon’s Observatory if you want to know more about the borough. The observatory is an evidence base providing access to data and information, including the annual Joint Strategy Needs Assessments (JSNA’s) which assess the current and future health and social care needs of the local community. Website: http://www.croydonobservatory.org/.
Adult social care in Croydon

People may need extra care and support for a wide variety of reasons at different times in their lives, this could be due to age, an illness or accident, disability, alcohol or drug dependency and other situations. Croydon is focused on ensuring the delivery of high quality services which help to support and enable people to live as independent life as possible, achieving the goals and aspirations that matter to them.

Our performance

- We monitor, analyse, benchmark and assess our performance through a range of different methods. This includes the Council’s key performance indicators data set, annual surveys to people who use adult social care services and involvement in the sector led improvement approach for adult social care which provides a framework for strengthening local accountability, peer challenge, sharing good practice and learning through regional structures and networks.

- Performance is also measured against the Adult Social Care Outcomes Framework (ASCOF) which sets national priorities for care and support and is focused on assessing progress and strengthening transparency and accountability. For the purposes of the framework an 'outcome' is the end result for an adult who has used a local authority funded social care and support service.

- We are also committed to a more ‘outcomes focused’ approach, concentrating on what people want to achieve, their goals and aspirations and how these can be realised, rather than set activities which are not centred around what matters most to people.

Developments in adult social care

- Government reform of the adult care and support system has continued to progress, underpinned by the key policy aims of taking a preventative approach, supporting independence and improving access to adult social care information and advice.

- The Health and Social Care Act 2012 transferred responsibility for public health to local authorities from April 2013 and contains a number of provisions to encourage and enable the NHS, local government and other sectors to improve patient outcomes through more effective integrated, joined up working. The Act also required the setting up of Health and Wellbeing Boards from April 2013 to oversee the planning and delivery of health services in an area. Croydon’s Health and Wellbeing Board provides collective leadership to improve health and wellbeing for the local area. Further information is available here: http://www.croydon.gov.uk/democracy/dande/hwbb

- The framework document ‘Integrated care and support: our shared commitment’ was published in May 2013. The document is signed by 12 national partners, sets out how local areas can use existing structures such as Health and Wellbeing Boards to bring together local authorities, the NHS, care and support providers, education, housing services, public health and others to make further steps towards integration. More information can be found here: https://www.gov.uk/government/policies/making-sure-health-and-social-care-services-work-together

The Care Act 2014

- The Care Act, which received Royal assent on 14 May 2014, places a range of new duties on local authorities. The aim of the Care Act is to put people and their carers in control of their care and support, and to change the way in which people are cared for with the concept of...
‘wellbeing’ being central to the act. This means local authorities have a duty to consider the physical, mental and emotional wellbeing of the individual needing care. Consultation on the draft regulations and guidance for implementation of part 1 of the Care Act in 2015/16 closed in August 2014 and the final versions were published on 23rd October 2014.

### Care Act measures from April 2015

- New duties, including -
  - to provide information and advice, including about paying for care
  - to shape local care and support the market, including production of a Market Position Statement
  - to arrange care for self-funders, including for residential care
  - to provide support plans and personal budgets for people with assessed eligible needs
  - to provide deferred payments (i.e. local authorities currently have discretion about when to offer deferred payments)
  - new duty of prevention and wellbeing to prevent or delay the need for care and support

- The introduction of national eligibility criteria for adult social care, covering both service users and carers (i.e. the removal of local discretion about setting eligibility). This includes a new duty to meet the eligible support needs of carers and new duties around the portability of assessments where people move to a different local authority.

- The introduction of statutory Adult Safeguarding Boards and associated responsibilities for adult protection.

### Care Act measures from April 2016

- The introduction of care accounts and a cap system where the local authority becomes responsible for the costs of meeting eligible needs once the cap has been reached.
- The extension of the means test (upping capital thresholds for financial assessment) so that more people qualify for state funding towards the cost of their care.
- A new duty to provide direct payments for people in residential care.

‘Making it Real’ – assessing adult care and support services

The ‘Making it Real’ framework was developed by the National Co-production Advisory Group and a range of national organisations which are part of the programme ‘Think Local, Act Personal’.

The ‘Making it Real’ themes set out below support a series of ‘I’ statements which seek to demonstrate in detail what people would experience if personalisation is working well. The full ‘I’ statements, and further information about ‘Making it Real’ can be found at the website: www.thinklocalactpersonal.org.uk.

Making it Real Themes

- **Information and advice** – having the information I need when I need it
- **Active and supportive communities** – keeping friends, family and place
- **Flexible integrated care and support** – my support, my own way
- **Workforce** – my support staff
- **Risk enablement** – feeling in control and safe
- **Personal budgets and self-funding** – my money

We used the ‘Making it Real’ self-assessment framework to engage with services users and carers as part of the development of our last local account. Using the feedback gathered from a series of engagement events, meetings and interviews priority themes were identified and an action plan was developed to deliver improvements.

Updates on progress for each of the actions are included throughout this report and the full action plan can be accessed on the ‘Think Local, Act Personal’ website (link above).

During late 2014 and early 2015 we will be carrying out a fresh set of engagements using the ‘Making it Real’ framework in order to review the action plan and identify current priorities with service users and carers. If you are interested in taking part in this please get in touch using the information on page 22.
Ensuring quality of life for people with care and support needs

What this means:

- Every person has choice and control over the shape of their care and support in all settings.
- Personal, sustainable outcomes are delivered that maximise independence and choice.
- People are supported to plan for a fulfilling life in accordance with their individual aspirations and goals – maximising their life chances whenever possible.
- Supporting and enabling people to live independently in their community and promoting social inclusion to prevent people from becoming isolated.

Our progress in 2013/14

- Delivery of adult social care preventative services, to enable service users to receive information, advice, advocacy and a range of support services to reduce social isolation and increase health & wellbeing, including:
  - Day opportunities - range of services including lunch clubs, social activities and wellbeing services.
  - Business Support and Community Link Project – to support the further development of community - led day opportunities services and work with the Council to implement Croydon’s preventative services agenda.
- A survey based on the 'Making it Real' I statements has been developed and will be used by providers of day opportunity services to learn more about the experiences of service users in order to measure outcomes and develop and improve services.
- The Carers Support Centre, based in Central Croydon, opened in October 2013. This venture between the Whitgift Foundation, voluntary sector & Council provides a single point of access for carers, with reception area, meeting space for carers and confidential meeting rooms. The centre delivers:
  - Drop in & phone line access
  - Information & general carers services from a central point
  - Carers Café, open every day and supported by volunteers
  - Referral systems & links to specialist carers & other services
  - Carers Support Centre membership card
  - Carers register - 4,000 registered, keeps carers up-to-date with information and events with free bulletin
- A range of specialist carers services have also been delivered, including:
  - Early intervention & preventative services - information, advice, advocacy & support
  - Carers Support groups, peer networks, befriending, counselling, training and respite provision

Making it Real action – improve information and support for direct payments

- Direct payments - work has been on-going in 2013/14 to improve the information, guidance and support offered to people who are interested in direct payments for care and support. This has included:
  - A workshop to look at processes and procedures in detail, identifying where things work well and where there are problems or delays. The aim being to design new ways of doing things which are simplified and faster for everyone.
o Development of an action plan, setting out a wide range of activities to address the issues and barriers identified during the workshop and through engagement with service users.

o The decision that the Direct Payments Support Services will remain within the Council so that the close working relationships with other teams is maintained, continued ease of access to the service and the team of advisors who have worked with service users over a number of years providing support in setting up bank accounts, responding to tax enquiries and finding personal assistants.

**Key activities for 2014/15**

- Engagement with service users, carers and families using the ‘Making it Real’ framework during late 2014 and early 2015 will provide an opportunity to find out more about people’s experiences of personal budgets and direct payments so that we can continue to develop care and support services which focus on personalised outcomes.

- Introduction of ‘CarePlace’ - an online directory will be made available to Croydon residents, providing information about community groups and activities, care and support, residential and nursing care services in the borough and the opportunity to purchase these services for people with a personal budget or those who self-fund their care and support.

- Public Health Croydon produces Joint Strategic Needs Assessments (JSNA) every year which are published on the Croydon Observatory website (link on page 5). The purpose of the JSNA’s is to improve the health and wellbeing of the local community and reduce inequalities for all ages. The 2014/15 JSNA’s will focus on the topics below, providing essential information which will be used to determine what actions the Council, NHS and other partners need to take to meet health and social care needs:
  - Service provision for the over 65s
  - Respiratory illness, children and young people

- Maternal health

**Making it Real action – improve information and advice for people with dementia, their carer’s and families**

- The Mental Health Older Adults service re-design project will continue to take forward recommendations from both the Croydon Dementia Strategy and review of Older Adults mental health services in the borough, with a focus on achieving improved access for service users, carers and family members, and improving choice and quality of care. A series of workstreams, including ‘Raising Awareness, Wellbeing, Prevention, Early Identification and Training’ (as below) will be responsible for delivering on the aims and objectives of the project.

- The 3 main outcomes for the ‘Raising Awareness, Wellbeing, Prevention, Early Identification and Training’ workstream are:
  - to raise awareness of Older Adults Mental Health Issues (focusing on dementia and related conditions) in Croydon.
  - to improve the support to people with dementia and their carers in Croydon.
  - to develop Croydon’s workforce (statutory, voluntary and community) so that it has appropriate skills, cultural sensitivity and a better awareness and understanding of issues facing older adults around dementia and related conditions

**What did respondents to our local survey tell us?**

- 87% said their quality of life ‘could not be better, is very good, good or alright’ and 84% said care and support services helped with quality of life

- 93% said they had ‘as much as they want, some or adequate’ control over their daily life and 81% said care & support services helped them in having control
Delaying and reducing the need for care and support

What this means:

- Enabling people, and those close to them, to take preventative action at an earlier stage to avoid problems from occurring, or increase the delay in a condition deteriorating and potentially requiring further help.

- Encouraging people to make positive lifestyle choices which can help to reduce potential negative health impacts so that they can live longer, healthier lives.

- Supporting people to get their confidence back and learn/re-learn activities of daily living following illness, accidents and other life changing event to provide better long term solutions.

- Helping people to re-establish their ability to successfully manage their own lives, recognising their own strengths and resilience capabilities.

Our progress in 2013/14

- Work has progressed during 2013/14 with a number of housing providers to refurbish and develop supported housing, this has included:
  - Refurbishment of Eldon’s special sheltered housing scheme, Westdene, which includes specialist housing for older people with dementia.

- Croydon’s development of a range of early intervention and reablement services has continued, helping to improve outcomes for service users and prevent hospital admissions. This has included delivery of:
  - Six reablement beds – for patients being discharged from hospital, but who are not quite ready to go home following discharge, these beds have been established in a residential home having access to on-site facilities (including gym, adapted kitchen and consultation rooms) where occupational therapists and social care reablement staff can provide input to enable the individual to return home.
  - Four reablement flats (within two special sheltered housing schemes) – to support people to develop skills and confidence in living alone, with the security of staff being present on site, as a step towards returning to their own home.
  - Launch of a new Rapid Response Service in October 2013 – this service is able to provide health and social care interventions at short notice in order to avoid a hospital admission, stabilise the individual, and provide the opportunity for a range of early intervention services to be made available to the person as appropriate. The Rapid Response service model is staffed by nurses, physiotherapists, occupational therapists, social workers, mental health specialists, pharmacy, and support workers. Services are provided in the person’s own home wherever possible, or in intermediate care beds, with the rapid response team working closely with community health and social care services.

- A new supported housing scheme of self-contained flats for people with physical disabilities and people with learning disabilities, providing 7 additional units of supported housing.
Key activities for 2014/15

- Establishment of the Short Term Assessment and Reablement Team (START) – this team works with hospital health and social care discharge coordinators in ensuring that post discharge reablement services are in place and an independence plan implemented with the patient and their carer/s. Once discharged the START reablement coordinators ensure that all parts of the independence/reablement plan are working together to achieve the reablement outcomes for the individual and adjust the plan as appropriate.

- A community based ‘Falls & Bones’ Health Service has been launched to work alongside reablement services and will be part of the range of community based services that will support early intervention for people identified through G.P areas and the Rapid Response Services to prevent unplanned admission to acute services.

- Delivery of a range of initiatives, focused on assisting people to stay in their own homes, will be delivered throughout 2014/15 including:
  - Staying Put Scheme and Enhanced Staying Put Scheme – the Staying Put Scheme supports homeowners and private tenants in getting repairs, improvements and adaptations carried out. The Enhanced Staying Put Scheme (launched in Jan 2013) operates in conjunction with reablement services to provide practical housing support to people who are in danger of admission to hospital or who are about to or have recently been discharged from hospital, to continue to remain living independently and safely in their own home.
  - Disabled Facilities Grants - to help people with disabilities to live more independently in their home by carrying out essential adaptations to enable access into, and around, their home.
  - Discretionary Home Investment loans – available to help owner occupiers to remove/reduce hazards including those associated with falls, excess cold and disrepair.
  - Home Repair Loans – to provide help with small-scale works of repair, improvement and adaptation for clients who are 60 years of age or over, or disabled or infirm persons of any age.

- A service review for Mental Health commissioned supported housing services has been carried out to ensure housing related support services are outcome and person centred and they provide high quality asset based needs assessment and support planning.

What did respondents to our local survey tell us?

- 66% said they are able to spend their time as they want (or enough of their time) doing things they value or enjoy.
- 77% said they had ‘as much as I want’ or ‘adequate’ social contact with the people they like.
Ensuring that people have a positive experience of care and support

What this means:

- Ensuring people have easy access to local information, advice and advocacy which supports people to make good decisions about care and support.

- Promoting seamless health and social care services which focus on the individual and work together to provide better co-ordinated care and support so that their care and support needs are managed more effectively and their outcomes are improved.

- Helping people to live longer, healthier lives through positive lifestyle choices and by using their own, and other, resources in the local area.

- Supporting carers by recognising, valuing and supporting them to remain mentally and physically well and enabling them to fulfil their potential in all aspects of their lives.

Our progress in 2013/14

Making it Real action – ensure new information and advice services are shaped and informed by the Making it Real ‘I’ statements

- ‘Advice Services Croydon’ was launched in July 2014 making information and advice on health and social care available from one central point of contact. The services will be available to all adults and their carers (including self-funders) with care and support needs, irrespective of their condition, age or disability. The need for people to have easily accessible, good quality, local information and advice is one of the central themes of the Care Act 2014 and this new service helps to deliver this for people in Croydon.

Making it Real action – working with service users on the design and delivery of care and support services

- The Council, in partnership with Croydon Clinical Commissioning Group (CCG), has been working towards establishing an Integrated Framework Agreement (IFA) for care, support and health related services to enable people to live independently in the community and/or stay within their home. The services within the framework include personal care, reablement, housing support, health related services and end of life care.

- During development of the IFA we worked with people who use day resource centres and a reference group of care and support service users and carers at key points, taking a collaborative approach to the design and development of the framework, and selection process for provider organisations. This has included:
  - Visiting a day resource centre to talk with people using the centre facilities about what they want from care and support services and what is most important to them.
  - Holding a workshop to review and revise the service specifications for personal care and support & reablement services with service users - the specifications set out the activities and outcomes which providers are expected to deliver for people who use their services.
  - Key points in the discussions were - what matters most to service users, were there other outcomes we should be seeking to achieve, and was there anything more we can do to ensure services are a high standard.
The IFA evaluation panels included service user members who worked with us assess submissions from potential providers.

**Key activities for 2014/15**

- Croydon has continued to develop a collective and joined up approach to health and social care challenges with a focus on integrated services which can deliver better outcomes and working together to give the best care based on a person’s individual circumstances.

- An Integrated Commissioning Unit (ICU) has been established by the Council and Clinical Commissioning Group - moving to more integrated approach to commissioning for health and social care to enable:
  - commissioning of personalised services – responsive to people’s changing needs and value for money
  - move towards ‘whole system approach’ & increased co-ordination
  - choice for individuals - with clear information about services & resources
  - partnership working – with service users, providers, voluntary sector and staff from all agencies and communities

- The Integrated Framework Agreement will go live during 2014/15 and will aim to offer a range of benefits including:
  - Taking an outcomes focused approach to service delivery - this means moving away from having a set of fixed activities or tasks that a service provider is asked to do in a certain way, to looking at what the service user wants to achieve as an end result and then finding the best way to make this happen.
  - Providing increased choice and control to people through the use of managed personal budgets and improved rates for people who want to organise their own care through the use of a direct payment. By working in partnership the Council and

CCG can provide a more integrated approach to delivering these services to ensure that the needs of vulnerable people are meet in a holistic way.

**What did respondents to our local survey tell us?**

- 73% of those who had looked for information or advice in the past year said it was ‘very’ or ‘fairly’ easy to find
- 83% felt ‘extremely, very or quite satisfied’ with care and support services
Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm

What this means:

- Promote dignity and respect and ensure compassion, kindness and respect are principles at the heart of care and support.
- Enable people who need care and support to retain independence, wellbeing and choice and to access their right to live a life that is free from abuse and neglect.
- Ensuring individuals, families and carers are well informed and enabling them to be engaged with support and independence options available.

Our progress in 2013/14

- The annual Adult Social Care Survey carried out in Spring 2014 included extra questions, which we added locally, asking people to tell us more if they did not feel as safe as they wanted to, both inside and outside of the home. We added these questions so that we could find out more about what helps people to feel safe and so that we could respond to any concerns raised. The majority of people stated that they did ‘feel as safe as they wanted / adequately safe’ but some people told us about things that worried them, often around the fear of having a fall.
  - We made contact with over 60 people who made comments about feeling safe on their survey response. We were able to help people by signposting to other services, information and advice, make referrals for assessments where appropriate or just have a conversation about their concerns to ensure they had the information or support they wanted or might need in the future.
- A seminar was held on 5th December 2013 to consider the local response to recommendations made within two important national reviews which looked at significant failures of the health and care system - the Francis Report and Winterbourne View Hospital Serious Case Review.
  - Presentations at the seminar set out work undertaken by Croydon Clinical Commissioning Group, Croydon Health Services NHS Trust, South London and Maudsley NHS Foundation Trust and Croydon Council to improve patients’ and service users’ safety and to promote dignity in care.
- The work of the Croydon Adult Safeguarding Board is set out in the Multi-agency Safeguarding Adults Board annual report for 2013/14, which can be found here: http://www.croydon.gov.uk/healthsocial/sva/svaboardgp/svaboard
  - The Care Act 2014 makes it a matter of statute for Local Authorities to establish a Safeguarding Adults Board with three main lead statutory agencies, social services, health and the police. Croydon Council has facilitated such a board for many years and this practice is now being enshrined in law.
  - Croydon’s board comprises Adult Social Services, Health Services in Croydon, such as the Clinical Commissioning Group, Croydon Health Services, South London and Maudsley Mental Health Trust and the Metropolitan Police.
- Priorities and objectives are set out in the Safeguarding Board Business Plan 2013-15 and progress against the objectives in 2013/14 has included:
An external audit of Adult Social Services safeguarding case work and multi-agency work to look at how well agencies were working together. The audit concluded that, in terms of Croydon Adult Social Services safeguarding adults work, ‘safeguarding practice is safe, secure and ‘solid’ and ‘the quality and effectiveness of safeguarding practice is a testament to the commitment and skill of social workers, their managers and Independent Chairs (of safeguarding meetings)’.

Croydon has engaged in the national programme ‘Making Safeguarding Personal’ which is about shifting how people who have been harmed are supported, moving away from following a standard procedure for investigations towards working more closely with the individual who may have been harmed. There is now more of a focus on what the individual wants to achieve and less on the process of investigation which has led to people being actively involved in all meetings which discuss what has occurred.

The Care Support Team, which consists of social workers and nurses, continues to provide training, coaching and support to providers to help them maintain and improve standards of care. There has been an increase in the total number of staff trained from 1,940 in 2012-13 to 2,363 people in 2013-14.

During 2013/14 the Care Support Team also developed its reablement work with the aim of reducing avoidable admissions to hospital. Going to hospital can be an unsettling experience for anyone and particularly so for people who are vulnerable. The work of the team is to support care providers to be better equipped to maintain residents’ health and to work effectively with community health providers.

4 Care and Support Provider Forums and 3 Dignity in Care Forums were held during 2013/14. Care Forums continue to be an important means of coming together with service providers to ensure consistency of understanding and sharing of good practice. The themes for the forums have been dictated by the emerging issues and learning from actual cases.

The promotion of good workforce development (which is about how staff are selected, supported, trained and supervised) is critical to ensuring that people who need care and support receive services that they can trust, from staff they can trust. Care providers receive ongoing advice on the safer recruitment and supervision of staff through the work of the Care Support Team, Care Provider Forums and the Multiagency Partnership Training Programme delivered in conjunction with Skills for Care.

Key activities for 2014/15

- Croydon Safeguarding Adults Board has identified priorities to support ongoing progress in delivery of its business plan objectives in 2014/15, including:
  - Further develop links with the Safeguarding Children Board and the Health and Wellbeing Board.
  - Strengthen service user involvement in safeguarding enquiries in line with Making Safeguarding Personal and develop regular service user feedback to inform practice.
  - Develop clear guidance and standards on workforce issues for application across the partnership.
  - Develop a common approach to identification, assessment and management of risk across the partnership.

- A review of advocacy provision in Croydon was carried out in September 2014 which updated a review from 2012. This work is particularly timely and valuable as the Care Act 2014 places far greater responsibility on Councils to provide information, advice and advocacy
for people who have care and support needs, and therefore the review helps us in our preparation for implementation of the Care Act.

○ The 2014 review focused specifically on the main statutory advocacy services, posing a range of questions to advocacy providers and gathering views from care managers / social workers about their experience of accessing advocacy for service users.

What did respondents to our local survey tell us?

- 94% said they felt ‘as safe as they want’ or ‘adequately safe’ both inside and outside of the house
- 71% said that care and support services help in feeling safe
Priorities and challenges for the future

The pressures faced by local authorities in meeting the care and support needs for local people will continue to be complex and challenging. On-going reductions in local government funding, increasing demand and demographic changes all indicate that new approaches to meeting these challenges will need to be explored alongside further development of work already underway.

Some of the key health and social care programme and initiatives for the next year and beyond are outlined here to illustrate some of the ways in which we will respond to the challenging period ahead.

Integration of health and social care services

- Croydon will continue its journey towards more integrated health and social care to ensure that services are better at working together. The focus for integrated services is on delivering better outcomes and working together to give the best care based on a person’s individual circumstances. This will include:
  - The Better Care Fund (BCF) - announced by the Government in the June 2013 spending round with the aim of helping to join up local health and care services to improve care and reduce accident and emergency admissions.  
  - The BCF introduces a pooled budget between NHS Commissioning Groups and Local Authorities and is in Croydon it is an important enabler for Croydon to build on the work it has already started and take the integration agenda forward.
    - The Croydon BCF Plan was submitted to NHS England on 19th September 2014 and finally approved in January 2015. It focuses on delivery of improved integrated community services that enable patients to receive the care they need at or close to home and in doing so reduce demand on acute health services.
  - Transforming Adult Community Services (TACS) – this programme of work aims to enhance care for people with long term conditions, reduce unnecessary emergency admissions and providing high-quality, personalised care, as close to home as possible.
    - TACS works in alignment with wider early intervention and reablement services in the borough so that we can provide co-ordinated support for individuals, avoiding unnecessary use of acute services and maintaining independence within their own home.
    - TACS services include initiatives such as the ‘Single Point of Assessment’, which offers a 24 hour, 7 days a week triage service whereby GP’s and other practitioners can speak with an experienced community nurse for advice on community service options or referral to the appropriate health team for early intervention support.

Care Act 2014 Implementation

- An extensive programme of work is underway to ensure that we are
taking the necessary action in order to be fully prepared for implementation of the Care Act. This will focus initially on measures within phase one of the Care Act in April 2015 (further details about the measures within each phase of the Care Act can be found on page 6/7).

- More information about the Care Act, and what it means for local people, will be made available over the next few months, in alignment with national communication activities.

**Improving health and social care outcomes for over 65’s Programme**

- This programme has been exploring alternative models to improve the health and social care system for people over 65 years old and ensure development of a strong independence model. Croydon Council and Croydon Clinical Commissioning Group (CCG) have been working collaboratively to identify how improvements could be achieved by taking a whole systems approach to care and health in a time of constrained resources.
  
  o The programme reflects the Council’s ambitions to enable independence, liveability and growth. A set of outcome categories (also called ‘domains’) have been developed through public engagement work and these align to the Council’s strategic priorities to increase healthy life expectancy, facilitate increased community and citizen resilience, and ensure enhanced high quality community-based care.
  
  o Outcome categories for the ‘Improving health and social care outcomes for over 65’s programme’:
    - stay healthy and active for as long as possible
    - access the best quality care available in order to live as they choose and as independent a life as possible
    - be supported as an individual, with services specific to them
    - be supported to manage any long-term condition they may have and experience improved control and reduced complications
    - be supported by a member of the health and social care team who has had the training and has the specialist knowledge to understand how their health and social care needs affect them
  
  o As the programme continues to progress into its next phase further detailed work will be carried out on the outcome categories as well as working with providers on many aspects of the programme including services to be in scope and developing the preferred delivery model.

**Public Health Croydon**

- Public Health Croydon joined the Council in April 2013 and continues to focus on promoting and protecting health and wellbeing, preventing ill health, reducing inequalities, and increasing healthy life expectancy. Key pieces of work include:
  
  o Croydon signed up to the British Heart Foundation initiative ‘Heart Town’ in Spring 2013 and has since committed to delivering this as a major five year programme to improve heart and vascular health in the borough. The ‘Heart Town’ delivery plan has a number of elements including campaigns and awareness raising, support and advice in schools and work places, support and advice for the general population, service re-design/new services, partnership working and charitable fund raising and volunteering.
Flagship food borough – Croydon has been chosen as a flagship food borough for London to promote healthy eating, cooking better food and reduce obesity in schools and communities. Croydon will receive support from the Greater London Authority’s (GLA) food health, and education teams and Mayor’s Fund for London, and £600,000 in funding from the Department for Education and GLA over the next 2 years to help transform the food environment in the borough.

The annual Public Health report for 2014 focused on reducing inequalities between different parts of the borough, and took a close look at how communities in New Addington and Fieldway are tackling the health issues that affect Croydon as a whole. The report examines the ways in which the local community and its people are working to improve their health and examines how wider issues such as lifestyle, economy, genes and ethnicity, social networks, health and social services, and housing and local neighbourhoods all have an impact on people's health. The full report can be found here: http://www.croydon.gov.uk/healthsocial/phealth/croydon-aphr

Digital enabling

- We will develop longer term plans to improve digital services to enable carers, family members and other local people in identifying the outcomes they wish to achieve, and to provide knowledge about how to access relevant services. Alongside the introduction of ‘CarePlace’ and some new online referral forms we will be looking for other ways of strengthening our local offer so that a variety of channels of access are available.
### Summary of performance in 2013/14

<table>
<thead>
<tr>
<th>Adult Social Care Outcomes Framework (ASCOF) Domain / Indicator</th>
<th>Croydon</th>
<th>London</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 1: Enhancing quality of life for people with care and support needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social care-related quality of life (proportional score derived from several questions in the annual survey) <em>(bigger is better)</em></td>
<td>18.7</td>
<td>18.5</td>
<td>19</td>
</tr>
<tr>
<td>Proportion of people who use services who have control over their daily life <em>(bigger is better)</em></td>
<td>74.9</td>
<td>72.4</td>
<td>76.8</td>
</tr>
<tr>
<td>Proportion of people using social care who receive self-directed support <em>(bigger is better)</em></td>
<td>70</td>
<td>67.5</td>
<td>62.1</td>
</tr>
<tr>
<td>Proportion of people using social care who receive direct payments <em>(bigger is better)</em></td>
<td>10.4</td>
<td>22.6</td>
<td>19.1</td>
</tr>
<tr>
<td>Proportion of adults with learning disabilities in paid employment <em>(bigger is better)</em></td>
<td>5.6</td>
<td>8.8</td>
<td>6.7</td>
</tr>
<tr>
<td>Proportion of adults in contact with secondary mental health services in paid employment <em>(bigger is better)</em></td>
<td>5.7</td>
<td>5.4</td>
<td>7</td>
</tr>
<tr>
<td>Proportion of adults with learning disabilities who live in their own home or with their family <em>(bigger is better)</em></td>
<td>66.2</td>
<td>68.6</td>
<td>74.9</td>
</tr>
<tr>
<td>Proportion of adults in contact with secondary mental health services who live independently, with or without support <em>(bigger is better)</em></td>
<td>71</td>
<td>78.6</td>
<td>60.8</td>
</tr>
<tr>
<td>Proportion of people who use services who reported that they had as much social contact as they would like <em>(bigger is better)</em></td>
<td>44.3</td>
<td>40.7</td>
<td>44.5</td>
</tr>
<tr>
<td><strong>Domain 2: Delaying and reducing the need for care and support</strong></td>
<td></td>
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<tr>
<td>Permanent admissions of older people (aged 65+) to residential &amp; nursing care homes (per 100,000 population) <em>(smaller is better)</em></td>
<td>421.3</td>
<td>454</td>
<td>650.6</td>
</tr>
<tr>
<td>Permanent admissions of younger adults (aged 18-64) to residential &amp; nursing care homes (per 100,000 population) <em>(smaller is better)</em></td>
<td>7.7</td>
<td>10.2</td>
<td>14.4</td>
</tr>
<tr>
<td>Delayed transfers of care from hospital which are attributable to adult social care (per 100,000 population) <em>(smaller is better)</em></td>
<td>1.4</td>
<td>2.3</td>
<td>3.1</td>
</tr>
<tr>
<td>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services -effectiveness of the service <em>(bigger is better)</em></td>
<td>85.2</td>
<td>88.1</td>
<td>82.5</td>
</tr>
<tr>
<td><strong>Domain 3: Ensuring that people have a positive experience of care and support</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of people who use services who find it easy to find information about services <em>(bigger is better)</em></td>
<td>73.1</td>
<td>72.8</td>
<td>74.5</td>
</tr>
<tr>
<td>Overall satisfaction of people who use services with their care and support <em>(bigger is better)</em></td>
<td>57.9</td>
<td>60.3</td>
<td>64.8</td>
</tr>
<tr>
<td><strong>Domain 4: Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of people who use services who feel safe <em>(bigger is better)</em></td>
<td>64</td>
<td>62.8</td>
<td>66</td>
</tr>
<tr>
<td>Proportion of people who use services who say that those services have made them feel safe and secure <em>(bigger is better)</em></td>
<td>71</td>
<td>76.8</td>
<td>79.1</td>
</tr>
</tbody>
</table>
## Getting involved - ways you can get involved, have your say or work with us to develop and improve adult social care

### Croydon Adult Social Services User Panel (CASSUP)
CASSUP is a group of service users, carers of service users and Croydon residents who have a strong commitment to improving services and championing the interests of service users. The panel works in partnership with officers and service providers to raise key concerns regarding adult social care in Croydon and identify ways to improve services.

**Contact:** The Resident Involvement Team  
Tel: 020 8726 6000 Ext: 62321  
Website: [http://www.croydon.gov.uk/healthsocial/userinvolvement](http://www.croydon.gov.uk/healthsocial/userinvolvement)

### Talking about adult social care
‘Talking about adult social care’ provides adult social care service users and their carers with the opportunity to meet with service managers and to comment on a full range of issues that affect adult social service users in the borough with events held every year.

**Contact:** The Resident Involvement Team /  
Tel: 020 8726 6000 Ext: 62321  
Website: [http://www.croydon.gov.uk/healthsocial/userinvolvement](http://www.croydon.gov.uk/healthsocial/userinvolvement)

### Healthwatch Croydon
Healthwatch Croydon is a new consumer champion for health and social care services. It represents people who use health and social care services and its functions include providing information, advice and support about services and influencing the set-up, commissioning, design and delivery of services.

**Contact:** Healthwatch Croydon  
Tel: 020 8253 7090 / Email: haveyoursay@healthwatchcroydon.co.uk  
Website: [http://www.healthwatchcroydon.co.uk](http://www.healthwatchcroydon.co.uk)

### ‘Making it Real’ – assessing progress for personalisation and community based support in adult social care and support services
The ‘Making it Real’ assessment framework will continue to be used by the council to consult with adult social care service users and carers on a regular basis. If you are interested in being involved please use the contact details below.

**Contact:** Tracy Stanley, Strategy & Planning Manager (adult services, health & housing)  
Tel: 020 8726 6000 Ext: 61623  
Email: tracy.stanley@croydon.gov.uk

### The Mobility Forum
Croydon Mobility Forum reviews and makes recommendations to improve access and facilities in Croydon for older people and those with disabilities. Elected forum members, representing voluntary sector workers, service users and carers with disabilities, meet with councillors, senior council staff, taxi organisations, Transport for London and bus and rail companies to discuss how best to improve services in Croydon.

**Contact:** Croydon Access Officer  
Tel: 020 8760 5776  
Website: [http://www.croydon.gov.uk/healthsocial/userinvolvement](http://www.croydon.gov.uk/healthsocial/userinvolvement)