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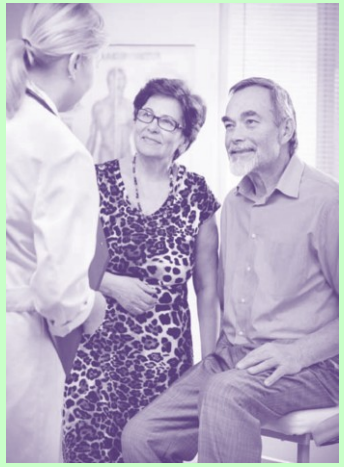

Croydon's local account annual report to residents 2012 - 2013

CROYDON
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Introduction [to be added]

Councillor Margaret Mead
Cabinet member for health and adult social care

Welcome from Hannah Miller
Executive director for adult services, health and housing

Welcome Croydon's local account

What is the local account?

The local account is an important part of how we demonstrate accountability for performance and outcomes for adult social care services. It is an opportunity for us to share information with local people who use care and support services, and the wider community, by reporting on progress, outcomes and achievements during the year and outline priorities for the future for the council and its partners.

About Croydon

- Croydon has the largest population of all London boroughs with 363,400 residents from a wide range of ethnic origins and cultures. The latest population projections for 2013 estimate that Croydon's population has increased to 374,061 residents and that it will increase by another 9% by 2021. Croydon's communities speak more than 100 different languages and 45% of the population are from a BME background. While the borough's residents are ageing, it also has the largest population of young people in London.

- Between 2011 and 2021 the 65+ population in Croydon is estimated to rise by 24.4%, higher than both the national and London average. Demand for adult social care increases in numbers and complexity with assessments of adults and older people leading to provision of a service increasing by 38% during 2006-12, and the total number of people helped increasing by 12%.

Older people in Croydon

- People are living longer and our population is ageing with projections suggesting that the number of people aged over 85 will increase by two thirds by 2029. This is an important trend because we know that older people generally have more health problems and are more likely to use health and care services.

- Within the older population the number of people requiring support with domestic tasks is projected to increase, with an additional 3,739 people during 2012-20 in Croydon, and an additional 3,006 people requiring self-care within the same period. In 2012-13 the council provided more than 4,900 residents aged 65 years and over with a care package, and of these 87% were supported to live independently through community based services.

Our mental health

- One in four people will experience a mental illness in their lifetime. There are around 105,000 people in Croydon who suffer from depression and mood disorders and there are about 4,000 who have been diagnosed with severe mental illness. Amongst the working age population in Croydon it is projected that by 2021 there will be an increase of 24% in people with a serious mental illness.

All people (18-64) with a common mental disorder- projected to 2020

Year	2012	2014	2016	2018	2020
Number of people	37,454	37,865	38,334	38,817	39,196

Source: Projecting Adults Needs and Service Information (PANSI)

By gender, people aged 18-64 with a common mental disorder, projected to 2020

Year/no of people	2012	2014	2016	2018	2020
Males	14,050	14,225	14,438	14,625	14,788
Females	23,404	23,640	23,896	24,192	24,408

Source: Projecting Adults Needs and Service Information (PANSI)

People with dementia

- There are an estimated 3,300 people living with dementia in Croydon, this is projected to rise by 30% over the next 15 years, reaching 4,500 by 2025 and approximately two thirds (62.1%) are female. Croydon's Dementia JSNA 2011-12 revealed that Croydon has higher dementia needs compared to other London boroughs.

- In Croydon the rise in the prevalence of dementia roughly coincides with the increasing number of older people in the Borough but there are also people as young as 45 who have been diagnosed with dementia.

People aged 65+ predicted to have dementia, projected to 2020

Year	2012	2014	2016	2018	2020
No of people	3,225	3,401	3,572	3,782	4,021

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

People with long term conditions

- Three out of every five people aged over 60 have a long term health condition and as the population ages, this proportion is likely to increase which will have implications for the level of future health and social care needs and the way in which these requirements can best be met whilst supporting people to maximise independence and avoid hospital admissions.

- The fastest-growing long-term condition in the borough is Chronic Obstructive Pulmonary Disease with an increase of 54% projected by 2021, followed by diabetes at over 46% and dementia at nearly 44%.

People aged 65+ with a limiting long-term illness, projected to 2020

Year	2012	2014	2016	2018	2020
Number of people	20,432	21,331	22,093	23,064	24,034

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

People with disabilities

Physical disabilities

- There are an estimated 22,117 adults (aged 18-64yrs) with a moderate or serious physical disability and this is projected to rise to 24,134 by 2020. It is estimated that 10,179 people (aged 18-64yrs) with a moderate or serious physical disability require support with personal care which includes help getting in and out of bed or a chair, dressing, washing, eating meals and use of the toilet.

- In 2012/13 the council provided more than 1,000 physical disabled residents aged 18 to 64 with a care package and of these 96% were supported to live independently through community based services.

People aged 18-64 with a moderate or serious physical disability, projected to 2020

Year / no of people	2012	2014	2016	2018	2020
Moderate PD	17,204	17,512	17,893	18,296	18,666
Serious PD	4,913	5,014	5,155	5,314	5,468

Source: Projecting Adults Needs and Service Information (PANSI)

People with Learning disabilities

- There are an estimated 5,644 adults (aged 18-64yrs) in Croydon with a learning disability and this is projected to increase to 5,899 by 2020. In 2012-13 the council provided more than 1,010 people with a learning disability with a care package (900 people aged 18 to 64 and 110 people aged 65+), and of these 75% were supported to live independently through community based services.

People aged 18-64 with a learning disability/severe learning disability – projected to 2020

Year / no of people	2012	2014	2016	2018	2020
Learning disability	5,644	5,708	5,776	5,845	5,899
Severe learning disability	337	341	346	351	355

Source: Projecting Adults Needs and Service Information (PANSI)

People aged 18-64 predicted to have autistic spectrum disorders, projected to 2020

Year	2012	2014	2016	2018	2020
Number of people	2,261	2,288	2,322	2,352	2,377

Source: Projecting Adults Needs and Service Information (PANSI)

Substance misuse in Croydon

- During 2012/13 a total of 150 people (aged 18 to 64) with substance misuse problems received a community based care package.

- There were 667 drug users in effective treatment (for opiate and crack use) in 2012-13 in Croydon which means treatment for 12 weeks or more after triage, or with a planned exit from treatment. This is a slight reduction from 2011-12 but an additional 56 people sought and received effective treatment for other drug types meaning that overall the numbers receiving help for their drug issues increased during 2012-13.

- Croydon's annual Public Health Report 2012-13 reports that 77% of adults drink some alcohol. From this group 76% drink at lower levels of risk, 17% at increasing risk levels and 7% at high risk levels. There has been a decreasing trend in the number of people accessing treatment for alcohol consumption, however, hospital admissions related to alcohol have increased.

People aged 18-64 predicted to have a drug or alcohol problem, projected to 2020

Year/no of people	2012	2014	2016	2018	2020
Alcohol	13,699	13,861	14,051	14,231	14,381
Drugs	7,790	7,881	7,987	8,089	8,173

Source: Projecting Adults Needs and Service Information (PANSI)

Our life expectancy

- The health of people in Croydon is mixed compared to the England average. Life expectancy for men in Croydon is now 79.6 years and for women it is 83.3 years, both of which are slightly more than the average for England. However, there are variations depending on where people live in the borough with life expectancy 9.5 years lower for men and 5.2 years lower for women in the most deprived areas of Croydon than in the least deprived areas.

Our carers

- Carers look after friends, family members or neighbours who need help because they are ill, frail or have a disability. The support that they provide enables the people they care for to remain at home rather than move into a residential care environment which means they are more likely to live full, safe and healthy lives, affording them their dignity and independence.

- According to the 2011 Census there are approx. 33,600 unpaid carers in Croydon with 66% providing 1 to 19 hours of unpaid care per week, 14% provide 20 to 49 hours and 20% provide 50 hours or more of unpaid care per week.

Croydon Observatory – information about Croydon

- If you want to know more about Croydon you can visit the Croydon Observatory website at http://www.croydonobservatory.org/ which provides accurate and relevant information on the population in Croydon.

Adult social care in Croydon

The local authority has a responsibility to provide services for adults who need extra care and support. This includes all forms of personal care and other practical assistance for individuals who by reason of age, illness, disability, dependence on alcohol or drugs, or other similar circumstances, are in need of care or assistance. Croydon is committed to delivering personalised sustainable outcomes and provides an integrated approach to providing services and through the work of the Adult Services, Health & Housing (DASHH) department.

Our Croydon commitments

This report sets out our priorities in adult social care, the outcomes we are focused on achieving and the progress made in 2012-13. Outcomes describe the difference we make to people's lives.

- Outcome 1: to deliver personalised, sustainable outcomes and a positive experience of care.
- Outcome 2: to promote prevention, early intervention, recovery and reablement.
- Outcome 3: deliver integrated, safe, high quality services
- Outcome 4: support increased resilience and independent living

Our performance – how we assess our progress?

- Croydon council focuses on continuous improvement and cost reduction. We monitor, analyse, benchmark and compare our performance and progress using a variety of methods. This includes the Adult Social Care Outcomes Framework, the council key performance indicators data set and use of a 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.

- Every year we write to a sample of people who use adult social care services and responses to the survey used provides valuable feedback about care and support services, health and wellbeing and quality of life. The 2012-13 survey was completed by 462 service users, which represents a 30% response rate. Findings from both the annual survey and other performance measures are used throughout the local account to report on how we are doing against key priorities and objectives.

Developments in adult social care

The Governments 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 Care Bill was published in May 2013. The Bill seeks to modernise the law to put people's wellbeing at the heart of the care and support system. Measures within the Bill include:

    - The introduction of a cap on an individual's contribution to care costs and a universal deferred payment scheme which will mean people do

not have to sell their home within their lifetime to pay for residential care. It was announced in the 2013 Budget that a cap on care costs of £72,000 will be introduced in 2016.

- A duty on local authorities to carry out care and support functions with the aim of integrating services with those provided by health and health related services, such as housing.

- A focus on ensuring people receive services which prevent their care needs from becoming more serious, can get the information and advice they need about care and support services in their local area.

- New rights for carers, giving them the same rights to assessments and care services as those they care for.

- The 'Integrated care and support: our shared commitment' initiative (available at: **https://www.gov.uk/government/publications/integrated-care**) was published in May 2013 and has been informed by integrated care pilots and the personal health budget pilot programme. It looks at how national and local organisations can take action to achieve integrated care and support, i.e. doing things together across health and social care. With health care reforms leading to a greater focus on commissioning there is an opportunity to create shared visions across health, public health and social care with local authorities collaborating with providers from the public, private and third sector.

- The Health and Social Care Act 2012 is a crucial part of the Government's vision to modernise the NHS so that it is built around patients, led by health professionals and focused on delivering world-class healthcare outcomes. The Act 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 far 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**

- In March 2012 the Prime Minister launched the Dementia Challenge, a programme of work which aims to improve the lives of those living with dementia, their families and carers. The programme is built around 3 areas for action, health and care, creating dementia friendly communities and improving dementia research. A report on progress against actions was published in May 2013.

Making it Real – assessing adult care and support services

What is 'Making it Real'?

- 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 framework is built around "I" statements which express what people expect to see and experience if personalisation is working well. For example people might report, "I have the information and support I need in order to remain as independent as possible."

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 suppo**rt – my support, my own way
- **Workforce** – my support staff
- **Risk enablement** – feeling in control and safe
- **Personal budgets and self-funding** – my money

- In our last local account report we made a commitment to use the framework to engage with adult social care services users and carers to find out more about their experiences of social care, assess how well local services achieve good outcomes and decide where we should focus our efforts to make things better.

- We wanted to reach as many people as possible and to hear the views of those who are not always able to attend one off consultation events. In order to achieve this we set up a series of engagement sessions, going out and visiting local care, support & reablement centres and support groups for a range of social care service user groups and carers, listening to people's feedback and working through the assessment framework together.

- We also worked with service user groups such as CASSUP, the Mobility Forum and the Making a Difference group for people with learning disabilities.

Your response - results and actions

- The aim of 'Making it Real' is to highlight 3 priority themes, identify key issues that are being raised and develop some actions to deliver improvements in these areas.

- We met with over 40 people during the consultation and some consistent messages emerged which are set out below as a summary of what service users and carers told us and what we will do, with our partners, in response to your feedback. A more detailed version of the action plan will be published on the Making it Real website to share developments and learning.

Priority 1: Information and Advice - having the information I need, when I need it.

Making it Real statements:

- I have the information and support I need in order to remain as independent as possible.
- I have access to easy to understand information about care and support which is consistent, accurate, accessible and up to date.
- I can speak to people who know something about care and support and can make things happen.
- I have help to make informed choices if I need and want it.
- I know where to get information about what is going on in my community.

What you told us:

- Information and advice can come from a wide range of people and places, family, friends, and people who provide care and support, but it can still be difficult and confusing to know who to contact sometimes.
- Most people wanted a better understanding of what information and advice was available.
- Carers of people with dementia sometimes found it hard to navigate health and social care services when they need to seek advice or support.

What we will do:

- We will use the Making it Real 'I' statement as part of the service outcomes we ask providers to achieve when delivering the new information, advice, casework and advocacy services during 2014.
- We will use an annual survey, based on 'Making it Real' to assess how well the information and advice services are achieving outcomes.
- We will look at ways to improve the information and advice available to people with dementia and their carers as part of our delivery of the Croydon Joint Dementia Strategy.

Priority 2: Workforce – my support staff

Making it Real statements:

- I have good information and advice on the range of options for choosing my support staff.
- I have considerate support delivered by competent people.
- I have access to a pool of people, advice on how to employ them and the opportunity to get advice from my peers.
- I am supported by people who help me to make links in my local community.

What you told us:

- Most people were happy with the standard of care and support they received and reported that when they raised concerns they were dealt with effectively.
- More opportunities for people who use services to be involved in the commissioning of care and support services would be a good idea so that their experiences and priorities could be taken into account and help shape the services that are delivered.

What we will do:

- We will work with a group of service users to take a 'co-production' approach to commissioning services, including care and support and reablement services. This means working collaboratively on the design and delivery of the services needed with the people who use them.
- We will use feedback and insights from service users to help inform the standards, outcomes and performance that we seek from providers when delivering services.

Priority 3: Active and supportive communities - keeping friends, family and place

Making it Real statements:

- I have access to a range of support that helps me to live the life I want and remain a contributing member of my community.
- I have a network of people who support me - carers, family, friends, community and if needed paid support staff.
- I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities.
- I feel welcomed and included in my local community.
- I feel valued for the contribution that I can make to my community.

What you told us:

- You really value opportunities to go out, meet people and take part in activities and would like to hear more about what is happening in your local area on a regular basis so that you can do more of the things that you are interested in, when you want to do them.

- Some people are interested in having more flexibility in how the money for their care and support needs is used but are sometimes reluctant to consider direct payments because they are not sure they could manage them successfully.

What we will do:

- We will explore how we can work with existing networks, groups and individuals to ensure local people have more regular, easily accessible information about what is happening in their local area, and other opportunities to access support and get involved in activities and events. We will look at this alongside the work we are doing to put new information and advice services in place (see page 19 for more information).

- We will develop a set of actions to improve the information, guidance and support offered to people who are interested in having a direct payment for their care and support.

Next steps

- We will review progress every six months and continue to work with those we have engaged with to update them on developments, reconsider the framework themes, refresh what our priorities are and look at how we can continue to make improvements.

- We would like to hear from you if you are interested in being involved or adding your views as we take this work forward. Details about how to do this, and service user involvement other ways to get involved can be found on page 21.

Outcome 1 - To deliver personalised, sustainable outcomes and a positive experience of care

What this means:

- Ensuring that every person can have choice and control over the shape of their care and support in all settings.
- Delivering personal sustainable outcomes that maximise independence and choice.
- Supporting people to plan for a fulfilling life in accordance with their individual aspirations and goals, and to achieve health and wellbeing from engagement with the wider community.
- Encouraging greater personal responsibility for maintaining health and wellbeing.

Our progress in 2012/13

- The council is focused on working in partnership with service users to design independence plans that address their care and support requirements following assessment of need. The plans concentrate on the outcomes that the service user hopes to achieve in terms of meeting their identified needs and draw on the concept of social capital (which is about the shared values and sense of belonging that flow from being part of groups and networks within communities) with the aim to maximise an individual's potential and independence.
- We are continuing to build on existing links with local partner agencies that deliver universal education, training, employment, and housing services so that we can enable service users to move on from intensive therapeutic support and access mainstream services.
- More regular and transparent information has been made available for individuals about their personal budget allocation and spend where they have asked the council to administer the budgets on their behalf.
- Community mental health services staff have been trained in enabling users to develop their own self-directed support plan. This gives the people who use services greater control in their own care plans and has resulted in a much greater range of solutions to tackle their problems.

Case Study

Mr M is a 19-year old man with cerebral palsy, which affects all 4 limbs. He has no independent sitting ability, very restricted upper limb function and uses his power wheelchair for all his mobility needs.

He has been attending college in a residential unit to study Travel and Tourism and has achieved exceptional results. Mr M's relationship with his father is not ideal and he would rather not live with him any longer as he finds it very restricted.

He wants to pursue his educational goals, study for a degree and one day run his own business within travel and tourism. With the support of the social worker Mr M has sourced his own supported living accommodation which has been designed and planned to support young adults with physical disabilities using wheelchairs.

Following assessment and development of an independence plan Mr M has opted for a direct payment so that he can employ his own personal assistance and put some essential equipment in place. This will give him the independence and control over his life.

- Building on previous successes with self-directed support and personal budgets for users of mental health services we have worked together to promote the positive outcomes that can be achieved for people experiencing mental health difficulties.

- In order to encourage the use of direct payments as a method of taking personal budgets commissioners continue to stimulate the market to try to ensure local choice for individuals and also deliver safeguarding for these most vulnerable of people.

- We continue to develop the ways in which we can offer greater recognition of the contribution that individuals, families, carers and communities make in providing care and support. As part of the Croydon Carers Strategy 2011-15:

    - A range of preventative and early intervention carers' services were commissioned from 1st July 2012 under the Carers Support Network Commissioning Programme, using the hub (Carers Support Centre) with specialist services to complement this.

    - The new Carers Support Network provision has put in place early intervention and preventative services such as access to information, advice, advocacy, support (support groups, peer networks, counselling, befriending and respite services).

    - Croydon has a new Carers Support Centre which has been developed by the Whitgift Foundation and supported by the council. The Centre was officially opened on 7th of October in central Croydon to deliver information and general carers services from a central point, with referral systems and links to access specialist and other services. Any carer can simply walk in or phone to get support.

Carers Support Centre contact details:
Address: Carers Support Centre, 24 George Street, Croydon, CR0 1PB
Telephone: 020 8649 9339
Website: http://carerssupportnetwork.org.uk

What else did respondents to our local survey tell us?

- 90% said their quality of life 'could not be better, is very good, good or alright'
- 86% said care and support services helped with quality of life
- 95% said they had 'as much as they want, some or adequate' control over their daily life
- 79% said care & support services helped them in having control

Proportion of people using social care who:

- receive self-directed support
  Croydon 73.8%)
  (London 63.2% / England 55.5%)
- receive direct payments
  Croydon 9.6%)
  (London 19.3% / England 16.5)

Proportion of people who use services who have control over their daily life:
Croydon 72.4%
(London 70.9% / England 76.1%)

Proportion of carers who report that they have been included or consulted in discussion about the person they care for:
Croydon 63.4%
(London 65.9% / England 72.9%)

Overall satisfaction of carers with social services:
Croydon 29.2
(London 35.2 / England 42.7)

Outcome 2- To promote prevention, early intervention, recovery and reablement

What this means:

- Prevention is better than cure – enabling a person, or someone close to them, to take preventative action at an earlier stage and increasing the delay in deteriorating conditions and requiring further help.

- Support 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.

- Avoiding hospital admissions where possible, helping people to return home promptly when ready and preventing readmissions.

Our progress in 2012/13

- Better audit of infection control/ tissue viability in care homes for the prevention of admissions/ readmissions to acute care and enable earlier hospital discharge by better management in care homes, including those who provide nursing care. This work commenced with a baseline audit of infection control practice to identify any issues that needed to be addressed such as tissue viability management and environmental and cleanliness issues. Two nurses were then appointed who work with residential and nursing homes to provide practical advice and support in order to improve standards and prevent hospital admissions.

- Initiatives such as enabling carers to get access to health care on an emergency and planned basis in order to better support them and the person they care for and secondly, to reduce the number of unplanned admissions to hospital and emergency placements in care homes by having 'enabling' community-based and care home- based respite and other services.

- Provision of Occupational Therapist led reablement, recovery or treatment services at various venues around the borough. A workshop was held in September 2012 to review the service, and identify proposals for future improvements. The key aims of this initiative are to:
    - Ensure that the improvements achieved through treatment, reablement and recovery are maintained and built upon.
    - Offer reablement and recovery services for older people with mental health issues and dementia
    - Ensure the health and wellbeing of people is maintained and reducing the need for acute or emergency care.

Case study

Mrs J was admitted to an Intensive Care Unit in hospital following a stroke. She later moved to the Wolfson Neuro-rehabilitation centre for several months of treatment as she was experiencing left sided weakness, reduced mobility and cognitive difficulties. Prior to discharge from the centre a needs assessment was carried out for ongoing support at home to be put in place.

An independence plan was initiated after the assessment, with three visits a day to assist with personal care and assist with dressing and going to the toilet. Community Occupational Therapists were also involved to provide equipment and advice to make activities of daily living as independent as possible.

At Mrs J's 6 week review her husband felt able to take over his wife's care and the independence plan came to an end. The planned multi agency discharge and the initial support was enough to support both Mrs J and her husband to remain living independently in their home.

- Provision of reablement and recovery facilities at Addington Heights Reablement Centre including:
    - Gym / activity suite in the centre
    - Wheelchair clinics / assessments
    - Sensory Impairment & Community Access Team activities

- Increased the number of social care discharge co-ordinators with the aim of providing better co-ordinated discharge from hospital and ensure a safe return to home.

- Croydon's Joint Dementia Strategy 2013-16 was launched at the end of 2012. The strategy highlights a growing emphasis on prevention, early intervention and staying healthy in old age as being crucial to managing demand and improving quality of life for people with dementia and their carers within the community.

- Two reablement flats at the council's Southsea Court special sheltered housing scheme have been refurbished in order to offer a further range and choice of reablement facilities for service users.

- Age UK and Red Cross have been working together to provide reablement focussed services for people being discharged from hospital whose requirements do not fall within criteria that attract help from the council but for whom support can still reduce the possibility of further hospital admissions.

- Reduction of admissions to hospital and increased health and wellbeing of patients from increasing community pharmacy capacity to enable better management of drugs for people living at home and in residential and nursing homes.

- Use of a social care triage model (assigning an order of urgency) based in A&E to ensure patients can access appropriate help and support and to ensure an early discharge plan is put in place if they are admitted. The aim of this work is to reduce unnecessary admissions for acute care from A&E by enabling people to return home with short term support following focused treatment.

Permanent admissions of younger adults (aged 18 to 64) to residential and nursing care homes (per 100,000 population)**:** Croydon 6 (London 10.6 / England 15)	**Permanent admissions of older people (aged 65 and over) to residential and nursing care homes** (per 100,000 population)**:** Croydon 212 (London 478 / England 697)
Delayed transfers of care from hospital which are attributable to adult social care (per 100,000 population): Croydon 1.1 (London 2.7 / England 3.3)	**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): Croydon 85.1% (London 85.3% / England 81.4%)

Outcome 3 - deliver integrated, safe, high quality services

What this means:

- A proportionate, timely, professional and ethical response to any adult at risk
- Everyone has clear information about what abuse is, how to recognise the signs and what they can do to help
- All adults at risk maintain choice and control, quality of life and dignity and respect

Our progress in 2012/13

- Despite an unexpected drop in the numbers of safeguarding referrals in 2011/12, during 2012/13 there has been a rise in referrals alongside most other neighbouring authorities. This year has seen the development of a range of practice initiatives including supporting people who are at risk of neglecting themselves and action planning resulting from the Winterbourne care home abuse scandal to ensure Croydon's learning disabled residents are protected from such harm.

Key activities during 2012/2013

- **Adult safeguarding** - the Croydon adult safeguarding board has continued to strengthen its partnership representation to ensure consistent and shared standards and objectives around prevention and management of harm and the empowerment of people who are at risk.
- The council's social work and safeguarding teams responded to the increased volume of safeguarding referrals, taking the lead in conducting investigations and coordinating protection plans in conjunction with service users, their families and other agencies.
- During the year the council commissioned an external audit of the quality of safeguarding casework, with the auditor concluding that he was confident that Croydon residents were being safeguarded.
    - In addition, the council's Professional Standards unit carried out regular independent audits of the work of the safeguarding teams, with any learning points being taken forward to further improve practice. The quality of work was judged to be good in most of the audited cases.
- Development of the Croydon Care Forums, which are regularly attended by over 100 service providers offering:
    - opportunities to benefit from joint learning, partnership working and best practice.
    - presentations, including from the London Fire Brigade and London Ambulance Service
    - Forum dedicated to end of life care in September 2012
- Service user involvement with safeguarding work included consultations to identify priorities with service user forums such as, Hear Us, Croydon Older People Network and the Better Understanding Group.
- The Public Awareness and Information Dissemination (PAID) sub group produced a range of posters and leaflets aimed at getting clear messages across to the general public, and worked with the Croydon BME Forum on overcoming barriers to involvement with groups who are seldom heard
- Learning and development sub group continued to deliver training, workshops and briefings to help ensure staff are trained to recognise and report abuse

- **Dignity in Care -** the dignity in care campaign was launched in 2006, following a review of the implementation of the national service framework for older people, to raise awareness of the everyday experience of people receiving care services, of the right to be treated with dignity and respect at all times and instil zero tolerance of abuse. The campaign aims to improve the culture and quality of care services provided in hospitals, care homes and by home care services

- The councils Care Support Team (CST) raises awareness of, and standards in, Dignity in Care by working closely and collaboratively with other professionals in the council and other statutory, voluntary, and private agencies. The Dignity Agenda is promoted by all the teams in DASHH as an integral part of their approach of assessment, interventions, care planning and reviews.

- Dignity in Care activities and events in 2012/13 have included:
  - Age UK event in June 2012 focused on Dignity in Care as a key theme
  - Dignity Champions forum meeting sharing ideas and best practice in December 2012
  - Forum event to mark national Dignity in Care Day, with over 130 dignity champions attending representing over 90 agencies working in Croydon – February 2013
  - CST continued to deliver a programme of training to providers of care services .

- **Self-neglect, dignity and choice -** self neglect involves any failure by an adult to take care of him or herself, which causes or is reasonably likely to cause within a short period of time, serious physical, mental or emotional harm, or substantial loss of assets.

- Self neglect should not lead to judgemental approaches to another person's standards of cleanliness or tidiness. All people will have differing values and comfort levels, in those respects self neglect concerns a person whose ability to manage their surroundings, their personal care, their finances and basic daily living skills is so compromised that this is directly threatening their health and safety or the health and safety of others around them.

- In December 2012 a protocol was put in place 'Procedure and practice guidance for social services, partner agencies, voluntary and community groups – self neglect, dignity and choice'. It sets out guidance for managing cases where people who are self-neglecting may receive input from either the assessment and case management teams or may be referred in some cases to the social work and safeguarding teams.

What did respondents to our local survey tell us?

- 89% felt 'extremely, very or quite satisfied' with care and support services
- 92% said they felt 'as safe as they want' or 'adequately safe' both inside and outside of the house
- 60% said that care and support services help in feeling safe

Proportion of people who use services who feel safe:
Croydon 58%
(London 61% / England 65%)

Overall satisfaction of people who use services with their care and support:
Croydon 54%
(London 59% / England 64%)

Social care-related quality of life (*derived from responses to several Carers Survey questions)*:
Croydon 18 *(confirming figures)*
(London 18 / England 19)

Proportion of people who use services who say that those services have made them feel safe and secure:
Croydon 60%
(London 74% / England 78%)

Outcome 4 – support increased resilience and independent living

What this means:

- Helping people to re-establish their ability to manage their own lives, recognising their own strengths and resilience capabilities.
- Ensuring individuals, families and carers are well informed and engaged about support and independence options available.
- Support people to live independently the community, improve social inclusion and make the best use of their own and other resources to live as healthy and active citizens.

Our progress in 2012/13

- The Partnership for Older People (POP) bus has continued to travel around the borough offering information, support and advice from a range of specialist advisors for people over 50 including advice on advice on health, staying safe and secure, benefits and housing.
- In December 2012 an advocacy review was conducted, setting out current arrangements that had been put in place by the council and partner agencies and identifying any gaps in provision. The review made a number of recommendations including advice and guidance for when services are commissioned and that social workers and other staff should ensure that service users are supported and encouraged to access advocacy services and that they are open to all with an identified need.
- Easy access to equipment from local suppliers and Croydon Care Solutions (the councils local authority trading company) using 'prescriptions' from GPs. This service enables people at home to manage health conditions, mobility and other related problems by the speedy provision of simple aids, and potentially avoid hospital admission (since March 2012).
- Expanded the use of telehealth and telecare technology, enabling people to improve their health and wellbeing by taking a greater responsibility in monitoring their own health conditions. This work included the use of telehealth in community nursing services, piloting its use in residential care homes and developing a triage service within the community matron service.

Case study

Ms M is 80 years old and living at home when she began to experience episodes of confusion which led to incidents such as wandering outside of her home and calling the police when she felt frightened whilst at home on her own. These incidents led to a couple of stays in hospital and then a short term emergency residential placement. A mental capacity test was completed, Ms M was able to weigh up the risks, and made the decision that she wanted to return to living in her own home and felt that a telecare package (technology to help people live independently, such as the measures described below) would be helpful.

A number of measures were put in place to support Ms M with living at home including, a temperature sensor in the kitchen (to detect any possible high levels of heat such as a burnt pan), a wandering person alarm at the front door which provided reminders not to go out and can send an alarm to Careline and 'just checking' service which monitors movement and checks for any wandering incidents. Ms M also attends a lunch club once a week and has support from a local voluntary group. These measures were provided alongside two visits per day to support meal preparation, personal care and taking of medication, and meals on wheels. This care package has enabled Ms M to continue living safely and independently in her own home.

- In 2012/13 325 people were assisted with major aids and adaptions to their homes to support independent living and 99% of items of equipment and adaptations were delivered within 7 working days.

- The Heather Way short breaks care home was refurbished and re-opened in April 2013 offering new shower, bathing, personal care facilities and new furnishings and redecoration. This respite centre for adults with learning disabilities gives carers and families the chance to take short breaks from their normal caring routines, and ensures carers get some much needed time off knowing their loved ones are getting the care and support they need.

- Work commenced with a number of housing providers to refurbish and develop new supported housing, increasing the number of people supported to live in their own homes. This included the development of new supported housing within the councils own stock, refurbishment of an extra care sheltered scheme and a new supported housing scheme for people with physical disabilities and learning disabilities.

- The Learning Disabilities Partnership Board and Croydon People First Group (run by and for people with learning disabilities) explored ways to involve people with learning disabilities in decision making in Croydon and agreed to set up a planning group and hold 4 forum meetings a year with representations from different groups.

- The Croydon People First Group held workshops and produced a DVD and easy read booklet as part of the 'Lets Improve Your Health' project' aimed at increasing peoples understanding about health conditions they might be at risk of, and providing tips about healthy living. A 'Peer Support Group' was also launched for people who live independently to meet on a weekly basis and learn new skills.

What did respondents to our local survey tell us?

- 74% of those who had looked for information or advice in the past year said it was 'very' or 'fairly' easy to find
- 62% said they are able to spend their time as they want (or enough of their time) doing things they value or enjoy
- 74% said they had 'as much as I want' or 'adequate' social contact with the people they like

Proportion of people who use services and carers who find it easy to find information about services:
Croydon 67% (London 68% / England 71%)

Proportion of adults with learning disabilities who live in their own home or with their family:
Croydon 64%
(London 68% / England 74%)

Proportion of adults in contact with secondary mental health services who live independently, with or without support:
Croydon 78%
(London 80% / England 59%)

Proportion of adults with learning disabilities in paid employment:
Croydon 5%
(London 9.1% / England 7%)

Proportion of adults in contact with secondary mental health services in paid employment:
Croydon 7%
(London 6% / England 8%)

Priorities and challenges for the future

The financial challenge for local government remains extremely challenging and pressures on both the council and residents will continue for some years to come. Managing increasing demand for adult social care services will continue to be a key challenge in the future as the need for adult social care services is expected to increase significantly across all service user groups.

The on-going development of prevention, early intervention, crisis resolution, recovery and reablement initiatives which can prevent or defer care needs arising, or becoming permanent will be a crucial part of meeting the needs of local people in the future.

Public Health services transferred to the council in 2013 bringing a range of new statutory functions including sexual health services, NHS Health Checks, healthy weight services and a responsibility for protecting the health of the local population.

The council will work in partnership with key strategic partners, particularly the third sector and the new Clinical Commissioning Group for Croydon, to develop the local market of providers of services to support personalisation. This will include work with 'universal' services (services for everyone) to ensure that all public services are accessible and integrated around the needs of the individual.

The Council and Croydon Clinical Commissioning Group (CCG) are committed to establishing a fully integrated approach to the commissioning of health and social care services during 2013 by establishing an integrated, co-located commissioning unit to achieve improvements and to deliver savings across health and social care. Our commissioning approach is to ensure the council makes best use of its resources.

Key actions and activities for 2013/14

- We will continue work with the CCG and Croydon Health Services (CHS) to develop multi-disciplinary health and social care teams to support older people, and people with long term conditions, more effectively in their own homes thus reducing unnecessary hospital admissions.

- The council will commission a new Information, Advice, Casework, Advocacy and Support service which will form the Information and Advice Network, providing a single co-ordinated and collaborative approach to service delivery. The service will establish a single access route to seamless information, advice, casework, advocacy and support services and work closely will work closely with other care and support services and statutory services.

- Public Health Croydon will focus on promoting and protecting health and wellbeing, preventing ill health, reducing inequalities, and increasing healthy life expectancy. The team will do this by working in strategic partnerships, both within and beyond the council, that address the background causes or determinants of ill health, and support local people to make healthier choices in their daily lives.

- The 'Heart Town' campaign will be launched which is a five year programme to support people to take responsibility for their health and wellbeing and to improve people's measurable outcomes for cardiovascular health with a summer activities programme for

families including ‘Healthy Living Hub on Tour’ and ‘Summer’s Alive’ events, awareness raising through media coverage and signage and ‘Know Your Numbers Week’ blood pressure awareness in Autumn 2013.

- Framework agreements (contracts for approved providers) will be developed for commissioning care, support and health related services to provide a more integrated approach, better quality services and the development of an outcome based approach.

- A new supported housing scheme will be developed with 24 hour staffing for people recovering from mental ill health which will provide an alternative to residential care to support people in returning to an ordinary life following a crisis.

- Development of a mental health strategy with the mental health partnership group acting as the strategy steering group to oversee delivery.

- A ‘Falls & Bones’ service will be introduced to work with community resource centres and provide a range of inputs for people who have experienced falls but would not yet be eligible for the hospital based falls services. The service will aim to work with people at risk to prevent further falls which could lead to an unplanned hospital admission and potentially high cost post discharge package of care.

Getting involved

There are many ways you can get involved, have your say or work with us to develop and improve adult social care services.

'Making it Real' – assessing progress for personalisation and community based support in adult social care and support services

The 'Making it Real' assessment framework has already been used by the council to carry out a series of consultation engagements with adult social care service users and carers. More details about the outcomes so far can be found on page 8of this report. The council will build on this work, continuing to work with service users and carers to identify priorities and develop and deliver actions aimed at improving services.

Contact: Strategy & Planning Manager (adult services, health & housing)
Tel: 020 8726 6000 Ext: 61623

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**

The Inclusive Forum

The Inclusive Forum 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**

Croydon Adult Social Services 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**

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

If you have any comments on Croydon's Local Account please email your message to: localaccount@croydon.gov.uk