REPORT TO:	**Adult Social Services Review Panel 4 February 2014**
AGENDA ITEM:	**6**
SUBJECT:	**Developments in Older People's Services**
LEAD OFFICER:	**Hannah Miller, Executive Director of Adult Services, Health & Housing**
CABINET MEMBER:	**Councillor Margaret Mead, Cabinet Member for Adult Services and Health**
WARDS:	**ALL**

CORPORATE PRIORITY/POLICY CONTEXT:

Current and planned developments in services for older people are informed by Croydon's Older People's Strategy (2010-2013) and Croydon's Dementia Strategy (2013-2016)

The health and social care integration agenda, promotion of independence, and transformation of social care services are key components of Croydon's corporate priority *A Caring City*.

FINANCIAL IMPACT

None for the purposes of this report

FORWARD PLAN KEY DECISION REFERENCE NO: N/A

1. RECOMMENDATIONS

1.1 It is recommended that the report be noted and that the Panel take account of ongoing work in relation to developments in services for older people.

2. EXECUTIVE SUMMARY

2.1 The purpose of this report is to update the Panel on current and planned service developments in relation to older people.

3. DEVELOPMENTS IN SERVICES FOR OLDER PEOPLE

3.1 Background

3.1.1 Croydon's last Older People's Strategy (2010-2013) set out our vision to enable older people to enjoy an ordinary, independent life with the minimum appropriate support when it is needed. We said we wanted to improve their quality of life, ensure older people have choice and control over when they need support, and to be treated with dignity and respect. We said we wanted people to benefit from better health, housing and social care services and for them to feel safe and secure and we said we were determined to respect and celebrate the tremendous contribution of older people to Croydon's economy, community, civic and family life.

3.1.2 Croydon's Joint Strategic Needs Assessments have had a lot to offer us in terms of planning for the future needs of older people. People in Croydon are healthier than they have ever been. Over the last 10 years deaths from all causes have fallen in both women and men, with deaths from circulatory diseases falling during this period and hospital admissions and deaths from stroke below the national average. But Croydon is not a homogenous community. Health inequalities range across Croydon communities and the organisations set up to deliver services are not yet adapted to serve a population that is living longer with more complex comorbidities and wants bespoke services in communities closer to home, away from hospitals and institutions. This is a huge challenge and we have recognised we need to address this, but the financial climate means new solutions must also cost less.

3.1.3 Croydon's Dementia Strategy (2013-2016) added further information about some of the challenges demographic changes brings to services like the Council and the NHS. Croydon currently has 3300 people with a dementia diagnosis which will rise to 4500 by 2025, with those aged 65+ with dementia increasing by 21% by 2021. But again this overall picture masks a nuanced position, with Croydon's growing minority ethnic population having a propensity for dementia that will increase 20 times higher than in the white population, providing a challenge to dwindling resources, where the cost of looking after people with organic disorders like dementia is already high (estimated at around £83million to all agencies). The cost to carers is, of course, a largely hidden cost and their needs must not be forgotten.

3.1.4 The Dementia Strategy gave special emphasis to 4 strategic areas:

1. Good-quality early diagnosis and intervention for all.
2. Improved quality of care in general hospitals.

3. Living well with dementia in care homes.
4. Reduced use of antipsychotic medication.

3.1.5 For older people including those with dementia, an unnecessary hospital admission or a delayed transfer of care and/or discharge, which lead to extended periods of time in hospital, should be avoided, although we need to guard against inappropriately early discharges and poorly planned or executed discharges.

3.1.6 Carers want to be supported in their caring role, and to be well informed about the options available if in crisis. Of importance is having access to advice, information and support out of hours. Croydon carers play an important role and are crucial to informing and supporting services in the community.

3.1.7 So a growing emphasis on prevention, early intervention and staying healthy in old age is crucial to managing demand and improving quality of life for older people and particularly people with dementia and their carers within the community. Initiatives like 'Dementia friendly communities' have at their heart a solution to reduce isolation, create awareness and move Croydon to a place that can celebrate the richness and diversity of its population.

3.1.8 The new Care Bill supports this approach. When enacted, local authorities will take on new functions to make sure that people who live in their areas receive services that prevent their care needs from becoming more serious, can get the information they need to make good decisions about care and support and have a good range of providers to choose from.

3.1.9 The Bill will make clear that local authorities must arrange services that help prevent or delay people deteriorating such that they would need on-going care and support, taking into account what services, facilities and resources are already available in the area (for example local voluntary and community groups), and how these might help local people, identifying people in the local area who might have care and support needs that are not being met and identifying carers in the area who might have support needs that are not being met.

3.1.10 In taking on this role, local authorities will need to provide comprehensive information and advice about care and support services in their local area.

3.2 Commissioning Priorities

3.2.1 In relation to the above, commissioners have therefore worked together with Personal Support Services and providers in the recent past to ensure that those elements key to service delivery in those areas have been sustained and improved. Commissioners have concentrated on:

- Improving quality and safety in domiciliary, residential and nursing care, including training around medication administration and pressure sore care, through the Care Support Team and the Senior Pharmacist, by tighter contract management and reinforced through our extensive 'Dignity Champions' network

- Re-commissioning community meals (meals on wheels) and looking at any new models of delivery that can add social value in the community sector

- Re-commissioning preventative services, including:
  - An information, advice and advocacy network
  - Business Support to the sector
  - A range of day opportunities such as luncheon clubs, transport, wellbeing clubs, befriending schemes and so on

- A programme of physical improvements to special sheltered schemes such as 'wet-rooms' and hoists to ensure people can stay independent for longer

- A review of Extra-care housing with a view to significantly increasing the number of extra-care housing units we have to cater for those that need 24 hour cover, in a way which does not require moving into residential or nursing care

- Developing a framework for the provision of home-based care and support:
  - Guaranteeing better quality care speedily, at value for money
  - Moving our approach to specialist, home-based, dignified end-of-life care from pilot to mainstream
  - Improving our effectiveness in short term care from hospital to home
  - Improving our effectiveness in outcome-based, time-limited home care at keeping people at home, safer for longer, with greater confidence

- Improving the variety and capacity in the market and a means for self-funders and those with personal budgets to identify and 'shop' for their care and support needs without recourse to the Council if it is safe to do so

- Improving the offer of our Direct Payments and individual support planning service and planning for the introduction of personal health budgets

- Working with all providers, both those offering specialist and costly residential care and those providing high volumes of care towards a better commercial offer in order to make our budgets go further

3.3 Integrated Commissioning for Outcomes

3.3.1 A theme of our commissioning has been to focus on outcomes and this will continue to be a more important strategy as we continually look, along with NHS partners, for new solutions and new approaches to cope with changing demand. Commissioning must place greater emphasis on the outcomes for service users and communities, on improved provider quality and diversity in order to ensure that the local market of provision is able to respond to diverse and changing needs over time. And services on offer should be accessible to all Croydon residents who need them.

3.3.2 A critical plank in commissioning developments has been to work with Croydon Clinical Commissioning Group (CCG) towards the development of an Integrated Commissioning Unit (ICU). This important development, which has been in planning stages for over 12 months, is going live in shadow form in February and brings with it opportunities make significant efficiencies with public funding, reduce duplication, improve effectiveness and ensure that the agreed outcome intentions of the Borough's Health and Wellbeing Board are fully realised through a single team. The inclusion of Public Health commissioning within the integrated team builds on the positive impact that siting public health professionals within the local authority has already had.

3.3.3 The ICU will work with the CCG on its own large-scale plans to roll out 'OBIC' (Outcome-Based Incentivised Commissioning) programme, which, despite the name, is a common sense approach to securing both value for money and better outcomes for patients and service users.

3.3.4 Contracting for outcomes is a big step and a big change from existing contracts which reward for activity, whether it is good for patients and service users or not. The public, patient and service user groups and indeed clinicians want to see services that better reflect public and user values and properly engage those on the ground in service design.

3.4 Transforming Adult Social Care

3.4.1 Independence, Reablement, and Self-Care

3.4.2Personalisation (incorporating a strategic shift towards early intervention, prevention, and reablement) is now the cornerstone of social care services. It means that every person who receives support, whether provided by statutory services or funded by themselves, can now have choice and control over the shape of that support in all care settings. This concept and ideological intent is enshrined in *Think Local, Act Personal* and *Putting People First*.. We are developing an approach that maximises personal responsibility alongside greater choice and control.

3.4.3 Developing Community Capacity and Universality

3.4.4 Increasingly we are recognising the contribution that individuals, families, carers and communities make in providing care and support - both to those who are publicly funded and those who either pay for themselves or rely on family carers.

3.4.5 DASHH services work in partnership with service users to design independence plans that address their FACS eligible need following assessment. The plans focus on the outcome that the client hopes to achieve in terms of meeting their identified need. The plans draw on the concept of social capital, and aim to maximise an individual's potential and independence. Particular emphasis is placed on enabling clients to access universal services within their community.

3.4.6 Personalisation as ‘business as usual’ means that we consistently encourage people to plan for a fulfilling life in accordance with their individual aspirations, and to achieve health and wellbeing from engagement with the wider community in a variety of ways**.**. We are developing links with local partner agencies so that we can enable service users to move on from intensive therapeutic support and access mainstream services. Our desired outcome for service users is an increase in their experience of social inclusion and their sense of themselves as stakeholders in their communities. In all aspects of our work we reinforce the individual’s personal responsibility for creating the life they want for themselves, and we work to enable and support them to achieve this.

3.4.7 Integrated Service Delivery – Health and Social Care

3.4.8 Over the past year, Council officers, local health agencies, and service providers have been working collaboratively to personalise and integrate service delivery across health and adult social care and make vital public funding go further:

- Colleagues in Croydon Clinical Commissioning Group (CCG) have negotiated with Croydon Health Services (CHS) the development of an enhanced community health service to support mainly older people with long term conditions to receive appropriate health care and treatment in their own homes and thus reduce avoidable hospital admissions and support safe and timely discharges. The service also provides additional support to local care homes to reduce the number of avoidable A&E attendances. The new service comprises:

    - **Rapid Response Service (A 24/7 single point of assessment for professionals to access).** The Rapid Response Service is an admission avoidance service available 24 hours a day, 7 days a week. The service provides intensive nursing, therapy, and social care/social work interventions to prevent exacerbations; and in a crisis provides intensive crisis management to high intensity service users

    - **Multi-disciplinary teams (MDT)** based in the six GP clusters/CCG Networks in the Borough. The implementation of the Transforming Adult Community Services project has secured dedicated Community Matrons, Mental Health practitioners and Social Workers aligned to each Network. These professionals will spend a significant proportion of their time working collaboratively to provide advice, support and assistance for people not yet eligible for social care services to enable them to remain independent for longer. With the GP, these professionals will form the core MDT (known as the Network Support Team). Network Support MDT meet once a month to agree and progress integrated care plans for high intensity patients, most of whom will be identified through the:

    - **Risk Stratification Tool** – a predictive modeling algorithm that has now been installed in every GP practice in the Borough. MDTs focus on treating a patient holistically regardless of their condition(s) and take into consideration other areas of possible support such as local community, family and friends, voluntary sector organisations, use of Telecare, and other assistive technology and equipment. The Risk Stratification tool is being used by GP practices to identify any patients whose complex needs may benefit from a co-ordinated approach involving Health and/or Social Care. It identifies patients whose needs are likely to increase in the near future, thus providing the opportunity for Health and Social care partners to agree proactive response and support in advance.

    - **Intermediate Care Bed Service -** The Intermediate Care Bed Service provides support and rehabilitation for people who are considered unsafe to remain in or return to their own homes but who

have the capacity to live at home if provided with suitable support and rehabilitation services. The service will focus on those who are at high risk of:

- Prolonged hospital stay
- Inappropriate admission to acute inpatient care

3.4.8 Transforming Our Workforce

3.4.10 The Department is committed to investing in a robust base of social work talent and we have secured Members' agreement to put in place a programme of recruitment and retention initiatives for social work staff that will enable us to do this. We are using this opportunity to drive down the costs of employing agency staff by making our salary offer for permanent employees comparable with that of other Local Authorities, and our career progression scheme compliant with the new professional development framework introduced by the Health and Care Professions Council (HCPC) in 2013. We are confident that existing staff and new recruits will increasingly see Croydon as an employer of choice in terms of salaries that are commensurate with the responsibilities of their roles and opportunities for career development and enhancement. Encouraging skilled and experienced senior staff to stay with us for longer will mean that we have the right workforce in place in order to meet the challenges that Adult Services face; now, and into the future.

4. CONSULTATION

4.1 None for the purposes of this report

5. COMMENTS OF THE COUNCIL SOLICITOR AND MONITORING OFFICER

5.1 None for the purposes of this report

6. HUMAN RESOURCES IMPACT

6.1 None for the purposes of this report

7. EQUALITIES IMPACT

7.1 This report is concerned with service developments to support people who are protected by the Equalities Act due to the protected characteristic 'Age', and due to the fact that they are vulnerable adults.

7.2 This report is an update on progress against established policies and therefore there are no further comments for the purposes of this report

8. ENVIRONMENTAL IMPACT

8.1 None

10. CRIME AND DISORDER REDUCTION IMPACT

10.1 None

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