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NHS
Croydon Clinical Commissioning Group

CROYDON DEMENTIA STRATEGY

2012 -2015

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How you can comment on this document

This document sets out draft priorities for Croydon's joint health and social care dementia services for clients, carers and their families.

The final agreed priorities will be overseen and managed by the Older Peoples Mental Health Steering Group. We have included a number of questions at the end of the document that we would particularly welcome your feedback on.

The closing date for completion and return of this survey is **Friday 27th July 2012.**

To respond to the consultation you can write to:

Jan Saines
Service Development Manager
11th floor, North East Quadrant
Taberner House
Park Lane
Croydon CR9 2BA

Or you can email jan.saines@croydon.gov.uk

You can also respond to the questions online at:

http://www.surveymonkey.com/s/Dementia-strategy

Executive Summary

This strategy is based primarily on the National Dementia Strategy (2009). It has had formal recognition from the previous government and a further endorsement from the current coalition administration that identified 4 key areas that needed particular attention:

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.

Both governments accepted the core principles set out in the national strategy in particular using the document as a call for action. In addition, local consultation and the outcome of the Joint Strategic Needs Assessment (2012) has led to developing key values and aims for the future as follows:

- Greater user involvement in commissioning decisions and how services are delivered.

- Joint commissioning which utilises resources and provides effective integrated and personalised services including optimal use of the voluntary sector.

- Help and support to remain at home for as long as possible through early intervention, timely information and services which avoid hospital admission and support early discharge.

- If a hospital admission is inevitable, delayed transfers of care and/or discharge, which lead to extended periods of time in hospital, should be avoided.

- People would like coordinated and accessible information and advice about services. If diagnosed with dementia, people want to understand fully how they can manage their condition. Such services should be co-ordinated through one access point to avoid repetition.

- Carer support. 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 delivery the dementia strategy in addition to links with the Carers Strategy.

- Improved training for health, residential and home care staff to support all levels of need and ongoing training as required.

- Focus on outcomes. Commissioning should place greater emphasis on the outcomes for service users and communities. Commissioned services should include clear quality indicators and outcome measures which are monitored frequently to identify any issues.

- Increased 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. Services on offer should be accessible to all Croydon residents diagnosed with dementia.

Undeniably, the numbers of people diagnosed with dementia or showing signs and symptoms of a dementia/Alzheimers related disease is going to increase. In Croydon this rise in the prevalence of dementia roughly coincides with the increasing number of older people in the Borough. However, dementia is not only a disease of the elderly. There are signs of people as young as 45 who have been diagnosed with dementia.

There are an estimated 3,113 people living with dementia in Croydon; this is projected to rise by 30% over the next 15 years, reaching 4,098 by 2025.

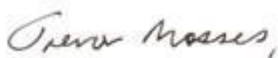
Currently there is no 'cure' for dementia though drug companies along with the NHS have sought to bring treatment that will slow down the progression of some types of the disease but still require social care support throughout.

No one service or organisation will be able to deliver the services, information, advice, information and support that is going to be necessary to ensure the increasing number of people with dementia can live as good a life as possible.

Therefore, this strategy developed on an integrated cross discipline approach, will need to similarly deliver the key services and support that are being used and will be needed in the next generation. This integrated approach will therefore seek to:

- Enable good early diagnosis;
- Support for those diagnosed and their carers / close relatives;
- Provide a range of preventative services and access to health and social care services based on need;
- Quality care whether provided in the community or in care homes;
- Co-ordinate effective end of life care that enables real choice;
- Plan investment, commission services, de-commission services and work to keep the individual at the centre of the strategy.

John Haseler
Senior Commissioning Manager for Mental Health



Trevor Mosses
Head of Commissioning Older People and Long Term Conditions

Introduction

Croydon's Dementia Strategy covers a 3 year period from 2012 to 2015. The purpose of this joint strategy is to bring together health, social care, independent providers and the voluntary sector in our shared vision to provide a range of services that will support people with dementia and their carers. The strategy will describe:

- The services and support available in Croydon for people of any age with various types of dementia and for their family carers
- Identified development areas
- How we will, in line with the National Dementia Strategy (NDS), improve services and support for people with dementia and their family carers whilst addressing the dual challenges of increasing demand for dementia services and resource constraints.

Background

This strategy sets out how health and social care partners will deliver against the NDS and how the 17 principles will be incorporated to deliver local priorities. This strategy has been developed together with Croydon's Dementia Joint Strategic Needs Assessment (JSNA) and will inform future commissioning of dementia services in Croydon. As this is a working document it will involve monitoring existing contracts and services for quality and effectiveness whilst ensuring that they produce the outcomes that people with dementia and their carers want as well as identifying areas for service development and improvement.

If you would like to read JSNA with regards to the dementia "deep dive" this document is now available on the Croydon Observatory:

http://www.croydonobservatory.org/jsna/1209677/1209742

Key themes and principles

Key themes and principles are based on current national guidance, policy and the views of key stakeholders including service users and providers. Intelligence was also identified from the consultation document on Croydon's Draft Joint Strategy for Mental Health and Social Care in Older Adults (2007-10), the Mental Health of Older Adults (MHOA) planning group and from Croydon Older People's Strategy 2010-13. They also represent the views expressed by a wide range of stakeholders during Croydon's Dementia JSNA Consultative Forum held on the 7th of March 2012. These values guide current service delivery and should underpin plans for future service development.

National Context

Living Well With Dementia: A National Dementia Strategy (NDS) 2009 defines dementia as:

"A syndrome which may be caused by a number of illnesses in which there is progressive decline in multiple areas of function, including decline in memory, reasoning, communication skills and the ability to carry out daily activities. Alongside this decline, individuals may develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering, which cause problems in themselves, which complicate care and which can occur at any stage of the illness".

The NDS estimated that the prevalence of dementia across the UK was over 700,000 although only one third of people with dementia receive any form of formal diagnosis at any point in their care or during the progression of their condition.

A revised, outcomes focused implementation plan called "Quality Outcomes for People with Dementia: building on the work of the National Dementia Strategy" was published by the Department of Health in September 2010. Key priority objectives can be highlighted under four themes:

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.

The Department of Health has confirmed local health and social care communities will be held to account, and expected to publish plans detailing how they will work together to deliver high quality care for people living with dementia. Please refer to Appendix A for key guidance and policy documents contributing to this strategy, noting the overarching recommendations that dementia be recognised as a priority area for service development, emphasising the need for improved public awareness, carer support, professional training and early diagnosis / intervention and support for people with dementia.

The Local Context

Croydon is a thriving and growing outer London Borough. It is the second largest London Borough According to Croydon's 2012 Dementia JSNA. Croydon has an estimated resident population of 345,600 (2010 mid year estimates) with 13% (45,200) of the population aged 65 years or older. Between 2011 and 2021, the number of people aged 65 years or older is expected to increase by 14% mostly due to an increase in BAME (Black, Asian and Minority Ethnic) groups which are estimated to increase by more than half the current numbers.

There are an estimated 3,113 people living with dementia in Croydon; this is projected to rise by 30% over the next 15 years, reaching 4,098 by 2025. Approximately two thirds (62.1%) are female. In 2011, 60% of people on Croydon CMHTs caseload had a diagnosis of Alzheimer's disease whilst 17% had a diagnosis of vascular dementia.

Croydon's 2012 Dementia JSNA reveals that Croydon has higher dementia needs compared to other London Boroughs, and that this need will rise in years to come. For example, Croydon has:

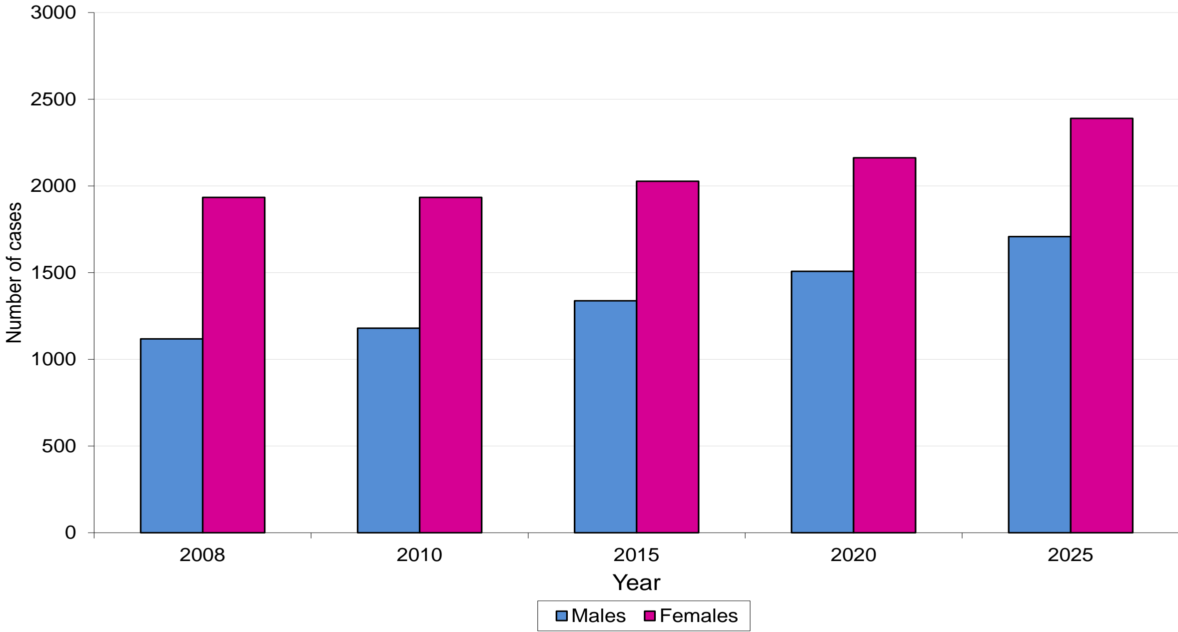
- 4th highest number of people aged 65 years or older with late onset dementia
- 5th highest projected number of people aged 65 years or older in care homes by 2030
- 5th highest projected number of people aged 65 years or older providing unpaid care by 2030
- 5th highest projected number of people from BME groups with dementia by 2020
- 7th highest projected number of people aged 65 years or older living alone by 2020

These demographic changes mean that conditions related to ageing, including dementia are likely to account for a larger proportion of the health burden and demand will increase for services such as support for people with memory loss. There will also be greater pressure on social care services to provide residential care.

Croydon's Older People's Strategy 2010-13 recognises the demographic changes occurring in Croydon and therefore focuses on supporting older people to live the best life that they can by enabling them to make personal choices about the health and social services they receive and how this is provided. The strategy indicates plans to utilise resources from a wider range of stakeholders and partners in order to provide choice and improve service quality. Its key priorities are to improve health and quality of life, improve independence, choice and control, to improve opportunities to make positive contributions, to ensure dignity, equality, respect and freedom from discrimination and to promote economic well being.

Dementia amongst black and minority ethnic communities in the UK is under researched; there is likely to be much misdiagnosis at present and standardised assessment tools may not be culturally specific enough to provide accurate diagnosis. The proportion of older people from the BME communities in the northern wards of Croydon is projected to grow faster than that in the southern and central wards. Although acquiring a second language is thought to delay the onset of dementia, the loss of a second language that is used on a daily basis due to dementia is an added consideration for an ageing minority population in Croydon.

Figure 1 Estimated future numbers of dementia cases, by gender, Croydon 2008-2025



Source: Mental Health Observatories; mental health brief no: 3, May 2008

Applying national data to Croydon's resident population aged 30-64 (162,875 mid 2005, Office for National Statistics) would give an estimate of 110 Croydon residents with early onset dementia.

There were 1,416 people on Croydon's Primary Care Dementia Quality and Outcomes Framework (QOF) registers at the end of 2010/11. This implies that 1867 (57% of) Croydon residents with dementia have not received a formal diagnosis (Dementia JSNA 2012).

In 2010-11, 155 people aged 65 or older recorded as having dementia received a social care package from Croydon Council (Croydon Dementia JSNA 2012).

There are no current estimates of the number of people with learning disabilities in Croydon who have Dementia.

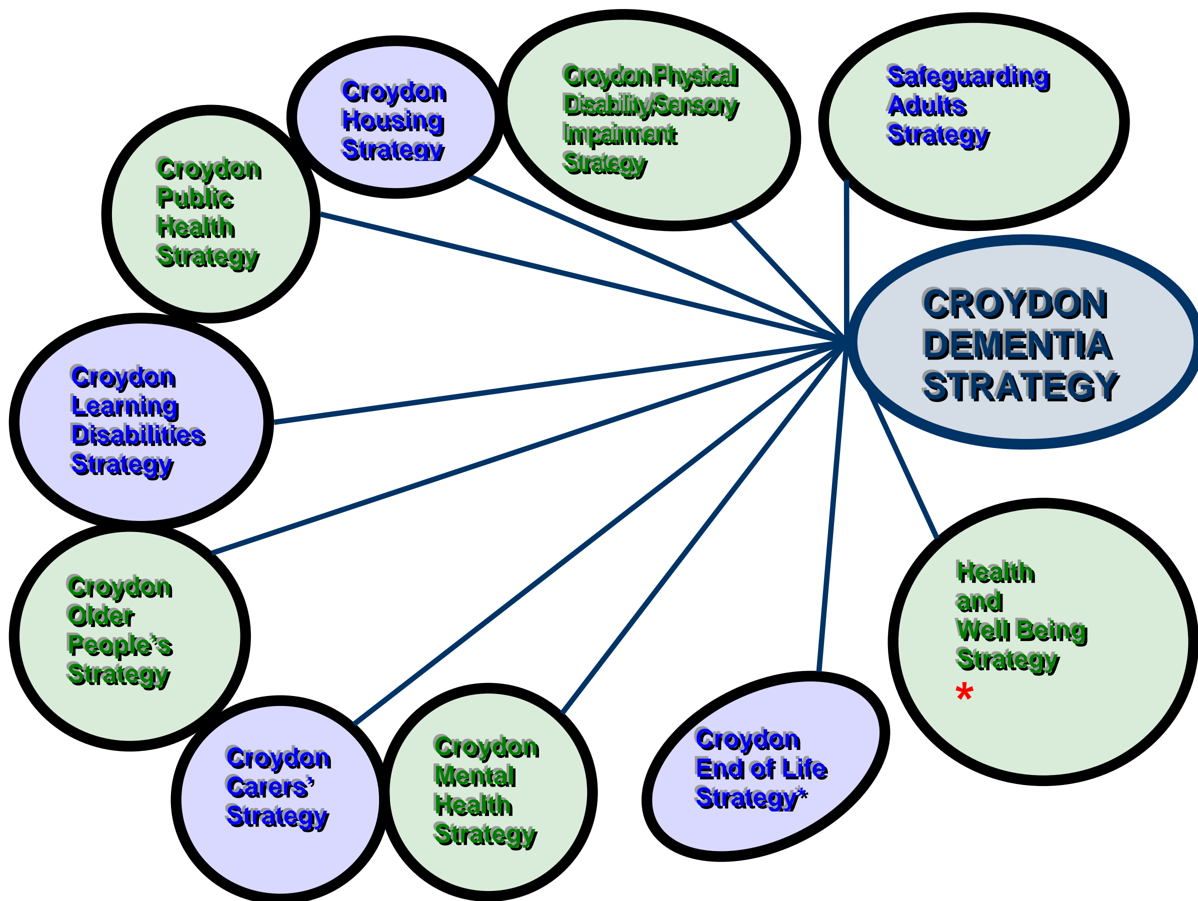
As of 31st March 2012, there were 57 people in Croydon receiving NHS continuing healthcare funding for a primary mental health reason, with another 32 people receiving NHS continuing healthcare funding for joint primary mental and physical health reasons bringing the total number of people receiving NHS continuing healthcare funding from NHS Croydon to 89. The majority of these people have a diagnosis of dementia.

5.9% of adults, older people and carers in Croydon received social care through a direct payment (compared with 13.4% in London and 13.0% in England). 12.7% of carers were supported with services, advice and information in Croydon, which is significantly below the London average (24.6%) and the England average (26.4%). Only 13% of carers reported that they received the advice and information they needed – half as many as nationally.

Croydon's Dementia Strategy has been written with a golden thread incorporating all other strategies including: Carers Strategy, Housing Strategy, Learning Disability Strategy, Older People's Strategy and the Mental Health Strategy to ensure effective joint working amongst commissioners / partners / stakeholders and clients / carers across all these areas. Of equal importance is transformation plan outlining how, as a council, we can manage increasing demand, identify innovative ways of commissioning services and continue to drive up quality.

Living well with dementia is dependent on a range of services commissioned from and co-ordinated across all relevant agencies encompassing the whole dementia care pathway. Croydon is aware of the challenges and the need to bench mark and map current performance to provide value for money alongside responsible services that are accessible to all who need them. This strategy will help drive up quality and improve dementia care services through robust intelligence gathering and high levels of engagement, consultation and monitoring.

CROYDON'S JOINED UP STRATEGIC APPROACH

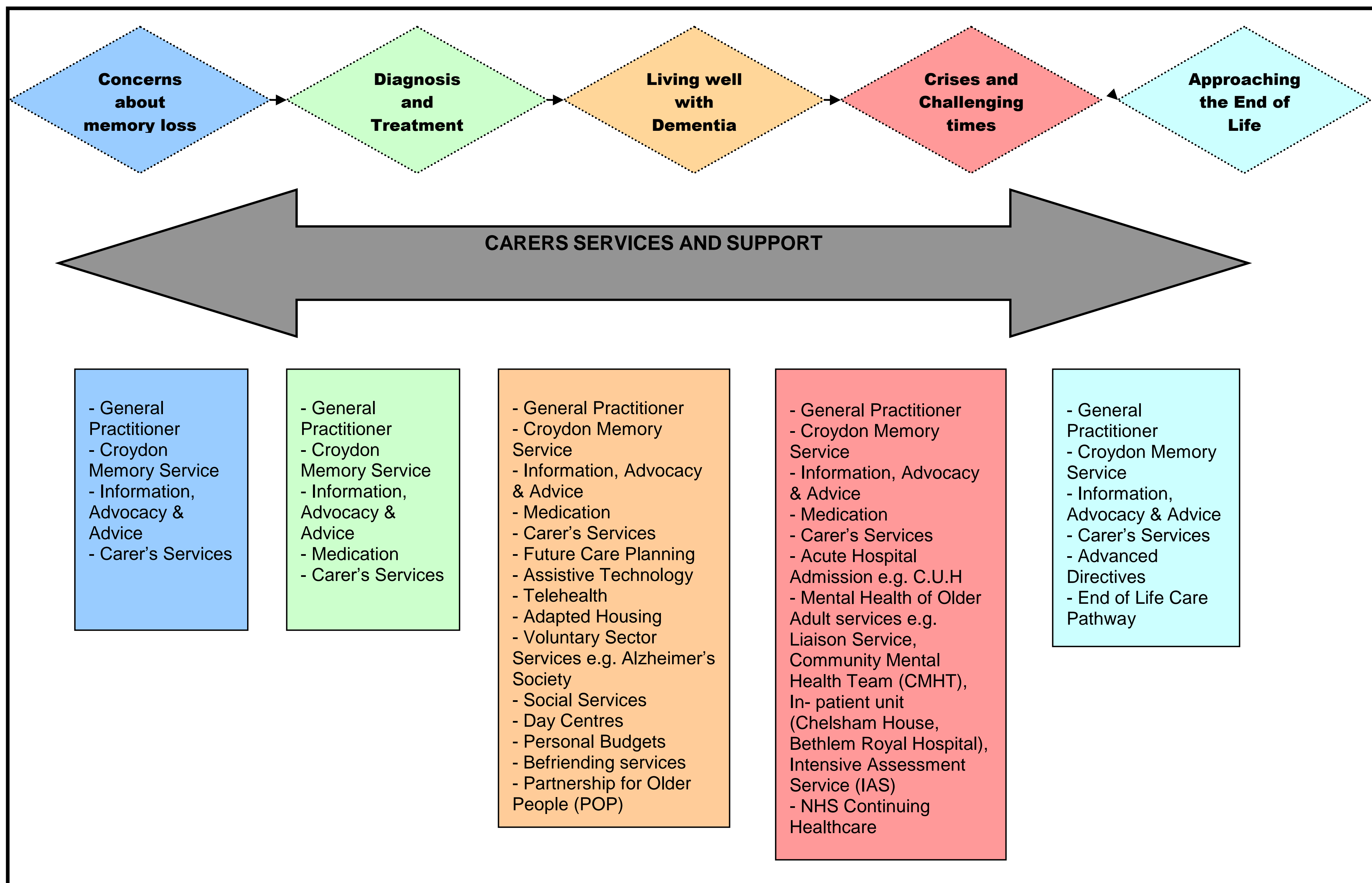


* In development

According to the 2001 census, there are 30,000 people in Croydon providing regular unpaid care for sick, frail or disabled family members or friends. POPPI (Projecting Older People Information) estimates suggest that in 2011, there were 5,000 carers aged 65 or older. A national survey of carers in contact with adult social services found that approximately one quarter of carers were looking after someone with dementia (Ref. Personal Social Services Survey of Adult Carers in England - 2009-10, Health and Social Care Information Centre, 2010).

Croydon's Integrated Carers' Strategy of 2011-2016 is an update of the previous strategy of 2008-11. It is aligned with the current government's 2011 refresh of the National Carers Strategy: *'Recognised, valued and supported: next steps for the Carers Strategy*'. The draft strategy recognises the valuable input of carers and aims to support carers by providing information, support, advocacy and respite breaks as appropriate.

Draft Croydon Dementia Strategy: Croydon Dementia Services Flowchart



Services available in Croydon for People with Dementia

This is a summary of services available to people in Croydon including access and how they link in to each other. Most dementia services are commissioned by Croydon Local Authority and NHS South West London, Croydon Borough Team. Other services are provided by voluntary organisations such as the Alzheimer's Society. Key Providers include:

- The South London and Maudsley Foundation NHS Trust (SLaM), which provides:

  - A One-stop Memory Service based at Heavers Resource Centre
  - Three Community Mental Health Trusts (CMHTs) based at Heavers Resource Centre, Queen's Resource Centre and Purley Resource Centre
  - One Mental Health of Older Adults (MHOA) Psychiatric Liaison Service based at Queen's Resource Centre but operating at Croydon University Hospital
  - One Acute In patient unit based at Chelsham House, Bethlem Royal Hospital
  - One Intensive Assessment Service (IAS) based at Greenvale Continuing Care Unit, Streatham.

- Croydon Health Services – Croydon University Hospital (Acute General Hospital)

- Croydon's Joint Learning Disability Team – This is part of Croydon Health Services NHS Trust and provides services to people with learning disabilities who have been diagnosed with dementia

- Croydon Council commissions a range of services for dementia clients and their carers in association with private and voluntary agencies

- Independent Sector organisations provide a range of services depending on level of needs. This includes care support at home, respite, special sheltered accommodation, residential and nursing care. Cost could be via social services, health or a joint funding arrangement. All clients are financial assessed for social care costs and some individuals may fund their own care

- Primary Care / General Practice Quality and Outcomes Framework registers referrals to the Croydon Memory Service.

Please refer to Appendix B for further details about each service.

Local Priorities

The local strategic actions, identified as part of the engagement process and the 17 key objectives of the NDS

NDS Objective/Description	Croydon Response	Service Gap	Action/Timeline	Lead
1. Public information campaign Increase public and professional awareness to enhance early diagnosis and intervention and also decrease stigmatisation, exclusion and discrimination.	Advocacy Services; POP Bus; Alzheimer's Society; Croydon Council/PCT – Dementia Consultative event; Home Support; Croydon Memory Service; Dementia Clinical Lead at CUH.	All information developed for dementia clients is required in a variety of formats including easy read versions.	CRAIN Steering Group to develop quality benchmark and increase awareness. Identify a single referral and access point for people with dementia and their carers. Possibility of one Croydon page for all dementia services.	
2. Memory services Accessible pathway to a local memory service with adequate capacity to deliver rapid and competent specialist assessment and diagnosis, treatment, information, care and support to people and their carers.	Croydon has a well established Memory Service offering diagnosis and follow up.	More non-pharmacological therapies and post Diagnostic Support within Croydon's Memory Service.	New post of Support, Time and Recovery worker to provide post diagnostic support. Revise acute hospital discharge pathway for people with memory problems and explore direct referrals to memory service.	

			Increased diagnosis of protected groups, in particular Asian groups.	
3. Information for people with dementia and carers Providing people with dementia and their carers with good-quality information on the illness and on the services available, both at diagnosis and throughout the course of their care.	Advocacy services; POP Bus; Alzheimer's Society; Croydon Council/PCT – Dementia Consultative event; Home Support; Croydon Memory Service; Dementia Clinical Lead at CUH	Access to information is variable and difficult to identify	Collate current information and identify with key stakeholders how we can make this more accessible for all users and carers.	
4. Continuity of support for people with dementia and carers Dementia adviser to facilitate easy access to appropriate care, support and advice for those diagnosed with dementia and their carers.	POP Bus; Alzheimer's Society; Croydon Council/PCT – Dementia Consultative event; Home Support; Croydon Memory Service; Dementia Clinical Lead at CUH. Contracts with voluntary sector organisations STR worker embedded within Memory Service to support people post diagnosis including help with personal budgets.	Expand provision of befriending services and outreach workers.	Develop robust local dementia intelligence to inform commissioning intentions. Review and optimise SLAs with Voluntary sector organisations to achieve effectiveness and value for money.	

5. **Peer support for people with dementia and carers** The establishment and maintenance of such networks will provide direct local peer support for people with dementia and their carers. It will also enable people with dementia and their carers to take an active role in the development and prioritisation of local services.	Croydon provides peer support for clients with dementia and their carers. Voluntary sector organisations run carers' groups and provide training e.g. the Alzheimer's Society runs Forget Me Not cafés	Currently not as widespread as it should be and needs to ensure people with dementia and carers are not waiting for assessments and support.	Review and optimise SLAs with voluntary sector organisations. Identify if increased capacity is needed to meet need	
6. **Improved community personal support** Provision of an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services which are responsive to the personal needs and preferences of each individual and take account of their broader family circumstances. Accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local	Croydon provides a range of services to dementia clients and their carers which are flexible to individual needs. These include personal budget, day care, prevention, assistive technology and home care services. STR worker at CMS will encourage service users and carers to engage more in service planning e.g. via focus groups.	Improve workforce training systematically. Croydon has few dementia clients with personal budgets. No reablement services currently in place.	Develop available community services for people with dementia or older people with mental illnesses in Croydon. Provide early memory loss/dementia specific advocacy. Identify solutions to increase personal budgets. Scope benefits of reablement beds/home care.	

authority-arranged services.		There is limited information regarding numbers of dementia clients and carers in Croydon .	Identify improvements to IAS to improve data for commissioning purposes. Explore synergy and scope for advancing dementia friendly communities	
7. Implementing Carers' Strategy for people with dementia Ensure that the provisions of the Carers' Strategy are available for carers of people with dementia especially timely carer's assessments and agreed support plans, (tailored to special groups of carers e.g. children) which may include good-quality personalised breaks.	Croydon has a Carers Strategy. Croydon Council commissions the Alzheimer's Society to carry out Carer's Assessments.	Short-term break services for carers are patchy across Croydon, with some areas not having a service. Carers' Strategy includes no specific mention of dementia.	Work with carer's commissioner to incorporate needs of carers of people with dementia within the Carers' Strategy. Improve access to carer support services.	
8. Improved care in general hospitals Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there	There is a Dementia Lead at Croydon University Hospital (CUH). There is a Mental Health of Older Adults Liaison Service at CUH.	Work with CUH to prevent unnecessary admissions, delayed discharges and to improve the care of people with dementia receiving acute care.	Develop integrated acute hospital dementia pathway including discharge protocols to be used at A&E and in patient	

and the commissioning of specialist liaison older people's mental health teams to work in general hospitals.			wards. Implement National Dementia CQUIN with local KPIs based on service user experience and outcomes. Increase focus on audits, staff training, promoting best practice, discharge planning, use of specialist advice and closer working with other agencies.	
9. Improved intermediate care for dementia Intermediate care which is accessible to people with dementia and which meets their needs.	Intensive Assessment Service Croydon Intermediate Care Service (CICS)	No commissioned reablement services for people with dementia. No intermediate care service for people with co morbid dementia and physical illness.	Highlight reablement and intermediate care services as a priority for commissioning and investment required Broaden eligibility criteria and referral sources for IAS and CICS.	

10. Housing including Telecare The needs of people with dementia and their carers should be included in the development of housing options, assistive technology and Telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services.	Croydon has flagship extra care sheltered housing scheme run by Care UK for clients with dementia. This provides specialist support and is a home for life. The Aztec Centre provides Assistive Technology and Telehealth interventions.	Move away from a service model based on inpatient and residential beds to one focussed on enabling treatment and care closer to home using Assistive Technology and Telehealth interventions. Lack of Joint commissioning and service development across health, social care and the private/voluntary sector. Limited intelligence on numbers of clients with dementia benefiting from housing and telecare interventions and successful outcomes	More robust data collection required. Develop Joint commissioning arrangements Decrease waiting list for housing services e.g. adaptations, telecare and assistive technology by increasing service capacity. Consult with key stakeholders on innovative telecare solutions to increase take up. Improve the waiting time for telecare assessments. Scope rationale for social care dementia register.	

11. Improved care home care Improved quality of care for people with dementia in care homes by the development of explicit leadership for dementia within care homes, defining the care pathway there, the commissioning of specialist in-reach services from community mental health teams, and through inspection regimes.	Reducing Anti Psychotic prescribing in care homes/Care homes grand round pilot run by NHS Croydon Pharmacy team Croydon Council is currently reviewed out dated contract and service specifications. Dedicated SVA team. Recruitment of Dignity Champions	Care Support Team – mainly trouble shooting with no systematic training/support mandate. Existing contracts are outdated and not clear on successful outcomes. Confusion in relation to safeguarding and care quality standards. Lack of systematic training in dementia care among care home staff. Currently only those at high end need of mental health services are managed by specialist trained staff.	Review Care Home contracts to incorporate quality standards and outcome based KPIs in line with delivering the Dementia Strategy. Develop systematic training and support around dementia for care home staff. Robust monitoring and data collection to enable support for homes with concerns	
12. Improved End Of Life Care People with dementia and their carers to be involved in planning end of life care which recognises the principles outlined in the Department of Health End of Life Care Strategy. Local work on the End of Life Care Strategy to	A pilot scheme involving nurses from St Christopher's Hospice supporting/training staff in residential and nursing homes to build up their end of life care skills is in development. There's an EOLC strategy group and a GP palliative care Directed	Dementia not a focus of current EOLC provision/palliative care DES.	Expand the focus of the current EOLC service provision/palliative care DES to include dementia. Develop and implement Croydon's	

consider dementia.	Enhanced Service (DES).		End of Life Care Strategy and pathways. Improve EOLC training for care home staff.	
13. Workforce competencies, development and training Ensure all health and social care staff have the necessary skills and training (professional and vocational) to care for people with dementia within various settings.	The SLaM Mental Health of Older Adults and Dementia Clinical Academic Group (CAG) have produced a Care Pathway for Service Users with Cognitive Impairment or Dementia. Care Pathway for memory impairment/delirium in place at CUH. Croydon Council support workers work alongside clients who are under the care of OPMH Team.	Need to plan for increasing demand from higher numbers of dementia service users. Currently no dedicated dementia social care staff commissioned. There is a lack of staff trained to provide prevention, early intervention services and advanced care planning. Poor joined up working across health, social care and voluntary sector to provide person centred care.	Structured and accredited training in dementia care for health and social care provider staff across all settings including primary care and in clients' homes. Workforce development teams across health (commissioners and providers) and social care to jointly develop and fund core training for all relevant staff groups.	
14. Joint Local Commissioning strategy and World Class Commissioning	Croydon Council and NHS Croydon have jointly developed a Joint Dementia Strategy. This should form a baseline for future	Joint commissioning and service provision not fully implemented in Croydon.	Develop a Joint Commissioning Dementia Steering Group.	

Local service mapping and developments to be informed by the World Class Commissioning guidance for dementia.	joint working.			
15: Performance monitoring and evaluation including inspection Inspection regimes for care homes and other services that better assure the quality of dementia care provided.	A number of resources support and monitor dementia clients in care homes including the CQC, Care Home Support Team and volunteers. The Care Home Support Team are a small team providing support to homes and monitoring practice	CQC has a monitoring function with care homes which helps to maintain service quality but this could be developed further. There are significant safeguarding issues as evidenced by the high volume of referrals regarding safeguarding issues received by the Croydon social work team.	Broaden remit of Care Home Support Service. Develop robust contract and service monitoring procedures.	
16. Research Evidence to be available on the existing research base on dementia in the UK and gaps that need to be filled.	CUH is signed up to the National Dementia Audit.	Improve local dementia intelligence and evidence base to compare with nationwide evidence base.	Public Health Dementia JSNA.	
17. Effective national and regional support for implementation of the Strategy Appropriate national and regional	To be led by national developments such as the Dementia Commissioning Pack developed in 2011.	Not applicable	Use relevant aspects of the National Dementia Commissioning Pack in developing local	

support to be available to advise and assist local implementation of the Strategy.	Croydon was a demonstrator site for the Dementia Advisers' Pilot which concluded in June 2011.		services. Implement the National Dementia CQUIN at CUH.	

Dementia Strategy Feedback

Please read the Draft Dementia Strategy and then answer these questions on the proposed strategy

The closing date for comments and feedback is Friday 20th July 2012

1. **Do you think the dementia strategy, as currently written, meets the needs and aspiration of the Croydon Community?**

   ☐ Yes fully

   ☐ Yes in part/needs more work

   ☐ Not at all

2. **If in Q1 you identified the strategy needed further recommendations which areas do we need to look at?**

3. **Our 17 local priorities are based on the evidence we have reviewed and that we think can have the most impact. Of these, which 5 would you prioritise as most urgent? (you can read about the priorities in the Dementia Strategy document)**

   Priority 1

   Priority 2

   Priority 3

   Priority 4

   Priority 5

4. The strategy aims to give people more control and choice over their lives. Does the draft strategy go far enough to enable this?

☐ Yes fully

☐ Yes in part/needs more work

☐ Not at all

5. If you answered partly met or not at all what would you like to see in the strategy?

6. Do you have any other comments that you would like to make about the Dementia Strategy?

7. I am responding to this document

- ○ As a health or care professional
- ○ As a patient, service user or member of the public
- ○ On behalf of an organisation or group

Other (please specify)

8. If you are responding on behalf of an organisation or group please give details

The deadline for feedback is **Friday 27th July 2012**

Please return to:

Jan Saines
11th floor, North East Quadrant
Taberner House
Park Lane
Croydon CR9 2BA

Or you can email jan.saines@croydon.gov.uk

You can also respond to the consultation online at:

http://www.surveymonkey.com/s/Dementia-strategy

Appendix A

Key guidance and policy documents

- Living Well With Dementia: a National Dementia Strategy (NDS) 2009
- Quality Outcomes for People with Dementia: Building on the work of the National Dementia Strategy 2010
- Revised National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care 2009
- Our NHS Our Future 2008
- Putting People First: A shared vision and commitment to the transformation of adult social care 2007
- The National Institute for Health and Clinical Excellence (NICE) Commissioning Guide on Memory Assessment Services 2010
- The National Carers' Strategy - Carers at the Heart of 21st Century Families and Communities 2008
- Croydon Draft Carers' Strategy 2012-2015
- Croydon's Older People's Strategy 2010 - 2013
- The National End of Life Care Strategy 2008
- The National Service Framework for Older People 2001
- Everybody's Business – Integrated Mental Health Services for Older Adults: a service development guide (CSIP and DOH) 2005
- NICE/SCIE dementia clinical guidelines 2006
- NAO Improving Services and Support for People with Dementia 2007
- National Dementia CQUIN

Appendix B

SERVICES COMMISSIONED BY NHS CROYDON / CROYDON COUNCIL

Some of the services described here are dementia specific such as the Croydon Memory Service; the others are commissioned for all older people with mental health needs but provide services to people with dementia.

Primary Care: Dementia Registers and Reviews

Most people with mental health conditions in late life are never seen by a specialist service, and are being seen in General Practice. General Practitioners (GPs) are well placed to identify later-life mental health conditions early, to provide people and their families with information and to organise further investigation, treatment and support when necessary.

The National Service Framework for Older People (Department of Health, 2001) required PCTs to ensure that every general practice was using a protocol agreed with local specialist services for the diagnosis, treatment and care of older adults with depression or dementia by April 2004. Physical investigations and cognitive testing instruments are included in many protocols for the treatment of people with Alzheimer's disease, facilitating both early detection of cognitive impairment in primary care and rapid access to anti-dementia drugs.

The Quality and Outcomes Framework (QOF), used by GPs and PCTs to assess performance under the new General Medical Services contract, provides useful information on services provided by GPs. Two new dementia indicators for General Practice were introduced for 2006 and GPs are now required to have dementia registers and to record the number and proportion of people seen from the register in the previous 15 months.

The QOF requires a face-to-face review of people on the dementia register, focusing on support needs of the patient and their carer. In particular, the review should address four key issues:

- An appropriate physical and mental health review for the patient
- If applicable, the carer's needs for information commensurate with the stage of the illness and his/her and the patient's health and social care needs
- If applicable, the impact of caring on the carer
- Communication and co-ordination arrangements with secondary care (if applicable).

The review should also assess for physical ill health. Patient assessments should therefore include the assessment of any behavioural changes caused by:

- Concurrent physical conditions (e.g., joint pain or intercurrent infections)
- New appearance of features associated with dementia (e.g., wandering) and delusions or hallucinations due to the dementia
- Depression should also be considered since it is more common in people with dementia than those without.

As the illness progresses, and more agencies are involved, the review should additionally focus on assessing the communication between health and social care and non-statutory sectors as appropriate, to ensure that potentially complex needs are addressed. Communication and referral issues highlighted in the review need to be followed up as part of the review process.

Croydon Memory Service / Early intervention

This service is provided by the South London and Maudsley Trust (SLaM). It was commissioned in 2003. The Croydon Memory Service provides early assessment, treatment and care for people aged over 65 who have memory problems that may be associated with dementia. It provides comprehensive assessments of people's cognitive abilities in general and their memory in particular in order to determine whether they are experiencing any memory impairment and whether this is greater than expected for their given age. People whose memory seems to be declining over a period of at least six months are eligible for referral to the Croydon Memory service by their General Practitioner. Where applicable, a diagnosis of dementia is made and clients are offered the appropriate intervention to help minimise the problems caused by declining memory. These may include treatment with medication, attendance at day centres and at therapy groups. Clients are followed up at clinically appropriate intervals and their therapy adjusted accordingly. Clients are discharged from the service back to their General Practitioner or another appropriate service such as a Community Mental Health Team (CMHT) when they are no longer able to benefit from the interventions offered by the memory service.

A recently concluded (June 2011) Dementia Adviser's pilot (a national demonstrator site for dementia advisers) staffed by the Alzheimer's society and based at/working closely with the Croydon Memory Service. The Institute of Psychiatry is currently compiling an evaluation report.

The Department of Health (DOH) has provided additional £52,000 funding for the Croydon Memory Service. This money is to be used to deliver an enhanced memory service and is due to be transferred to Croydon Council by NHS Croydon by the end of the 2011/12 financial year.

Chelsham House, Bethlem Royal Hospital (Acute mental health in patients unit)

This service is provided by the South London and Maudsley Trust (SLaM). Chelsham House is a 30 bed acute admission and assessment mental health of older adults inpatient ward located at the Bethlem Royal Hospital. This service is commissioned by NHS Croydon as part of the SLaM block contract. Adults over 65 years of age who have acute mental health problems are admitted to the unit for assessment and treatment following referrals from either the CMHT or Croydon University Hospital (admissions from Croydon University Hospital may be arranged via the Mental Health of Older Adults Liaison Service). During their in patient admission, people will receive various assessments and interventions from psychiatrists, the nursing team, general physicians, occupational therapists, social workers and other clinically appropriate healthcare professionals. For some clients, the multi disciplinary ward team may determine that they are eligible for NHS Continuing Healthcare, in which case a Continuing Care assessment using

the national assessment template (the Decision Support Tool) will be completed and thereafter presented to the Continuing Care panel for ratification of the multidisciplinary team's recommendation. Such clients will usually be discharged to a Continuing Care placement funded by the NHS or receive a home care package if appropriate. Discharge planning occurs during the admission. Following the resolution of acute mental health problems, people are usually discharged home with notification sent to their General Practitioners. There is usually a follow up within 7 days of discharge and sometimes people are reviewed in the outpatient clinic after a clinically appropriate interval. The CMHT may also offer further input as appropriate. A significant number of people admitted to Chelsham house have a diagnosis of Dementia.

Mental Health for Older Adults (MHOA) Liaison Service at Mayday Hospital

This service is provided by the South London and Maudsley Trust (SLaM). This is a specialist mental health service for older adults provided by SLaM at Croydon University Hospital. This service is available to people above the age of 65 years who are admitted to a medical ward at Croydon University Hospital for a physical health problem such as a urinary tract infection, and who may experience mental health difficulties during their admission. Any such people are referred to the Liaison service, which provides mental health assessments, support and advice to the client and to the multi disciplinary ward team to assist their clinical management of the client. If the multi disciplinary ward team believe that the client may be eligible for NHS Continuing Healthcare on the basis of a primary mental health need, a referral is made to the liaison team, which will complete or support the completion of the Continuing Care assessment using the Decision Support Tool (DST) by applying their particular expertise to the mental health domains of the DST. Otherwise the liaison team can refer to an appropriate mental health in patient unit for further assessment and DST completion there, in all cases; the completed continuing care assessment is presented to the Continuing Care panel for ratification of its recommendations. The liaison team also supports the discharge planning process and liaises with the CMHT and other community services as appropriate. A significant number of referrals to the liaison service are for people with dementia.

Community Mental Health Teams (CMHT) for Older Adults

This service is provided by the South London and Maudsley Trust (SLaM). There are 3 Community Mental Health Teams (CMHTs) serving Croydon's population - the North, South and Central CMHTs each serving North, South and Central Croydon respectively. The CMHTs are integrated teams, consisting of psychiatrists who specialise in older adult psychiatry, community psychiatric nurses (CPNs), mental health support workers, psychologists, occupational therapists, care managers, support workers and administrators. People are usually referred to the CMHTs from primary care services, usually their General Practitioner. The teams serve people older than 65 years who are experiencing acute or relapsing mental health conditions and their carers, and also people under the age of 65 with progressive memory problems. Patients are initially seen in their own home or outpatient clinic by a team member who carries out an initial assessment. They are then offered appropriate follow-up, treatment and referral to other appropriate services. People are usually assigned a care coordinator with

the CMHT and remain on the team's caseload until the resolution of their acute mental health problem at which point they are discharged back to the care of their General Practitioner or other relevant services. People may be referred to Chelsham house mental health in patient unit if their mental health deteriorates beyond the point that is manageable within the community. The CMHT is also able to perform continuing care assessments using the DST if deemed appropriate, and thereafter make recommendations to the Continuing Care panel.

MHOA Intensive Assessment Service (IAS)

This service is provided by the South London and Maudsley Trust (SLaM). NHS Croydon commissioned this service as a pilot from SLAM in September 2011. The service aims to provide a comprehensive mental health and continuing care assessment to people older than 65 years with mental health problems (usually related to dementia) who are on admission to a medical ward at Croydon University Hospital, where there is a likelihood that they may be eligible for continuing care. The service is provided by a Consultant Psychiatrist led multidisciplinary team. This team provides comprehensive mental health assessments (including Continuing Care assessments using the DST) and appropriate interventions including medication where appropriate. People are referred to it by the MHOA Liaison Service at CUH. Whilst not formally known as an intermediate care service, it fulfils some of the functions of an intermediate care service in the sense that it caters to people who are medically fit for discharge from Croydon University Hospital, but who are experiencing some mental health problems that prevents them from being discharged back to their usual place of residence. These mental health problems are typically not severe enough to warrant admission to Chelsham house mental health in patient unit. However, if a person mental health deteriorates whilst they are in the IAS, they are referred to Chelsham House mental health in patient unit. Other people are discharged to their previous place of residence following the resolution of their mental health problems, or otherwise admitted into NHS Continuing Healthcare for a primary mental health need if this is the recommendation of the MDT at the IAS to the Continuing Care panel.

Black and Minority Ethnic (BME) Mental Health Community Development Workers

NHS Croydon commissions a team of four BME Mental Health Development workers to work specifically with older people with mental health needs including dementia. The team has recently produced a focus group report on BME views on elderly abuse in Croydon.

Croydon Health Services – Croydon University Hospital (Acute General Hospital)

People in Croydon who have a diagnosis of dementia attend Croydon University Hospital (CUH) when they have a physical health problem. In some cases, dementia may complicate their medical treatment, in which case the medical team will refer individual cases to the Mental Health of Older Adults Liaison service. CUH has nominated a dementia lead clinician and has developed guidance on the management of Acute Confusional States (Delirium). This is helpful as people with

dementia may develop acute confusional states when physically unwell, and this may complicate their care, prolonging their hospital length of stay and leading to delayed discharges.

A Dementia CQUIN (commissioning for Quality and Innovation) has been nationally mandated for 2012/13. NHS Croydon is in the process of developing this further in consultation with the appropriate stakeholders.

Croydon's Joint Community Learning Disability Team (JCLDT) – part of Croydon Health Services NHS Trust

The Croydon JCLDT provides services to people with learning disabilities who have been diagnosed with dementia. The team includes consultant psychiatrists and Learning Disability and General trained nurses, Dieticians and Speech and Language therapists. The team has a mental health pathway that incorporates a dementia pathway in place for people diagnosed with learning disabilities who subsequently develop dementia. People are referred to the team by their General Practitioner. They remain on the team's caseload for as long as the team's input is appropriate and beneficial.

NHS Continuing Healthcare

NHS Continuing Healthcare is provided for people whose care needs are predominantly health needs and who meet continuing care criteria for care funded fully by the NHS as defined in The National framework for NHS continuing healthcare and NHS-funded nursing care - July 2009. Examples of people meeting continuing care criteria would be those in the end of life stage of dementia. In this case, they would be eligible on the basis of a primary mental health need.

Croydon has Continuing Care pathways for determining eligibility and providing assessment for continuing care. Where primary mental health needs e.g. dementia exist, people will be referred for a comprehensive assessment using the nationally mandated continuing care assessment tool – the Decision Support Tool (DST).

The referrals can come from any concerned individual but the assessment must be carried out by qualified mental health clinicians and social work practitioners. The assessment is usually provided by the Intensive Assessment Service or Chelsham House mental health in patient unit (referrals from the MHOA Liaison Team) if the client is an in patient at CUH or by the appropriate CMHT if the client is in a community location.

The completed assessment is then presented to Croydon's Continuing Care Panel for ratification and allocation of funding. An appropriate placement is then sought.

NHS Croydon has commissioned a block contract of 20 continuing healthcare beds from Care UK, a registered independent sector care home provider. These beds are provided at Amberley Lodge, Purley, which is a 60 bed unit providing NHS continuing care to the older adult population. Excluding the block contract of 20 beds with Care UK – Amberley Lodge, there are a further 98 people receiving NHS funded continuing healthcare in Croydon. These people are receiving care in

spot purchased continuing healthcare beds in various Croydon homes. Majority of these people have a diagnosis of dementia.

Some older people with mental health needs opt to have their continuing care needs met in their own homes; Croydon PCT funds Home Care Packages for these individuals. This is more often the case if people have combined physical and mental health needs. Although this care is funded by the PCT, it can be provided by a combination of health and social care professionals.

Due to ongoing demographic changes and the predicted rise in the incidence of dementia, we anticipate there will be growth in the number of people requiring NHS funded continuing healthcare.

End of Life care

Work based on the National End of Life Care strategy is ongoing. There will be an increased focus on streamlining and improving end of life care for people with dementia.

PARTNERSHIP WORKING / JOINT COMMISSIONING BETWEEN NHS CROYDON AND CROYDON COUNCIL

Croydon has established joint commissioning agreements between health and social care and several services are jointly funded for example:

The Croydon memory service

Independent Mental Capacity Advocacy (IMCA) Service

This service is jointly funded by health and social care and is well established in Croydon. It is provided by VoiceAbility, an independent charity. It supports people with dementia who lack the mental capacity to make decisions about their treatment, hospital discharge plans and other aspects of their care. People are usually referred to this service by health and social care professionals within hospitals and residential or nursing care homes when important decisions about people's care need to be made. The service provides independent advocacy to clients, and also training to health and social care professionals.

POP STOP services

Following a successful application for funding from the Department of Health Partnership for Older People, Croydon now provides the POP STOP mobile service. Its need was identified by older people and carers at the open space event in 2005. The POP service was introduced in 2007. This takes a range of services directly to older people in their own communities. More frail older people are now helped to live independently, with appropriate support when they need it.

It brings together Croydon's health, local authority and other statutory and voluntary agencies and is available 7 days a week with a flexible timetable including evenings and delivers information, services and support right to people's doorstep.

POP STOP:

- Provides one point of access for health, social care, transport, benefits, housing, leisure, social participation, community safety and crime reduction interventions
- Addresses the needs of carers
- Addresses the needs of people with long term conditions including dementia
- Ensure greater involvement and participation of the community, voluntary sector and independent sector.

Older people have been helped to access £1.5 million in extra benefits through the POP service.

SERVICES COMMISSIONED BY CROYDON COUNCIL

Housing Services

The Homes for the Future programme is the council's programme to modernise residential and day care services for older people in Croydon. It is funded through a £38 million private finance initiative source.

The Fellows Court extra care housing development was opened in 2008.

Extra care sheltered housing is also being developed to support people with higher care needs. Extra care sheltered housing provides a higher level of support to help people with their social care needs. "Homes for the Future" (New4Old) is a key partnership between the Council, Croydon PCT and South London and Maudsley NHS Foundation Trust to modernise local authority residential homes and develop extra care housing for older people.

Home Care Services

Social and nursing care, including palliative care, is available to support older people at home. This includes falls prevention and rehabilitation after falls.

The Health Visitors for Older People Service provides an intermediate care service to prevent unnecessary admissions to hospital or help facilitate early discharge.

Home care provides personal care to people living in the community. Care managers are responsible for assessing older people to see if they have significant social care needs and are eligible for home care. Independent home care agencies then provide the care in accordance with the person's care plan. Many of the people identified by the Older People's Care Management Team and the Community Mental Health Older Adults Team have personal care needs and are cared for in the community by home carers. As the carers usually visit people frequently, often on a daily basis, they are in a key position to monitor changes and deterioration in health. It is essential that home carers are trained to identify mental health needs so they can identify if their clients are developing memory problems or depression and can refer early to specialist services.

CARER SUPPORT SERVICES / INITIATIVES

Croydon Council provides services for carers internally and funds additional carers services in the community. These are listed below.

Croydon Council provides the following carers services:

1. A website dedicated to carers: http://www.croydon.gov.uk/healthsocial/carers/geninfo/. This page provides general information as well as information on carers' assessments, available services including respite and support organisations.

2. Carer's assessments: Referrals are made to Croydon Council's Social Services Department who will make the arrangements.

3. Respite services: Referrals are made to Croydon Council's Social Services Department. Respite services are means tested.

4. Croycare is a pilot emergency support service for carers. Over 2000 carers including older people have been enabled to get access to education, leisure and short breaks

5. There is also a Council-funded Guide for Carers in Croydon prepared by the Whitgift foundation's Carers information service available on Croydon Council's carers' web page and also here: http://www.carersinfo.org.uk/guide-for-carers-in-croydon.html

Croydon Council's externally funded carers services are as follows:

1. A range of newly commissioned holistic carers services are in place from July 2012 which will be part of the Carers' Support Network, Croydon. Carers' Network providers include Carers Information Service, Mind Croydon, Horizon Care and Welfare, Croydon Neigbourhood Care Assocation, Parents in Partnership, Crossroads Care and Mencap. The Network will provide information, advice, advocacy, breaks and support services to all carers in the community including carers of people with dementia. Within the Network, there will be additional provision of a centrally located carers hub where carers can these services from one common entry point.

2. The Council also funds Croydon Alzheimer's Society to provide specific services to dementia users and their carers including carrying out carers assessments. These services may also be delivered from the carers hub and be part of the Carers Support Network.

3. Additionally the Council funds South London and Maudsley (SLAM) for a specific carers assessment post.

Carers of people with dementia

1. Croydon Memory Service (020 3228 9500) provides an assessment, diagnosis and treatment service for adults experiencing memory difficulties, and support for their carers.
2. The Alzheimer's Society Croydon (020 8916 3587) provides information, advice and support. It also carries out carer's assessments on behalf of Croydon Council, provides training courses and support groups for carers, access to alternative care, help with benefit forms and a monthly social event called the Forget-Me-Not Café for people with dementia and their carers.

Carers of Older People

These are not dementia specific but are available to all carers including carers of people with dementia.

1. Age UK Croydon (0845 600 1090, www.ageukcroydon.org.uk) offers a range of services to people aged 55 and over, and to people of any age who have a disability, including children, and their carers. These services include information, advice, advocacy, befriending, handy person services, computer training, nail cutting, benefits advice and home safety checks. It also has an online directory (www.accdirectory.org.uk) that gives details of local and national services and organisations of use to older people and carers.
2. The Partnership for Older People (POP) Service (020 8654 4440, www.croydonpop.org.uk) has a bus that that goes to various locations across the Borough bringing services, information and advice to people aged 55 and over and their carers. There are many different professionals and services available at different times including: blood pressure checks, falls prevention, health 'MOTs' and medicines management, hearing assessments and benefits advice.
3. Croydon Neighbourhood Care Association (020 8662 1000, www.cnca.org.uk) has neighbourhood care groups all over the Borough. The groups are independent and have their own volunteers that offer a variety of services to meet the needs of people in their area who are isolated, vulnerable or disabled. The services provided differ from group to group, but examples of the help they can offer include short breaks for carers, befriending, occasional gardening and DIY, shopping, lunch clubs and transport.
4. Older People's Network (OPeN) (020 8683 7002) offers older people the chance to meet regularly and express their opinions about the issues that matter to them. The group's views are then passed on to service providers via representatives, ensuring everyone's voice is heard.

General carer's services (Croydon)

These are not dementia specific but are available to all carers including carers of people with dementia.

1. The Carers' Information Service (020 8649 9339, option 1, www.carersinfo.org.uk) offers advice, information, support and training to any adult carer living in, or caring for someone who lives in, the London Borough of Croydon.
2. Croydon Crossroads Carer Support Service (020 8667 9893, www.croydoncrossroads.org.uk) supports carers living in Croydon and can help you in various ways to access the support and services you need.
3. Croydon Carers Centre (020 8688 7219, www.croydoncarers.org.uk) runs a drop-in facility offering emotional support, help and advice with benefits, signposting to other services and advocacy. It also offers counselling, complementary therapies and outings for carers and those they care for.

General carer's services (National Organisations)

These are not dementia specific but are available to all carers including carers of people with dementia.

1. Carers Direct (0808 802 0202, www.nhs.uk/carersdirect) offers information, advice and support to all carers, including young carers. Lines are open 8 am - 9 pm Monday to Friday, 11 am - 4 pm at weekends.

2. Carers UK (0808 808 7777, www.carersuk.org) is an active campaigner for carers' issues, produces a range of publications and has a helpline for carers open on Wednesday and Thursday 10 am – 12 noon and 2 – 4 pm.

3. The Princess Royal Trust for Carers (0844 800 4361, www.carers.org) has carers' centres across the UK and hosts discussion boards on its website.

Preventive equipment and technology: Adaptations and Equipment

Croydon has a prize-winning Assistive Technology (Aztec) Project which installs assistive technology equipment packages to support people with dementia and their carers in their own homes and prevent long term residential or nursing placement. The Integrated Mental Health in Older Age Team delivers this project in partnership with the integrated Community Equipment Service and Croydon Careline. Between April and September 2006 an average of 129 calls per month were received activated by assistive technology devices to detect a range of problems including wandering, inactivity and gas leaks. The Aztec Centre has a Telecare dementia service for people with severe dementia.

Adaptive technology and aids in people's homes are also offered through CARELINE and the joint equipment service.

The Telecare in Homes for the Future project will help people in care homes who are at high risk of hospital admission with personalised care plans, information and education.

Croydon's Major Adaptations Unit adapts housing to meet people's needs to support them to live and remain in their own homes. People with mental health conditions in older age, who sometimes have co-existing physical health problems, may need to have their homes adapted to make them safe for living at home. Equipment can also be provided by the integrated Community Equipment Service to support people's care needs. The equipment store is open to the public one day a week for people to see what is available.

Croydon is one of the 11 local authorities that have been successful in obtaining funding for a self-assessment pilot project. The project focus is for the development of a fully accessible self-assessment tool and procedure for people to be able to independently determine their need for equipment and minor adaptations, to purchase equipment direct via the equipment store or via the online equipment store and to enable them, if they choose, to refer themselves for further Council services as appropriate.

Care Homes

There are 20 council accredited care homes specialising in the care of older people with mental health needs (elderly mentally frail, or EMF) in Croydon with a total of 558 beds designated for those with dementia. Three of the residential homes are run by the Council and will be redeveloped as part of Homes for the Future (New4Old).
Under Health Flexibilities Legislation, Croydon Council and the PCT have entered into a partnership arrangement enabling the PCT to provide the governance for the nurses who will be employed in Council new care homes as part of the modernisation and redevelopment of the Council's residential care homes. This enables the Council to become a provider of nursing home beds and increase extra care sheltered housing provision in line with the strategic aim to reduce residential beds, supporting more people to live independently at home, and increase nursing bed provision.

There are also currently 5 private and voluntary run homes in the Borough for older people with a past or present mental illness, with 105 beds.

The total number of residential beds for people with dementia is less than the anticipated estimated need for 770 beds in care homes based on national data. This is partially explained by the number of people with both physical and mental care needs living in nursing and residential homes in Croydon which are not registered as EMF providers. It may also be explained by Croydon's policy of supporting more people to live in their own homes for as long as possible.

As more people are supported to live independently at home for longer the point at which people will need 24-hour care and support in a care home will be later in their illness, when they are very frail and in need of high levels of care. For people with lower care needs, Homes for the Future (New4Old) will provide 32 one bed flats and 8 two bed flats together with small cluster communal lounges and

kitchenettes and assisted bathrooms. For those with higher level needs Homes for the Future (New4Old) will increase the number of nursing home beds for older people with mental health needs at the 60 place Heavers Farm resource centre.

Croydon Council commissions a Care Home Support Team to provide training, advice and support to Croydon nursing and residential care homes.

Self Directed Support

Direct payments are cash payments made to an individual directly, giving them the choice to buy and arrange their own social care services. Direct payments are intended to give an individual wider choice, control and flexibility to meet their individual social care needs. Direct payments can be used to buy services such as:

- Personal care: getting up, washing, dressing
- Practical tasks: preparing meals, shopping, housework
- Getting out and about: going to work, visiting a friend or relative, going to leisure activities
- Help for carers e.g. for breaks from caring.

People taking up direct payments are given the help to manage their direct payments - both in securing the services and the support they want the direct payments to provide, and in dealing with the finances. In 2009, 5.9% of adults, older people and carers in Croydon received social care through a direct payment (compared with 13.4% in London and 13.0% in England), and 12.7% of carers were supported with services, advice and information in Croydon. This is significantly below the London average (24.6%) and the England average (26.4%). Piloting of self directed support for those that meet the criteria started in 2009.

<u>Direct payments</u>

Croydon local authority has implemented self directed support and is assessed for this option. Current information reports low take up for clients with a dementia diagnosis.

Counselling and talking therapies

- Reablement fund set aside for IAPT in older adults

Equality/BME Services

BME Service Development Officers are employed by Croydon Adult Social services to support voluntary sector providers for BME elders.

Croydon Social Services commission a range of voluntary sector providers to support BME elders and also specific services to support BME elders with mental health conditions and their carers. An example is the Charisma Day Care Service provided by Topcare.

Safeguarding

A Safeguarding Vulnerable Adults (SVA) Team and a Care Support Team were established in 2008 to support vulnerable people at risk of neglect or abuse and to support care homes in improving their quality of care provision.

The establishment of a Safeguarding Adults Team has led to successful investigation of the highest number of allegations of abuse in London. Neither the council nor the NHS places anyone in a zero rated care home. Most domiciliary care providers are rated good or better by the care quality commission. All service providers for the council and NHS Croydon have to adhere to the multiagency Safeguarding procedures. Increasing numbers of staff in the statutory and non-statutory sector receive regular safeguarding training.

Croydon complies with the Deprivation of Liberty Safeguards (DOLS). This means that vulnerable older adults including those with dementia are not unnecessarily deprived of their liberty.

Advice and Information

Croydon Alzheimer's Society also offers a range of peer support services for people with dementia and their carers.
The Partnerships for Older People (POP) service provides information, advice and support to older people in their neighbourhood, helping them to live independently with appropriate support when they need it. The POP service is targeted at the over 55 population and tries to reach people who do not access services. Most services are offered direct from a mobile unit and advice is offered about other services. The aim is to prevent people allowing a condition to deteriorate to the point of needing intensive support or treatment. A 2009 evaluation found that the service was cost effective and well liked by service users, but it recommended encouraging uptake in those aged 50 to 70, who were less likely to access the service.

Health and Wellbeing

Free swimming is available for those aged over 60 years across the Borough.

There is an Older Peoples Network (OPeN), which campaigns for older peoples interests.

DAY SERVICES

Day centres enable older people to remain in the community by maintaining or improving their quality of life or that of their carer through social contact and therapeutic activities. Day services also provide support in periods of personal stress thereby helping to reduce the likelihood of admission to hospital and avoiding or delaying the need for long term residential or nursing care. They aim

to enhance the independence and social acceptance of service users and provide respite for carers through day support, respite care and carers groups.

“Homes for the Future” (New4Old) aims to increase the amount of care provision for older people with mental health needs as below:

Heavers Farm Resource Centre for Older People with Mental Health Needs

- A flagship one-stop service for dementia sufferers and their carers
- 60 place resource centre for the care of older people with mental health needs
- 16 place early onset dementia support unit
- 15 place outreach service
- 24 place day activities centre to support mentally frail older people living at home
- Central Croydon Community Mental Health Team for Older Adults
- Croydon Memory Service
- Offices for the Alzheimer's Society.

Fellows Court Extra Care Housing and Coleby Day Activities Centre (Physically Frail)

- 32 one bed flats and 8 two bed flats together with small cluster communal lounges and kitchenettes and assisted bathrooms
- 36 place day activities centre and shared facilities with Extra Care Housing.

Langley Oaks Resource Centre for Older People with Mental Health Needs

- 40 place resource centre for the elderly mentally frail
- 16 place specialist day activities centre.

Addington Heights

- 50 place resource centre for the elderly physically frail
- 10 beds for reablement and respite care
- 20 with 12 space unit which is being utilised for reablement

Bensham

- 25 place day activities centre for functional mental health clients

VOLUNTARY SECTOR SERVICES

The Positive Ageing project from Age UK Croydon offers a variety of services for those aged 50 to 90. They include support to eat well, manage weight, and increase physical activity, falls prevention, advice on housing options and using arts and crafts to promote mental wellbeing. Some groups are coproduced by service users, set up initially by the service and then run by members, including dining clubs and healthy eating clubs in sheltered housing.

Over 50 council supported lunch clubs, including the Neighbourhood Care Association lunch clubs, cater for those over 60, although some groups attract those aged 50 plus. These services provide befriending, advocacy, education, training and carers’ respite

In March 2007 Croydon Council was awarded Beacon Status in the category “Increasing Voluntary and Community Sector Service Delivery”, recognising the strong relationship that exists between the Council and the voluntary sector and the key contribution that the sector plays. Croydon has a diverse, flourishing voluntary sector that is made up of voluntary and community organisations, faith groups and social enterprises. For older people the voluntary sector is involved in five key areas:

- **Community Involvement** - The Voluntary Sector Service Providers for Older People (VoSSPOP) is an overarching body that represents voluntary organisations in Croydon which support older people by encouraging people to become involved in consultation and representing the interests of older people through events, networks and partnership groups.

- **Advocacy, Advice, Training and Information** - The Alzheimer’s Society runs a programme to train recruits to offer information to people caring for those with dementia. It trains around 30 people a year.

- **Respite Services** - Croydon Crossroads is a significant provider of respite care in people’s own homes. The Alzheimer’s Society also plays a key role assessing for and managing access to the respite beds at Amberley Lodge.

- **Day Services** - Topcare, through the Charisma Project, provides day services and luncheon clubs for older people with mental health problems and support and respite for their carers. Croydon Neighbourhood Care Association groups also provide a large number of day services and luncheon clubs for older people with dementia.

- **Practical help** - Age Concern Croydon and Croydon Neighbourhood Care Association groups are key organisations in providing services such as minor repair work and health related activities. The Alzheimer’s Society runs the Alzheimer Café attended by up to 100 carers. Six carer support groups offer a full programme of activities to improve the quality of life of carers and reduce the social isolation that can be a consequence of caring.