Adult Social Care Vision Statement:
Commitment to Promoting Independence, Individual Well-being and Safeguarding Adults
1. **Purpose of this document:**

This document accompanies our 'Guiding Principles for Adult Social Care'. Here, we describe our priorities for adult social care, the type of services and support available, and how we will work with you to help you to remain as healthy and independent as possible.

2. **Introduction:**

2.1 **The Care Act 2014:**

The Care Act 2014 represents the most significant change to adult social care in more than 60 years. The Act places a range of duties on the Council to:

- actively promote your well-being whether or not you are eligible for support.
- give you the information and advice you need to make good decisions about care and support.
- work with you to prevent or reduce the development of your care and support needs.
- offer an assessment or carers assessment to anyone who appears to need care and support, and to meet any eligible needs.
- offer independent advocacy to people who have no one else who can support them and would otherwise have significant difficulty in being fully involved in decision-making processes.
- co-operate as much as possible with partners, such as the NHS, and integrate our services where this will improve the quality of services or help with prevention or well-being.
- promote a diverse range of providers offering a choice of high quality, appropriate services.
- safeguard adults at risk from abuse and neglect through our statutory Safeguarding Adults Board.

Our vision statement fully reflects these duties and describes the practice that the Council aims to achieve when approached by residents about adult social care.

2.2 **Ensuring our residents enjoy the best quality of life:**

We want our residents to enjoy the best quality of life, based on choices that are important to them. We recognise that many things affect this – people's health and feelings of safety, opportunities for education and learning, employment and housing, social contact including relationships with friends and family, leisure activities and access to green space.

Whilst the vast majority of people in Bexley already experience a good quality of life, we know that this is not always the case for everyone and that some people may need help during their lives due to unemployment, disability, health problems, homelessness, social isolation or because they are victims of crime.

Our services play a crucial role in helping residents to remain healthy and independent, whether that be through the provision of information and advice, access to universal or prevention services, or more intensive support to those with very significant needs.
2.3 Transforming our health and adult social care services:

Our health and social care services face a complex mix of demographic change, rising demand and increased cost. We are working to address these challenges by transforming our services so that these focus more on preventing or delaying people’s care and support needs and by intervening early to help people maintain their independence. We work in partnership with health colleagues to deliver services and seek to provide appropriate “joined up” care and support to people close to home (see Case Study). By responding to people’s needs early in the community, we can prevent or avoid admission to hospital. Also, following a personal crisis, we can help people to maintain or regain their independence and skills so that they can continue to live safely in their own home.

We seek to give people greater choice and control over their own care and support through ‘personal budgets’ and by developing the local care market to ensure the quality and diversity of provision. At all times we work hard to ensure best practice in care, that people are treated with dignity and respect, and safeguarded from harm.

The changes we are making across health and adult social care are designed to improve the outcomes for our residents and their individual experience of care, whilst at the same time ensuring that we are making best use of the available resources. We, therefore, need to ensure that we have a sustainable system that supports the most vulnerable people and also delivers value for money for Bexley residents.

Against this backdrop, we need to think carefully about the role of the Council and set out how we will work with people to support them to live as independently as possible. This includes ensuring that individuals and communities understand their own responsibilities in terms of what they can do for themselves.
3. How we will work with you:

3.1 A shared responsibility for individuals, the Council and the wider community:

The focus for adult social care is to enable people to live as independently as possible. Key to this is working in partnership across the whole system to harness all the available assets and resources of individuals, their families and networks and within the community. Our starting point is to consider what people can do for themselves and build upon this.

Individuals can enhance their chances of retaining independence by having a healthy and active life. Good relationships with family and friends, opportunities for employment, learning and leisure, keeping active and healthy, an adequate income, and a secure home are all associated with being able to live well and stay independent for as long as possible.

Whilst it is everyone’s responsibility to do what they can to live a healthy and active life, the Council and our partners have a role in offering a range of universal and some targeted prevention services. These may be directly delivered or be commissioned from independent providers, including the voluntary sector.

The voluntary sector also has access to other external funding sources, not available to the Council, and benefits from the dedication of volunteers, who contribute their time and skills. We recognise and value highly the contribution that people already make to their communities and want to encourage this. Participation in volunteering and making a contribution to the wider community can be one way for people to remain active and independent. We see the potential in everyone to be full citizens and a resource for society, rather than as being dependent on it.

Case Study – Rapid Response Team (RRT)

A fax referral is received from a GP. The service user lives alone, has increased confusion and is frequently falling at home. Daughter has visited but was concerned that she could not get a response so called the police to gain entry. The GP is requesting emergency respite.

Rapid Response Nurse and Social Worker visit the service user. A full holistic assessment is undertaken. The service user found not to be taking medication, incontinent, unsteady mobility, requiring assistance of one, home environment cluttered and placing the service user at potential risk.

Outcome following RRT assessment

24 hour enhanced care is immediately organised for the same evening until telecare is in place two days later, dossett trays are organised and delivered, a key safe is installed, the district nurse is referred to and undertakes a continence assessment, the RRT Occupational Therapist and Physiotherapist visit the following day, to provide ADL (Aids to Daily Living) equipment and environmental planning to ensure the service user is safely set up in a micro-environment, and the service user is referred on to reablement care pathway following enhanced care provision.

The service user now has a twice daily package of care and continues to be safely supported at home with bed and door sensors and community alarm. RRT intervention prevented both permanent care pathway, unnecessary admission to hospital and fulfilled the service user wishes to remain at home.
We want to make sure there is a good balance of services available for residents so that people can make the most of opportunities that will help keep them independent. The Council can help to shape the market through its commissioning role and will work with our partners and providers to seek to ensure that services are inclusive, promote independence, and prevent needs from escalating. Our aim in the longer term is to build local capacity to enable people to manage their own needs and support each other.

3.2 Valuing Carers:

Carers make a vital contribution to society, giving their time and energy to caring for a family member, friend or neighbour. Many people with care and support needs rely on the person caring for them to help keep them independent in their own homes for as long as possible. We recognise and value the role of carers in Bexley and see them as key partners in the planning and delivery of support to the person they care for.

Caring can often have an impact on the health, wellbeing and independence of carers themselves. By working with our service providers and health partners, including GPs, we can continue to raise awareness and encourage the earlier identification of carers.

When people become carers, we want them to be able to access timely support when they need it. We will work with carers to ensure that they:

- have access to good information and advice.
- are informed of their right to have a carer’s assessment, either jointly with the cared for person or separately.
- are involved in care planning and decision-making from the outset so that they and the person they care for have choice and control over their care and support.
- can maintain a balance between their caring responsibilities and a life outside caring – this includes young carers.
- can access a range of prevention and support services when they need it (e.g., respite care/carers breaks, access to carers groups, support systems and emergency care) to help sustain them in their caring role.
- are supported to maintain their own health and wellbeing.

3.3 Everyone can access meaningful information and advice:

Our priority is to ensure that everyone has access to meaningful information when making decisions, can plan for the future, and know where to go when they need help. This includes the availability of a range of trusted information sources about care and support, which provide accurate information that is easy to understand, accessible, and up-to-date.

The Council has a single point of access via our Contact Centre. Through this service we can provide information, advice and signposting to residents about a range of services, not just those relating to adult social care (including universal and prevention services outside the Council). Information is also available via the Council’s website and other on-line resources.

It will be important to engage with people about planning and preparing for future care and support. Whilst the Council has a key role to play, this is not something that we can achieve alone. There will be opportunities throughout a person’s life to help them plan for the future, for example, during transition from childhood to adulthood, whilst they are still in employment or thinking about retirement. When people come into contact with the Council, GPs, or other parts of the NHS, these are opportunities to provide information about health and social care, tailored to people’s individual needs. There will also be opportunities to engage with people
with lower-level needs when they are signposted to prevention services. Through contact with a range of services, people will be able to access information and advice, understand what support is available, and be encouraged to self-manage their care and support needs appropriately.

3.4 Preventing or reducing your need for care and support:

There is increased recognition of the importance of early intervention and prevention in our work with adults. Our priority is to enable individuals to access appropriate support as early as possible and prevent any problems from getting worse. This will help us to avoid, delay, or reduce demand for longer-term social care and the need for more costly interventions downstream.

Those who have lower-level needs may benefit from a range of universal or prevention services, or more targeted support. The type of support will depend on a person’s needs but includes:

- provision of information and advice.
- access to universal services (e.g., GPs, schools, leisure centres, libraries, etc.).
- access to third sector prevention services, such as advocacy and self-help groups or activities to prevent social isolation.
- help for carers, such as respite care.
- provision of equipment or telecare.

A particular focus is to help those people with long term complex conditions to continue to live independently at home for as long as possible. We are seeking to do this in a number of ways:

(i) Provision of community equipment services and expansion of telecare/telehealth

We will help people to live safely, securely and independently in their homes through equipment provision and assistive technology (Telecare). This will help them to overcome everyday difficulties caused by their frailty, disability or illness. Some equipment can be provided on a short term basis to ease the recovery period following surgery, while other equipment will stay with the client to assist with their long term needs. We will use telecare to support people who are at risk of harm through falls or accidents in their home, including people with dementia. It will also help to provide peace of mind for relatives and carers, knowing that help can be summoned in the event of an emergency.

(ii) Working in partnership to deliver integrated services

By working in partnership across health and social care, we will achieve better outcomes for residents and make best use of limited financial resources. Through formalised arrangements, we will continue to have the ability to pool resources and improve the way we exercise our functions. Together with NHS Bexley Clinical Commissioning Group, we have established an Integrated Commissioning Unit, which will help ensure both strategic alignment of resources and reduction in duplication in the future.

We share common goals with our health partners to help people to remain independent in their own homes and to avoid unnecessary admissions to hospital or long term care. This includes supporting those who have urgent health and social care needs to remain at home or to return home from A & E. When a hospital admission cannot be prevented, we are committed to supporting people to have a planned and safe discharge from hospital. This includes thinking about intermediate or step down care for people coming out of hospital.
Case Study – Reablement

Mrs X is an 82 year old with poor mobility resulting in several falls. Following assessment she started a reablement programme on 17 January 2014.

The programme included three daily visits by agency care enablers. Within the first week of reablement the agency reported that Mrs X’s mobility had deteriorated and two carers were required for all calls. As a result an urgent Physiotherapist’s assessment was conducted on the same day. The Physiotherapist was in regular contact with the client’s GP for medical advice and assessment. Whilst this was organised, a risk assessment was completed and instructions given to the care agency to provide reablement in the safest possible way for both client and carers. Mrs X’s family were involved and informed throughout the process.

A multidisciplinary meeting with the Reablement Operational Manager, Physiotherapist and Reablement Social Care Worker considered the need for intensive rehabilitation in a bed-based setting. This was quickly followed by a visit to Mrs X by a Reablement Care Worker in the presence of the client’s family. The client’s mobility had improved but her ability appeared to fluctuate. Information about the service was given and Mrs X agreed to be admitted to the Residential Rehabilitation Unit.

Following a successful pre-assessment visit from the Unit Manager and Social Care Worker, Mrs X was admitted to the Unit for intensive Physio and Occupational Therapy, aiming to maximise her independence, reduce the risk of further falls and increase confidence.

Mrs X is progressing well with her rehabilitation programme. She is able to mobilise within her room and carry out personal care tasks independently. Arrangements for discharge are being made, including the provision of equipment to ease transfers and reduce the risk of falls. She is likely to need ongoing support with a minimal care package on discharge, which will be reviewed within six weeks, following her return home.

(iii) Reducing admissions to residential care

Our aim is to help people to continue to live as independently as possible in their home, where this remains feasible and affordable. We will only use residential or nursing care if this is the only way of safely meeting a person’s assessed needs within the available resources and there are no other viable options.

Given the right support many older people will recover well from a period of illness or other crisis. Through better intermediate care and reablement services, we will make every effort to avoid older people being discharged directly from hospital into residential or nursing care.

By preventing admissions to residential and nursing care, we can make best use of our resources. Reducing these costs to the Council is one way in which we can potentially free up resources to invest in prevention or refocus local services on interventions that promote independence.

3.5 Eligibility for care and support:

Our residents may have varying levels of need at different times of their lives. The majority of people may need no additional help or find that their main needs can be met from universal services (e.g., GPs, schools, leisure centres, libraries, etc). However, we recognise that this is not the case for everyone.

In order to find out if you are eligible for care and support, we must first assess your needs.

We will offer an assessment to anyone who requests one or who appears to be in need of community care services. The assessment is designed to identify your needs and evaluate any risks to your independence, if those needs are not met.
When we have worked out your needs with you, we will decide if you have eligible needs and whether you will need to pay towards the cost of your care and support. In order to help our social workers make fair and consistent decisions, we use national eligibility criteria set out in Government guidance and undertake a separate financial assessment.

If your level of needs means you are not eligible, you will be given further information and advice about how to access alternative sources of support, including universal or prevention services.

### 3.6 Personal Budgets:

If the Council agrees to pay for some or all of your care and support costs, you will be given a personal budget. We will talk to you and your carer about your goals and help to prepare a support plan. This plan sets out how you will use your budget to achieve your goals. With a personal budget you can decide to manage your own support (known as a Direct Payment) or you can ask the Council to help you manage your budget and arrange your support for you. Another option is to ask a third party to manage your personal budget. This could be a range of people from family members, friends, other professionals or even care providers. Depending on your needs, you will be able to use your personal budget to purchase a range of services such as day care, home care, respite care and carers’ breaks.

### 3.7 Managing risk:

We will seek to achieve better outcomes for individuals by balancing protection from harm with the need for individuals to exercise choice and control over how they live.

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**Case Study – Moving On Programme**

Mr W is a 47-year-old vulnerable adult registered with the LB Bexley’s Adult Learning Disability Team. He has a diagnosis of a Severe Learning Disability and Severe Autism. He also exhibits behaviour that challenges services.

On 12 March 2012, Mr W moved into a one bedroom apartment in the Borough with an individualised supported housing care package. This provision has significantly reduced Mr W’s levels of anxiety in relation to his autism due to having greater control of his unshared living environment. Mr W experiences a consistent and reasonable degree of choice, privacy and control over his life. A weekly activity timetable, individually designed for Mr W’s needs and backed by allocated support hours, form part of an outcome-led Enablement Plan. This tailor-made care and support gives Mr W the advantages of independence and privacy, together with the reassurance of 24 hours on-site support.

**Testimony from service user’s sister**

“Before my brother moved, I was very anxious as to whether he would settle in his new home, but I need not have worried. The whole move was dealt with carefully and thoughtfully, with him being taken to see his new flat several times before he moved. All his familiar possessions were placed so as to give him comfort and no stress. He is very happy in his new home, and I am delighted with everything that has been done both for him and with him. It is good that he has a modicum of independence now and the carers take him out regularly, which he enjoys. His quality of life has improved considerably since he moved.”
We recognise the rights of adults and family carers to make their own decisions. Where we have concerns about the decisions an individual is making, we will always seek to discuss this with them so that they understand the potential risks involved. Our approach will be based on the aspirations of the individual concerned and aim to support them to get the best out of life. Wherever possible, we will respect people's views and choices, even if this sometimes results in them making the wrong decisions. Our role will be to offer advice and support so that people can make informed decisions, having weighed up the potential risks for themselves.

In certain circumstances, we may need to intervene, particularly when evidence suggests that an individual is lacking in ‘Mental Capacity’ in relation to a specific decision. Where this is the case, we will comply with any legal requirements and ensure we follow best practice guidance. This includes providing access to independent advocacy for those who need it and where they have no-one else who can act as an advocate on their behalf. We will always consider your best interests and ensure that these are at the heart of everything we do.

### 3.8 Supporting Transitions:

For young people, who are likely to require support into adult life, we want their experience of transition to be a positive one that assists them in reaching their full potential as an adult. Transition from children's to adult's services is being reshaped to minimise duplication across services, and further promote the concept of whole life planning. We aim to support people throughout their lives and seek creative ways of making the best use of resources over the long term. We are working with local education providers to deliver our Local College First offer to all young people coming through transitions, ensuring that opportunities for local education, employment and independent living are maximised, where possible.

### 3.9 Safeguarding adults and ensuring dignity in care:

We believe that safeguarding is ‘everyone’s business’ with individuals, organisations and the wider community playing a part in preventing, identifying and reporting neglect and abuse. We will work across all relevant agencies and providers to promote the welfare of adults, ensure good practice in care and encourage the early identification of safeguarding issues. This includes giving individuals the right information about how to recognise abuse and what they can do to keep themselves safe. We will make available clear and simple information about how to report abuse and the support we can give.

When we are alerted to suspected cases of abuse or neglect, we will make sure that prompt action is taken to investigate concerns. Where abuse or neglect has occurred, we will put in place plans to protect the victim and make sure regular monitoring is in place to prevent a recurrence. We will always take account of the victim’s views before taking decisions, keep them informed of progress and provide them with feedback on the outcome of any investigations.

People who use health and care services have the right to be treated with respect, dignity and compassion by staff who have the skills and time to care for them. We will work across the Council, our partners and with providers to ensure you receive safe, effective and high quality care. In Bexley, the Council will monitor the quality of care and support provided across adult social care services, including those commissioned from providers, to ensure that these meet essential standards and help people to achieve the outcomes that they want.
Where there are safeguarding concerns or issues regarding the standard or quality of care, this will require a variety of responses, including a provider or other agency investigation, a disciplinary process, a clinical governance response from within or by external bodies, the involvement of police, staff training or other actions.

We will endeavour to work with providers to support them in their efforts to take remedial action and will undertake compliance visits to check that this has resulted in improvements. We will cease using providers who do not meet essential standards of care, where the necessary improvements have not been made or serious concerns remain about the safety or quality of care.

4. Conclusion:

Our vision statement for Adult Social Care clearly sets out how we will work with our residents to help them live healthy, fulfilling and independent lives. In publishing this vision, our aim is to set out a clear direction of travel for Adult Social Care in the London Borough of Bexley that is understood by all.

Our vision will only be successful by working together. Our residents, and in particular those with care and support needs, are at the heart of our approach. By optimising their control and choice over care and support, we aim to help people achieve the outcomes they want. By shifting the balance of care towards more personalised services in community settings, we can help people to lead more independent lives.

Case Study – Local College First

Bexleyheath resident, Mr B is one of the young people attending the Local College First programme. Mr B is 19 and has autism. When it came to leaving his previous school, his Mum and Dad did not want him to continue his education out of the borough.

His Dad is delighted with the progress that his son has made so far. He said; “My son has changed beyond all recognition. He has gone from a young person who didn’t like to socialise to someone who now enjoys going to college and days out with his Personal Assistant. He now willingly gives us information about his day and what he is doing.

We didn’t want our son to move out of the borough to continue his education. The most important thing about this programme for us is the word ‘Local’. We wanted him to stay with us. He is a member of our family and he belongs with us.”

Mr B attends Bexley College three days a week, following a Personal Progression Programme (EdExcel L1), and Adult Education College two days a week to follow courses chosen by himself, which complement other elements of his learning. During one of the days spent at Adult Education College, he attends a Bexley Two-Fold Job Club. These courses are designed to support him to move to independent/supported living and to access employment, when he is ready.
We will be able to judge whether we have been successful in achieving this vision against the following outcomes:

- We have prevented, avoided or delayed an individual’s need for care and support.
- We have enabled more people to remain living independently in their own home for as long as possible.
- People with care and support needs feel that they have a better quality of life with increased choice and control over their lives.
- People have a positive experience of care and support, and feel that they are treated with dignity and respect.
- People feel safe and adults at risk are protected from avoidable harm.

This vision provides a basis for engaging with stakeholders and the wider community on the work ahead. It will help us to raise awareness of how care and support works, the challenges and opportunities we face, and encourage a shared understanding of the role and responsibilities of everyone involved.