Central Bedfordshire

Assessment Framework Practice Guidance

Community Assessment Service

A great place to live and work.

Assessment Framework

Directorate:	Social Care, Health, and Housing (SCHH)		
Division & Service:	Adult Social Care – Community Assessment Service		
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It is the responsibility of every individual to ensure that they are working to the most current version of this document.

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Assessment Framework Practice Guidance and Supporting Materials.

The following document contains the following information.

Part 1. A guidance section intended to outline the legal framework within which we operate.

Part 2. Assessment Guidance. General information outlining the purpose of assessment, who and how we assess in compliance with the Care Act 2014.

Part 3. Assessment Framework. Overview of the assessment framework components and how practitioners are expected to interact with the framework whilst acting on behalf of Central Bedfordshire Council.

Part 4. Practice Recording Governance. Best practice recording principles and audit procedure overview.

Part 1: Legal Framework

Legal Framework Overview.

The following key legislation informs the way we practice as an authority and also as individuals.

Practitioners are expected to be cited and have a working knowledge of legislation relevant to their position and role and be able to act in accordance with the provisions and values.

The Care Act 2014.

Care Act 2014 received royal assent on 14th May 2014. The purpose was to consolidate social care legislation in England. Central to the Care Act is wellbeing and a person-centred approach. The Care Act and associated statutory guidance sets out the legal framework within which we operate.

Key provisions within the Care Act 2014. Sections 1-7 Provides a set of guiding principles.

- Section 1 – Wellbeing
- Section 2 – Preventing, reducing, or delaying needs.
- Section 3 – Integrating services.
- Section 4 – Information
- Section 5 – Market shaping and commissioning of adult care and support
- Section 6/7 – Co-operating with relevant partners

Whilst the Care Act sought to merge provisions, in reality we still have to consider additional regulations and relevant guidance to ensure you practice within the law. The following regulations should be read in conjunction with the Care Act 2014.

Regulations:

The Care and Support (Assessment) Regulations 2014.

The Care and Support (Eligibility Criteria) Regulations 2014.

Management of the Health & Safety at Work Regulations 1999.

Manual Handling Operations Regulations 1992

Housing and Regeneration Act 2008

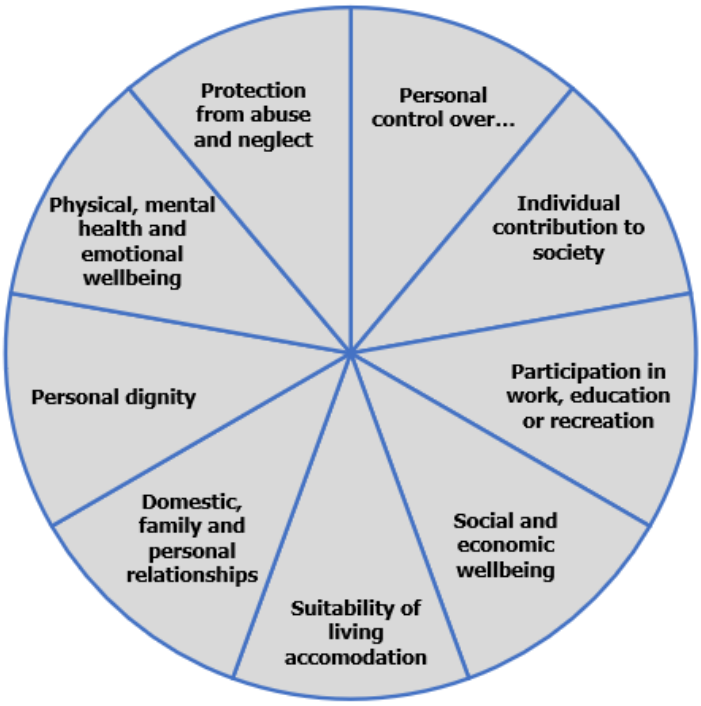
Guidance:

Care and Support Statutory Guidance.

Wellbeing Principle.

The Care Act sought to build on ideology from previous agendas such as person-centered practice and personalisation by introducing the wellbeing principle as central to the Care Act. Wellbeing is defined as the following 9 principles.

Wellbeing Principles



Wellbeing is considered throughout all of our interactions with people and is at the heart of assessment, care and support. Key elements of the wellbeing principle are as follows:

- Wellbeing focuses on the needs and goals of the person concerned.
- It applies to adults with care and support needs and their carers.
- There is no hierarchy, all principles are of equal importance.
- Critically wellbeing applies in all situations where a local authority is carrying out a care and support function or making a decision.

The act reminds us that the individual is best placed to judge their own wellbeing. There is no set approach to promoting wellbeing as it is dependent on a person's needs, goals and wishes. Our duties to promote wellbeing also extend to those who do not have eligible needs. Stressing the importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist.

Models of preventative working, voluntary sector, signposting and public health are critical to promoting wellbeing.

The Mental Capacity Act 2005

The Mental Capacity Act 2005 covers people in England and Wales who can't make some or all decisions for themselves. The ability to understand and make a decision when it needs to be made is called 'mental capacity'.

One of the 5 key principles of the Act is that any act done for, or any decision made on behalf of a person who lacks capacity must be done, or made, in that person's best interests. A practitioner trying to work out the best interests of a person who lacks capacity to make a particular decision ('lacks capacity') should follow the statutory checklist (Section 1 [5] of the Act). The focus is to

demonstrate that the process undertaken to assess best interests complies with the Mental Capacity Act 2005. Further detail on the Mental Capacity Act can be located here.

The Mental Health Act 1983.

Aims to advise people with a mental health problem what their rights are regarding:

- Assessment and treatment in hospital
- Treatment in the community
- Pathways into hospital which can be civil or criminal.

Many people who receive inpatient treatment on psychiatric wards have agreed to go into hospital as informal patients (also known as voluntary patients).

However, some people are in hospital without their agreement as formal patients. This is because they have been detained under the Mental Health Act (sectioned).

Where someone is a formal patient they lose certain rights, including the right to leave hospital freely, in this situation it is important to support people to understand and be aware of their rights under the Mental Health Act.

Advocacy is extremely important when supporting people with mental health needs. Qualifying patients may be entitled to help and support from an Independent Mental Health Advocate (IMHA). Alternatively, if a person requires a 'needs assessment' (under the Care Act 2014) and they are not eligible for an IMHA practitioners should consider an advocate under the Care Act 2014.

There is an interface between the Mental Health Act and the Care Act and Implications for local authorities as a person may be assessed under Care Programme Approach (CPA) and /or the Care Act 2014.

For this reason, it is common for local authorities to work together with mental health professionals and many integrate or align processes in order to better fit around the needs of the individual.

The Human Rights Act 1998

Section 6(1) of this Act states that 'It is unlawful for a public authority to act in a way which is incompatible with a Convention right'. There are 16 basic rights in the Human Rights Act 1998, all taken from the European Convention on Human Rights. They do not only affect matters of life and death like freedom from torture and killing; they affect people's rights in everyday life: what they can say and do, their beliefs, their right to a fair trial and many other similar basic entitlements.

As a practitioner, it is necessary to be aware of all of the rights. However, in day-to-day social care practice there are two in particular that you should always have regard for.

- Article 5-Right to liberty and security. (Relevant for those involved in activity which may limit or restrict liberty)
- Article 8- Right to respect for private and family life, home, and correspondence. (Relevant for those dealing with families or children and provision of social care).

The Autism Act

The **Autism Act 2009** was the first ever disability-specific law in England.

The Act did two key things:

- The first was to put a duty on the Government to produce a strategy for autistic adults, which was published in March 2010.
- The second was a duty on the Government to produce statutory guidance for local councils and local health bodies on implementing the adult autism strategy by the end of 2010. This guidance was published in December 2010.

Statutory guidance has been published to ensure the implementation of the adult autism strategy. This guidance tells local authorities, NHS bodies and NHS Foundation Trusts what actions should be taken to meet the needs of autistic people living in their area.

The Government published a new statutory guidance in March 2015, which replaced an existing guidance from 2010. The 2015 guidance included a lot more information, in fact, 5 additional chapters were added.

The statutory guidance clearly states that local authorities and the NHS:

- should provide autism awareness training for all staff.
- must provide specialist autism training for key staff, such as GPs and community care assessors.
- cannot refuse a community care assessment for adults with autism based solely on IQ.
- must appoint an autism lead in their area.
- have to develop a clear pathway to diagnosis and assessment for adults with autism.
- need to commission services based on adequate population data.
- As the guidance is statutory, local councils and local health bodies have a legal duty to implement it.

Part 2: Assessment Guidance.

Assessment Guidance.

Purpose of assessment

The aim of the assessment is to have a genuine conversation to identify an individual's needs and desired outcomes. The assessment should seek to establish the total extent of needs (including fluctuating) before considering eligibility for care and support. Assessment is, however, not always about meeting needs directly.

The Care Act advises local authorities to seek to achieve a balance between the person's wellbeing and that of friends or relatives who are involved in caring for the individual.

Practitioners need to ensure that any restriction on the individual's rights or freedom of action that is involved in the exercise of the function is proportionate and least restrictive. Practitioners should always consider capacity and need to ensure that decisions are made having regard to all of the individual's circumstances.

During the assessment, local authorities must consider all of the adult's care and support needs, regardless of any support being provided by a carer.

Where the adult has a carer, information on the care that they are providing can be captured during assessment, but it must not influence the eligibility determination.

After the eligibility determination has been reached, if the needs are eligible or the local authority otherwise intends to meet them, the care which a carer is providing can be taken into account during the care and support planning stage.

The local authority is not required to meet any needs which are being met by a carer who is willing and able to do so, but it should record where that is the case. This ensures that the entirety of the adult's needs are identified and the local authority can respond appropriately if the carer feels unable or unwilling to carry out some or all of the caring they were previously providing.

Who should have an assessment?

Local Authorities have a duty to assess any adult with the appearance of need for care and support.

S 9. (1) Where is appears to a local authority that an adult may have needs for care and support the authority must assess-

a- whether the adult does have needs for care and support and

b- if the adult does, what those needs are.

(2) An assessment under subsection 1 is referred to as a 'needs assessment'

(3) The duty to carry out a needs assessment applied regardless of the authorities view of –

a- the level of the adults needs for care and support or

b- the level of the adult's financial resources

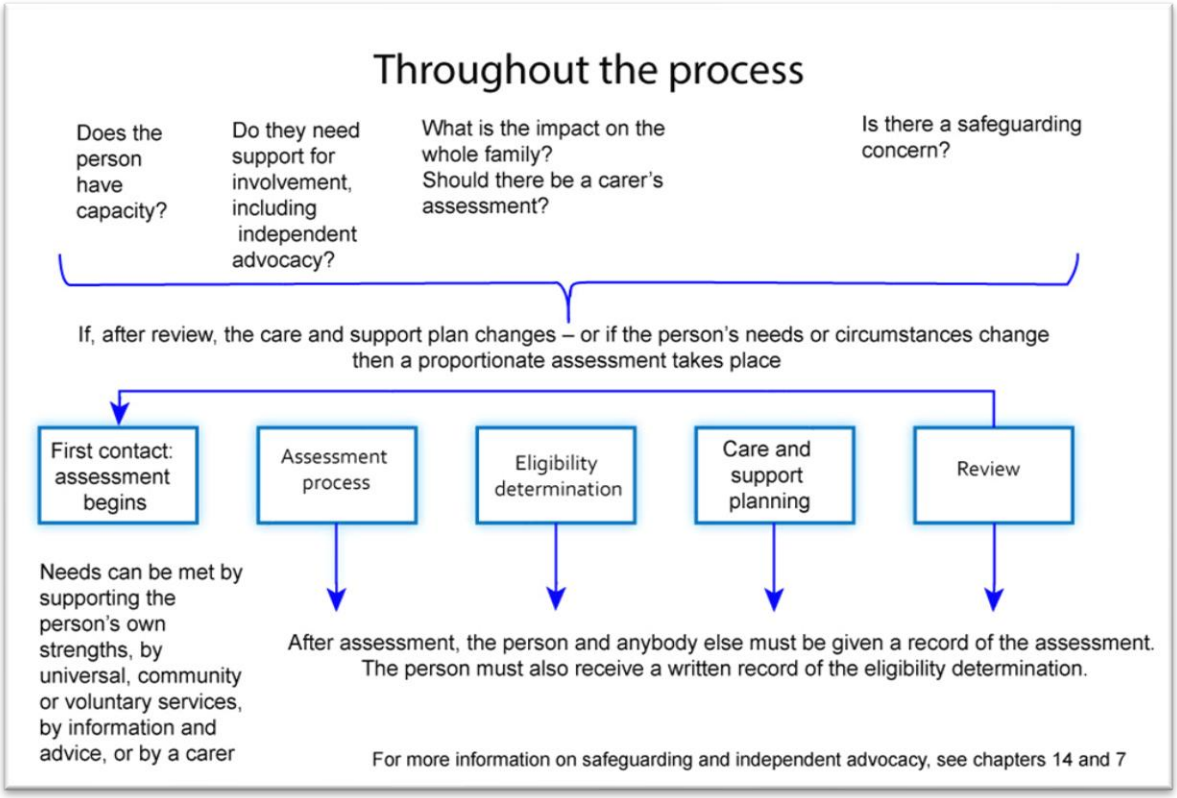
An ‘assessment’ must always be appropriate and proportionate. It may come in different formats and can be carried out in various ways, including but not limited to:

- a face-to-face assessment between the person and an assessor, whose professional role and qualifications may vary depending on the circumstances, but who must always be appropriately trained and have the right skills and knowledge.
- a supported self-assessment, which should use similar assessment materials as used in other forms of needs or carers’ assessments, but where the person completes the assessment themselves and the local authority assures itself that it is an accurate reflection of the person’s needs (for example, by consulting with other relevant professionals and people who know the person with their consent)
- an online or phone assessment, which can be a proportionate way of carrying out assessments (for example where the person’s needs are less complex or where the person is already known to the local authority and it is carrying out an assessment following a change in their needs or circumstances)
- a joint assessment, where relevant agencies work together to avoid the person undergoing multiple assessments (including assessments in a prison, where local authorities may need to put particular emphasis on cross-agency cooperation and sharing of expertise)
- a combined assessment, where an adult’s assessment is combined with a carer’s assessment and/or an assessment relating to a child so that interrelated needs are properly captured, and the process is as efficient as possible.

Consent and Refusal of an Assessment

- For every needs assessment consent must be sought from the person and recorded in Care Director within the assessment form
- Where an adult refuses a needs assessment, the local authority is not required to carry out the assessment unless either of the following apply:
  - the adult lacks capacity to refuse the assessment and the authority is satisfied that carrying out the assessment would be in the adult’s best interests, or
  - the adult is experiencing, or is at risk of, abuse or neglect.
- The refusal of a needs assessment should be recorded in Care Director on the Assessment form with a sufficient explanation of the practitioners ‘reasonable belief’ that the adult either.
  - has mental capacity to refuse the needs assessment and is refusing, OR,
  - lacks mental capacity to refuse the needs assessment and it is, or is not, considered to be in the adult’s best interests to proceed.
- Where a carer refuses a carer’s assessment, the local authority is not required to carry out the assessment subject to there being no risk concerns.

Key principles of the Assessment process as detailed in the Care Act statutory guidance.



Part 3: Assessment Framework.

Assessment Framework.

The assessment process starts from when local authorities begin to collect information about the person and will be an integral part of the person's journey through the care and support system as their needs change.

The assessment process will not always be the same for all people, depending on the circumstances, it could range from an initial contact or triage process which helps a person with lower needs to access support in their local community, to a more intensive, ongoing process which requires the input of a number of professionals over a longer period of time.

Assessment should not just be seen as a gateway to care and support. Assessment should be a critical intervention in its own right, which assists people to understand their situation and the needs they have, to reduce or delay the onset of greater needs and to access support when they require it.

The assessment process will also assist people to understand their strengths and capabilities, the support available to them in the community and through other networks and services.

People may approach a local authority for an assessment, or be referred by a third party, for a number of reasons. The 'assessment' which they receive must follow the core statutory obligations, but the process is flexible and can be adapted to best fit with the person's needs, wishes and goals.

Central Bedfordshire's Assessment Framework has been designed with the intention of allowing practitioners to use their professional judgement to record and respond to a particular request or situation.

To facilitate this, a range of documents are available to support practitioners representing the local authority to practice effectively and to accurately and safely record the assessment process and interactions with persons.

Advocacy.

Having someone to speak on your behalf is often known as advocacy. Advocacy is helping someone, particularly adults at risk, to:

- be involved in decisions about their lives
- speak out about issues that matter to them
- protect their rights

The Care Act advises us that where a person may have substantial difficulty participating in the Assessment/Review/Support Planning process then advocacy should be sought.

This may be in the form of an informal advocate, usually a family member or friend with a vested interest in the persons wellbeing. It is important that an advocate can provide impartial advice and support to the person to represent their views fairly.

Formal advocates should be commissioned where a person does not have informal support. Using a formal advocate is also more preferrable where you have identified any tensions or conflicting views between involved parties. This ensures the person has a voice and objective support to enable decision making.

In Central Bedfordshire we use VoiceAbility Advocacy service.

VoiceAbility provides a range of free, confidential and independent advocacy services to help people make choices about their lives, to understand their rights, to be treated as equals and to be heard.

For more information, please visit Independent advocacy | Central Bedfordshire Council

https://www.voiceability.org/support-and-help/services-by-location/bedfordshire-borough

Risk Enablement.

We recognise that risk is an inevitable consequence of people taking decisions about their lives. Practitioners will support people, families and involve necessary partner agencies to explore the issues and make arrangements which go as far as possible towards meeting the people's aspirations, whilst balancing the needs and risks to themselves, others and the Council.

Practitioners are expected to ensure that risk is not only identified but that subsequent appropriate action is then taken to support and enable persons to live their lives whilst taking informed risks with consideration of the likelihood of significant harm arising from the situation in question.

Our practice will always be strengths based and promote a culture of choice that entails responsible, reasonable, supported and shared decision-making.

The following core considerations must be central within Risk Enablement:

- Ensure that mental capacity is considered and, where appropriate, assessed
- Ensure that all risk work is person centred
- Ensure that all relevant legislation is considered

Key Elements and Model of Risk Assessment.

Any risk assessment must include these key elements:

- The individual's history
- The individual's own view of risks
- Strengths and/or vulnerability. Support including natural support.
- The nature and extent of any risk
- The impact of potential Harm. Including the impact in terms of loss of independence and the likelihood of it happening again/ continuing.
- Anticipated future: What influences will increase risk? What influences will decrease risk?

Understanding and managing risk involves recognising that situations can change very quickly as can the nature of the risk. We will therefore need to look at how things might have been in the past, how this relates to the present and how environmental factors might influence the situation.

The risk assessment will need to be an integral part of the assessment process so that the process can be understood as a part of the individual's story, to highlight their strengths and resources as well as their needs and challenges.

Questions like "what has worked well in the past?" or "how have you managed this before?" are important.

Risk enablement is a key skill for practitioners in promoting wellbeing and achieving outcomes.

As an approach, risk enablement identifies a link between risk and enablement. Risk enablement recognises that taking carefully considered risks can enable individuals and help improve their wellbeing.

Positive risk-taking is a way of working with risk that promotes enablement. It is important to remember that the 'positive' in positive risk-taking refers to the outcome not the risk.

The Assessment Framework contains the following key documents:

Needs Assessment / Review

The Care and Support Assessment and Review forms are the principal documents used by practitioners to meet our statutory functions.

The aim of the assessment is to identify what needs the person may have and what outcomes they are looking to achieve to maintain or improve their wellbeing.

The documents are utilised across the whole of Community Assessment Services however completion of the documents will be proportionate or fine-tuned to the practitioner's specialism or service area. (Such as OT, HDS or First Response intervention).

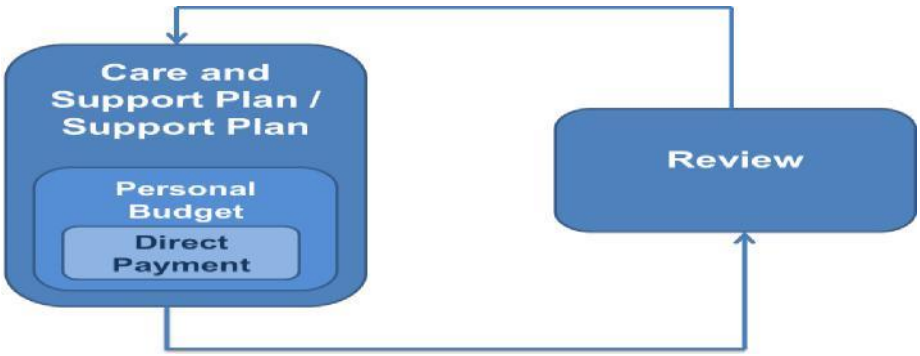
The outcome of the assessment is to provide a full picture of the individual's needs so that the local authority can provide an appropriate response at the right time to meet the level of the person's needs.

This might range from offering guidance and information to arranging for services to meet those needs. The assessment may be the only contact the local authority has with the individual at that point in time, so it is critical that the most is made of this opportunity.

The document can be used flexibly and can also be used to facilitate and record a review of needs and existing plan of support.

If being utilised for the purposes of joint assessment (person/carer) practitioners must ensure in this scenario that eligibility determinations and rationale is included for both parties in the assessment outcome. Where a joint assessment is completed, this will be attached to both parties' records with obtained consent from the individuals concerned.

Review.



The local authority is under an ongoing duty to keep the person's support plan and personal budget under **review**, to ensure that their needs continue to be met.

The review should be a positive opportunity to take stock and consider if the support plan enables the person to meet their needs and achieve their aspirations. Reviews must be proportionate, take place periodically (depending on individual circumstance). The process should not be overly complex or bureaucratic and should be flexible wherever possible.

There are several different routes to reviewing a care and support or support plan including:

- a planned review (the date for which was set with the individual during care and support or support planning, or through general monitoring)
- an unplanned review (which results from a change in needs or circumstance that the local authority becomes aware of, for example, a fall or hospital admission)
- a requested review (where the person with the care and support or support plan, or their carer, family member, advocate or other interested party makes a request that a review is conducted. This may also be as the result of a change in needs or circumstances)

The frequency of a planned review will differ dependent on the individual and will be determined by the practitioner at the point of sign off of the support plan.

Review frequency should be agreed in consultation with the person, should be proportionate to the situation and also be accompanied by robust contingency planning discussions during the support planning stage. Review should be undertaken a minimum of annually.

The majority of reviews will take place face to face, however there are occasions where it may be appropriate to request the review is completed virtually. This can enable relatives and involved professionals to attend and participate when they may not be able to be present at a face-to-face meeting due to their location or work commitments.

A Review may also be carried out by another party for example where a person resides out of county and the host local authority is prepared to review on our behalf.

Reviews can take place face to face via the telephone or video call. The method of review will be determined on an individual basis; however, the method of contact must be appropriate, considerate of risk, mutually agreed and involve the persons advocates and significant others with given consent.

Carers Assessment.

Where an individual provides or intends to provide care for another adult and it appears that the carer may have any level of need for support, local authorities must carry out a carer's assessment. When assessing the carer practitioners should consider the impact of caring, the outcomes the carer wants to achieve and also the sustainability of the role.

Where a person is providing care under contract (for example, for employment) or as part of voluntary work, they should not normally be regarded as a carer, and so the local authority would not be required to carry out the assessment.

Carers can be assessed in a variety of ways; practitioners will discuss how the carer would like to be assessed and then select the most appropriate document to record the assessment and support plan.

For example, where a carer wishes to be assessed jointly with the cared for person the assessment document can be utilised. In this scenario the practitioner must ensure that the views of the person and carer are separated and clearly defined within the assessment. The practitioner must also ensure eligibility determinations are evidenced for both parties.

Carers are entitled to an assessment in their own right so, for those not wanting to be jointly assessed practitioners will use the dedicated carers assessment and combined support plan.

A review for carers will be recorded using the review document except where there are significant changes to the support plan in which case a reassessment and new support plan will be required.

Mental Capacity Assessment.

Where there is concern about a person's capacity to make a specific decision, for example as a result of a mental impairment such as dementia, acquired brain injury or learning disabilities, then an assessment of capacity should be carried out under the Mental Capacity Act 2005 (MCA).

Those who may lack capacity will need extra support to identify and communicate their needs and make subsequent decisions, and practitioners should consider if there is a need for an Independent Mental Capacity Advocate.

Assessors must in these situations carry out supported decision making, helping the person to be as involved as possible and must carry out capacity assessments alongside the assessment of need and support plan process.

The Mental Capacity Lead has created Mental Capacity Act Practice Guidance and a range of tools that should be utilised to support and enable practitioners when working with persons.

Occupational Therapy Assessment.

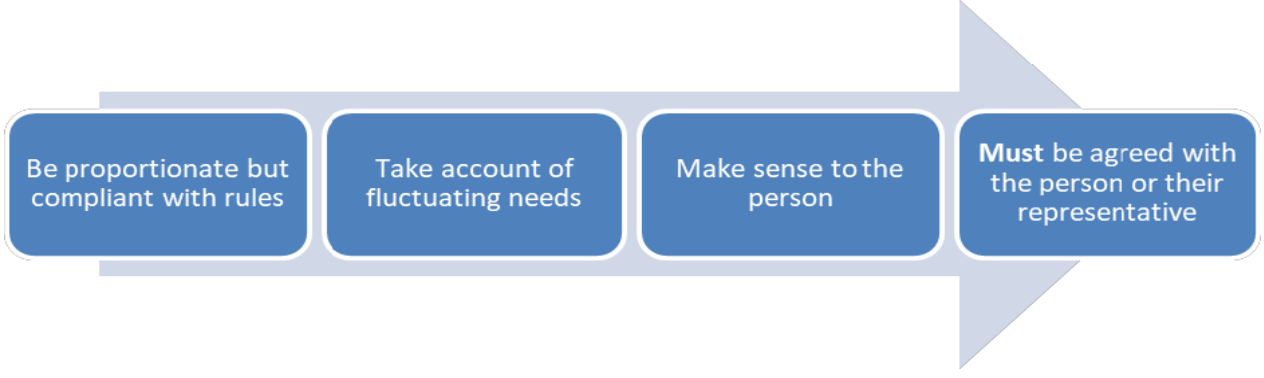
Occupational Therapy complete assessment/review forms to capture specific details around the needs of the person, the environment and risk management.

Occupational Therapists and Social workers regularly work alongside each other to assess and achieve the most appropriate outcome for a person. The information collected, via either professional, is transferable and 'trusted' to ensure that persons tell their story once and the assessment process is proportionate.

The service also works closely with other professionals such as Health Professionals, Housing Services and Reablement to complete an assessment and appropriate care and support plan.

Support Plan.

The following key principles should be adopted when assisting persons with support planning.



A support plan must be created following the assessment and eligibility determination. The support planning process and the outcomes should be built holistically around people's wishes and feelings. The plan that is created should be person led and encourage people to be in control of their care.

When support planning, practitioners should ensure they detail the needs to be met and how these will be met. The narrative must link back to outcomes that the person wishes to achieve and to the wellbeing principle. Support plans should encapsulate support provided formally but also record where universal services such as voluntary and charitable sector are meeting needs or providing advice, support and guidance. It is also imperative to add the contributions of friends and family or 'informal' support assisting a person to meet their needs and goals.

Support planning should be flexible and creative considering the types of support that may be available and appropriate to meet a need. This may range from more traditional 'service' options such as community support or equipment/adaptations to other types of support such as assistive technology in the home. A need can also be met by providing information and advice, or signposting to appropriate support e.g. putting a person in contact with a local community group or voluntary sector organisation.

Recording should demonstrate how the person and practitioner have considered available and appropriate options allowing an informed and balanced decision to be made.

The support plan will clearly indicate which needs the authority will meet, who else will contribute which could be the person themselves, carer, other agency, or a combination approach. A person can choose to detail outcomes that do not meet the eligibility criteria in their support plan in this circumstance this will be clearly documented with an explanation of how these will be met. (For example, support to manage a health need).

Personal Budget.

An individual personal budget must be included in the support plan and signed off by a person with budgetary responsibility, using the Brokerage Funding Request (BFR).

There are various ways to calculate a personal budget amount. The persons social worker will:

- identify the number of hours of care and support needed to meet a person's eligible needs,
- agree outcomes and
- discuss how the person would like that support delivered. The Brokerage Team will provide the calculations for Direct Payment costings.

Appeals Process.

If a person or their representative does not agree with a decision about their care and support arrangements, they can appeal this decision by completing the appeals form. The person can also call the Contact Centre who can help complete the form if required.

ASC Appeals Practice Guidance final May 2023 (for Practitioners) (centralbedsappp.co.uk)

Adult social care appeals | Central Bedfordshire Council

Associated practice documents.

Safeguarding Adults documentation

An authority must make enquiries or cause others to make enquiries when it believes an adult is experiencing abuse or neglect.

Safeguarding duties apply equally to those adults with care and support needs regardless of whether those needs are being met, regardless of whether the adult lacks mental capacity or not and regardless of setting.

There is a suite of documentation that practitioners use to record safeguarding activity. Safeguarding policy, procedures and supporting materials are located on the Safeguarding Adults pages of the policy hub.

Safeguarding, MCA & DoLS (LPS) – Central Bedfordshire APPP Resource (centralbedsappp.co.uk)

Risk Assessment.

Risk discussion, enablement and decision making must be a key feature in the narrative of all recording and clearly evidenced within the assessment, support plan and review.

However, where practitioners are supporting situations in which risk, ambiguity or complexity is greatest, practitioners may wish to record a more detailed standalone risk assessment for a person. In this circumstance the Safeguarding Risk Assessment can be used outside of safeguarding practice.

Moving and handling Risk Assessments

Moving and handling risk assessments (including those provided by OT services in health) should be considered as part of the wider needs assessment process, and appropriate referrals made. This helps identify where injuries and problems could potentially occur and how to prevent them and achieve the best outcomes for the person.

Part 4: Practice Recording.

Practice Recording Governance.

Practice governance arrangements have been operational within CBC since 2014 and are led by the Practice Governance Board and Principal Social Worker. Central Bedfordshire's quality improvement framework and incorporated improvement activities are directed by the board, and this includes governance over case audit requirements and arrangements.

Individual practitioners should expect to participate in a minimum of 2 audits per year and a variety of other activities intended to support reflection and continuous learning.

The Case File Audit seeks to ensure that recording is of a satisfactory standard, meets our statutory obligations and demonstrates person centered and safe practice.

Case audits are undertaken by a range of people including direct line managers, peers, quality improvement team and also senior management. Practitioners will always be provided with feedback to enable learning.

The following general standards for recording highlight the minimum expectations for practice recording and should be adhered to at all times.

General Standards for recording

- We will create and maintain accurate records of all the work we do with people.
- The record belongs to the person entries should be appropriate.
- Recording is clearly legible, dated and signed (where appropriate).
- Professional decisions are supported by a clear rationale and evidence base.
- The level and scope of the assessment is appropriate to the needs of the person. The person's views, abilities, aspirations and strengths are recorded in addition to their support needs throughout the assessment process.
- Recording is factually accurate and objective. Where an opinion is given it must be made clear that it is opinion and must be relevant.
- All communications, written and oral, and including assessment reports, support plans and any other reports are clear and readily understandable to persons and their carers
- Recording is completed as soon as possible after the event it describes to ensure it can be defended in legal proceedings and is accurate. The 'Profile notes' section in CareDirector is used to record ongoing communications and activity in each case.
- The correct forms are used for recording information and stored appropriately in accordance with CareDirector operational instructions.
- There is a Support Plan for every open case. It will be 'outcome focused' and will be prepared with the service user and their carer/s in partnership, where appropriate.
- Persons always receive a copy of their assessment and support plan.
- Cases are closed or transferred appropriately when required.
- All case file recording and management is carried out in accordance with policy and procedure and discussed with managers in Supervision.

Policy and Practice Support Tools.

Central Bedfordshire's ASC Assessment Framework is complemented by a suite of resources designed to support and enable best practice.

All practice appropriate policy and procedures are located on the new online policy hub. A one-stop shop for social care legislation and direction to support practice excellence and decision making.

Resources, guidance materials and practice tools are currently located on the Investing in You and Safeguarding intranet pages.

Documents are added frequently, an example of current resources include:

- Benefits and Burdens analysis.
- Complex case evaluation tool
- Risk supported decision making tool
- Legal literacy challenge.
- Mental capacity guide to carrying out assessments

Stated documents can be found via the following link:

Central Bedfordshire Council Team Site - Search (sharepoint.com)

Further Guidance.

Further guidance and resources to enable evidence-based practice are available on the Research in Practice and Community Care Inform websites.

Central Bedfordshire Council maintains subscriptions with both services as part of our commitment to maintaining a learning culture, supporting and enabling evidence-based practice and continuous improvement models.

https://www.researchinpractice.org.uk/register/

https://adults.ccinform.co.uk/