Central Bedfordshire

Community Assessment Service Operational Policy

Adult Social Care

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Community Assessment Service Operational Policy

Directorate:	Adult Social Care and Housing (ASC&H)		
Division & Service:	Adult Social Care / Commissioning / Resources		
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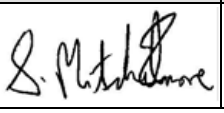
Stuart Mitchelmore	Service Director – Adult Social Care		Central Bedfordshire Council	09/06/2025

CQC Assurance Key Areas:

This policy document supports CQC Assurance Key Areas:

Safe	Effective	Caring	Responsive	Well-led
●	●	●	●	●

This document is not controlled when printed.

It is the responsibility of every individual to ensure that they are working to the most current version of this document.

Contents

1. Introduction

1.1 This document aims to outline how the Community First Response Service, North and South Locality teams, Adult Assessment and Review Team, Occupational Therapy and Young Adults Independent and Living Team within Adult Social Care will operate within our vision of helping Central Bedfordshire residents to live their own lives and play a full part in the life of the community.

1.2 The Emergency Duty Team also forms part of this service and has its own Standard Operating Procedures

AMHP & EDT Protocol – Central Bedfordshire

2. Context

2.1 Under Section 9 of the Care Act 2014, Central Bedfordshire Council has a statutory duty to assess the needs of any adult or carer who has needs for care and support and to determine whether those needs are eligible for support or services from the council.

2.2 The council also has duties to provide advice and information about what can be done to meet or reduce any needs identified, whether they are eligible for support from the council.

2.3 Practitioners (depending on your role) have a professional duty to develop and maintain an understanding of current legislation applicable to health and social care and to take account of relevant policies and guidance in their practice. Other relevant Legislation and Policies which will underpin our practice may include:

- Mental Capacity Act 2005
- Deprivation of Liberty Safeguards
- Mental Health Act 1983 (as amended by the Act in 2007)
- Bedfordshire and Luton Multi Agency Safeguarding Policy
- Human Rights Act 1998
- National Continuing Health Care Framework 2012
- Autism Act 2009 and Autism Statutory Guidance 2015
- Children and Families Act 2014
- The Equality Act 2010
- Transforming Care Programme 2015
- Housing Grants, Construction and Regeneration Act 1996

Who is Community Assessment Services?

2.4 Community Assessment Services' role is to support the well-being of adults and communities across Central Bedfordshire. The service is committed to collaborating closely with people and partners in meeting the needs of its residents.

2.5 Social care practitioners, act as assessors and enabler's signposting people to a wide range of advice, support and services designed to support people to maintain and improve their independence, enable them to engage in their local community, protect them in vulnerable situations and meet a variety of eligible assessed care and support needs.

2.6 Community Assessment Services currently incorporates the following teams:

- **First Response Team** - (Front door to adult social work and short-term interventions)
- **The Hospital Discharge Team** – supports people who require on-going support when being discharged from hospital.
- **South Locality Older Persons Team** - provides assessment and review for areas such as Dunstable, Houghton Regis and Leighton Buzzard and surrounding areas.
- **North Locality Older Persons Team** - provides assessment and review for areas such as Ampthill, Flitwick, Biggleswade and surrounding areas.
- **Occupational Therapy Team** – provides assessments and support for all age adults to support independence and safety and enable people to remain at home. Including consideration of equipment, minor works, or assistance to facilitate major adaptations.
- **Adults Assessment and Review Team** - provides support to individuals with a learning disability and/or autism and people with a physical disability.
- **Young Adult and Independent Living Team** – provides support to young people transitioning form children's services who require adult social care support and individuals (working age) known to the service who would benefit from support to develop/improve their independent living skills.
- **Emergency Duty Team** - provides an emergency social worker response out of hours across Luton, Central Bedfordshire, and Bedford Borough.

2.7 The nature of Community Assessment Services is such that it is required to work in partnership with a number of private and voluntary organisations as well as health, education, and housing.

2.8 Mental Health and Specialist Learning Disability Services are provided by East London Foundation Trust (ELFT) on behalf of Central Bedfordshire Council. East London Foundation trust also deliver community health services locally.

2.9 Community Occupational Therapy are provided by ELFT and supports with equipment and minor works assessments for people with a Bedfordshire GP. The service provides comprehensive moving and handling assessments for equipment and where required, will demonstrate and advise to people and their carers. The service refers to and liaises with social services occupational therapists (OTs) regarding major adaptations referrals. The service is part of Bedfordshire Community Health Services (BCHS)

2.10 Community Mental Health Teams – provide social care (in addition to health) support for adults with enduring mental health issues via a S75 arrangement. Monthly liaison meetings are held with the service to provide oversight and assurance, in addition to a formal Performance Management Meeting.

2.11 Bedfordshire, Luton Milton Keynes ICB (BMLK) are the local ICS organisation.

3. Responsibilities

3.1 The procedure will be overseen via the line management and supervision structure within Adult Social Care

Standard Operating Procedures for Adult Social Care (ASC) Operational Teams

3.2 Below is the vision developed by Central Bedfordshire. It has been created to achieve the best possible outcomes for all individuals and carers supported by Adult Social Care. The key elements of achieving this will be:

- Taking a person-centred approach
- Using co-production principles, as people who use services, and their carers, are best placed to help design them.
- Focussing on enabling people to be as independent as possible
- Embracing new ways of working
- Making the most of opportunities for partnership and integrated working with other organisations for the overall benefit of the communities we support

3.3 This document aims to outline how the Community Assessment service operational teams within Adult Social Care will operate within our vision of helping Central Bedfordshire residents to live their own lives and play a full part in the life of the community. This Standard Operating Procedure (SOP) will be reviewed regularly to ensure best practice and positive outcomes are delivered.

3.4 The service will work collaboratively with a range of stakeholders from across the health and social care system, in ways that recognise strengths, promote independence, and prevent, reduce and delay the need for formal long-term care and support provision.

Description of Service Areas

Community First Response (Short Term Teams)

The Community First Response Service is for people, aged 18+ who are in the community or hospital and have been identified as having care and support needs. It comprises two teams, First Response and Hospital Discharge.

First Response

The First Response Service is the ASC front door. They triage all referrals (for unallocated people) and consider whether they can:

- Signpost/ give information.
- Provide short term support (including reablement)
- Amend existing support.
- For new referrals, undertake an assessment and commission support.

This service will provide appropriate signposting, information and advice and where appropriate short-term interventions (including assessment). The service will provide a crisis response (during office hours) where there is a need to ensure people are safe and will also proactively consider relevant options to prevent the need for on-going social care and to enable individuals to remain independent for as long as possible.

Only individuals with long term or complex needs will be passed to the relevant locality team to undertake an assessment and/or provide on-going support.

Hospital Discharge Service

The Hospital Discharge Service support people who require social care support at the point of being discharged from hospital. The team will provide information and advice and an assessment (as appropriate) and support plan to ensure a person's identified outcomes are achieved and independence is maintained wherever possible.

This service will work collaboratively with a range of stakeholders from across the health and social care system in Central Bedfordshire to provide appropriate short-term interventions (including assessment) and ensure people are safe and also to reduce the risk of delayed transfers of care from acute and community hospitals. It will also ensure that people are discharged from acute and community hospitals in a safe and timely way.

This service will have a key role influencing and shaping Discharge to Assess/Home first models in Central Bedfordshire and ensuring that in all instances people are supported to achieve their most independent outcome in keeping with the Adult Social Care vision.

Long Term Teams

The teams work in alignment with the Primary Care Networks (PCN) across Central Bedfordshire and provide social care support/expertise to those networks that have adopted a multi-disciplinary team approach, enabling one access point for individuals being supported by the PCN who require coordinated support. There is a primary focus on ensuring that all support:

- is person centred and strength based.
- promotes personal resilience including considering contingencies to manage temporary changes in need/circumstance.
- is proportionate to the presenting needs and reflects individual choice and control.
- demonstrates how people will meet their needs from a range of sources, including friends, family, third sector, the community, equipment or assistive technology (TEC) and that funded support is allocated for the provision of formal support for identified unmet needs.

North and South Locality teams

The North and South locality teams support people, aged 65+ who are living in the community (including residential and nursing care) and have been identified as having long term care and support needs. The team mainly provides support to individuals who need social care support either due to frailty, the impact of long term/health conditions or dementia.

Adult Assessment and Review Team (AART)

The Adult Assessment and Review Team provides support to adults 18+ who have a physical disability, learning disability or autism. AART is an integrated team of social care staff and learning disability nurses.

Young Adults Independent Living Team (YAIL)

The Young Adults and Independent Living Team provides support for young adults (with eligible social care needs) aged 18 and over but work in partnership with the Children's service from 14. Additionally, the Independent Living Workers within the team provide support to working age adults to develop or regain independent living skills.

Occupational Therapy

The Occupational Therapy service provides assessment and support for all age adults to support independence and safety and enable people to remain at home. Including consideration of equipment, minor works, or assistance to facilitate major adaptations.

The team work closely with health professionals, social care colleagues and housing teams to facilitate appropriate works and provide advice to promote and / or enable independence, quality of life and safety within the home.

In addition to the assessment team, there are OT's working with CBC Housing and Registered Social Landlords to identify suitable properties for people with disabilities where their current properties are unable to be adapted.

The Occupational Therapists are aligned to the first response and locality social care teams and operates across services providing people with specialist support as necessary. The decision for allocation to the appropriate team is profession specific.

Occupational therapy best practice will be facilitated and overseen by the Principal OT via the Occupational Therapy Team Manager.

Technology Enabled Care (TEC)

The TEC team provide support to practitioners who are seeking to support people with TEC.

TEC refers to the use of telehealth, telecare, telemedicine, tele-coaching and self-care apps to provide care and support for people as an alternative or complimentary to traditional care support. TEC can provide the opportunity for people to engage and control their own health care and support, empowering them to manage it in a way that is right for them,

The TEC team will work closely with practitioners to identify new TEC solutions and work with providers to ensure they can support practitioners with expertise in this field.

See links below for further information:

https://www.england.nhs.uk/tecs/

https://www.nhsinform.scot/healthy-living/preventing-falls/help-and-support/technology-enabled-care

https://www.nhsinform.scot/healthy-living/preventing-falls/help-and-support/technology-enabled-care

4. Our Principles

4.1 The fundamental principle of our practice is that the support delivered to individuals should be proportionate, appropriate and most of all equitable. Community Assessment Services work to deliver support to individuals that reflects the 'I statements' based on the values of Think Local Act Personal. We are committed to ensuring a person-centred approach is at the heart of working with individuals, their families, and carers in Central Bedfordshire. And that individuals feel able to say:

- I can live the life I want and do the things that are important to me as independently as possible.
- I am treated with respect and dignity.
- I feel safe and am supported to understand and manage any risks.
- I am supported to manage my health in a way that makes sense to me.
- I have people in my life who care about me- family, friends, and people in my community.
- I am valued for the contribution I make to my community.
- I have a place that I can call home, not just a bed or somewhere that provides me care.
- I live in a home which is accessible and designed so that I can be as independent as possible.

4.2 We will support this by:

- Focusing on what's important to the person and taking what is working well now as a starting point.
- Supporting people to identify their aspirations, goals and outcomes.

  Identify steps to get there and who/what we can use to help.

4.3 This is referred to as a strengths-based approach defined as an approach that is:

"Collaborative between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets." **Care Act 2014.**

Promotion of Wellbeing

4.4 Wellbeing underpins all the care and support that the local authority offers to adults and carers in their area. Everyone's idea of wellbeing is different because it is personal to each person. Wellbeing is a very wide term. It is much more than enjoying good physical, mental or emotional health but it is also about someone:

- being treated with dignity and respect.
- feeling safe from abuse or neglect
- being in control of their life; – including any care and support needed and how it is provided.

- being able to join in work, education, training or leisure activities.
- living in accommodation that is right for them.
- taking part in what's happening in their local area.
- having relationships with family, friends, and neighbours.

4.5 Some of the things listed above will be more important than others to different people.

4.6 The Care Act says that wellbeing must underpin all the care and support that the council provides to adults and carers in their area. Community Assessment Service staff should work together with people to understand their individual needs and not make assumptions about what might be best for them.

4.7 There is no set approach but some things to consider include:

- making sure the person can make their own choices and decisions.
- their views and feelings and the goals that they want to reach are fully considered.
- that all services and support provided help people to live as independently as possible.
- recognise that everyone's needs are different and personal to them.
- assume that the person is the expert and knows best their own outcomes, goals, and wellbeing.
- ensure that the person can participate as fully as possible in all decisions about them.
- providing information and advice to help the person to make informed decisions.
- protecting people from abuse and neglect.
- understanding that care and support can be provided in a number of different ways; and taking a flexible approach to the provision of care and support which focuses on the aspects of wellbeing which matter most to the person concerned.

4.8 The focus should be on supporting people to live as independently as possible for as long as possible.

Safeguarding Adults

4.9 Adult Social Care Service is responsible for ensuring that those who are in receipt of support, obtain the right level of support they require to meet their needs and that they are safeguarded.

4.10 The Care Act statutory guidance defines adult safeguarding as:

> "Protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances."

4.11 Safeguarding adults includes:

- Protecting a person's rights to live in safety, free from abuse and neglect.
- People and organisations working together to prevent the risk of abuse or neglect, and to stop them from happening.
- Making sure people's wellbeing is promoted, taking their views, wishes, feelings and beliefs into account.

See procedures on 'Safeguarding Adults': PAN Bedfordshire (trixonline.co.uk)

Prevention, Information, Advice, Guidance and Signposting

4.12 Providing information, advice and guidance and signposting people to alternative sources of support is essential to support people, carers and families to take control of, and make well-informed choices about their Care and Support and to help promote people's Wellbeing. Providing appropriate information increases people's ability to exercise choice and control, it is also a vital component of preventing or delaying people's need for Care and Support.

4.13 When offering advice about the meeting of Care and Support needs, either currently or in the future, the service should always consider its duty to prevent/delay and/or reduce needs.

4.14 The council's responsibilities for preventing, reducing, and delaying needs apply to all adults, including:

- those who do not have any current needs for care and support.
- adults with needs for care and support, whether their needs are already being met by the council; and
- carers, including those who do not currently have any needs for support.

4.15 Under Section 4 of the Care Act the service provides proportionate advice and local information relating to Care and Support for people and Support for carers. The service may provide information and advice directly or signpost to relevant agencies or a relevant partner as some information or advice may be more accessible when provided impartially. The service will be proactive in its identification of opportunities to offer information and advice regardless of whether the person (or carer) is already receiving a Care and Support (or Support) service.

4.16 Reasonable adjustments should be made to ensure that people have equal access to information and advice services.

Assessment

4.17 Everyone has the right to request an assessment under the Care Act. The purpose of an assessment is to identify what needs the person may have and what outcomes they are looking to achieve to improve or maintain their wellbeing. The aim of an assessment is to find out what needs someone may have and what goals (also known as outcomes) they want to achieve to maintain or improve their situation. Assessments should help people to understand their strengths and abilities, areas of their life that they need support and what help available.

4.18 The person should be at the centre of the assessment and must be able to participate as much as they can, and want to, in contributing to it. They must be given all the support they need to do that, including considering any reasonable adjustments that need to be made.

4.19 If it is difficult for the person to be fully involved and there is no family member or friend who can represent or support them, an independent advocate should be considered.

4.20 If it is apparent that the person requires urgent support to safeguard them, the council must make immediate provision for care before carrying out a full assessment of the person's needs.

4.21 Individual assessment is key to understanding an individual's strengths, challenges, and desired outcomes. The objective is to place the individual in control of the assessment and enable them to lead as fully in the assessment as they wish to.

4.22 The Care Act states that the focus of assessment should be:

- To identify what strengths and challenges a person may have (needs)
- The impact of those on the person's wellbeing
- What is available to meet the needs – including their own strengths and capability and their informal network.
- The outcomes the person wants and possible preferences.

See Assessment Guidance (Appendix One):

4.23 Assessments should be compliant with the Care Act legislation. Assessments for long term support should take place at the most appropriate time for the person and once their situation has been stabilised and any rehabilitation or reablement needs have been optimised.

4.24 In exceptional circumstances it may be necessary for an assessment to take place prior to the situation being optimised and stable. In these circumstances the practitioner should assess and meet urgent need under the Care Act. The information should be recorded on the ASC assessment documentation BUT the practitioner may choose not to finalise eligible needs and the assessment until the person's circumstances are more settled. The practitioner should then visit later to update the assessment and complete it.

Consent

4.25 For every assessment consent must be sought from the person and recorded in CareDirector within the assessment form.

4.26 You should ensure that you ask the person's consent to share the assessment (and support plan and review) information and that this is recorded on the form within CareDirector.

4.27 Where a person is unable to consent, this should be considered under Best Interest Principles.

Refusal of an Assessment

4.28 People have the right to refuse an assessment. 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.

4.29 The refusal of a needs assessment should be recorded in CareDirector on the Assessment form with a sufficient explanation of the practitioner's '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.

See Mental Capacity Considerations (Section 6):

4.30 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.

Support Planning

4.31 Support Planning is a key part of the Assessment and Reviews process which sets out how a person's desired outcomes and identified needs will be met. This includes any regular support as well as creating contingency plans for when fluctuations in the situation occur or when other support is unavailable. Support planning should take place with the individual, and where appropriate, their carers, social workers and other professionals involved. The person should be at the centre of the plan and must be able to participate as much as they can, and want to, in developing it. They must be given all the support they need to do that, including considering any reasonable adjustments that need to be made.

4.32 The support plan should identify how the person's needs will be met in ways that work best for them, as an individual and if they are part of a family.

4.33 There are lots of ways a person's needs can be met, depending on an individual's particular circumstances and wishes. 'Meeting someone's needs' is more than just arranging services. The process of support planning makes sure everyone involved can contribute and can agree how the person's needs identified in the assessment will be best met. Care and support is not just provided by commissioned services, needs may also be met by a local community group, social networks or via the voluntary sector for example.

4.34 Each person's needs are unique to them and how people would like their needs to be met will depend on their circumstances, values, wishes, beliefs, and their goals in life.

4.35 When developing the plan, there are some things which must always be included. These are:

- the person's needs that were identified in the assessment.

- whether those needs are eligible for council support.
- what needs the council is going to meet, and how it will do that.
- the outcomes that the person wants to achieve, their wishes and preferences.
- the outcomes the carer wants to achieve, their wishes about providing care alongside their work, education, and recreation and where support could be useful to them.
- if the person's needs change, the plan should show how this will be responded to; and
- plans should include dealing with any sudden change or an emergency, such as a carer becoming ill.

See procedures on 'Care and Support Planning':

Assessment Framework Practice Guidance

https://www.centralbedsappp.co.uk/care-and-support-planning/

In the instance where an adult with Care and support needs lacks mental capacity to manage their finances and there is no appropriate person identified to support, a referral needs to be made to Money management. It is of key importance that the allocated worker shares all the relevant information with the Finance Team so all necessary arrangements can be made.

Charges and Paying for Care

4.36 Adult social care is chargeable, therefore if it is determined that a person is eligible for care or support from us, they receive a financial assessment to determine if they will need to contribute towards the cost of their care.

4.37 If the person receives a Direct Payment, their contribution will be deducted before the payment is made.

Deferred Payment Agreements

4.38 A deferred payment agreement is an arrangement with Central Bedfordshire Council that will enable people to use the value of their home to help pay care home costs. If a person is eligible, the council will help to pay a person's care home bills on their behalf.

4.39 The Council then places what is called a 'legal charge' on the person's property to safeguard the loan. A person can then delay repayment to the council until they sell their home, or until after their death.

4.40 The agreement can end at any time (for example if the property is sold) and the loan then becomes payable immediately.

Third Party Top Up – In care homes

4.41 To ensure that funding for care is fair and equitable the council work out the total amount a person's care should cost based on the level and type of support a person needs, this is called a personal budget. The council will offer care home placements that can meet a person's care and support needs and at fees that are within that budget;

however, people can choose to move into a more expensive home if someone other than the resident can pay the additional amount. This is called a third-party contribution or 'top up'.

4.42 A third-party top up is usually made by a relative or friend of the resident. The person paying the contribution must be willing and able to pay the additional cost for the whole duration of the placement, recognising how long this may be for. If the person is unable to continue to pay the contribution, and there is no other person available to undertake this, then the Council will look to move the resident to another room within the home or to another home that can meet the resident's needs within the personal budget amount.

See link below for Charging and Financial Assessments:

Charging and Financial Assessments (centralbedsappp.co.uk)

Direct Payments

4.43 There is a statutory requirement, other than in exceptional circumstances, to offer a Direct Payment to enable a person to choose and pay for their own support.

4.44 A Direct Payment is for people who have been assessed as needing help from social services and, would like to arrange and pay for their own care and support services instead of receiving them directly from the local authority. A Direct Payment can provide an individual with greater choice, control and flexibility in how they meet their identified eligible social care needs and agreed outcomes.

What can direct payments be used for?

4.45 Direct payments can be used in creative, flexible ways, as long the needs and outcomes agreed in the person's care and support plan are met.

Examples are:

- employing a personal assistant to help with daily household tasks or personal care – at times that best suit the person and their daily routine.
- buying services from a private care provider that the person chooses.
- helping someone to stay in touch with friends and family or make new social contacts.
- paying toward leisure, education, or social activities
- buying support to give unpaid family carers a break.

4.46 There are some things that it can't be spent on, including:

- permanent residential or nursing care
- any services or goods that haven't been agreed with the council in the care and support plan.
- employing a close relative who lives with the person.
- support provided by the council; and
- household bills, clothes, food and housing.

See links below for practice guidance.

Direct Payment Process Workflow

Direct Payments Policy & Procedure

https://www.centralbedsappp.co.uk/direct-payments/

4.47 In addition to when undertaking support planning with a person, discussion should also be held at the point of a full annual review, and where appropriate during a light touch review, about the use of direct payments and whether this is something an individual may wish to consider, to increase their choice and control of on-going support.

Appropriate and Proportionate Reviews

4.48 People's needs, circumstances, and hopes change over time and without regular reviews, plans can become out of date, meaning that people do not receive the right care and support to meet their needs.

4.49 Reviews can:

- give people the opportunity to look at what is working, what is not working and what might need to change.
- make sure that plans are kept up to date and are relevant to the person's needs and what they want to achieve.
- give the person confidence that people who are working with them understand what is important to them.
- reduce the risk of crisis situations.

4.50 A review should be seen as a positive opportunity for everyone to take stock and to have a say in how the plan is working.

4.51 Under Section 27 of the Care Act 2014, the local authority must keep Care and Support Plans under periodic review. This means they must have a system or process in place to ensure that reviews are carried out and monitored in a manner appropriate to the needs and circumstances of the person / carer whose plan it is. "Ensuring all people with a care and support plan, or support plan have the opportunity to reflect on what is working, what is not working and what might need to change is an important part of the planning process. It ensures that plans are kept up to date and relevant to the person's needs and aspirations, provides confidence in the system and mitigates the risks of people entering a crisis". (DOH Care and support statutory guidance 2018, s13.1).

4.52 The Council therefore has a duty under the Care Act to ensure that there is continued reviewing of the care and support plan that is in place for anyone assessed as having a need for care and support, or support for a Carer, from the Local Authority. This is to ensure that the arrangements in place continue to meet the identified needs and outcomes and to identify whether anything has changed that requires a change in the plan or a reassessment. Reviewing intended outcomes detailed in the plan is how the local authority complies with its ongoing responsibility towards people with care and support needs. The duty on the local authority therefore is to ensure that a review occurs, and if needed, a revision follows this.

4.53 Because every person / carer is different, the Care Act does not specify the frequency in which a Care and Support Plan review must take place, it merely states that the review 'will be proportionate to the level and complexity of the care and support received.'

4.54 All reviews must involve the person, their carer and anyone else the person wants to be involved, where appropriate.

4.55 If it is difficult for the person to be being fully involved and there is no family member or friend who can represent or support them, an independent advocate should be considered.

4.56 All efforts must be made to make sure the person is involved in the review, as much as possible.

4.57 Things to consider.

- Have the person's circumstances and / or care and support needs changed?
- What is working in the plan, what is not working, and what might need to change?
- Have the outcomes identified in the plan been achieved or not?
- Does the person have new outcomes they want to meet?
- Could improvements be made to the plan for the person to achieve better outcomes?
- Is the person's personal budget helping them to meet their needs and outcomes identified in their plan?
- Is the current way of managing their personal budget still the best one for what they want to achieve, for example would direct payments be better?
- Are there any changes in support the person gets from family and friends that might affect the plan?
- Have there been any changes to the person's needs or circumstances that might mean they are at risk of abuse or neglect?
- Is the person, their carer and / or independent advocate satisfied with the plan?

Frequency of Reviews

4.58 All people will receive at least an annual review of their support and the first review of a support plan should be face to face unless it is requested that the review is completed virtually.

4.59 Occupational Therapy Service reviews can be undertaken via telephone or alternative ways as appropriate to the needs of the person.

4.60 Many people in receipt of social care support will have been in receipt of the same stable support, that has been meeting their needs for a number of years, without any changes needed to that support. For those individuals following a full annual review, provided there has been no change in circumstances, the following year a light touch review can be undertaken. This would involve telephone contact being made with the person and/or their carer to check how things are and that they are happy with the support they are receiving and feel it is meeting their needs/desired outcomes. (If the

person is not happy then this would trigger a full review). A record must be made of this conversation within the 'client record' and identified as a proportionate review.

4.61 Information about the review should be given to the person in advance so they can plan and prepare e.g., arranging a representative to be at the review. We will do this by sending appointment letters to the person ahead of the visit where possible. Alternatively, information can be provided via telephone or email.

4.62 It is important to remember that what is being reviewed is the Care and Support Plan, and how well it is meeting a person's identified outcomes, not the person's needs. If there is a significant change in a person's needs or circumstances, a reassessment should be completed, and the support plan rebuilt, in this circumstance, the Care Act states that the reassessment should use what is already known about the person rather than starting again.

Where a light touch review is NOT appropriate.

- The first annual review for a person
- Where there are on-going safeguarding concerns
- Where an individual has complex and fluctuating needs
- Where the support commissioned is jointly funded by health and social care
- Where a person is receiving support as part of S117 aftercare
- Where a person is living alone and there has been no other contact in the year
- Where there are formal concerns about the provider delivering support
- Where the previous annual review was a 'light touch'/telephone review
- Where there are concerns regarding the use of Direct Payments or a person is accumulating debt

Section 117 Aftercare

4.63 Section 117 (s117) of the Mental Health Act 1983 (MHA 1983) sets out that certain people who have been sectioned are entitled to aftercare in order to reduce the risk of their mental health deteriorating and therefore further hospital admissions.

4.64 A person is entitled to section 117 aftercare if they have been in hospital under sections 3, 37, 45A, 47, or 48 of the Mental Health Act 1983.

- section 3 – detained in hospital for treatment;
- section 37 or 45A – ordered to go to hospital for treatment by a court;
- section 47 or 48 – transferred from prison to hospital under sections of the Act.

Council and ICB's have a duty to provide free aftercare to eligible people. This is applicable Section 117 aftercare needs only. The allocation of costs will depend on specific after care services the person needs. Other support needs not relating to after care services may be subject to a financial assessment.

4.65 This includes people given leave of absence under section 17 and people going on community treatment orders (CTOs). It applies to people of all ages, including children and young people.

4.66 For people with more complex needs, who may require interventions from a number of different professionals, one person will have responsibility for coordinating care and support.

4.67 The care and support plan will include timescales for review, which should be discussed and agreed with the person and those involved in their care from the start.

4.68 The aftercare plan must reflect the needs of the person. It is important to consider who needs to be involved, in addition to the person themselves.

See Section 117 Aftercare Guidance

5. Referrals to the Community Assessment Service

Community First Response referrals

5.1 First Response and the Hospital Discharge service will provide short term support, including crisis intervention and Care Act Assessment. Referrals for the First Response team will come mainly via the Customer Contact Centre and/or community partners and from the acute hospitals for the Hospital Discharge service.

5.2 The Community First response Teams will provide assessment and support on a short term basis for:

- Individuals who have had no prior involvement from the Community Assessment service requesting social care support.
- Individuals making contact in a crisis who do not have an allocated worker.
- Individuals being discharged from hospital who do not have an allocated worker and require social care support.

5.3 The following is an indication of the types of support that may be undertaken by the Community First Response Teams. Please note this list is not exhaustive and there may be scenarios where it would be more appropriate for these activities to be undertaken by another team.

- People with complex needs who are in hospital.
- Discharge to assess pathways up to 6 weeks (acute and community hospitals)
- Short term work to support a period of crisis or change unless the person concerned is already known to and being supported by a practitioner in the long-term team, or the issue is a safeguarding concern.
- Low level equipment needs/immediate equipment needs.
- Working and supporting services to avoid admission into hospital.

Community Assessment Service Locality (Long Term) Teams

5.4 Referrals for the locality teams will mainly come via Community First Response teams, due to complexity/on-going needs that longer term support and/or review will be required.

5.5 All referrals to the OT Service are made via the contact centre, unless internal (from another long-term team).

5.6 Principles that the locality teams will work to: -

- We will always adopt a strengths-based approach.
- Work to the Care Act principles of reduce, prevent, and delay.
- Ensure people receive good quality information and advice to help people plan for the future, reduce the need for care services and where possible maintain independence.
- We will enable people to live with the risks inherent in living independently whilst ensuring they are safeguarded from significant harm.
- Promote preventative approaches and adopt strengths-based approaches which help to reduce, prevent, and delay the likelihood of people going into crisis and demand for residential/nursing care and the need for long term care in the community.
- We will promote individual health and wellbeing through joint and collaborative approaches across the health and care system.
- We will maximise independence through targeted and timely, cost effective use of equipment and assistive technology.
- We will regularly review people's support to ensure outcomes are being met and met in the most cost-effective way.

Preparing for Adulthood

5.7 The Care Act 2014 places a duty on local authorities to conduct transition assessments for children, where there is a likely need for care and support after the child in question turns 18 and a transition assessment would be of 'significant benefit.

5.8 Central Bedfordshire Council's (CBC) Young Adult and Independent Living Team (YAIL) based in Adult Social Care (ASC), works with a variety of services including Children's Services (CS's), schools, health, and mental health services to identify young people as early as possible. This enables the opportunity to plan for or prevent the development of care and support needs with the young person and fulfil the Council's duty.

5.9 The transition into ASC needs to be at an appropriate time for the young person, with the young person and their family fully informed of any changes and with no gaps in provision to meet the young person's assessed needs.

5.10 A referral should be made to Adult Social Care by the young person's 17th birthday; however, discussions can take place from the young person's 14th birthday.

5.11 The principles that guide an effective transition to ASC services are as follows:

- Timely referral.

- Early information sharing and monitoring to understand future commissioning needs.
- Active joint working between partners; this is to include co-operation, good communication and positive relationships between ASC, Health, and Children's Services.
- Awareness and ownership of roles and responsibilities.
- Clearly agreed and communicated point of transition.
- Co-production, working with parents/carers and young people to be a responsive service.
- Early intervention and high aspirations for all children and young people.
- Preparing for adulthood- including independence support, training, and employment

Technology Enabled Care (TEC)

5.12 There are many types of TEC available to help support our community to remain living safely, comfortably, and independently in their home. Equipment can range from activity monitors and medication reminders to personal alarms and much more.

5.13 We aim for TEC to be an integrated part of the Community Assessment & Support Services as it:

- gives people more control over their health, safety, and wellbeing.
- supports them to be more independent or feel less isolated.
- enhances the care providers offer.
- link them to services which are important for them.
- helps them communicate with families, professionals, and staff.

The First Response Team will be the first point of contact for new TEC requests under the Care Act 2014. If the person is not eligible First response will signpost to the private pay option provider. If the person is eligible the referral will either remain with First Response or passed to the longer-term teams as appropriate.

5.14 The ASC Policy Hub TEC section can be accessed via the link here.

6. Mental Capacity Considerations

6.1 The Mental Capacity Act 2005 helps to make sure that people make their own decisions for as long as possible. It is decision and time specific.

6.2 The starting point for any contact with a person is that they have capacity to make decisions, however, there will be circumstances where it is evident or unclear that a person has capacity to make certain decisions.

6.2.1 Practitioners should recognise that individuals may have fluctuating capacity and consider this as part of the assessment process.

6.3 The main purpose of the Mental Capacity Act is to keep people safe and ensure that they have the right to make their own decisions, as far as possible. It sets out a way of carrying

out assessments which helps to decide if a person lacks mental capacity. It does this in three ways:

1 By making sure people make decisions for themselves wherever possible (**empowering them**).
2 By **protecting** people who lack mental capacity by having a process which is flexible and can adapt to their particular needs.
3 By allowing people to **plan ahead** for a time in the future when they might not have mental capacity anymore.

6.4 The Act sets out five 'statutory principles':

The five key principles are:

- Principle 1 – A presumption of capacity.
- Principle 2 – The right to be supported when making decisions.
- Principle 3 – An unwise decision cannot be seen as a wrong decision.
- Principle 4 – Best interests must be at the heart of all decision making.
- Principle 5 – Any intervention must be with the least restriction possible.

6.5 The Mental Capacity Act provides a set of questions to help decide if a person lacks mental capacity. If the answer is no to one or more of the following questions, the person lacks capacity.

1. Can they understand information given to them?
2. Can they retain that information long enough to be able to make the decision?
3. Can they weigh up the information available to make the decision?
4. Can they communicate their decision? This could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

Best Interests Decisions

6.6 A Best Interests decision is a decision made for and on behalf of a person who been assessed as lacking capacity to make their own decision.

6.7 These decisions must be made following section 4 of the MCA and adhering to the fourth and fifth principles of the MCA:

- "An act done, or decision made, under this Act, for, or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action."

6.8 If a relevant Lasting Power of Attorney (or Enduring Power of Attorney) has been made and registered with the Office of the Public Guardian, or a deputy has been appointed

under a court order, the attorney or deputy will be the decision-maker, for decisions within the scope of their authority.

6.9 When making a best interest decision, staff must also consider the impact of the decision on the person's rights and freedom of action. If any subsequent best interest decision goes against what the person has expressed in the past, or is currently expressing, great caution is required. Likewise, if any of their human rights are potentially engaged, including a person's right to liberty and private and family life.

6.10 If any subsequent best interest decision potentially interferes with their past or present wishes, as far as they can be ascertained, or any of their human rights under the European Convention on Human Rights (ECHR), legal advice, the Deprivation of Liberty Safeguards (adult care homes or hospitals) or Court of Protection might be required.

6.11 If it is in the person's best interests to deprive them of their liberty, this should be done with the minimum restriction. Ensure that any DoLS is authorised.

Deprivation of Liberty Safeguards (DoLS)

6.12 A deprivation of liberty can occur in any care setting and is when a person has their freedom limited in some way.

6.13 The Deprivation of Liberty Safeguards (DoLS) is an amendment to the Mental Capacity Act 2005, used to check that actions which limit the liberty of a person, who does not have the capacity to consent to this, are done in the least restrictive way necessary. That the restrictions are to keep the person safe, are appropriate and proportionate, and are in the person's best interests.

6.14 DoLS provides a process for a deprivation of liberty to be made legal through either 'standard' or 'urgent' authorisation processes. These processes are designed to prevent the making of arbitrary decisions to deprive a person of liberty. They also give people a right to challenge deprivation of liberty authorisations.

6.15 The Deprivation of Liberty Safeguards are applicable when a person is in hospital or a care home. If a person is living in another setting it is still possible to deprive the person of their liberty in their best interests, via an application to the Court of Protection.

Community DoLS

6.16 Depriving a person of their liberty within a community setting is referred to as Community DoLs – Community DoLS applies to individuals who live in settings other than hospital or care homes, and lack capacity to consent to their support, where they may be deprived of their liberty.

See links below for practice guidance.

Safeguarding, MCA & DoLS (LPS) – (centralbedsappp.co.uk)

7. Policies and Procedures

7.1 ASC procedures, documents and practice guidance are located on our bespoke policy hub internet site.

Local Adult Social Care Policy & Practice Guidance – Central Bedfordshire APPP Resource

Appendix 1 – Assessment Framework

Assessment Framework Practice Guidance

Community Assessment Service

Directorate:	Adult Social Care & Housing		
Division & Service:	Adult Social Care – Community Assessment Service		
Author:	Amy Thulbourne		
Owner:	Community Assessment Services		
Approved By:	Practice Governance Board	**Approved Date:**	January 2020
Reviewed by:	Community Assessment Services	**Review Date:**	June 2023
Effective From:	January 2020	**Version No.**	2.1
Next Review:	June 2025		

Contents

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 – 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

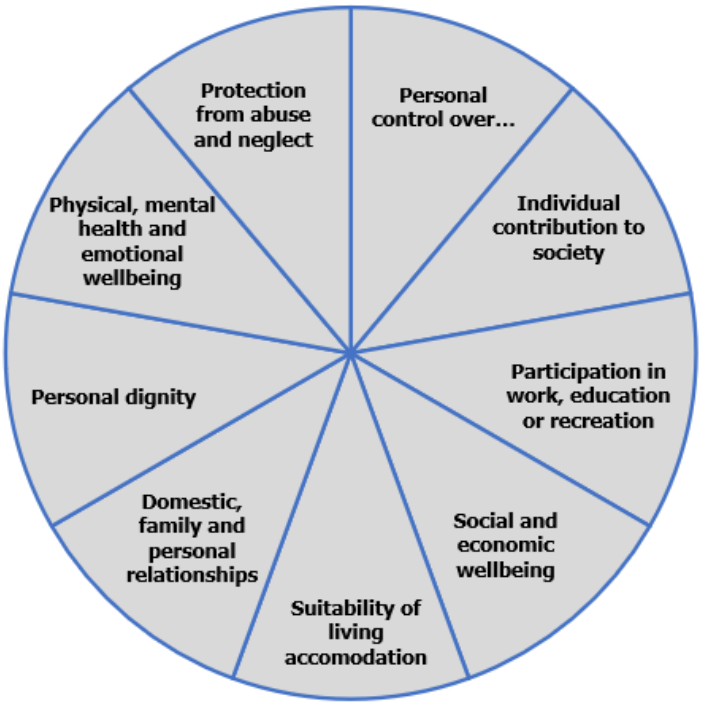
Guidance:

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 details 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 care 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 –

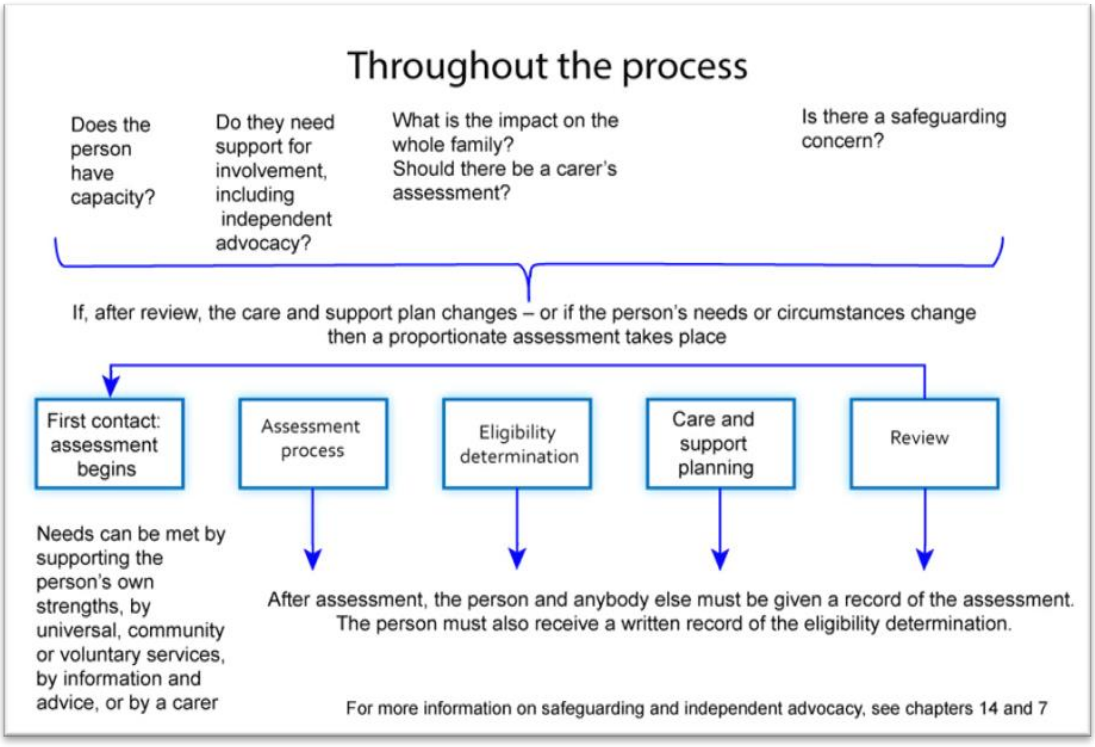
a- the level of the adults needs for care and support or

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.

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).

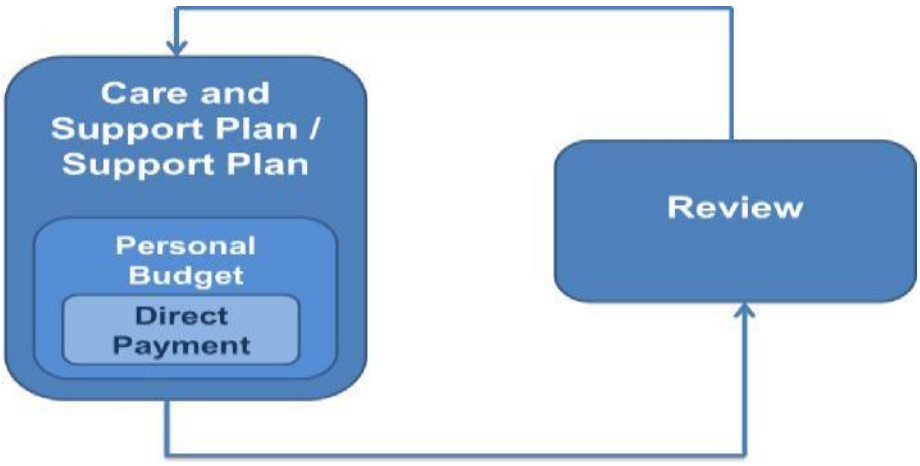
The outcome of the assessment is to provide a full picture of the individual's needs so that the local authority can provide an appropriate response at the right time to meet the level of the person's needs.

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 depending 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 at a minimum 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 people.

Occupational Therapy Assessment.

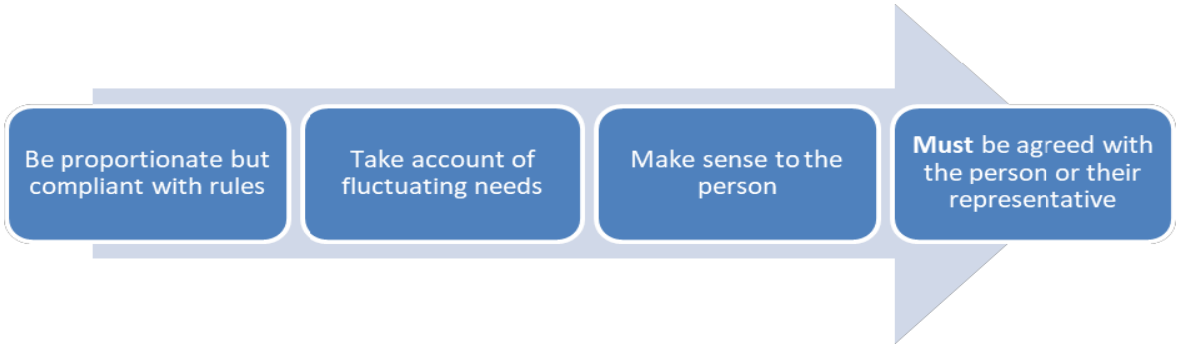
Occupational Therapy complete assessment/review forms to capture specific details around the needs of the person, the environment and risk management.

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 people 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 should 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, and includes, where possible, capturing the views of the person as part of the audit process.

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).
- Use plain English and avoid acronyms and jargon.
- Ensure, where possible, the views (and voice) of the person, are captured (consider using direct quotes).
- 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.

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/