



RE-ASSESSMENT and RE-PROVISION METHODOLOGY

For users of Birmingham City Council
'attached' day centres

**OLDER ADULTS MODERNISATION
RE-PROVISION PROJECT**



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1. **EXECUTIVE SUMMARY**

This document describes the methodology that will be used to undertake the re-assessment and re-provision of the people who use the Birmingham City Council (BCC) Older Adults Day Centres included in the first phase of the Older Adults Modernisation Project Re-provision plan. The methodology will be reviewed and revised as appropriate before the second phase of closures commences.

The methodology has been created by the incorporation and adaptation of input from a wide range of sources. These sources include:

- Research conducted by the University of Birmingham of Published Literature on the Experience of closure of Personal Care Centres in the UK
- A multi agency workshop
- Individual interviews with Social Workers, BCC Care Staff, older people and their representatives
- Internet searches for relevant information
- Various other reading.

The methodology is designed to ensure that the re-assessment and re-provision process is undertaken in a person centred way. That the wishes, preferences and aspirations of individuals are identified and acted upon as well as the care and support needs the person may have.

Process of Re-assessment

A multi disciplinary Assessment and Re-provision Team will be established consisting of Social Workers, Occupational Therapy, Health professionals, Housing and Assistive Technology officers. This team will undertake the re-assessment and re-provision of all the individuals who use the day centres attached to BCC residential care homes. Multi disciplinary re-assessments will be undertaken with all individuals to identify their needs and preferences.

Individual users of the day centre will have a Social Worker allocated to them to co-ordinate their re-assessment and care planning. The Social Worker will include in the re-assessment process all the people important to the individual.

Any specific communication needs of individuals will be addressed.

The provisions of relevant legislation such as the Mental Capacity Act 2005 and the Mental Health Act 1983 will be considered wherever appropriate.

Ensuring the health and well being of all individuals throughout this very significant change will be of central importance and a Risk Assessment and Management process will be an integral part of the re-assessment and resettlement methodology. Any Adult Protection issues that arise will also be dealt with as matters of the highest importance.

All individuals will be offered the opportunity to complete a 'Life Book'. The content will be determined by the individuals though the suggested framework is likely to cover such areas as personal history, likes and dislikes, relationships, education, memories and interests. It could also include photographs (past or present).

A new and detailed Care Plan will be produced in conjunction with individuals. This document will provide clear statements of future care needs and of the preferred way this care should be provided in the new care setting. It will specify in detail the ways the individuals care and support should be provided so as to ensure that their personal dignity, independence, abilities and control over services is maximised.

Internal monitoring processes will be in place to ensure that progress is being made at an appropriate rate on the re-assessment and future care planning for all individuals.

Re-provision

The identification of the appropriate resource to meet the care needs and preferences of individuals will be based on the multi-disciplinary re-assessment and the care plan agreed as a result.

It will be important for people to feel that they are given the maximum amount of control over their future care provision. This will be enhanced by them being able to consider all available options and to make an active positive choice about which provision they prefer. They will be facilitated to visit alternative provisions that appear to be able to meet their care needs and for which they appear to meet any relevant criteria.

The widest possible range of alternative community activities will be discussed with individual day centre users to ensure that the best possible choice for future provision is chosen. Resources in the voluntary and private sector may be appropriate. People may wish to pursue a Direct Payment/Self Directed Care option – they will be assisted in this by their allocated Social Worker.

The financial implications to the person of the various options they are considering will be carefully explored with them in order to assist them to make the best decision for themselves.

The smooth, safe and positive resettlement of individuals will be of the highest importance and the 'Risk Assessment and Management Tool' will be used as part of this process. A number of checklists have been produced to assist in ensuring all important issues are addressed during the periods before, during and after any move from the day centre. Reviews of the new arrangements will be undertaken.

The Assessment and Resettlement Team – Composition and Roles.

The team will be led by a Team Manager and an Assistant Team Manager from the Adults and Communities Directorate. Other team members will be:

- 15 qualified Social Workers
- 2 qualified Occupational Therapists
- 1 Occupational Therapy Assistant
- 2 Nurses (Physical Health) – seconded.
- 1 Community Psychiatric Nurse or Registered Mental Nurse – seconded.
- 2 Adults and Communities Administration Officers

Day Centre Managers and other centre staff will be integral to the closure programme and the team will work with and alongside them.

In addition professionals from other areas will be linked to the team to assist with the programme – e.g. Assistive Technology.

The core role of each of these professionals will be:

Social Workers – to lead and co-ordinate the Person Centred Re-assessment of each individual attending a day centre attached to a residential care home. To ensure their safe and positive move to an alternative community activity provision. To produce a detailed re-assessment and care plan. To monitor and review the care arrangements made for each person. To co-ordinate the Risk Re-assessment and Management process for all residents.

Occupational Therapy – will undertake a screening and re-assessment process to determine which individuals might benefit from a programme of rehabilitation and re-ablement. To devise, implement and review that programme. This work will primarily look to develop individuals' capacity for self-care and more independent living.

Nursing Professionals – to undertake relevant nursing re-assessments or refer for other specialist re-assessment or treatment as required. If necessary to review the nursing needs of people attending the day centre and liaise with other nursing professionals as necessary. To contribute to the Risk Re-assessment and Management process for all day centre users.

Administrative staff – to support the efficient running of the team administrative functions. Assist in the management of information, files and budgetary control.

Day Centre Staff – to provide support to, and information about the people who attend the centre. To provide vital information for the re-assessment and for an individuals 'Moving Book'.

Assistive Technology – to advise on, and supply when appropriate, assistive technology equipment to promote the independence and safety of individuals.

Advocacy

Residents and families/carers will have access to an independent information, support and advocacy service. The advocacy service is primarily aimed at those people who lack capacity or have communication difficulties and do not have other support available.

Timescales

The actual timescale for the closure of any individual day centre is subject to many factors. In particular the place of the attached residential home in any closure order is not as yet confirmed. Some provisional timescales for the overall closures in the first phase (i.e. first 14 homes) has been proposed – this timescale would see the commencement of the re-assessment process in January 2008 and the closure of all the homes and attached day centres in the first phase by the end of August 2009.

Review and Evaluation

Research by the University of Birmingham into the outcomes of the Older Adults Modernisation project has been commissioned. This research will provide a very valuable evaluation of the outcomes for the older adults affected by the modernisation programme. The findings of this research will be used to inform the way the second phase of the homes and day centre decommissioning is undertaken, with 'best practice' lessons being identified and applied to any future closures.

RE-ASSESSMENT AND RE-PROVISION METHODOLOGY

2) PURPOSE OF THE METHODOLOGY

The purpose of this methodology is to ensure the consistent, co-ordinated and efficient undertaking of high quality person centred re-assessments of the people of the (BCC) Older Adults Day Centres included in the first phase of the Older Adults Modernisation Re-provision programme.

The methodology details the basic principles, staffing arrangements and procedures to be employed by the Assessment and Resettlement Team to achieve the above objective.

3) BASIC PRINCIPLES OF THE RE-ASSESSMENT AND RE-PROVISION PROCESS

The Re-assessment and Re-provision process will be undertaken in a Person Centred way.

It will be conducted in the preferred language/communication method of the individual.

The Individual can have support from family/friend and/or advocate if they wish.

All available options for individuals to be fully shared – there will be honesty about the reasons if any desired option is not available to the individual.

Re-assessments will be timely, efficient and comprehensive but without being intrusive.

4) **RE-ASSESSMENT**

Process

All the users of Birmingham City Council Older Adults Day Centres will be provided with an individual re-assessment during the time prior to the closure of their centre. Each individual's re-assessment will be co-ordinated by a named Social Worker. The re-assessment will be person centred to ensure that the needs and wishes of the individual person are of central importance and will be conducted in ways that meet the person's language and communication needs. It will cover the individual's skills, interests and care needs with a focus on promoting and maintaining independence. High importance will be given to the health and well being of each individual. The re-assessment will also identify important relationships for people and how best these can be maintained within the context of the closure of the centre.

The Social Worker will work in conjunction with various other people – especially people identified by the person as important to them. Relatives and carers will be involved in this process as fully as the person wishes. Various professionals will also contribute to the re-assessment, so that the fullest possible picture of the individual is acquired. These professionals may include Health, Day Centre Staff, Occupational Therapy, Assistive Technology, Pensions Service and/or others.

The Social Worker undertaking the re-assessment will work closely with the individual and those who know the person well to ensure that the re-assessment truly reflects the person, their life, the people and things that are important to them and their wishes for their future. It is expected that the care staff at the centre will be identified as a very important part of this process.

The re-assessment will include the Birmingham City Council Single Re-assessment Process Overview Re-assessment (Easycare), and the Specialist Social Work Re-assessment. A full Carers Re-assessment will be offered carers in order to ensure that they are supported in their caring role and that any support required as a result of the change of care provided to the person they care for is addressed.

Re-assessments from other professional will be added where appropriate as part of the Comprehensive Re-assessment .

The individual communication needs of day centre users will be identified and addressed within the re-assessment process. These needs may be in a variety of forms:

- Specific language requirements – to be met via the Birmingham City Council Interpreting Service
- Large print. Important documentation will be supplied in large print for those who require it

- Use of techniques such as 'Talking Mats' will be used in situations where this is felt to be appropriate eg for some people with a dementia or other difficulty in expressing themselves
- Sign Language. A British Sign Language Interpreter will be used when required, via BCC Interpreting Service/Birmingham Institute for the Deaf
- Other equipment to be acquired as necessary to meet the specific needs of any individual.

Mental Capacity Act and Capacity Re-assessments

In planning to undertake the re-assessment of each individual person, initial consideration will be given to whether the person has the necessary mental capacity to contribute to the re-assessment in an informed manner.

It is imperative that any decisions made regarding the future service an individual will receive, are made with full regard to the requirements of the Mental Capacity Act 2005.

Any re-assessment undertaken will fully address the 5 key principles of the Act.

Any decisions made for, or on behalf of a person who has been assessed as lacking capacity, must be made in his or her best interest.

It is not expected that any person involved in this day centre re-provision will fall into the category of qualifying for an Independent Mental Capacity Advocate.

Directorate procedure in relation to Mental Capacity Act re-assessments will be followed, and decisions recorded in line with Directorate requirements

All work done in relation to the Re-assessment and Re-provision project will be undertaken in line with the legal duty to have regard to the Mental Capacity Act Code of Practice. A full version of the Code of Practice is available at www.dca.gov.uk/legal-policy/mental/capacity.

Care Plan

A new, agreed Care Plan will be produced for each individual. The Care Plan will need to reflect the person centred outcomes of the re-assessment process. The Plan will need to be signed by the person and Social Worker. A copy to be given to the person and/or their representative.

The Care Plan will be a very important document in ensuring that the needs and wishes of the individual are relayed to the new service provider. A copy of the Care Plan to be given to the new service provider.

Adult Protection

Should any Adult Protection issues be picked up during the course of the re-assessment and re-provision work, these will be referred to the local area Social Work Team to undertake the lead role in investigation/registration etc. The Re-assessment and Resettlement Team will work in liaison with the area team.

Moving Book

All re-assessments undertaken, information on care needs, personal details, contact details for family/friends, contact details for involved professionals etc will be collated into a single book/portfolio. This book will be held by the person during the course of the re-assessment and re-provision process and will go with the person to their new placement.

Tracking of Progress (for both re-assessment and re-provision elements)

Overall progress

A spreadsheet covering all day centre users will be established. This will detail progress in terms of actions completed, next steps, issues of concern, projected possible outcomes.

To be discussed at meetings at the centre. To involve Social Workers, Team Manager and Centre Manager.

Action points to be identified with timescales for completion.

Individual Progress Reviews

Will be held every 3 weeks. To be in addition to individual re-assessment meetings with Social Worker or other professionals. To discuss:

How process is going

Indication/confirmation of the individuals preferred option

Identification of suitable available resources

Plans for visits

Meeting can involve other professionals if required – e.g. to discuss/resolve particular issues.

5) **RE-PROVISION – FINDING AND MOVING TO SOMEWHERE NEW.**

During the course of the re-assessment of an individual some initial exploring of possible re-provision options may take place. Once an appropriate re-assessment has been completed the identification of, and move to, the new provision for the individual will be arranged.

Identifying alternative provision

Social Workers will provide details to people of the current potential resources that are available. Alternative provision based within a wide range of community-based settings will be explored. In order to help facilitate the greatest possible range of alternatives Social Workers will discuss the use of Self Directed Support arrangements to enable individuals to identify resources that most closely meet their individual support and care needs.

Social Workers will have information regarding a wide range of local alternative support available via Birmingham City Council provision, the voluntary sector, Health and independent/private providers.

Transport will be provided via Adults and Communities if necessary for individuals to visit at least 3 alternative resources.

Risk Management

The process of moving and settling in at any new care setting is likely to be highly stressful for all concerned. In order to identify and address possible adverse effects on the health and well being on individuals during the course of the re-provision, the 'Risk Re-assessment and Management Tool' (see Appendix 1) will be used. The use of this tool will already be in place at the re-assessment phase.

Checklists

In order to facilitate the smoothest possible transition from the present centre to the new provision, a number of checklists have been drawn up to provide guidance on issues that need to be covered.

The checklists cover the areas of

- Pre move arrangements
- Post move arrangements and review

Reviews

A review of the new care arrangements for each individual will be co-ordinated by the Social Worker 28 days after the start of the new care plan. An earlier review can be arranged if required. The Social Worker will arrange for notes and outcomes of the review to be provided to all those in attendance and to those who it is agreed should also receive them. The review will consider all aspects of the new care package and will pay close attention to the Risk Re-assessment and Management tool. The Care Plan will be amended as necessary. At the end of this period the case file responsibility will transfer back to the originating area Older Adults team.

6) ROLES

Assessment and Resettlement Team Management

The team will be led by a Team Manager (TM) and Assistant Team Managers (ATMs), and they will be responsible for both the residential and day care aspects of the re-provision project.

They will ensure the efficient undertaking of re-assessments and re-provision planning in the day centres and provide reports and summaries of progress as required to the Business Project Manager.

In relation to Adults and Communities staff, the managers will undertake the usual duties of managers in area Older Adults Community Care Teams including supervision of Adults and Communities staff, performance management, team deployment and work allocation, adult protection responsibilities etc.

For staff from other sections/agencies (OT, Health, Assistive Technology), the TM/ATM will provide day to day operational support and guidance and co-ordination but professional supervision will continue to be provided by those worker's own agency.

Team Administrative support

A small team of dedicated admin workers will provide support to the team. Duties will include the efficient acquisition and maintenance of files, CareFirst updates, typing and distribution of letters, spreadsheet maintenance, stationery stock and ordering, collation and production of 'Life Books'.

Team to consist of 1 supervisory Admin worker (Scale 4) and other Admin staff as required

Social Workers

Social Workers will undertake person centred re-assessments of all the users of the day centres in conjunction with the individuals, their carers/families/friends and a range of other agencies/professionals.

The re-assessments will be undertaken at day centres on a phased basis in line with the agreed residential centres/day centre closure order. Named Social Workers will be assigned to a day centre to co-ordinate the re-assessment and re-provision of all the people who use the centre.

A new, detailed and person centred care plan will be produced by the Social Worker that will provide high quality information to the new service provider for each day centre user.

Day Centre Staff

Day Centre Managers

Centre Managers will facilitate the access to, and provision of information about, the users of the centre. They will be involved in meetings at the centre in relation to the progress of the re-assessment and re-provision process. They will deal with straightforward queries or issues raised by people or their advocates in connection with the re-assessment and re-provision process. Major issues raised by the independent advocacy service, will be forwarded by the manager to the Project Review Group.

Care Staff

A very significant amount of information about day centre users is known by the care staff at the centre. With the agreement of people, care staff will be asked to share their knowledge of individuals – history, preferences, specific care needs, relationships etc. This information can be used as part of the overall re-assessment or form part of the person's 'Life History Book' if they are completing one.

Care staff may be involved in completing the OT 'Community Dependency Index' screening tool (see below).

Health Professionals

Physical Health

In order to ensure the most efficient and consistent response to any identified nursing needs there will be dedicated nursing support as part of the Assessment and Resettlement Team. The role of this worker is:

- To perform an initial screening function of all people to identify if any appear to be in need of nursing or other health intervention and make referrals as appropriate.
- To liaise with existing nursing and other health input to clarify current needs, diagnosis, etc.
- To undertake re-assessments themselves within the remit of their professional responsibilities and make referrals for other health re-assessments as appropriate (e.g. dietician, specialist nurse).
- To liaise with and advise Social Workers and other professionals who make up the Assessment and Resettlement Team.
- To provide information and advice to people or their family on general or specific matters as regards the health of the person.
- In liaison with the Social Workers/Social Work manager to have an overall view of the coordination of the nursing support to people.
- To be involved in a risk re-assessment and management plan for each person in connection with their move from the centre.

GPs

In order to ensure the best quality information is gathered for each person a number of pro-forma letters are available to inform/request information from the GPs of individual people if required. *Currently draft letters*

- Pro-forma letter to GP informing them that one of their registered patient's is involved in the closure programme. (See attached letter)
- Pro-forma letter to GP requesting information. (See attached letter)
- Pro-forma letter of authority from the person to the GP to disclose information. (See attached letter)

Mental Health

As for physical health nursing support above. A dedicated mental health worker will be part of the Assessment and Resettlement Team to provide expert re-assessment and risk management input to the overall process.

Occupational Therapy (OT)

Occupational Therapist input from the Adults and Communities Rehabilitation and Enablement Service (R&ES) will form part of the Assessment and Resettlement Team.

- For centres that are actively involved in the re-assessment and re-provision phase of closure.

Allocated Social Worker and centre staff complete the 'Community Dependency Index' for all people as an initial screening tool, to help identify people who appear to have some potential for rehabilitation. This form is passed to the OT.

OT to complete full re-assessment and devise a re-ablement plan for those people who appear to have the potential for some effective rehabilitation. The re-ablement plan will be implemented and monitored by an OT Assistant (OTA). The OT or OTA can also make requests for equipment or adaptations and make referrals for physiotherapy or other therapies as necessary.

OT re-assessment and enablement plan to be incorporated by the allocated SW into the person's new Care Plan and also into the Risk Assessment and Management Tool.

- For centres that are later in the closure order.

In order to give the best opportunity for an effective re-ablement plan to be identified and implemented with people who use day centres, a process to identify those with potential for rehabilitation is proposed.

The centre will be visited by member/s of the Assessment and Resettlement Team to discuss the purpose and process of the early intervention with them to identify people with potential for rehabilitation.

Centre staff complete the 'Community Dependency Index' for all people as an initial screening tool to help identify people who appear to have some potential for rehabilitation.

OT to complete full re-assessment and devise a re-ablement plan for those people who appear to have the potential for some effective rehabilitation. The re-ablement plan will be implemented and monitored by an OT Assistant (OTA). The OT or OTA can also make requests for equipment or adaptations and make referrals for physiotherapy or other therapies as necessary.

Once the centre moves into the full re-assessment and re-provision phase the allocated SW will liaise with the OT about the progress of the person towards more independent living. Plans for possible future service provision will look to build on the independent living skills of the person.

- For people entering any City Council Day Centre after the closure plan has been agreed by Cabinet (or who entered one of a centre in the 2 months prior).

Centre staff to identify anyone who fits the above. They will complete the 'Community Dependency Index' as an initial screening tool to help identify people who appear to have some potential for rehabilitation and make a referral to the Assessment and Resettlement Team.

The OT will have skills in working with people that have physical and/or mental health issues, however :

For those people with some level of dementia or other mental health issue it is proposed that:

- If the person is currently known to the Mental Health Service for Older People (MHSOP), then the MHSOP Occupational Therapist (OT) will be the lead OT worker.
- If the person has a mental health issue but not currently open to the MHSOP, then the Adults and Communities OT will be the lead OT but will seek advice and guidance from the MHSOP service as necessary.
- For people with no evident mental health issue the Assessment and Resettlement Team OT will be the lead worker.

To ensure that OTs from both services are aware of the issues relevant to the other, a period of joint training/shadowing for A&C and OAMH OTs will be arranged prior to the commencement of this role.

Assistive Technology

Recent developments in Assistive Technology provide the potential for checking and monitoring the present health of people as well as providing support that can support independent living.

As part of the Social Work re-assessment process, people will be offered information regarding the Assistive Technology that is available to support them in living as independently as possible. Opportunities will be provided to visit the Birmingham Assist Centre to see and try out the equipment and systems. Alternatively some of the available resources can be brought to the centre to be demonstrated. This will be co-ordinated by the allocated Social Worker.

The part that Assistive Technology can make in managing risks for individuals will be included in the Risk Assessment and Management process.

Advocacy Service

An advocacy and information and support service has been commissioned as part of the Older Adults Re-provision project to provide an impartial and professional advocacy, information and support service for older people, who attend Birmingham City Council attached day centres

The Advocacy Information Service makes planned visits to all Birmingham City Council's residential homes and attached day centres for older people. These happen once every two months, increasing to monthly where a home and attached day centres is due to close in the near future. This service is for all day centre users and their relatives/next of kin. Information of dates and times of visits is sent to all day centre attenders and relatives on their database, is publicised on the Advocacy Information website (www.advocacyinformation.org) and also on posters at the residential homes and attached day centres. During these planned visits, advocacy workers talk to day centre users and relatives in small groups or one to one dependent on preference, with interpreters booked by BCC where needed. The visits are to give people information about the planned changes to their day centre, to answer any questions they can, to follow up any questions they cannot answer with BCC and to seek the views of individuals and relatives on the changes to be made by BCC.

7) SUPPORT

To people and families.

An independent advocacy service has been commissioned to undertake an information and support service to people and their families (see above).

In addition during the course of the closure process support will be provided by the allocated Social Worker and day care staff. This support will be both in terms of information about the overall process and the progress of each individual's re-assessment and re-provision plan. The need for emotional support to individuals will be provided over the course of the centre closure and re-provision of each person.

8) TIMESCALES

The projected timescale for the completion of closure of centres in the first phase closure programme is the end of August 2009. The closure plans for day centres will be linked to the closure of the Elderly Person's Homes to which they are attached.

The basic order of closure of the centres in the first phase will be that agreed by the City Council Cabinet. The Assessment and Resettlement Team will commence work in the initial group of centres at the top of the closure order

and proceed through the rest of the centres in an ordered manner. The Assessment and Resettlement Team may commence their work in a centre before the final closure of centres earlier in the closure order.

Research undertaken by the University of Birmingham summarises the recommendation by people and relatives about closure timescales in relation to residential care but given the linkage between the residential homes closures and the closure programme for day centres the same timescale is proposed. The recommendation made is that:

Notice of closure (or departure date) should be flexible and sufficient to allow time for alternatives to be properly explored and choices considered. Some establishments have waiting lists and these must be taken into account. At least two months is recommended, more in areas where there is limited supply. A specific day should not be named. [Univ Birm Review of literature]

In response to this recommendation and in order to ensure that sufficient time is available for fully comprehensive and person centred re-assessments and re-provision plans are undertaken with all people at a centre it is projected that the re-assessments and re-provision process will take about 4 months to complete. This would mean that the possible timescales for this process in centres in the first phase would be approximately

Homes 1 - 3

Re-assessments and resettlement - April 2008 to end July 08

Homes 4 - 6

Re-assessments and resettlement - Aug 2008 to end November 2008

Homes 7 – 10

Re-assessments and resettlement - Jan 09 to end Apr 09

Homes 11 – 14

Re-assessments and resettlement - May 09 to Aug 09

It is planned that a period of evaluation and amendment of the methodology as necessary will be included in the process. Assuming this period of evaluation takes place a timescales for the second phase of homes could be :

Homes 15 – 18

Re-assessments and resettlement – Jan 2010 to end Apr 2010

Homes 19 – 22

Re-assessments and resettlement – May 2010 to end Aug 2010

Homes 23 – 26

Re-assessments and resettlement – Jan 2011 to Apr 2011

Homes 27 – 29

Re-assessments and resettlement – May 2011 to Aug 2011

NB These dates are currently only indicative and not a confirmed date for closures. The progress of any closure programme is subject to the availability of suitable alternative resources to meet the needs of individual residents and also the differing capacity of individual residents to adapt to the prospect of a change in their care arrangements.

The multi agency workshop arranged in connection with the Re-provision project considered the timing of events in relation to the re-assessment and re-provision process. A best practice sequential order for the tasks/activities that need to be undertaken to achieve the best possible process was devised. This order was not linked to a particular chronological timescale and was largely focussed on the closure of the residential homes but can be used to guide the timing of events within the closure process. [Workshop Summary]

9) **REVIEW AND EVALUATION**

Evaluation of the re-assessment and re-provision process will be undertaken as part of the evaluative research, to be undertaken by the University of Birmingham, of the whole of the Older Adults Modernisation Project.

Ongoing internal monitoring, review and evaluation of the progress and outcomes of the re-assessment and re-provision process will be undertaken by a range of quality assurance methods. These will be:

- Line manager formal supervision.
- File quality checklists by supervising manager – Team Managers checklist (Form SS1029) and Assessment and Resettlement Team checklists (Appendix 2 and 3).
- Individual satisfaction questionnaire.
- Transfer to New Provision Summary and Feedback Sheet – completed by Assessment and Resettlement Team members.
- Assessment and Resettlement Team meetings.
- Monitoring of 3Cs data.

Identification of positive aspects of new support provision.

Reviews will include an analysis of any identifiable benefits that the move may have had for the individual

- identify any specific improvements for the individual
- identify any aspirations for new provision the person had and have these been met?
- is there any new skills training needed to access new opportunities and has/will this be provided?

10) **ACKNOWLEDGEMENTS AND BIBLIOGRAPHY**

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Winston Mosquito	Equalities & Diversity
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Lisa Clarke	Care Worker, George Canning
Laurence Braithwaite	Communications
Peter Whitehouse	SW, OA Team, Sutton AO
Debbie Collins	SW, Edgbaston OA
Steve Johnson	Project Manager
Caroline Johnson	Unison
Felix Okwuadigbo	SW TM/HoB
Linda Wickens	TM, HoB OT Area Team
Annette Hanny	Continuing Health Care Manager HoBtPCT
Bridget Sharkey	CPN BSMHT
Jackie Mallett	Lead OT BSMHT
Tracy Jones	Care Worker, Florence Hammond
Mike Ewins	User involvement & Carer Unit
Christine Ransome-Wallis	Carer Representative
Enid Said	Carer Representative
Jean Lucas	Older Adults Representative
Anne Shearer	Older Adults Representative
Judy Preston	CHCC HoBtPCT
Stevell McDonald	Manager Wallace Lawler Care Home
Teresa McKenna	Strategy, BCC Housing
Sonia Mais-Rose	Team Manager Residential & Day Care

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Mental Capacity Act – Code of Conduct (2007) – Dept of Constitutional Affairs

Making Decisions – A Guide for people who work in health and social care – Dept of Constitutional Affairs

11) APPENDICES

Appendix 1	Health and Well Being Risk Assessment Tool
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HEALTH and WELL BEING
RISK ASSESSMENT AND MANAGEMENT TOOL

This tool is designed to be used as part of the Older Adults Modernisation Assessment and Resettlement Team to identify any risk indicators for individual residents involved in the closure of the City Council Day Centres .

Name of Service User -

Gender –

Name of the Day Centre –

Date tool completed -

SW name :

RISK INDICATOR	Details of concerns	Plan to address and manage the identified risk
Is there any evidence of a previous breakdown due to stress?		
Has the person experienced any significant loss or bereavement recently?		
Has the person experienced a previous involuntary move of day provision?		
Is there any cognitive impairment?		
Does the person have any current mental health issues?		

Is the person aware of the plan to close the centre and what feelings are they expressing about this?		
Does the person have any effective support system?		
Are there any current physical health conditions that might be affected by the move?		
What concerns would indicate that a postponement of the move is necessary?		
Any other Health and Well Being matters that have not been covered above		

Date sheet completed :

Pre move Checklist

Have the new Care Plan and Moving Book been completed and available?

Have any necessary adjustments been made to the Care plan to ensure that other services are aware of the changes and care/support amended as necessary?

Are all relevant re-assessments up-to-date, detailed and available?

- Social Work
- Health (Physical and Mental)
- other specialist re-assessments
- Assistive Technology
- OT

Has the Health and Well Being Checklist been completed? Is it up to date and available? Are measures in place to address identified risks?

Is there a contingency plan for what happens if the person is not fit to move on the day?

Has the key worker or Social Worker been in discussion with the new provision manager/organiser in the provision who will be responsible for the service user?

Do the service user and their relatives or carers know who this will be?

Have arrangements been made for the new provision manager/organiser to get to know the service user and be involved in their planning the care prior to transfer?

Are the staff of the new provision familiar with the person's care plan, including issues such as how to handle distress?

Have the assessed needs and the care plan been reviewed in the 3 to 4 weeks before the planned transfer?

Has it been decided who will be travelling with the service user on the first day at the new provision?

Has transport been arranged taking account of how many people will be travelling with the service user and who they will be?

Post Move Arrangements and Review

Have contact details been provided to the receiving centre

- details of previous centre
- Health contacts, particularly the GP / District Nurse / CPN with responsibility for the service user
- Social Worker
- Family / next of kin
- Contact details of users of previous day centre that the person wishes to continue have contact with.

Have arrangements been made for a follow up visit by the Social Worker in the 2 – 3 weeks after the move?

Has a provisional date for the 28 day review been set? Are all potential attendees aware of this date?

Has the Transfer to New Provision Summary and Feedback Sheet been completed and passed to Team Manager?

TRANSFER TO NEW PROVISION **SUMMARY and FEEDBACK SHEET**

This feedback sheet is designed to collect information about the experience of each of the moves arranged by the Assessment and Resettlement Team. This information will be used to inform the way other moves are arranged.

NAME OF SERVICE USER :

Summary of move

Aspects of the move that went well

Aspects of the move that did not go well

Any general comments / observations

Social Worker :

Date of move :

Appendix 5

Re-assessment and Resettlement Methodology

Development History

The Older Adults Modernisation Project, Re-assessment and Resettlement Methodology has been developed via a range of sources. This development commenced with the commissioning of research by the University of Birmingham. The report undertaken by Nick Le Mesurier and Rosemary Littlechild entitled ' A Review of Published Literature on the Experience of Closure of Residential Care Homes in the UK' was received by the City Council on 2nd April 2007. This report provides a very comprehensive resume of the literature in relation to homes closures.

The research report was presented to a multi-disciplinary workshop held on 23rd April 2007 – attendees at the workshop came from a wide range of stakeholders including elderly people, carers, the voluntary sector, health and from social care and are listed within the Methodology. This all day event considered the findings of the research and undertook work around the good practice issues it identified and how they could be incorporated in the Re-assessment and Resettlement Methodology.

A City Council 'Equality Impact and Needs Assessment' of the methodology was undertaken on 3rd July 2007 and no adverse effects on equalities issues were identified.

A summary presentation of the methodology was given at the Older Adults Managers Briefing held at Highbury Hall on 19 June 2007. Questions raised and comments made have been used to further develop the methodology

A draft of the methodology was distributed on 17th July 2007 to all attendees at the April workshop. Responses were received from a number of the attendees and incorporated as relevant.

The Adult Protection elements of the methodology were presented to the Adults and Communities Adult Protection Workshop for Managers on 19th July 2007. This was followed up by circulation of the proposals in this area to Older Adults Operations Managers and Team Managers for comments.

A revised draft was distributed to a wide range of Adults and Communities operational managers on 10th August 2007 and to PCT representatives on 15th August 2007

Other specific individuals have been approached for their comments on the methodology such as Professor Jon Glasby of the University of Birmingham, Health Service Management Centre and members of the Adults and Communities Communications Team.

Throughout the whole process of the methodology development extensive reading has been undertaken by the author of relevant materials. Sources explored have included the internet websites of the Department of Health, Social Care Institute for

Excellence, Dignity in Care, Alzheimers Society, Personal Social Service Research Unit, Help the Aged and many others.

Reference has been made to relevant legal cases and reports produced for court – such as the report of professor David Jolley to the High Court in February 2003.