



# **RE-ASSESSMENT and RESETTLEMENT METHODOLOGY**

For Residents of Birmingham City Council  
Older Adults Care Homes

**OLDER ADULTS MODERNISATION  
PROJECT**



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## 1. **EXECUTIVE SUMMARY**

This document describes the methodology that will be used to undertake the re-assessment and resettlement of the people resident in the Birmingham City Council (BCC) Elderly Person's Homes (EPH) 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 Residential Care Homes in the UK
- a multi agency workshop – which included older people and their representatives
- individual interviews with Social Workers, Residential Care Managers,
- internet searches for relevant information
- various other reading
- revision of draft versions following extensive distribution to various stakeholders

The methodology is designed to ensure that the re-assessment and resettlement 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 Resettlement 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 resettlement of all the individuals residing in the BCC Care Homes. Multi disciplinary re-assessments will be undertaken with all individuals to identify their needs and preferences.

Individual residents of the homes 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 / Safeguarding 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.

### **Resettlement**

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 admission criteria.

The range of alternatives may include – BCC Care Centre, alternative residential care homes in the private/voluntary sector, Extra Care Housing, Care Homes with Nursing, independent/supported living, living with family and others. Individuals will be given choice as to where and how their care and other support needs will be met.

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 care home. 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 :

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

Residential Care Home Managers and other care 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 closure programme – e.g. Extra Care Housing, Assistive Technology.

The core role of each of these professionals will be:

Social Workers – will lead and co-ordinate the Person Centred Re-assessment of each individual residing at the BCC Care Homes. Work with other members of the team to ensure the safe and positive resettlement to alternative care provision of all individual residents. Produce a detailed person centred re-assessment and care plan. Monitor and review the care arrangements made for each person. Co-ordinate the Risk Assessment and Management process for all residents. To complete the University of Birmingham research questionnaires with individual residents during the assessment and at specified reviews

Occupational Therapy – will undertake a screening and 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.

Geriatrician and Psycho-Geriatrician – expert support, advice and guidance will be provided by specific Consultants linked to the team. They will undertake interventions as necessary, make referrals for further specialist re-assessments and advise on any amendments to the re-assessment and resettlement process.

Nursing Professionals – to undertake relevant nursing assessments or refer for other specialist assessment or treatment as required to ensure all health care needs are identified and met. To review the nursing needs of people living in the Care Homes and liaise with other nursing professionals as necessary. To contribute to the Risk Assessment and Management process for all residents.

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

Residential Care Home Staff – to provide support to, and information about the people living in each home. To undertake work on the 'Life Story Book' with each individual who wishes to compile one. To support the completion of University of Birmingham research questionnaires.

Assistive Technology – to advise on, and supply when appropriate, assistive technology equipment to promote the independence and safety of individual residents of the Care Homes. To share (with consent) information acquired by any TeleHealth or TeleCare systems that are in use in any homes at the time of re-assessments being undertaken.

Extra Care Housing – to assist in supplying information regarding ECH vacancies and assist in the smoothest possible access to suitable vacancies for people from the Care Homes who may wish to move to such accommodation.

Business Project Manager – in addition to the operational team management support will be provided by the Business Project Manager. Their role will be to oversee the progress of the project, assist in the review of quality standards and liaise with Older Adults Modernisation Project as required.

### **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. An Independent Mental Capacity Advocate will be provided for those who require this type of support.

### **Timescales**

The actual timescale for the closure of any individual home is subject to many factors. In particular the place of the 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 April 2008 and the closure of all the homes in the first phase by the end of 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 decommissioning is

undertaken, with 'best practice' lessons being identified and applied to any future closures.

## 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-assessment and resettlement of the individuals of the BCC EPHs 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 RESETTLEMENT PROCESS**

The re-assessment and resettlement process will be undertaken in a Person Centred way.

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

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

Risk Assessment and Management will be an integral part of the re-assessment and resettlement process in order to identify and mitigate against possible negative effects on the health and well being of individuals.

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

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

#### 4) **RE-ASSESSMENT**

##### **Process**

All the long-term individuals of Birmingham City Council residential care homes will be provided with an individual re-assessment during the time prior to the closure of their home. 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 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. The re-assessments will be undertaken in a person centred manner using techniques drawn from Person Centred Planning.

High importance will be given to the health and well being of each individual. The re-assessment will also identify important relationships for the individual and how best these can be maintained within the context of the closure of the home.

The Social Worker will work in conjunction with various other people – especially people identified by the individual 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, Residential Care Staff, Occupational Therapy (OT), Assistive Technology, Pensions Service and/or others.

The Social Worker undertaking the re-assessment will work closely with the individual resident 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 residential home will be identified as a very important part of this process.

The closure of the BCC EPHs presents a situation where the future care arrangements for all residents will have to be addressed. Part of this process will include consideration of the possibility of individuals being enabled to live in a more independent manner. Work will be undertaken by the Rehabilitation and Enablement Service (RE&S) to identify people who have the potential for developing current and new skills and confidence in living more independently. A programme of rehabilitation will be offered and implemented with individuals where appropriate. Further details of the RE&S and OT input is detailed below.

The overall re-assessment will include the Birmingham City Council Single Assessment Process, Overview Assessment (Easycare), the Specialist Social Work Assessment and assessments from other professionals will be added as appropriate as part of the Comprehensive Assessment.

## **Communication issues**

The individual communication needs of individuals will be identified and addressed within the re-assessment process. These needs may be in 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 difficulties 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

We will aim to provide accessible communication support within ten working days of the need being identified.

## **Mental Capacity Act and Capacity Re-assessments**

In planning to undertake the re-assessment of each person, initial consideration will be given to whether they have 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 a service user 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.

As this process is concerned with a change of accommodation reference will be made for an Independent Mental Capacity Advocate (via the commissioned Advocacy Information and Support Service – see below) for any individual who lacks capacity and has no friends or family who can be consulted on decisions made for, or on behalf of, the person.

Adults and Communities Directorate procedures in relation to Mental Capacity Act assessments will be followed and decisions recorded in line with Directorate requirements.

All work done in relation to the re-assessment and resettlement process 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](http://www.dca.gov.uk/legal-policy/mental/capacity).

### **Guardianship**

If any resident of a home is the subject of a Guardianship Order under Section 7 of the Mental Health Act 1983 the nominated guardian shall have the power to require the person to live at a place specified by them. The guardian will be the person named in the Guardianship Order – it may be an officer of the Local Authority, a relative of the person or someone else. It is essential that the guardian is fully involved in the plans to assess and resettle the person.

People subject to Guardianship Orders have someone (i.e. the guardian) who can be consulted regarding future care arrangements. Therefore they do not fall within the criteria for the appointment of an Independent Mental Capacity Advocate (see above).

Recent clarification has been given that people subject to Guardianship Orders are liable to make a contribution to the costs of their care.

### **Adult Protection / Safeguarding**

If during the course of the re-assessment and resettlement work at a home an Adult Protection / Safeguarding issue should arise in connection with a resident the initial responsibility for investigating, registering and management of the referral will lie with the Assessment and Resettlement Team. Liaison and information sharing with the appropriate area team will take place to inform any investigation and determine any on-going case responsibilities.

### **Risk Management**

In order to identify and address possible adverse effects on the health and well being of individuals during the course of the re-assessment the 'Risk Assessment and Management Tool' (see Appendix 1) will be completed. This tool will be used during both the re-assessment and resettlement phase of the closure process.

### **Care Plan**

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

The Care Plan will be a very important document in ensuring that the needs and wishes of the person are shared with the new service provider to ensure the best quality outcomes for each individual. A copy of the Care Plan will be given to the new service provider.

### **Life Book**

Individual's current life situation, their likes and dislikes and their own history is of great importance. In order to 'catch' these matters the opportunity to complete a 'Life Book' will be offered to all individuals as a means of recording personal aspects of them and their life. This book will go with the person when they move for them to share in their new care setting if they wish to. The completion of this book may well be led by a member of the EPH staff.

### **Moving File**

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 file/portfolio. This book will be held by the individual during the course of the re-assessment and resettlement process and will go with them to their new placement/care setting.

### **Tracking of Progress**

#### **Overall progress**

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

To be discussed at weekly meetings at the home. To involve Social Workers, Team Manager and Home 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 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) **RESETTLEMENT – FINDING AND MOVING TO SOMEWHERE NEW**

During the course of the re-assessment of an individual some initial exploring of possible resettlement options will take place. Once a fully comprehensive re-assessment has been completed the identification of, and move to, the new provision for the individual will be arranged. The closure of the homes offers people the opportunity to consider all the alternatives as regards their future care and support needs. The full range of viable options for individuals will be considered to help ensure that the particular wishes and needs of each person are met as fully as possible whether this is through Care Centres, Extra Care Housing, alternative residential care homes, care homes with nursing, or other possibilities such as moving to live with family etc. Individuals will be offered choices as to where and how their care and other support needs will be met.

### **Identifying alternative accommodation**

Social Workers will provide details to individuals of the current potential resources that are available.

Social Workers will be updated about vacancies in Extra Care Housing (ECH) on a regular basis via the Assessment and Resettlement Team administrative support and will share this information with individuals.

Vacancies in care homes and care homes with nursing are available via the Bedvacs website service which also provides a Care Home Checklist as a possible aid to comparing homes. Printable copy of the checklist is available via [www.bettercaring.co.uk](http://www.bettercaring.co.uk) .

Commission for Social Care Inspection (CSCI) care home reports will be made available to assist individuals to make a comparative judgement on the quality of homes.

Alternatively people may wish to obtain information on care home selection and funding from Care Aware - an independent, non profit making organisation which offers a public information, advisory and advocacy service on the wide range of issues associated with long term care need. Contact via [www.careaware.co.uk](http://www.careaware.co.uk) or telephone 08705 134925.

In order to help people make fully informed choices about their preferred future accommodation, visits to alternative resources will be arranged where it is agreed that the resources appears to be a potentially suitable option.

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

People will be able to take items of furniture and possessions they personally own with them to their new home (as long as relevant Health and Safety and Fire Regulations are complied with).

## **Finance**

If there appears to be the potential of an individual moving out of residential care and into community accommodation of some sort (including Extra Care Housing) a benefits check and Contributions Assessment will be undertaken by the BCC Fairer Charging Team. Information concerning the potential financial consequence of moving out of residential care will be important information for the person to have in order to make an informed choice about their individual situation.

Referral to The Pension Service for a benefit entitlement check using referral form SS8171 can be made as an alternative to the Fairer Charging Team for those individuals who are considering moving to a non-residential care setting. Individuals may be entitled to a Community Care Grant from the Social Fund if they are moving out of residential care. Referral can also be made to The Pension Service for any 'full fee payers' to ensure that they are receiving the maximum benefits they are eligible to.

Social Workers will discuss Self Directed Support options as a potential method of funding support needs with all individuals considering moving into the community.

## **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 resettlement the 'Risk Assessment and Management Tool' (see Appendix 1) will be used. The use of this tool will already be in place the re-assessment phase.

## **Checklists**

In order to facilitate the smoothest possible transition from the present home to the new care setting, 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 (Appendix 2)
- The process of the move (Appendix 3)
- Post move arrangements and review (Appendix 4)
- Process of Moving to Extra Care Housing (Appendix 5)

## **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 Assessment and Management tool. The Care Plan will be amended as necessary. Even if the review does not raise any issues of note that need attention the Social Worker from the Assessment and Resettlement Team will continue to be the allocated worker for a further 28 days to ensure consistency in case of any issues that arise. At the end of this period the case file responsibility will transfer back to the originating area Older Adults team with all relevant documentation to ensure effective follow up.

## **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 resettlement planning in the residential homes, 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 / Safeguarding 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, stationary stock and ordering, collation and production of 'Life Books'.

Team to consist of 1 Senior Admin and 1 non-Senior Admin worker

## **Social Workers**

Qualified Social Workers will undertake person centred re-assessments of all the individuals resident in the BCC EPHs in conjunction with the individual themselves, their families/friends and a range of other agencies/professionals.

The re-assessments will be undertaken at homes on a phased basis in line with the agreed homes closure order. Social Workers will be assigned to a residential home to co-ordinate the re-assessment and resettlement of all the individuals in that home.

A new, detailed and person centred care plan will be produced by the Social Worker, that will provide high quality information to the new care setting for each individual.

Social Workers will also undertake the sensitive completion of the University of Birmingham research questionnaire with individuals who have consented to take part in this research.

## **Residential Care Staff**

### **Home Managers**

Home Managers will facilitate the access to, and provision of information about the individuals in the home. They will be involved in meetings at the home in relation to the progress of the re-assessment and resettlement process. They will deal with straightforward queries or issues raised by individuals or their advocates in connection with the re-assessment and resettlement process. Major issues raised by the independent advocacy service will be forwarded by the home manager to the Project Review Group. Home Managers will assist in the completion of the University of Birmingham Research by obtaining the consent of those residents who are agreeable to taking part in the research.

### **Care Staff**

A very significant amount of information about individuals is known by the care staff at the home. With the agreement of individuals, care staff will be asked to share their knowledge of individual 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 Book'.

Care staff may be involved in completing the OT 'Community Dependency Index' screening tool (Appendix 6).

## **Health Professionals**

### **Consultant Geriatrician and Psycho-geriatrician**

Support will be provided to the multi disciplinary team by a Consultant Geriatrician and Consultant Psycho-Geriatrician. They will

- provide expert advice on the re-assessment and resettlement process
- be available to advise and support the Assessment and Resettlement Team
- advise on whether specific interventions are necessary in individual situations and if further referral to other specialists is required
- undertake specialist assessments themselves as necessary with individual service users
- provide advice and guidance as to any adjustments that may be necessary to the re-assessment and resettlement process overall

### **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 undertake an initial screening function of all individuals 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 assist in facilitating the transfer of individual's registration with a new GP and / or community nursing support if necessary
- To undertake assessments themselves, within the remit of their professional responsibilities, and make referrals for other health assessments as appropriate (e.g. consultant geriatrician or psycho-geriatrician, 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 individuals or their family on general or specific matters as regards the health of the individuals
- In liaison with the Social Workers/Social Work manager to have an overall view of the coordination of the nursing support to individuals
- To be involved in a Risk Assessment and Management plan for each individual in connection with their move from the home.

## **GPs**

In order to ensure the best quality information is gathered for each individual a number of pro-forma letters are available to inform/request information from the GPs of individual individuals.

*[Note – these letters are currently in draft form awaiting advice re wording from PCT representative.]*

- Pro-forma letter to GP informing them that one of their registered patient's is involved in the closure programme. (Appendix 6)
- Pro-forma letter to GP requesting information. (Appendix 7)
- Pro-forma letter of authority from the individuals to the GP to disclose information. (Appendix 8))

## **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.

- To undertake an initial screening function of all residents to identify if any appear to be in need of nursing or other health intervention and make referrals as appropriate (eg consultant psycho-geriatrician).
- To liaise with existing Community MHSOP to clarify clients they are engaged with and clarify current needs
- To undertake assessments for residents not known to MHSOP within the remit of their professional responsibilities
- Assist in facilitating the transfer of individuals between consultants and Community Mental Health Teams as required
- To liaise with and advise Social Workers and other professionals who make up the Assessment and Resettlement Team
- Offer advice and support on such matters as Capacity Assessments under the Mental Capacity Act 2005.
- To provide information and advice to residents or their family on general or specific matters as regards the health of the resident
- In liaison with the Social Workers/Social Work manager to have an overall view of the coordination of the nursing support to residents
- To be involved in a Risk Assessment and Management plan for each resident in connection with their move from the home

## **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 homes that are actively involved in the re-assessment and resettlement phase of closure.

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

OT to complete full assessment and devise a re-ablement plan for those individuals 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 assessment and enablement plan to be incorporated by the allocated SW into the individual's new Care Plan and also into the Risk Assessment and Management Tool.

- For homes 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 individuals of the home a process to identify those with potential for rehabilitation is proposed.

Home 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 individuals with potential for rehabilitation.

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

OT to complete full assessment and devise a re-ablement plan for those individuals 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 home moves into the full re-assessment and resettlement phase the allocated SW will liaise with the OT about the progress of the individuals towards more independent living. Plans for possible future service provision will look to build on the independent living skills of the individuals.

- For individuals entering any City Council EPH after the closure plan has been agreed by Cabinet (or who entered one of the EPHs in the 2 months prior).

Home staff to identify anyone who fits the above. They will complete the 'Community Dependency Index' as an initial screening tool to help identify individuals 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 individuals that have physical and/or mental health issues, however :

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

- If the individual 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 individual 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 individuals 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 promote more independent living.

Where TeleHealth or TeleCare equipment is being used with any residents of a home the information provided by these systems will be incorporated into the overall re-assessment of the person.

As part of the re-assessment process all individuals 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 home 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 are living within Birmingham City Council Care Homes.

The Advocacy Information Service makes planned visits to all Birmingham City Council's residential homes for older people. These happen once every two months, increasing to monthly where a home is due to close in the near future. This service is for all residents and their relatives/next of kin. Information of dates and times of visits is sent to all residents and relatives on their database, is publicised on the Advocacy Information website ([www.advocacyinformation.org](http://www.advocacyinformation.org)) and also on posters at the residential homes. During these planned visits, advocacy workers talk to residents 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 home, to answer any questions they can, to follow up any questions they cannot answer with BCC and to seek the views of residents and relatives on the changes to be made by BCC.

Additionally, the Advocacy Information Service has an Independent Mental Capacity Advocate who will, following referral from the Assessment and Resettlement Team, work with residents who may have specific difficulty making a decision with regard to the proposed move and who have no relatives or next of kin available to assist in this process.

### **7) SUPPORT**

To individuals and families.

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

In addition during the course of the closure process support will be provided by the allocated Social Worker and residential 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 resettlement plan. The need for emotional support to individuals will be provided over the course of the home closure and resettlement of each person.

### **8) TIMESCALES**

The projected timescale for the completion of closure of homes in the first phase closure programme is the end of 2009.

The basic order of closure of the homes 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 homes at the top of the closure order and proceed through the rest of the homes in an ordered manner. The Assessment and Resettlement Team may commence their work in a home before the final closure of homes earlier in the closure order.

Research undertaken by the University of Birmingham summarises the recommendation by individuals and relatives about closure timescales. 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 resettlement plans are undertaken with all individuals at a home it is projected that the re-assessments and resettlement process will take about 4 months to complete. This would mean that the possible timescales for this process in homes in the first phase would be approximately

Homes 1 - 3	Re-assessments and resettlement - Apr 08 to July 08
Homes 4 - 6	Re-assessments and resettlement - Aug 08 to Nov 08
Homes 7 - 10	Re-assessments and resettlement - Jan 09 to 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 and the closure programme recommences afterwards the possible indicative timescales for the second phase of homes could be :

Homes 15 – 18	Re-assessments and resettlement – Jan 10 to Apr 10
Homes 19 – 22	Re-assessments and resettlement – May 10 to Aug 10
Homes 23 – 26	Re-assessments and resettlement – Jan 11 to Apr 11
Homes 27 – 29	Re-assessments and resettlement – May 11 to Aug 11

**NB** These dates are 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 also considered the timing of events in relation to the re-assessment and resettlement 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 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 resettlement process will be undertaken as part of the evaluative research to be undertaken by the University of Birmingham of the first phase of the Older Adults Modernisation Project. This evaluation is in two parts :

- The surveying of all individual residents in BCC Care Homes or users of an attached day centre in the first phase of the closure programme. The survey to be undertaken at the time of re-assessment, at the 28 day review and at the 12 month review. This part of the research will generate data on the outcomes for individuals affected by the re-provision / resettlement programme.
- An in depth qualitative analysis of the experience of service users in one home and its attached day centre. This research will in particular help to inform any change in the methodology of the re-assessment in later homes and day centre closures.

On going internal monitoring, review and evaluation of the progress and outcomes of the re-assessment and resettlement 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)
- Transfer to New Provision Summary and Feedback Sheet (Appendix 9) – completed by Assessment and Resettlement Team members
- Assessment and Resettlement Team meetings
- Monitoring of 3Cs data

### **Identification of the outcomes for individuals.**

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 individuals had and whether these have been met
- whether there is any new skills training needed to access new opportunities and has/will this be provided
- the University of Birmingham research detailed above will be linked to reviews by the completion of the research questionnaire as part of the review process.

## 10) ACKNOWLEDGEMENTS AND BIBLIOGRAPHY

Grateful appreciation is extended for the contributions of a large number of people including:

The attendees at the Multi Agency Workshop that included–

Berni Blackledge	Alzheimer's Society
Winston Mosquito	Equalities & Diversity
Bev Badger	Manager, George Canning Care Home
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

Special thanks to Nick Le Mesurier and Rosemary Littlechild as attendees at the Workshop but also for their work in providing the Literature Review that informed much of the Workshop content.

Valuable contributions were also provided by – Sarah Gimson (PCP Team Manager) and Jay Barr (Senior PCP Co-Ordinator), Gillian Brooks (DISC), Emma Pugh (Greenlands EPH), Mark Hatfield (SW Yardley AO), Lendeater Huggins (Elderfield EPH). Sue Coffey (LD)

Particular thanks to close colleagues Lucy Ashton (Project Director) and Andrew Errington (Business Project Manager) and Mary Neal for excellent administrative support.

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11) **APPENDICES**

Appendix 1	Health and Well Being Risk Assessment Tool
Appendix 2	Pre move Checklist
Appendix 3	Process of the Move Checklist
Appendix 4	Post Move Arrangements and Review Checklist
Appendix 5	Process of Moving to Extra Care Housing
Appendix 6	Community Dependency Index
Appendix 7	Letter to GP 1
Appendix 8	Letter to GP 2
Appendix 9	Residents agreement letter
Appendix 10	Transfer to New Provision Summary and Feedback Sheet
Appendix 11	Methodology - History of Development

**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 EPHs.

**Name of Service User:**

**Gender:** Male/ Female

**Name of Unit:**

**Date tool completed:**

<b>RISK INDICATOR</b>	<b>Details of Concerns</b>	<b>Plan to address and manage the identified risk</b>
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 accommodation?		
Is there any cognitive/ sensory impairment?		

<p>Does the person have any mental health issues that may have impact on the process?</p>		
<p>Is the person aware of the plan to close the home and what feelings are they expressing about this?</p>		
<p>Does the person have any effective support system?</p>		
<p>Are there current physical health conditions that might be affected by the move?</p>		
<p>What concerns would indicate that a postponement of the move is necessary?</p>		

## **Pre move Checklist**

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

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?

Have arrangements been made for a settling in period in the receiving care setting with staff who are familiar to the service user?

Has the key worker or Social Worker been in discussion with the care home manager or care assistant (or nurse) in the receiving care setting 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 home manager / scheme manager / care assistant (or nurse) in the receiving care setting to get to know the service user and be involved in their care prior to transfer?

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

Have the staff of the receiving care setting been involved in drawing up the transfer plan?

Has medical cover been discussed and arranged – in particular what arrangements are in place for transfer to another GP where this is necessary? Also has access to District Nursing support been confirmed where required?

Has an adequate (at least two weeks) supply of medication, dressings, and equipment been ordered to cover the post transfer period?

Has the local pharmacy been informed about any special needs?

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 during the transfer?

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

## **Process of the move**

Is all the necessary documentation completed, dated and ready to travel with the service user?

- New Care Plan
- Moving Book
- Life Book
- details of when the most recent medical examination took place
- has the Health and Well Being Risk Assessment document been shared with special note made of any significant risk factors identified and an agreed plan of action if intervention is required

Are the identified equipment, aids and supplies, either ready for travel with the service user or in place in the receiving setting?

Have arrangements for packing and transporting the service user's possessions been made?

Do they include:

- identifying the items to travel with them and those to arrive in advance?
- packing personal possessions in a suitcase or suitable travel bag (not in a plastic bag)?

Have travel arrangements been made?

Do they include:

- who is to travel with the service user (eg, key worker, relative or carer, or a combination)?
- the date and time of day travel is to take place, avoiding times that would disrupt routine?

Have arrangements been made for the service user to be received in the new setting?

Do they include:

- confirmation, in advance, by staff in the receiving care setting that the new setting is fully prepared?
- identification of the home manager / care assistant /scheme manager on duty in the new setting to receive them?
- whether the service user and their relatives or carers accompanying them are to receive a meal or snack and drink on arrival?
- the receiving staff knowing what is likely to be the patient's greatest concern - for example where their personal possessions are?
- informing relatives and carers or friends of their safe arrival?

Have any arrangements been made for staff in the 'originating' home to support the service user at the new placement?

Do these arrangements (if any) include:

- the length of time staff from the previous setting should continue to help provide care in the receiving care setting?
- the identification of the individual staff involved in co-working in both settings and facilitation of co-working?

Have arrangements been made in the new setting for relatives and carers or friends to be able to contact or visit the patient?

Does this allow for continuation of previous visiting patterns?

Does it allow for continuation of communication arrangements between relatives or carers and members of staff?

## **Post Move Arrangements and Review**

Have contact details been provided to the receiving home

- Originating home
- Health contacts, particularly the GP / District Nurse / CPN with responsibility for the service user at the new home
- Social Worker
- Partner /family / next of kin
- Contact details of residents of the previous home 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 days after the move?

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

Are arrangements clear for any agreed visit from staff of the previous home – date / time, for how long?

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

### **28 day review**

Has 28 day review been held?

Was it on schedule? If not, why not?

Has an action plan to address any identified issues been drawn up and acted upon?

Has review of any issues from the Risk Assessment and Management tool been undertaken and acted upon?

Has the University of Birmingham research questionnaire been completed and submitted?

**PROCESS OF MOVING FROM RESIDENTIAL CARE  
TO EXTRA CARE HOUSING**

Has a potential void been identified

Has person visited the extra care scheme and seen the vacant tenancy

Are any adaptations needed to the tenancy

Is any significant refurbishment, redecoration required

Has Housing Benefit and other Benefit applications been submitted – who will ensure progress on these applications

Has a list of furniture, carpets, equipment (kitchen, TV, vacuum cleaner etc) etc been drawn up

Has finance to purchase these items been identified – Community Care Grant, person's own resources, other source

Who is available to assist the person in purchasing these items – eg family, friends, residential care staff, Social Worker

Has delivery been arranged, fitting of carpets, installation of electrical items, cooker etc

Are all utilities connected and functioning – electric, gas, water etc

Who will assist in getting tenancy ready for occupation – family / friends, Handyperson (Age Concern or similar – or via self directed support arrangement), scheme manager, Social Worker, Community Links Service

Has 'final' visit to the tenancy by the person taken place before the moving in date

Has a specific moving in date been confirmed with person, scheme, family/carers

Is scheme manager fully aware of moving in arrangements and their

Has a Care Package been devised following re-assessment

Is a detailed Care Plan available and has it been shared with the person, carers, scheme manager, care provider

Has the Health and Well Being Risk Assessment and Management Tool been completed and are strategies to monitor and respond as necessary in place

Are details of who will provide on-going support to ensure successful 'settling in' of the person clear and what are the details – family, Community Links Service, scheme manager, care provider

**COMMUNITY DEPENDENCY INDEX**

Client's Name: ..... M/F DoB ..... GP  
 ..... Carefirst No. ....

## Dates / Scores

	Dependent independent	-----				
1. Personal toilet (wash face, comb hair, shave, clean teeth)	0 5	0	0			
2. Feeding (if food needs to be cut up = help)	0 10	5	5			
3. (Wheel)chair to bed and return (includes turning in bed)	0 15	5	10			
4. Getting on and off toilet (handle clothes, wipe, flush)	0 10	5	5			
5. Walking 50 yards outside (or propelling wheelchair) * score only if unable to walk	0 15 0* 5*	10	10			
6. Dressing (includes laces, fasteners)	0 10	5	5			
7. Bathing self	0 5	0	0			
8. Ascend and descend stairs	0 10	5	5			
9. Controlling bowels	0 10	5	5			
10. Controlling bladder	0 10	5	5			
			<b>TOTAL</b>			
<b>NB</b> Four columns are given to allow for subsequent re-assessments following interventions			<b>Assessor's signature</b>			

**NB** – guidance notes for the completion of this form are contained in the BCC Adult Procedures 'South's Enablement Approach to Receiving Care at Home'.

# ***DRAFT***

## **Letter to GPs**

[GP name and address]

Dear Dr.

**Re ;** [name of person] **Resident at** [name of home].

I believe that the above named person is currently registered as a patient with your surgery. If this is not the case please could you let me know as a matter of urgency.

Birmingham City Council is currently undertaking a phased closure of all of its residential care homes in order to modernise and improve future services to older people. As this major project progresses the best interests of the residents of the homes will be of paramount consideration. I see it as vital that the health and well being of all the residents is fully addressed. To this end I wish to requests your fullest possible involvement in ensuring the health of your patient is effectively assessed and monitored during this process.

A Care Manager responsible for the overall re-assessment and resettlement of your patient will shortly be in contact with you. They will wish to discuss with you the current health of your patient and any health issues there may be that need to be addressed as their move from the home approaches.

I am sure you share our concern to ensure the best possible health of the people involved in this significant change and look forward to working with you.

Yours sincerely

# *DRAFT*

Appendix 8

## **Letter to GPs**

[GP name and address]

Dear Dr.

**Re ;** [name of person] **Resident at** [name of home]

I wrote to you recently to inform you that your patient named above is a resident in an Elderly Person's Home that is in the process of being closed.

In order that the best health and well being of your patient is fully addressed during this process I would like to request your assistance in identifying any physical or mental health issues that could be of importance.

As part of a Risk Assessment of any factors that might may result in a negative affect on the health of your patient please could you complete the attached short questionnaire and return it in the stamped and addressed envelope.

I attach the signed agreement of your patient for the disclosure by you of information regarding their health.

# *DRAFT*

[Name of Resident]

To Dr .....  
[GP address]

I write to give my agreement to release of information to Birmingham City Council regarding my physical and mental health.

This information will be used to help ensure that any health needs I have are addressed as fully as possible both during the time I am being assessed and in making arrangements to meet my future care needs.

Yours sincerely,

## **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 :**

**Date sheet completed :**

## **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 2<sup>nd</sup> 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 23<sup>rd</sup> 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 Re-assessment' of the methodology was undertaken on 3<sup>rd</sup> 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 17<sup>th</sup> 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 / Safeguarding elements of the methodology were presented to the Adults and Communities Adult Protection / Safeguarding Workshop for Managers on 19<sup>th</sup> 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 10<sup>th</sup> August 2007 and to PCT representatives on 15<sup>th</sup> 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.