Date written: April 2013.

Approved by:

Date of next review: April 2014.

Person responsible for reviewing and updating:

Cara Murphy – Review Team Manager
Niamh Rigby – Service Manager
1. Introduction

Fair access to care services local authority circular LAC (2002) 13 provides guidance about the review process.

1.1 Definition of a Reassessment.

A reassessment should be completed when a referral is received at CDT identifying a change in circumstances, or when a support plan review has been undertaken and a new eligible outcome and increase in support is identified. At this point the case will be allocated / transferred to a social worker or occupational therapist who will complete / update the new or existing social care assessment document and completion of a new Resource allocation questionnaire. The social worker / OT will then follow the agreed process identified in the adult social care personalisation/customer journey. Referring on to the Brokerage team or the relevant team to instigate the change in service users support plan.

1.2 Definition of a Review.

All service users should have one scheduled review on the system. The aim of the review process is to review the support plan agreed at the last assessment. The support plan review document is completed where the level of eligible need appears unchanged or reduced. This process is completed by a review officer and it is within their remit to reduce the support provided where a need / outcome is no longer eligible or where a service is no longer required. Where a review officer identified that an increase in support may be required the case will be transferred to a social worker or an occupational therapist and the above reassessment process followed.

2. Reviews

The review team will receive their casework via two routes:

- Reassessment referrals via CDT (see appendix A).
- Via the monthly scheduled review report on info view.

2.1 A review should:

- Establish how far the services provided have achieved the outcomes set out in the social care support plan.
- Re-assess the needs and circumstances of individual service users.
- Help determine individuals’ continued eligibility for support.
- Confirm or amend the current support plan or lead to closure.

2.2 Establish how far the services provided have achieved the outcomes set out in the care plan.

Desired outcomes should be negotiated with service users/carers when Support is being offered or arranged (see care plan guidance notes). The person carrying out the review can then establish if outcomes have been achieved. If it is the intention to continue to provide services or to provide new
services, desired outcomes should be renegotiated with the service user / carer.

2.2.1 Documentation.

A support plan Review document should be completed.

The revised support plan review can be found in AIS. The front sheet contains basic information such as name, address and swift ID. It is important to complete the following dates:

- Date of original care plan (this will be the package that is under review).
- Date the review took place.
- Date of next review.

Like the support plan the review should be authorised by a team manager and agreed with the service user/representative.

2.3 Reassess the needs and circumstances of individual service users.

During the review process the needs and circumstances of service users should be reassessed. It is important to remember that assessment / reassessment is a process and not the document it is written on.

2.3.1. The social care assessment should be used to record new information, additional information or a change of circumstances that is not included in the original assessment document. This means that all assessments will be completed on the new style social care assessment document within AIS.

2.3.2 Where there is a new assessment document information gathered during the reassessment can be recorded on the original assessment document. any new entry on an existing document should be dated so it is clear that the new information is being added.

2.3.3. The only exception to the above is when a review officer identifies a minor change to the existing package (See 1.2). They will record the evidence on the support plan review document on AIS.

<table>
<thead>
<tr>
<th>Old Outcome Focused Assessment</th>
<th>Reassessment</th>
<th>Complete new Social Care Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Old Outcome Focused Assessment</td>
<td>Review by Review Officer</td>
<td>Complete Support Plan Review</td>
</tr>
<tr>
<td>New Social Care Assessment</td>
<td>Reassessment/ Review</td>
<td>Update existing Social Care Assessment</td>
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</table>

2.4 Help determine individuals’ continued eligibility for support

During the reassessment / review the worker must establish if the person is still eligible to receive services. If a person is deemed to have risks to independence that fall into critical and substantial band a service can be
provided or the current service can continue.

3. Frequency of reviews

3.1 Reviews should be arranged at least annually or more often if the individuals circumstances warrant it, or where the are identified short term outcomes to be achieved.

3.2 The review of Assistive Technology equipment can be completed where appropriate over the telephone and using the telephone review documentation.

3.3 Reviews can also be requested prior to the set review date, by service users, Carers, family or providers of services via the Central Duty Team.

4. Attendance at Reviews.

4.1 Reviews should be co-ordinated by the social worker or review officer.

4.2 Reviews should involve service users, carers / representative of the individual and if appropriate providers of service. The review should where possible take place in the setting where the care/ support is provided. While it is not always necessary to have providers present at the review their opinion should always be sought.

5. Referrals to other teams and exemptions to the Review Team remit.

Safeguarding Issues.

Any case where a potential safeguarding issue arises needs to be brought to the attention of the Team Manager/ Senior. Where the Team Manager is in agreement that there are potential safeguarding issues the case will be closed down to the worker and referred via CDT to the appropriate team.

Referral to Early Intervention.

Where it is felt that a service user has potential to improve or there are inconsistencies regarding the persons abilities or it is felt assistive technology equipment may be of benefit then a referral to EI should always be made using the EI referral form.

Admittance to hospital.

Any cases open to the team where the service users are admitted to hospital will not be case managed by the team and responsibility for such cases would need to be transferred to the hospital team

Long term case work.
Cases that require long term case work do not fall within the remit of the review team and where it is felt that a case requires long term case management (more than 12 weeks) the case will be arranged for transfer to the appropriate locality team.