Achieving closure: good practice in supporting older people during residential care closures

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ACHIEVING CLOSURE

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- An excellent review of the literature by Nick Le Mesurier and Rosemary Littlechild at the University of Birmingham (which is to be published as an accompanying resource).
- A study of the outcomes of the modernisation of older people's services in Birmingham, commissioned by Birmingham City Council. This work is still underway but, given Birmingham's size, the care home closure programme is believed to be one of the biggest in the UK – and possibly in Europe. HSMC are grateful to Kathleen Martin, Kevin Halliday and their team and to Paul Dolan for their help and support with this study.

This guide should also be read alongside work by the Social Care Association (2011) on *Managing Care Home Closure* and guidance by the Welsh Assembly Government (2009). Much of the key research in this area has been undertaken by the Personal Social Services Research Unit (see, for example, Netten *et al*., 2005).

1. Introduction

SINCE THE NHS and Community Care Act 1990, both health and social services have increasingly been delivered via markets (see Means and Smith, 1998 for a recent history of adult social care). Over time, it has become commonplace for purchasing and providing functions to be separated, and for public bodies such as local authority social services to become commissioners of services from a mixed economy of public, private and voluntary providers (see Greve, 2008; Le Grand, 2003, 2007 for a broader summary of such changes). Those in favour of markets have tended to argue that they increase value for money, stimulate innovation and improve responsiveness. Those opposed often claim that they damage equity, fragment provision and increase transaction costs. Either way, a key feature of markets is that providers can sometimes *fail* – indeed the ultimate sanction of going out of business altogether is thought to be an important incentive to continue to perform well. Thus, a natural consequence of using markets to deliver services is that we inevitably have to think about how we handle market failure (see also Netten *et al*., 2005; Scourfield, 2004).

In adult social care, the most mixed economy of care is probably to be found in the care home sector. Here, historic changes in social security led to a rapid growth of private and voluntary homes from the 1980s onwards. More recently, there has been significant consolidation in the sector, with funding pressures, changes in the regulatory environment and labour market/economic changes leading to a series of mergers, acquisitions and the outsourcing of a number of previously in-house services. As Holden (2002, p 80) observes:

By the end of 1999, the ten largest [care home] operators owned or leased 15.1 per cent of total United Kingdom for-profit capacity, whilst the three largest owned or leased 8.1 per cent… [B]y November 2000 the largest of these operated 233 homes with 16,625 beds, whilst its nearest rival operated 145 homes with 8,326 beds. As with other providers, both of these organisations grew rapidly during 1996 and 1997, as a result of multiple mergers and acquisitions.

By 2010-11, Laing and Buisson (2010, p 8) concluded that:

Market concentration (defined here as the share of for-profit beds held by the four largest for-profit providers) fell by 0.4 percentage points during the year to reach 23.7 per cent by April 2010…, as the largest providers curtailed or ceased acquisition or development in response to the shut down in credit markets. However, whilst the pace of consolidation at the large corporate end of the market has slowed down, there still remain powerful economic drivers of further consolidation in the longer term.

Although the care home sector was once characterised by a diverse and large number of different providers, therefore, there has been a trend over time towards a smaller number of large providers – often national companies who have merged with other providers or bought up other companies and acquired care homes across the country. On the one hand, this might be expected to produce businesses that have enough capacity, economies of scale and resilience to survive the peaks and troughs of service provision. However, should

one of these large chains fail, it would have an immediate impact on a large number of older people in a large number of local authorities all at the same time. This has always been a potential risk, but is arguably even more of an issue at present following the global economic and banking crisis and with significant cuts in public services. Arguably the task for Directors of Adult Social Services will be to secure best value for money (which might sometimes involve contracting with very large providers) whilst at the same time not putting all their eggs in one basket and ensuring there are always alternatives if something goes wrong. In lay person's terms, if plan A does not work, there will always need to be a plan B – and this will be difficult in a challenging financial context and when public bodies are increasingly being encouraged to divest themselves of previous in-house provision.
As Holden (2002, p 89) suggests:

Government policies towards long-term care will encourage greater concentration in the sector. Since this is not the stated aim of these policies, it may perhaps be regarded as an unintended consequence, yet there is a distinct economic logic to the process. Through the combination of its funding and regulatory policies, the government is seeking the highest possible quality-of-care for the lowest possible cost; while its labour market policies are raising the minimum standards of protection for workers in sectors, such as long-term care, that employ 'flexible' labour on low wages. This combination, of the highest possible quality-of-care and the lowest possible cost, can best be provided by large firms that can draw upon economies of scale, and for the same reason they will most be able to meet the costs associated with raised employment conditions. Several of these firms are international, and can thus draw on resources and expertise from abroad.

There are three areas of concern associated with this process of concentration: the effects of increased ownership transfers; the implications of standardisation; and the possibility of a decline in the quality-of-care if local monopolies emerge.

It is the first of these three concerns which is the focus of the current guide: the risk of increased ownership transfers and the impact that this might have on older people if carried out in too rapid or unplanned a manner. Although concentrating more on change in ownership rather than closure per se, Holden is clear that (p 89):

When a provider acquires new stock, it normally seeks to bring all the homes in its acquired portfolio up to the standard of its other homes. Acquired homes may not meet these standards, and the organisation may not consider it cost-effective to renovate them.

Transfers of residents should, however, be kept to a minimum. Interview respondents from four different voluntary organisations working for older people said that residents find such transfers severely disruptive emotionally, psychologically and physically. In the worst cases, fatalities result.

Often, there seems to be a complex array of factors at work when care homes close or change hands, including local authority pricing, staffing issues, demand, changes in regulation and commissioning and changes in the property market (Netten *et al*., 2002, 2005):

- Financial problems (sometimes connected to concerns about local authority pricing but also to do with the business becoming non-viable through a bank about to foreclose, an owner being over-committed, a loss of motivation or rising costs and perceived funding shortfalls).
- Personal circumstances including an owner wanting to retire or the death of a spouse. Whereas such homes sometimes continue and simply change hands/management, they can close if property prices make it profitable to exit the market.
- Increased costs due to new care standards introduced from 2001 onwards.
- Shortage of staff (especially nurses).
- Possible changes in demand.
- Changing property prices making it possible to sell (sometimes to a developer).

Over time, therefore, local authorities have started to develop significant experience of closing care homes, reassessing residents and resettling them in alternative services. This has sometimes been an individual care home which has experienced a major incident of some sort, or where a local authority is closing its own homes and commissioning alternatives from the independent sector.

Historically, both health and social care have experience of closing the long-stay hospitals of the 1960s and 1970s (and some more recent NHS campuses) and developing more community-based alternatives for older people, people with mental health problems and people with learning difficulties.

However, closing a single unit involves only a small number of people, while closing a long-stay hospital or a number of in-house services can be planned in detail over a number of years. If a major national chain of care homes fails, local authorities will need to act on a significant scale and in very short timescales – quite possibly at a time when local authorities themselves are losing staff, making cuts and undergoing rapid change.

Despite this recent history, even a brief glance at the literature shows that there is a significant lack of formal evidence and resources to support local authorities in this task. As Peter Scourfield's commentary argued in 2004:

Successive government policies have created a situation where most residential and nursing care is provided by the independent sector. It is in the nature of a marketized… care system that homes will periodically close or change ownership. The physical and mental wellbeing of elderly residents experiencing eviction and relocation can be seriously damaged by the experience. No policy and practice guidelines have been issued from central government to cover how care home closures should be managed. Local authorities are therefore dealing with such events on an ad hoc basis. (Scourfield, 2004, p 501)

A similar point is raised by Woolham (2001, p 50):

A number of studies of relocation have observed an increase in mortality after relocation… However, very few studies suggest that increased mortality rates are an inevitable consequence of the relocation process… In effect this means that although relocation is undesirable in most circumstances, if it has to occur, it is possible to manage the process of relocation in ways that are least damaging for the residents involved. To achieve this, it is essential that the relocation process is informed by what is 'best practice'.

But what is best practice? Unfortunately at the present time, sources of information about best practice are hard to find… In effect, local authorities are left pretty much to their own devices. It would therefore be reasonable to assume that standards will vary between authorities.

This is also emphasised in Department of Health-funded research into the causes and consequences of care home closures, which called for national guidance and points to the wide variety in practice between different local authorities (Williams and Netten, 2005a).

What little published evidence exists is explored in more detail in Chapter 2. However, it seems likely, as Scourfield notes, that localities facing such situations are understandably focused on the task of finding alternative services (and therefore might not have time to learn and publicise the lessons from such experiences). With a planned closure programme, there can often be significant uncertainties for service users, families and staff – and such processes are often subject to detailed public, media and legal scrutiny. While this is entirely appropriate, it can often make it difficult for local authorities to find sufficient time and space to reflect on the process in detail and be fully open about what has worked and what has not. As a result, it is possible that knowledge of what constitutes good practice (and indeed what should be avoided) resides primarily in the heads of those who have experienced such closure programmes. If it has ever been collated and written down, it is probably in local 'grey' literature and not widely available (Williams *et al*., 2003) – and it may never have been written down in the first place. It also seems as though those local policies that do exist (or have existed in the past) may vary considerably, with some policies contradicting each other and some authorities potentially focusing more on underlying legal issues that on issues such as the notice to be given, the quality of information provided, resident preparation or preparing care staff (Williams *et al*., 2003).

Against this background, this guide summarises emerging evidence about best practice when care homes for older people close and when residents need to be re-assessed and resettled. As set out in Chapter 2 to 4, it draws on:

- A rapid review of the (limited) literature to date. As described in more detail in Chapter 2, this draws mainly on a prior review published in 2007 and briefly updated for present purposes. This initial review is also being published by the University of Birmingham and ADASS as an accompanying document to this guide (see Le Mesurier and Littlechild, 2007/11).
- In-depth interviews with Directors of Adult Social Services with experience of overseeing care home closures (Chapter 3).
- Emerging data from a more detailed study in Birmingham – believed to be one of the largest care home closure programmes in the UK (and possibly in Europe) (Chapter 4).

Aimed at policy makers, managers and practitioners with responsibility for older people's services, this guide seeks to make a modest contribution to overcoming the current gap in evidence (whilst recognising that this very broad overview of emerging best practice is only a starting point). It should also be read alongside recent guidance from the Social Care Association (2011) which updates a previous key publication (1992), offers practical advice on managing closures and provides a series of helpful checklists.

2. Overview of the literature

THIS SUMMARY OF the literature draws on a prior review published by the University of Birmingham in 2007 as part of a broader contribution to the modernisation of older people's services in Birmingham (Le Mesurier and Littlechild, 2007 - see also Chapter 4 and Appendix A for further details). This initial review has been republished as an accompanying document to this guide, so that anyone interested can read the full review in detail. Although this review is now several years old, we have updated this initial search to check that there have been no major changes since the initial review and have found very little extra material (see below for further discussion and two notable exceptions).

While there have been significant care home closure programmes in a number of local areas, Le Mesurier and Littlechild found:

Very little empirical research evidence on the closure of residential care homes for older people. What there is comes from a limited range of sources and concentrates mainly on the experience of closure in the independent sector (p 3).

Similarly:

An extensive review of local authority guidelines of care home closure found that few had been developed and that most were developed 'in-house' without reference to experience elsewhere. Consequently there are few, if any, reliable benchmarks available to … [local authorities]… by which to compare performance (p 3).

That little guidance and research exists in this complex area of policy and practice seems a major oversight given that the transfer and/or resettlement of frail older people is thought to have the potential to lead to significant harm to older people's physical and psychological health and well-being (see, for example, Hallewell *et al*., 1994; Jolley, 2003; Scourfied, 2004; Woolham, 2001; Castle, 2001; Beirne *et al*., 2004 for further discussion).

According to Le Mesurier and Littlechild (2007) key principles of good practice should include:

- The importance of placing service users' needs and wishes at the heart of care plans and of consulting properly with service users and their families/carers.
- Maintaining continuity of care and relationships with staff wherever possible.
- Paying particular attention to the needs of people with cognitive impairments.
- Providing adequate support for care managers (who may experience complex and stressful demands).
- The importance of training and support to enable care staff to work in different ways in future services.

This list is similar to that provided by Scourfield (2004), who suggests that:

Minimizing 'transfer trauma' necessitates an ongoing piece of work involving the whole system around the individual old person concerned. This would include, for example, friends, family, care staff, professionals and companions in the home. The older people concerned need to be allowed 'voice' and given as much control over events as possible in what is a very disempowering and anxiety-provoking situation. In most cases any meaningful control over events will be negligible. Consequently those involved need to be given proper opportunities to articulate their feelings about their situation and to make sense of what is happening. Various interventions such as advocacy, counselling, groupwork, even the offer of transport facilities to keep in contact with former companions, could have a therapeutic value to individuals and could go some way to giving them a sense of involvement. (Scourfield, 2004, p 511-12)

It is also similar to a list provided by Woolham (2001), who emphasises the need to prepare residents properly in order to avoid relocation stress - for example, through:

- Consultation and discussion to improve people's sense of autonomy.
- Visits to new accommodation before transfer.
- The ability to select a new home in a *"calm, panic-free manner"* (p 53).
- Allowing *"the maximum possible time"* for this (with a minimum of at least three months notice - p 53).
- Emphasising potentially positive outcomes.
- Trying to reduce the amount of environmental change (moving people to physically similar places or services with a similar atmosphere).
- Providing *"relevant, robust and detailed information about each relocated person"* (p 54).
- Moving staff and residents together (to minimise disruption).
- Supporting staff affected by relocation (to limit the risk of a loss of morale).
- Allocating a keyworker to be responsible for each person's care (with scope to visit the person in their old home, get to know them, talk to staff and greet the resident as they arrive in their new home).
- Providing additional support for particularly vulnerable residents.
- Moving as much as possible of residents' familiar furniture with them.
- Providing particular support on the transfer day itself (for example, with familiar staff, family and close friends accompanying the person, a keyworker to greet the person as they arrive, new staff knowledgeable in advance of the person's routines, encouraging residents to unpack themselves or seeing where everything is put and encouraging residents to talk about how they are feeling).
- Monitoring the adjustment process after relocation (ideally on a weekly basis at first and then at 6 weeks, 3 months, 6 months and 12 months).
- Robust care planning and communication to support people's preferred lifestyles in the new home.
- Care planning and goal setting for care staff to help residents adjust (including spending as much time as possible with a new resident).

This links to recommendations by residents and relatives themselves, who suggest that (Williams and Netten, 2003):

- Notice should be no less than two months and should be flexible where possible. It should include the reasons for closure, reassurances that other places are available and any expectations of relatives.
- Relatives should have the opportunity to talk to the home owner (ideally being involved before the decision to close is taken and in attempts to find an alternative).
- Owners should notify councils quickly so they can respond promptly.
- Providers should be open and tell people about any changes, including changes in timescales.
- Information about other care homes, what they offer and their vacancies should be available.
- Care managers should contact relatives and identify what support they need.
- When visiting other homes, residents should be accompanied by someone they know and should be able to influence the nature and length of visits. Their views should be listened to.
- Standards of care and staffing levels should be maintained in the home that is closing, familiar routines should continue and existing staff should be employed throughout the closure period if possible.
- Obvious signs of packing should be minimised.
- Practical help should be available to move, with packing, transport and unpacking all planned and someone the person knows travelling with them.
- Staff at the new home should know about the closure and be sensitive to the person's needs, there should be a dedicated worker to look after the resident on arrival, residents should meet their keyworker on the first day and be shown round, and residents should be able to spend time with other residents and staff from the old home.

For care managers, good practice is similar to that identified by residents and relatives, but might also include the importance of independent advocacy, working collaboratively with care homes, flexibility in the timing and frequency of reviews, a small team to

support communication and the availability of ring-fenced resources (especially in an emergency) (Williams and Netten, 2005b).

More recent developments

Since Le Mesurier and Littlechild's (2007) overview, an updated version of their original search suggests that many of the underlying issues are still the same. Despite ongoing public and policy interest, there remains limited evidence, a lack of national guidance and, presumably, little consistency between local approaches. However, there have been key additions to the literature:

1. In 2009, the Welsh Assembly Government published statutory guidance to address the management of escalating concerns with, and closure of, care homes, based on work led by Care and Social Services Inspectorate Wales. While the guidance does not introduce any new responsibilities, it clarifies how statutory bodies can carry out their current functions when quality declines and/or when care homes close. This sets out key ways in which statutory bodies should discharge their duty of care and covers issues raised by other commentators in this guide, such as communication and information, meaningful user and care involvement, mental capacity and choice. It also provides an example of closure arrangements and key questions about home closures.

2. In 2011, the Social Care Association updated a previous guide on *Managing Care Home Closure* (Social Care Association, 1992, 2011). While this reiterates many of the key themes summarised above and by Le Mesurier and Littlechild (2007), the guide offers practical and helpful advice at every stage of the closure process, including consideration of key values and principles, project management, managing information, managing change, risk, managing the workforce, handling practicalities, the post-closure period and assessing impact. It also includes appendices with a series of good practice checklists.

What *has* undoubtedly changed is the financial context in which care homes operate. Following a global financial and banking crisis, the economic outlook is now much more difficult than it was when Le Mesurier and Littlechild first reported in 2007. Following an international economic crisis, there have been a series of changes in the banking sector and around the availability of finance, in the property market, in the labour market and in the funding of public services – all of which might be anticipated to create very complex and challenging conditions for any business. Against this backdrop, the issues discussed in this good practice guide may well be even more fundamental and urgent than ever before.

3. Local experience

ALTHOUGH THERE SEEMS to be relatively little published evidence given the importance and complexity of this topic, a number of local authorities have begun to develop significant experience of managing care home closures (both planned and in an emergency). To gain an insight into this practice-based knowledge, the Association of directors of Adult Social Services identified a number of current directors with most experience of these issues. The research team then approached each director individually via email to request permission to conduct an in-depth telephone interview of the person's experiences and lessons learned about what does and does not work. Although the interview schedule is set out in Appendix B, interviews focused on:

- Directors' personal experience of managing care home closures and that of their local authority.
- The nature of the closure programme (in terms of scale and whether planned or an emergency).
- The mechanisms they used and the principles they tried to incorporate into local processes.
- Whether or not they had local guidelines and how helpful/current these seemed.
- What impact the closures seemed to have on residents, relatives, care staff and assessors and whether/how these were formally evaluated.
- Lessons they learned about what constitutes good practice.
- Key barriers and success factors.
- Any advice they would give to other authorities and colleagues facing a similar situation (including their top three priorities for others).
- What would help in terms of future policy or resources.

Interviews were carried out over the telephone and typically lasted between thirty minutes and one hour. During interviews, detailed notes were taken (including any key direct quotes or statistics) and then written up immediately afterwards. Where a local guideline or evaluation existed, a copy was requested. The research team then compared their notes, and used these to identify key cross-cutting themes emerging from the directors' experiences. Where local guidance existed, was publicly available and had been perceived locally as useful, a copy was requested and made available to ADASS for them to request permission to circulate more broadly.

Altogether, 12 participants were interviewed from nine authorities. While some directors took part in person, others also suggested interviewing a senior colleague from the authority who had led the home closure process. These nine authorities included a mix of urban and rural authorities, two-tier and unitary authorities and different parts of the country. Overall 6 key themes emerged:

- The importance of established policies and procedures
- The importance of time
- The role of assessment
- The impact of closures
- Communication and information
- Barriers and success factors

Interviewees' experience was of either planned and/or unplanned (emergency) home closures. Typically, planned closures had tended to take place when authorities had developed an explicit modernisation strategy and embarked upon a series of home closures in order to develop newer services to more fully meet the needs of service users. Such programmes could often be large-scale but take place over a number of years, with significant scope for pre-planning, consultation and engagement.

Unplanned or emergency closures were often due to breach of contracts and related to issues around safeguarding (quality and safety) or financial issues. A further type of unplanned closure could be due to the owner or proprietor deciding to close a care home and thus give the council and other private residents notice of closure. In terms of unplanned closure, the majority of experience from those we interviewed tended to be around closure due to quality and safeguarding issues, rather than in relation to financial issues or owners wishing to close the care home. Such closures tended to be smaller scale in nature and, by definition of being a response to an emergency, tended to happen much more rapidly and with less scope for detailed preparation.

Local policies and procedure

There are a number of different policies in place locally, and copies from participating authorities have been made available to ADASS to circulate more widely (with permission). These have often been developed locally, in the absence of detailed national guidance, and have been designed to set out good practice, minimise risk and ensure that authorities are acting within the law. The latter seemed particularly important to a number of participants given the perceived complexity of the legal situation:

The document is written to respond to any changes, but the reason we had it done is because we are changing a lot of our services for older people and [a] number of care homes are closing. We wanted to make sure that the way we are doing it [is set out] clearly,…, minimising risk for people. In addition, we have been subject to numerous legal challenges from a local solicitor, who is fairly notorious in this field. We wanted to make sure primarily that we were protecting individuals, but also that we wouldn't fall foul of the law.

Having clear policies and procedures (especially practical checklists) was seen as particularly important in an emergency:

If you are going for emergency closure, you may not have the time to read a huge policy document - but need something that you can tick off and run through… If closure happens on a Friday night then we have the check list and we can start running with this immediately.

Time is probably your most important asset but unfortunately you don't always have it... If you are starting from scratch and you have nothing to follow, that is when mistakes can happen.

But if you can pull something off the shelf it helps and it helps even more when you have staff who are experienced in undertaking those procedures.

When the phone call comes to say a home needs to close next week there must be an immediate understanding of the tasks that need to be done.

The importance of time

Whilst there were different policies and procedures across localities, most participants seemed to adopt similar mechanisms and principles for both emergency and planned closures. A recurrent theme during interviews in relation to both types of closure was that careful planning and organisation needs to take place.

Clearly, the process for planned closure operates within longer time frames, with more time to consult, plan and work with key stakeholders. In contrast, emergency closures tend to be quick and reactive (i.e. due to a quality or financial issue) rather than planned.

Often planned closures involve local authority-run centres, whilst emergency closures tend to involve the independent sector. Wherever possible, interviewees suggested that closures should take place at the pace of the individual:

Tell people from the beginning "This will take as long as it takes" and that means people will not be shoehorned into vacancies that just happen to be there. It means people are offered choice and the specific needs of individuals can be addressed properly.

Once a closure is underway, some respondents suggested a need to conduct it in a timely fashion so as not unnecessarily to extend the period of uncertainty for residents.

Having reviewed both planned and emergency closures, therefore, it seems as though local authorities need enough time to operate in a manner consistent with good practice, but should also not delay once the closure process is underway.

The role of assessment

Once a decision is taken to close a home, a key role is played by the assessment team put in place to lead this process. With this in mind, participants were clear that choosing the right assessors was crucial:

Assessors are really important. We have through the years identified certain people in certain teams – who are highly skilled and willing to go and talk to people – I'm not saying we don't have a very good work force but I think there are certain teams we go to first to hand pick people to lead on closure.

Interviewees stressed the importance of separating the assessment process from any prior consultations or discussions about home closure so as to enable the assessment team to carry out its work effectively:

We kept that team [assessors] at arm's length from all the initial announcements and consultation. We didn't want them to be perceived as part of this. They could then come in and do their job objectively, rather than being the 'men-in-suits'.

Despite maintaining this professional distance from the political context of closures, assessment staff were seen as central to communication (*see below for further discussion*).

Many interviewees regarded basing an individual assessor (or assessors) in a closing home full time as good practice, providing a known point of contact. The availability of a dedicated member of staff to discuss concerns with residents and family members was seen to significantly reduce anxiety for all concerned:

The way we have found most successful is to have a care manager based in the home over a 9 month period. Responsible for making sure all the arrangements are in place, she holds at least twice weekly surgeries where relatives can just drop in…if they have questions. She also sees relatives by appointment, she'll go to their homes if needed, as well as arranging advocates for residents.

In order to support the vital role of assessment, participants stressed the need to regard closure work as high profile within the council concerned, giving the team quick and easy access to senior staff:

The [assessment] team were located together, they knew they could have a direct line to me [closure project manager] or the Director and we met on a regular basis. It was really clear that this work was a priority for us as a Council and that we would make sure that we managed the process effectively. So they [assessment team] weren't scrabbling around trying to get their voices heard.

A key element of good assessment was felt to be risk assessment. In several cases individual risk assessments and individual impact assessments played a vital role in decisions to close homes (or not):

The risk assessment is absolutely vital. After taking an 'in priniciple' decision we moved on to undertake risk assessments with individual residents... We took the decision we wouldn't close the home for the time being. It was a home in a rural community and when we looked at the impact on individuals some people would have had to move too far away from their own community.

Having mechanisms in place to manage the financial aspects of moving individuals was helpful in many authorities. Several interviewees increased choice by paying the top-up fee for people moving from local authority to privately run homes (where needed). In many cases local authorities took full responsibility for the negotiation of all financial issues as this was considered to be a significant concern for families. One authority described the success and benefits of having a dedicated contract officer throughout the closure process:

[The contracts manager] does negotiations with the homes that people are moving to. So the care manager doesn't have to negotiate the financial side of it. That's turned out to be really helpful because…we were worried about providers driving up rates [because they knew about a programme of local authority closures]. Having our contracts officer who is regularly in contractual discussion has been beneficial for keeping an eye on potential cost creep in care home places.

In order to collate information about residents, one local authority uses a resident grid to record basic information about age, sex, mental capacity, next of kin, needs of service users and information from previous care plans. Interviewees also stressed the need to be sensitive to certain groups, such as those with dementia or people in end of life situations, making sure such groups are flagged up early in the process so that appropriate support can be put in place.

For several participants, a key difference between planned and emergency closure seemed to be the information held on residents. In planned closures, authorities are able to carry out their own detailed assessments and make sure they are matching residents to services. The difficulty in emergency closure is that the local authority does not always have access to relevant information, and so it is much harder to provide the right support. Some interviewees also suggested that the information provided by the care homes in question did not always seem to match the needs or wishes of the individual, and that the quality and level of

detail of information held by individual homes can vary significantly. Sometimes, therefore, a new assessment from the assessment team could provide a very different picture of the person's needs and wishes than information held by the care home.

The impact of closures

Closures of any type can have an impact and cause major stress to residents, families, care home staff and assessors. During interviews we explored respondents' views on the impacts of closure on these different groups. One of the themes emerging through interviews was the different perceptions of care when unplanned or enforced closures take place. Even when monitoring bodies such as the CQC identified poor quality or unsafe services, many residents, families and care home staff often perceived that the level and quality of care was good. This can impact on the closure process and be a potential barrier to the closure:

We were considering an enforced closure of a ….home. Their [relatives, residents and care staff] perception was that there was nothing wrong with the care and it didn't need to close, but CQC saw clear cases of neglect and thought it did need to close. Also in many cases family will not accept that care was deficient - I think this is partly about guilt and how it reflects on them. So you get different perceptions from clients/families/council/regulators.

Throughout interviews, a key issue was the need for honesty, openness and a commitment to making sure that individuals get a chance to express their views and can genuinely influence the consultation and/or closure process:

You do have relatives, family members, staff and home owners, in some instances, who say if you do move my mother or these residents they will die – but it is about being honest with residents… I had a very honest and open discussion with relatives and got good feedback after that – but you need to recognise that people will go through… denial – … but once they realise we will take into account their individual wishes and needs and we start to treat them as individuals we will start to win them around.

Some interviewees had tried to monitor the impact of closure and changes in services on residents. Overall, there were some suggestions that outcomes for the majority of service users had actually improved following changes to services. Although a small number of individuals had died, this was consistent with what would have been expected without the move:

Our experience shows that the majority of service users and residents have improved their weights, are now static and stable and their whole conditions [have] improved.

One of our major concerns was that the research at the time suggested that moving people may result in deaths. Due to the high-profile nature of the closures we were carefully monitored in this respect and we know that this prediction was not the case.

The most common method of measuring impact on residents was individual reviews. These became more frequent before and after moves, and consistency of the key worker undertaking the reviews before, during and after the move was widely regarded as good practice.

One of the highest risks when a care home is going to close is the impact that such closure can have on care staff morale. Care staff are the individuals that residents and families come into contact with on a daily basis and were felt to be crucial to the closure process and to successful resettlement. Often the threat of closure meant that some care staff started to look for other jobs.

A number of interviewees suggested that once the decision to close had been taken then additional resources needed to be put in place to support the people that are left. If this does not happen then the risk to the health and well-being of residents can increase. It was also felt important to support care staff through potentially difficult changes (as a result of a duty of care to staff) and to try to keep good staff in the sector.

For some localities this involved senior staff from another care home going into the home and leading and running services during the closure period. For others, it involved calling on district nurses and/or agency staff to assist in the care of residents. Other closures involved inputs from care home support teams, staff from fieldwork teams or additional support staff. Other authorities tried to ensure regular communication with staff from adult social services (to get accurate information 'straight from the horse's mouth') and/or support from outside agencies (such as a Citizens Advice Bureau or Job Centre Plus):

We will put additional support in where necessary which comes from our LA quality improvement team or we ask the district nurses to support the home or we have a home support team.

We put additional resources in to reduce the risk to people and support the team during the transitional period when the home may be due to close or not. So we attempt to avoid crises and the resulting secondary stress that closure can cause individuals.

Staff can be a key source of enabling people to move on in a decent way. So it's important to engage staff, particularly those who know their job is not being replaced. So it's about aligning an HR process which offers staff support and opportunities… We've run jobs fairs, one to one support and counselling. We continue to train our staff even though they're exiting. We've funded NVQs to strengthen their position in the jobs market.

Communication and information

As noted above, closures of any type can be stressful for all concerned - so making sure that information is accurate, clear and communicated well was viewed as important by all those interviewed:

There should be continual communication and channels should be open for everyone to express their views and concerns. It's important to keep everyone in the loop.

Honesty, transparency and integrity are really important – [it is] no good trying to hide something because it is not popular or negative. You need to be clear and transparent about the reasons you are doing this, whatever it is you are doing.

Whilst it was clear that most local authorities thought they needed to lead on the closures there was acknowledgment of the need to take a multi-agency partnership approach to home closures (both planned and unplanned). There was a clear message from interviewees that engagement with a variety of stakeholders at an early stage was important – including service users themselves, their families, care staff, partner agencies and external advocacy agencies:

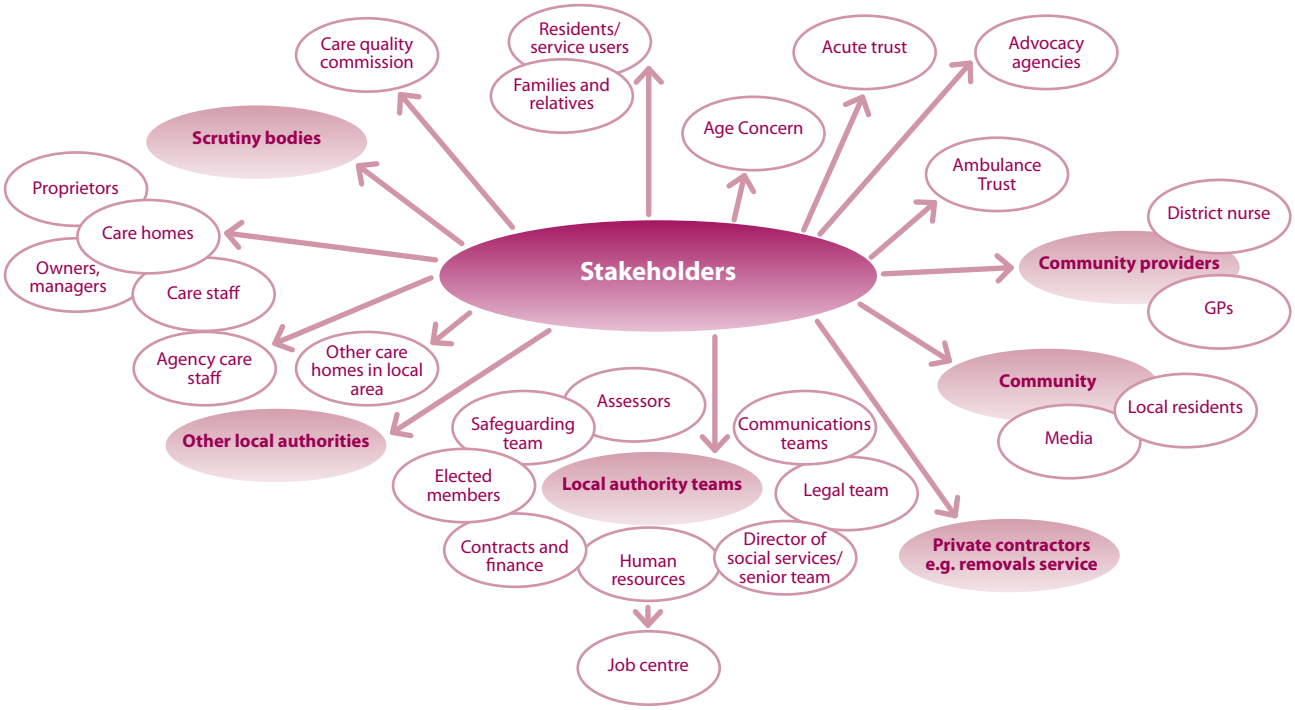
It's absolutely about engagement at an early stage, making sure people are in control as much as possible.

Prior to the closures we commissioned a national charity to do listening events… Using an independent organisation that is well known and linked into older people's forums gave us a high response and was a valuable source of impartial information.

To aid the assurance process we set up a sub-committee right at the beginning of the programme [of local authority home closures]. It involved [an] elected member, representatives from older people's community groups and relatives of people in the homes that were closed, in the process of closing or were going to be closed in the future… It gave a kind of assurance that somebody is keeping a track of this. It was very helpful to have an outside challenge.

Engagement involves consultation and communication with a variety of stakeholder groups. Figure 1 highlights the different stakeholder groups that interviewees suggested they work with during care home closures. A key difference between planned and emergency closures was the importance of working closely with the local safeguarding team in the case of unplanned closures (which often happened suddenly in response to concerns about quality).

Figure 1 Key stakeholders



To aid communication, local authorities need to be clear about the messages they give and organised in how these messages will be communicated to different stakeholder groups. A key person here was the manager of the home in question – who might be a home owner angry at the decision to close the home:

We have also learned not to rely on the message given by home owners – no matter what the circumstances are, we… need to be clear and have clarity about what our message is as a local authority – because it often gets skewed by home owners and people managing homes. Making sure that the manager is on board with the message, making sure there is a clear message and a clear line of communication [is crucial].

Barriers and success factors

Interviewees also identified a number of additional barriers and success factors, including:

1. *Legal support* was felt to be crucial, and the active involvement of local authority legal teams was fundamental (in an area many perceived to be something of a 'grey area' legally). Also important was having the right contract in place to begin with, and one interviewee in particular spoke of using the contract when the home owners threatened legal action:

   A barrier would be not to have that legal document in place to begin with – so when a big corporate provider was to be decommissioned we went back to our terms and conditions of contract that said if you fall below these standards and/or you go into receivership then you are in breach of that contract, which we can terminate with immediate effect. We pointed that clause out and they have backed away – had we not had that in place there would have been greater power to complain.

   Authorities that had been through a high profile legal challenge suggested that key facilitators had been:

   - Awareness of the media and good links with local media
   - Having a strong and documented central message and strategy for the closures, which focused on quality of care and the wellbeing of residents
   - Clarity of staff roles and responsibility and managing anxiety among exiting staff
   - Political/cabinet member visibility, direct engagement and support – described by one participant as *"politicians owning the decisions that they are making."*

2. *Home owners and managers* were sometimes seen as a potential barrier. These individuals may well be worried about losing their jobs and their livelihoods/future reputation could well be at stake. All interviewees mentioned the importance of working with these individuals and getting staff to focus on the needs of the residents, whatever else had happened in the run up to closure:

   I think it is about how you work with individuals – it is about getting staff members on side. Most people are there for the good of individual residents so working with this is the main focus and you can turn people around once you play on that.

3. *Availability of other services* was crucial - making sure there is capacity and space locally to take on residents when the home in question closes.

   This may well mean that hospital discharges are delayed (especially during unplanned closures) – thus communication with acute trusts is also important:

   You do really need to have an alternative in place - that is really key. We stop new placements - we make that decision quickly. We make sure we are aware of all of our current vacancies and what needs can be met by those current vacancies and many times we actually hold vacancies so we stop them being filled.

   So we work with the hospital trust and we recognise that discharge from hospital might be delayed because the placements are needed as a priority by other people that are at risk in the community.

   It was noted that services such as the ambulance service should be aware and on hand to support closure, and available to move residents and vital equipment when required:

   Other professionals [might not have as much knowledge of what's happening, so…] we do need to have a very robust communication strategy with all of them. I am talking about district nursing teams, community teams and colleagues from across health - for example even our ambulance trust. We were moving people at weekends and our expectations was that we would have help and support to move people and equipment.

In order to overcome such transport issues some local authorities procured specific removals companies in advance of the moves. The drivers and removals staff were briefed on the situation and were able to execute the moves with the appropriate sensitivity.

There are a number of local authority teams who play a vital role in home closures, including the press team, human resources and the legal team. It was felt to be vital that all these different departments are aware of the process and communicating the right message at the right time. As one interviewee noted "*you need to make sure that all parts of the council are aligned.*" This is difficult at the best of times, but becomes even more complex if a home closure involves out of area placements (and hence other local authorities/stakeholders).

4. *Leadership skills* are also fundamental (including the active support of elected members). This can be a difficult and anxious time for a number of different stakeholders and strong leadership and direction from senior leaders is vital as a facilitator to the success and smooth operation of home closures. The majority of leadership tasks pertain to more complex, relationship-based issues (influencing others, engaging key stakeholders etc), and this involves skills such as creating alignment between stakeholders, fostering vision and mobilising support for change.

4. Emerging data – a case study

Background

IN 2008, THE Adults and Communities Directorate of Birmingham City Council commissioned a 3-year evaluation of the modernisation of older people's services in the city. Following longstanding debates and a detailed process of engagement and deliberation, the council had decided to close all its local authority care homes for older people (and attached day centres), reassessing all current service users and finding alternative services for them. As part of this process, a series of new special care centres were to be opened from 2008 onwards and additional extra care sheltered housing capacity was anticipated (see Birmingham City Council, 2007 for a summary). These changes were justified through a desire to respond to:

- The rising expectations of older people
- The changing and differing needs of people using services
- Financial pressures
- Changing legislation and standards
- The need for different types of services

Initially it was intended that all local authority care homes and attached day centres would close, with a series of new special care centres being constructed and extra capacity to come on stream within independent sector extra care sheltered housing. The care home/day centre closures were also planned in two phases, with an independent evaluation commissioned from the Health Services Management Centre (HSMC), University of Birmingham to learn lessons from the process adopted and outcomes achieved during the first phase (in order to inform future actions). Given Birmingham's size, we understand that this closure process may be one of the most significant attempted to date in the UK – and possibly in Europe. Certainly, the case study seems unusual in the commissioning of an independent evaluation and a willingness to publish and share lessons learned.

The approach adopted

Building on the literature review summarised in Chapter 2, Birmingham City Council developed an approach to assessment and resettlement which included:

- A dedicated assessment, resettlement and review team with staff working out of the units concerned and getting to know residents and care staff.
- A pledge to keep groups of friends together if at all possible.
- Detailed and regular communication with everyone involved in the process.
- Working at the pace of individual older people.
- Supporting people and/or their families to visit potential new homes as often as they wished.
- Commissioning a specialist information and advocacy service. While this worked closely with the city council, it was felt to be important that it was separate and independent.
- Phasing the programme so that small numbers of units closed at a time, thus not overloading care staff, assessors or alternative service providers.

- Commissioning independent research on the first half of the closure programme so that results could be shared publicly with other authorities and fed back into subsequent actions.

The study

In order to identify the impact of the modernisation programme on older people currently using services, we conducted interviews with some 49 older people, families, care staff and assessors during the resettlement process and completed a short questionnaire (*see Appendix C*) for each person taking part in the research at three points in time (essentially, 'before', 'during' and 'after'):

- When they were first assessed by the council's Assessment and Resettlement Team
- At the first 28 day review after moving to new services
- At the first annual review (approx. 12 months after the start of the new care package)

The questionnaire concerned combined an internationally recognised measure of health status and health related quality of life (the EQ-5D) and a modified version of a tool already piloted by the national In Control project (of which Birmingham is a member and a total transformation pilot – see Poll *et al*., 2006). Together, the questionnaire asked participants about a series of outcomes identified as being important by older people themselves (Glendinning *et al*., 2006):

1. Outcomes involving change:
    - Changes in symptoms or behaviours
    - Improvements in physical functioning
    - Improving morale
2. Outcomes involving maintenance or prevention:
    - Meeting basic physical needs
    - Ensuring personal safety and security
    - Living in a clean and tidy environment
    - Keeping alert and active
    - Having control over everyday life
3. Service process outcomes:
    - Feeing valued and being treated with respect
    - Being treated as an individual
    - Having 'a say' and control over services
    - A 'good fit' with informal sources of support
    - Compatibility with and respect for cultural and religious preferences

The questionnaires were completed by older people together with Assessment and Resettlement Team staff as part of the assessment/review process (i.e. face to face with individual service users), and subsequently submitted to the research team. While this added to the workload of the team, this approach meant that all those who consented to take part completed the questionnaires with support from professionally qualified workers, and that this process could be tailored according to individual needs (for example, for people who do not speak English as a first language or people with some form of cognitive impairment). Building data collection in to the standard assessment and review process also enabled us to involve a much broader group of older people in the research than might have been possible if the research team had been required to collect data from individual service users directly. To avoid any potential conflicts of interest for Assessment and Resettlement Team staff, all survey questions focused on overall quality of life (not on specific issues such as the role of Resettlement staff).

Completed questionnaires were collated by a co-ordinating officer from the city council and returned to the research team in batches as the modernisation process progressed. Surveys were coded and entered in an Access database, where they were analysed using Excel and SPSS. Altogether 70 older people completed a survey at initial assessment, 28 day review and 12 month follow up (see Glasby *et al*., 2011 for full details of the study).

Emerging findings

The study of the BCC care home and day centre closures compared survey data collected at: initial assessment, 28 day review and 12 month follow up. At the time of writing, we have data from 70 older people who completed the survey at each of the three stages, and the research is ongoing. However, at this early stage, emerging findings from the survey data are very positive, in that older people's sense of health and wellbeing was not any worse at 28 day follow up and 12 month review. These results are perhaps surprising given the fact that participants were already frail enough to be receiving support from the local authority in either a care home or a day centre at the start of the study, and were a year or so older at 12 month follow up. They had also experienced significant changes in their services and, in the case of care home residents, had moved to another home altogether. However, results from this study suggest that the policy and process adopted by BCC seemed to have limited potential negative impacts on individual's health and well-being and, for some people, there was a slight improvement in outcomes.

In terms of quality of life, there were some individuals in the sample group who reported very poor health states. To some extent this is to be expected as often those who are in contact with health and social care services are likely to have some chronic or long-term illness. Furthermore, the quality of life scores in the BCC study are similar to another study which undertook research with older people of similar age groups who were accessing social care services (Windle *et al*., 2009).

Assessing the impact of service changes on respondents' quality of life can be difficult due to the fact that individuals are likely to experience deteriorating health over the course of the research. Having said that, this study found no overall significant changes in quality of life (either negative or positive) at 12 month follow up. There were, however, a number of individuals reporting a positive change for some of the quality of life dimensions. The biggest positive change related to anxiety and depression, and to pain and discomfort. Findings from this study also suggested that most people felt valued and treated as individuals throughout the process.

There was also a generally positive response in relation to questions posed around health and well-being (i.e. feelings of self worth, control and independence), and this was consistent at all stages throughout the study. It was not something that increased during initial assessment and resettlement and then declined once in long-term services. This seems to rule out the possibility that the detailed time and attention given to people during assessment and resettlement might have improved their sense of well-being in the short term, and that this might decline over time as they settled in to new services. The findings from the survey were also supported by an independent information and advocacy service commissioned to support residents, who, in a recent interview with the HSMC research team, suggested that they *"perceived a positive long term impact in terms of user satisfaction, including rising expectations for their everyday environment and care in some cases."*

Although the Birmingham study is ongoing, key lessons seem to include:

Strategy and preparation: having a clear strategy and policy that could be easily articulated to stakeholder groups was seen as important. This aided subsequent communication and enabled the closure programme to take place on a phased basis (which prevented rushed decisions and overloading care staff and assessors). Being forewarned of potential risks and negatives was also seen as important, so that every possible step could be taken to overcome these (or at least acknowledge them and support people through the process).

Engagement and involvement: engagement and involvement of all relevant stakeholders was seen as crucial. Involving key people (especially older people themselves) upfront in initial decisions about services also seemed important. Anxiety and stress is often increased when service users are facing a perceived loss or change to services, especially if they do not feel they have any control over the subsequent process. Providing as much certainty as is feasible by being honest and clear with people as soon as possible about where they may be going in the future helped to reassure service users and their families.

Implementation and operational capacity: assessment provides the primary mechanism by which new services are determined and getting this right is crucial to the health and well-being of service users, both short- and long-term. A key strength of the BCC process suggested by stakeholders (including the information and advocacy service) was a dedicated group of assessors who were able to take the time to get to know people well, meet families, work alongside care staff and carry out holistic assessments.

Working with care staff: a further key ingredient is the role of care staff in homes that are closing, who can be well placed to provide help and support to older people and their families (but who may be feeling just as worried about the changes as service users). Supporting care staff through such closures, providing them with up-to-date information and treating them as partners in the process seems key.

Overall, whilst there was a natural sense of loss from those individuals who lived and worked in services that have now closed, this study seems to suggest that if the process is conducted well (with high levels of respect, communication and empathy) then life after resettlement can be positive (*see Box 1*).

Box 1 Summary of findings from the Birmingham modernisation programme

Important elements that led to the success of BCC programme seem to include:

- Having a clear strategy that can be easily articulated to all stakeholders
- Involving key stakeholders (especially older people themselves) upfront in initial decisions about services, rather than after the key decision is taken
- Providing as much certainty as is feasible by being clear with people as soon as possible where they may be going in the future - it was also important to inform family members and friends
- Keeping friends and service users together as much as possible
- Spacing out the closure programme so as to prevent rushed decisions and overloading care staff and assessors
- Avoiding placing people in services that are in imminent risk of shutting in the near future
- Providing personal, individual information
- Ensuring all information is accurate and making sure that any early pledges or deadlines are subsequently met (or any changes well communicated)
- Treating service users with respect and valuing them as individuals
- Having a dedicated assessor who works with service users and their families and continues to provide support for a set period after resettlement
- Taking a holistic approach to the assessment and needs of service users
- Basing assessment teams in homes that are due to close so they can get to know the older people and work alongside care staff
- Ensuring independent advocacy support for people with particular needs

5. Conclusions

IN A MARKET, services will inevitably fail – and this seems even more likely in a challenging financial context. Often, our experience of closing care homes and resettling older residents has been connected to a sudden emergency in a single home or to a planned process of modernisation and outsourcing. If a national chain of care homes were to fail, however, the scale and pace of the actions required could have extremely negative consequences for older residents (if not handled well).

If planned and conducted well, this guide suggests that care home closures might be able to improve outcomes for older people (if they were in a poor environment before) and might be able to support people through very difficult changes without making things very much worse for them in the mean time. However, the key word here is *'if'*, and it is crucial that local authorities have the *time and space* in order to:

- Put in place well organised, dedicated and skilled assessment teams.
- Involve all relevant parties (especially older people themselves) in decisions about future services.
- Get to know people well and carry out holistic assessments of their needs.
- Support older people, families and care staff through potentially distressing and unsettling changes.
- Work at the pace of the individual and give as much time and space to explore future arrangements as possible.
- Help residents and key members of care staff to stay together if possible.
- Ensure independent advocacy is available.
- Plan the practicalities of any moves and ensure as much continuity as possible after the move has taken place.
- Stay in touch with people and assess the longer-term impact of resettlement.
- Work in partnership with a range of external agencies and key stakeholders, managing information and communication well.

While all these can be built into a planned home closure, it would seem important that any emergency closures try to follow the same emerging good practice if at all possible.

While local authorities have developed significant experience of home closures at local level, the most important ingredient seems to be *time* to conduct closures well, as none of the good practice above (or in the Social Care Association's practical guide) is easy when timescales are rushed.

Ultimately, this guide concludes with a summary from Scourfield's (2004) critique, which argues that:

The way in which Britain's system of residential and nursing care is currently funded and organized means that home closures are a regrettable fact of life. This, in turn, means that each year hundreds – possibly thousands – of vulnerable elderly people face the experience of involuntary relocation... There are, however, no centrally published guidelines that might inform responses. Different practices are emerging in different areas on an ad hoc basis. This [article]… raises questions about a system that allows homes to close, it suggests that more should be done to understand the effect of home closures, it argues for the need for national protocols to be issued and it calls for a realistic debate about how the necessary responses in terms of knowledge, expertise and time can be developed and delivered properly. (Scourfield, 2004, p 514)

Although only a broad and initial overview, it is this gap in evidence and resources that the current guide seeks to begin to fill.

References

Beirne, N. *et al* (2004) Effects of a fast-track closing on a nursing facility population, *Health and Social Work*, 20(2), 116-122

Birmingham City Council (2007) *Changing care, meeting needs: Birmingham's plan for the future of older people's services*. Birmingham, Birmingham City Council

Castle, N. (2001) Relocation of the elderly, *Medical Care Research and Review*, 58(3), 291-333

Glasby, J., Robinson, S. and Allen, K. (2011) *An evaluation of the modernisation of older people's services in Birmingham – final report*. Birmingham, Health Services Management Centre (forthcoming)

Glendinning, C. *et al* (2006) *Outcomes-focused services for older people*. London, SCIE

Greve, C. (2006) *Contracting for public services*. London, Routledge

Hallewell, C., Morris, J. and Jolley, D. (1994) The closure of residential homes: what happens to residents, *Age and Ageing*, 23, 158-161

Holden, C. (2002) British government policy and the concentration of ownership in long-term care provision, *Ageing and Society*, 22(1), 79-94

Jolley, D. (2003) *A report to the High Court in the matters of Lancashire Care Association and others.* Lancashire County Council, Penn Hospital, Wolverhampton

Laing and Buisson (2010) *Care of elderly people: UK market survey, 2010-11 (23rd ed.)*. London, Laing and Buisson

Le Grand, J. (2003) *Motivation, agency and public policy: of knights and knaves, pawns and queens*. Oxford, Oxford University Press

Le Grand, J. (2007) *The other invisible hand: delivering public services through choice and competition*. Princeton (NJ), Princeton University Press

Le Mesurier, N. and Littlechild, R. (2007/2011) *A review of published literature on the experience of closure of residential care homes in the UK*. Institute of Applied Social Studies, University of Birmingham (republished in 2011 by the University of Birmingham/ADASS/SCIE - forthcoming)

Means, R. and Smith, R. (1998) *From poor law to community care*. Basingstoke, Macmillan

Netten, A., Darton, R. and Williams, J. (2002) *Closures of care homes for older people: summary of findings, no. 1*. Canterbury, Personal Social Services Research Unit

Netten, A., Williams, J. and Darton, R. (2005) Care-home closures in England: causes and implications, *Ageing and Society*, 25, 319-38

Poll, C., *et al* (2006) *A report on in Control's first phase, 2003-2005*. London, in Control Publications

Scourfield, P. (2004) Questions raised for local authorities when old people are evicted from their care homes, *British Journal of Social Work*, 34(4), 501-516

Social Care Association (1992) *Managing the crisis of closure: a good practice guide for residential care*. London, Social Care Association

Social Care Association (2011) *Managing care home closure: a good practice guide*. London, Social Care Association (forthcoming)

Welsh Assembly Government (2009) *Statutory guidance on escalating concerns with, and closures of, care homes providing services for adults*. Cardiff, Welsh Assembly Government

Williams, J. and Netten, A. (2003) *Closures of care homes for older people: summary of findings, no. 3 – relatives' and residents' views*. Canterbury, Personal Social Services Research Unit

Williams, J. Netten, A. and Darton, R. (2003) *Closures of care homes for older people: summary of findings, no. 2 – local government guidelines*. Canterbury, Personal Social Services Research Unit

Williams, J. and Netten, A. (2005a) English local authority powers, responsibilities and guidelines for managing the care home closure process, *British Journal of Social Work*, 35, 921-36

Williams, J. and Netten, A. (2005b) *Closures of care homes for older people: summary of findings, no. 4 – care managers' experiences and views*. Canterbury, Personal Social Services Research Unit

Windle, K. *et al* (2009) *Evaluation of the Kent INVOKE POPP programme* (research summary, 52). Canterbury, Personal Social Services Research Unit

Woolham, J. (2001) Good practice in the involuntary relocation of people living in residential care, *Practice*, 13(4), 49-60

Appendix A: Recommendations from the literature (2007)

REPRODUCED BELOW IS the executive summary from Le Mesurier and Littlechild's (2007) review of the published literature on the experience of closure of residential care homes in the UK:

1. This literature review has been written in support of the Birmingham City Council Adults and Communities Directorate (BCC hereafter) Reprovision Programme. This programme will see the closure over the next five years of all 29 residential care homes for older people currently owned and operated by BCC and the development of eight Special Care Centres with half of the beds in each centre providing long-term stay. The centres will also provide intermediate care and rehabilitation. Extra Care Housing will be expanded, with enhancements made to existing provision and new development schemes undertaken.

2. This review provides an overview of policy and practice literature on issues related to the effects of closure of residential care homes for older people on their health and wellbeing, and on the policies governing the way care homes are closed. The experience of residents and their families/informal carers is prioritised, as is the role and quality of assessment.

3. No information has been made available to the research team on the needs or characteristics of the residents who will be affected by the reprovision programme, though it is expected that some, perhaps many, people will be very frail.

4. A scope of the published academic and professional literature found very little empirical research evidence on the closure of residential care homes for older people. What there is comes from a limited range of sources and concentrates mainly on the experience of closure in the independent sector.

5. An extensive review of local authority guidelines of care home closure found that few had been developed and that most were developed in-house without reference to experience elsewhere. Consequently there are few, if any, reliable benchmarks available to the Reprovision Programme by which to compare performance.

6. Principles informing current government policy and legal obligations imposed by the Human Rights Act 1988 emphasise the responsibilities of local authorities to place service users' needs and wishes at the heart of care plans and to implement preventive strategies where possible. In the context of closure and reprovision of residential care, this means a duty to consult properly with residents and their families or informal carers and to provide care that is appropriate and responsive to changes in individual needs.

7. The impact of resettlement on the health of frail elderly people is a natural cause of concern. It is difficult to establish a correlation however, mainly because the population under consideration is likely to be very frail in the first place and often in

need of high levels of care. Such evidence as there is suggests that adverse effects can be minimised if continuity of care is maintained and there is good consultation and planning. The importance of relationships with staff, in particular key worker relationships, should not be overlooked.

8. People with cognitive impairments have preferences and wishes and should not be excluded from the resettlement process. Interpretation of cognitive ability should be undertaken with the service user's participation and on the basis of detailed and comprehensive assessment.

9. The role of care managers is crucial in the process of reprovision. Demands placed upon them are likely to be complex and stressful. As assessors they may have to make controversial decisions or recommendations, sometimes contrary to the wishes of residents or their families, or indeed of their own local authorities. They should receive adequate support and guidance.

10 Emphasis is placed within this programme of reprovision on the role of Extra Care housing, which offers a disseminated form of provision with care and accommodation being provided under many roofs rather than one, albeit often on one site. It is more difficult to monitor and maintain levels of security and support in these circumstances. Technology can help, but should not be seen as a replacement for human contact.

11. The role and legal status of occupiers of Extra Care housing is different from traditional residential care services. People living in Extra Care housing are normally owners or tenants of individual properties.

12. Provision of alternative housing alone will not assure that goals of independence and autonomy are achieved. There is some evidence that residents of good quality traditional care homes are able to feel as empowered and in control as those in extra care settings of equal quality. The key here seems to be quality of care. Some older people may therefore benefit from or prefer the extra security and support offered by traditional residential care provision.

13. Staff are likely to have to work in different ways in Extra Care settings if they are to facilitate the 'doing-with-rather-than-doing-for' culture that is envisaged. A different relationship is likely to exist between staff and residents compared to traditional care homes. This relationship will need training and good management and support if it is to be more than tokenistic. Economies of scale may be harder to achieve in Extra Care settings.

14. Assessment provides the primary mechanism by which an individual's need for support is determined, and as such is likely to embody not only the thresholds of eligibility offered by providers, but the philosophy and ethos of the monitoring authority and its partners and agents. It is possible that, for some, re-assessment may identify needs that are more suitably met in nursing homes or in NHS Continuing Care provision.

15. Assessments of need should not focus solely on a person's impairments, but should take into consideration the context of the way help is provided in the environment in which they may live. They should not be used to predict workload.

Appendix B: Interview schedule for Directors of Adult Social Services

Good practice in care home closure – topic guide

- Your experience of/involvement in care home closures (including scale and whether planned or in an emergency) – include personal experience and/or that of the local authority.
- What mechanisms were used and what principles did you try to incorporate into local processes?
- Did you have local guidelines (can we have a copy?) and how helpful/current were these?
- What impact did the closures seem to have on residents, relatives, care staff and assessors? Was there any formal evaluation of this and is this available? Can we have a copy?
- What lessons did you learn about what constitutes good practice?
- What were the key barriers and success factors?
- What advice would you give to other authorities and colleagues facing a similar situation? Could you prioritise 3 areas you think are most important?
- What policy measures and/or resources would help in future?

Appendix C: Survey from Birmingham's modernisation programme

Modernisation of Older People's Services		**ID NUMBER:** _ _ _ _
PARTICIPANT'S INITIALS: _ _ ASSESSOR/REVIEWER'S INITIALS: _ _	DATE OF COMPLETION: _ _ / _ _ / _ _ _ _	STUDY PERIOD: _ _ 00 = Initial assessment 01 = 28 day review 12 = 12 month review

A. Note for assessor/reviewer to emphasise to the research participant:

You may remember that you agreed to be interviewed for a research project about how you feel about your life and your care following the planned closure of Birmingham residential homes and linked day centres. I want to ask you a few questions for the project and make a note of your answers. This is confidential as we said before, and is to help the Council should any other homes or day centres need closing in future. Is it Ok to go on?

For the assessor: Does this participant have a history/diagnosis of a mental health problem (e.g. dementia, depression)?

Yes ☐ No ☐

If yes, please specify:

B. About you:

Date of Birth: **Gender:** Male ☐ Female ☐

Age group:

50 – 64 ☐ 65 - 74 ☐ 75 - 79 ☐

80 - 84 ☐ 85 -89 ☐ 90 + ☐

Are you: (please tick as appropriate)

Single ☐ Married / Co-habiting ☐ Living alone? ☐

Widowed ☐ Divorced / Separated ☐ Living with family? ☐

Ethnicity
please specify:

1. White British
2. White Irish
3. Other White Background
4. Mixed White & Black Caribbean
5. Mixed White & Black African
6. Mixed White & Asian
7. Other Mixed Background
8. Indian or British Indian
9. Pakistani or British Pakistani
10. Bangladeshi or British Bangladeshi
11. Other Asian or British Asian Background
12. Black or Black British Caribbean
13. Black or Black British African
14. Other Black or Black British Background
15. Chinese
16. Any Other Background

C. About the care services that you receive:

Before the modernisation process, were you living in a Birmingham City Council care home or going regularly to a linked day centre? (*please tick as appropriate)*

Care home Day centre linked to a Council care home

What care services are you receiving?

(Note to Assessors/Reviewers, please set out the person's current care plan in full, including the amount, frequency and type of services being received. This needs to be as detailed as possible so that we can cost and compare the services the person was receiving when first assessed with services received as a result of their assessment and new care packagage).

As an example, you might be receiving one hour of home care 3 times a day (from 9am to 6pm) and five days a week (Monday to Friday)...

Alternatively, someone esle might be receiving a direct payment of £X in order to meet X, Y and Z assessed needs, and may be spending this money on....

Do you receive:

Direct payments/individual budgets? *How much do you get? £*

Day care? *If so, how often?*

Home care? *If so, how many hours a week?*

Residential care?

Meals? *If so, how often?*

Short breaks? *If so, how often?*

For the assessor, please give details:

D. About the impact that your care services have on your life:

1. How would you rate your overall physical health? (*please tick as appropriate)*

☐ Very good ☐ Good ☐ Neither good nor bad ☐ Bad ☐ Very bad

2. How would you rate your quality of life? (*please tick as appropriate)*

☐ Very good ☐ Good ☐ Neither good nor bad ☐ Bad ☐ Very bad

3. Are you happy with the care services you receive? (*please tick as appropriate)*

☐ Very happy ☐ Fairly happy ☐ Neither happy nor unhappy

☐ Fairly unhappy ☐ Very unhappy

4. How well do your care services meet your basic physical needs? (*please tick as appropriate)*

☐ Very well ☐ Well ☐ Neither well nor not very well

☐ Not well ☐ Not very well at all

5. How safe and secure do your care services make you feel? *(please tick as appropriate)*

☐ Very safe ☐ Safe ☐ Neither safe nor unsafe ☐ Unsafe ☐ Very unsafe

6. Is the place where you live clean and tidy? (*please tick as appropriate)*

☐ Very clean and very tidy ☐ Clean and tidy

☐ Neither clean nor unclean /neither tidy nor untidy ☐ Unclean

☐ Very unclean and very untidy

7. How far do your care services help you to stay alert and active? (*please tick as appropriate)*

☐ Definitely ☐ To some extent ☐ Neither yes or no ☐ No ☐ Definitely not

8. How happy are you with the control you have over your life? (*please tick as appropriate)*

☐ Very happy ☐ Happy ☐ Neither happy nor unhappy

☐ Unhappy ☐ Very unhappy

9. How far do you feel valued and treated with respect? (*please tick as appropriate)*

Definitely | To some extent | Neither yes nor no | No | Definitely not

10. How far do you feel as if you are treated as an individual? (*please tick as appropriate)*

Definitely | To some extent | Neither yes nor no | No | Definitely not

11. How far do you feel as if you have 'a say' and control over your care services? (*please tick as appropriate)*

Definitely | To some extent | Neither yes nor no | No | Definitely not

12. How far do your care services help you to stay in touch with family and friends? (*please tick as appropriate)*

Definitely | To some extent | Neither yes nor no | No | Definitely not

13. How far do you feel that your care services try to help you to take part in community life? (*please tick as appropriate)*

Definitely | To some extent | Neither yes nor no | No | Definitely not

14. How far do you feel that if your cultural and religious preferences are respected? (*please tick as appropriate)*

Definitely | To some extent | Neither yes nor no | No | Definitely not

Note to assessors – Q. 15 (below) is a new question to be asked at 12-month review only

15. Do you think that the new services you have received since the closure of your care home/day centre have helped you have a better life?

Has life:

Got better?

Stayed the same?

Got worse?

Please include an explanation of your views on this issue if you would like to:

E. About your health and well-being:

Note for assesor/reviewer:
I am now going to read some statements and ask which is closest to your every day healthy status today:

Mobility

I have no problems in walking about

I have some problems in walking about

I am confined in bed

Self-care

I have no problems with self care

I have some problems washing or dressing myself

I am unable to wash or dress myself

Usual activities (e.g. work, study, housework, family or leisure activities)

I have no problems with performing my usual activities

I have some problems with performing my usual activities

I am unable to perform my usual activities

Pain / Discomfort

I have no pain or discomfort

I have moderate pain and discomfort

I have extreme pain and discomfort

Anxiety / Depression

I am not anxious or depressed

I am moderately anxious or depressed

I am extremely anxious or depressed

Compared with my general level of health over the past 12 months, my health state today is:

Better than it was

Much the same

Worse than it was

How did you answer the questions in this survey? *(please tick as appropriate)*

I answered the questions myself

I answered the questions with help from a friend/family member

I answered the questions with help from a paid staff member

Someone else mainly

Thank you for taking the time to complete this survey.
Please give this completed survey to your social worker, who will return it to the research team.

We will come back to see you again in the future and ask the same questions, to see how things have gone for you over the coming weeks and months.

directors of

adass

adult social services

Charity Registration number 299154