University of Kent
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Policies and Perspectives on Closing Independent Care Homes for Older People

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Abstract

The thesis presents research that investigated the process of closure of care homes for older people by independent sector providers. The care home closure process has received little policy attention and is under-researched. The study aimed to identify and review existing national and local policies and guidelines for voluntary independent closures, to better understand the process and consequences of such closures and to identify recommendations for good practice. The research comprised a survey of council guidelines and a qualitative study of closures. This focused on the activities, experiences and views of older people, their relatives and friends, care home staff and social services care managers. It is the first in-depth study to explore what happens from the perspective of those directly involved.

Little process regulation or specific national guidance was found. However, around one-third of councils responded to enquiries and of these, two-thirds reported having guidelines. This suggests that a significant proportion of councils have none. The content of guidelines varied across councils and inconsistencies and differences were found in recommendations, including approaches towards providing community care needs assessments and views about councils' ability to prolong closure periods by sending in council staff.

Nine care home closures in five local authority areas were investigated. The research found variation with regard to the length and form of notice, provision of support, and needs assessment and financial support from councils. Falling standards of care during closures were reported and are highlighted as a particular concern, and self-funded residents without relatives identified as a particularly vulnerable group. A range of outcomes and consequences are identified along with structural and individual level influences. Good practice recommendations are presented and issues to consider in guidance and practice development discussed. The findings highlight a need for greater clarification of the responsibilities of councils and the regulator during voluntary closures. They also highlight room for improvement in areas of wider policy relevance, including the nature of state and councils' involvement in the provision of good quality care homes, access to support, and complaints and protection.

Preface

The thesis is based on work that was undertaken by the author while employed at the Personal Social Services Research Unit, at the University of Kent. The study on which the thesis is based developed out of an existing programme of work funded by the Department of Health and led by Professor Ann Netten. The programme of work investigated care home closures in England via a series of linked studies that focused on the rates, causes and consequences of care home closures in England (See Appendix 1 for a summary of the findings from this work). The author contributed to the three studies which comprised this initial phase of the programme of work: a quantitative survey of registration and inspection units to establish the rates of closure nationally; a telephone survey of a sub-sample of units to explore the types and characteristics of homes that were closing; and structured interviews with twenty providers about the circumstances and reasons for closure. The author contributed to various elements of these studies, including publication of the findings, which are discussed along with other literature on the subject in the literature review chapter.

The thesis reports research that was conducted by the researcher as a second, more qualitative phase of this Department of Health funded programme of work investigating home closures. The author took the lead on this work and planned and devised the study aims and methodology, which sought to shift the focus towards better understanding the process and consequences of closures from the perspective of those involved, while also exploring the nature and extent of policy guidance and regulation of the closure process.

The research discussed in the thesis comprises two main types of data collection: a survey of existing local authority closure guidelines and interview data with residents, relatives, care home staff, and social services staff about their experiences of particular 'case study' closures. The data collection element of the case study research was collaborative. As indicated in the Acknowledgements, data collection across the closures was conducted with Dr Patricia Ware and Kate Henderson. Some sections of the thesis present work that has been written and published elsewhere, including in two journal articles, with the author of the thesis as lead author (see the List of publications

and presentations). Most of these publications include Ann Netten and Patricia Ware as co-authors to acknowledge their input into what was a large project that involved collaborative elements; the overall lead role, particularly in terms of the study design, project management, analysis and write-up was undertaken by the author.

Publications and Presentations

Some of the work presented in this thesis has been published and presented elsewhere, and in the author's maiden name of Williams:

Journal articles (peer reviewed)

Williams, J., Netten, A., and Ware, P. (2007) Managing the care home closure process: Care managers' experiences and views, *British Journal of Social Work*. 37 (5) 909-924.

Williams, J. and Netten, A. (2005) 'English local authority powers, responsibilities and guidelines for managing the care home closure process', *The British Journal of Social Work*. 35 (6) 921-936.

Reports

Williams, J. (2005) Consumer behaviour and care homes - a literature assessment prepared for the Office of Fair Trading, Annexe K of *Care Homes for older people in the UK: A market study*, Office of Fair Trading, London.

Netten, A, Darton, R, Davey, V, Kendall, J, Knapp, M, Williams, J, Fernández, J L and Forder, J (2005) *Understanding Public Services and Care Markets*, King's Fund Working Paper, King's Fund, London.

PSSRU Discussion Papers produced for Department of Health

Williams, J, Netten, A and Ware, P. (2005) *Managing the care home closure process: care managers' experiences and views*. PSSRU Discussion Paper, DP2246

Williams, J., Netten, A. and Ware, P. (2003) *The closure of care homes for older people: relatives' and residents' experiences and views of the closure process*, PSSRU Discussion Paper 2012/3

Williams, J. and Netten, A. (2003) *Guidelines for the closure of care homes for older people: prevalence and content of local government protocols*, PSSRU Discussion Paper 1861/2

Presentations

Williams, J., Netten, A., and Ware, P. (2004) *Care home closures: care managers' responsibilities, activities and recommendations*, paper presented at the British Society of Gerontology Annual Conference 2004 'Challenging Perceptions of Later Life', Roehampton, University of Surrey, 9-11 September 2004.

Williams, J., Netten, A. and Ware, P. (2004) *Care management, assessment and support: the nature and scope of activities during the closure of care homes for older people*, paper presented at 'From Third Way to Which Way?', UK Social Policy Association Conference, University of Nottingham, 13-15 July, 2004.

Darton, R., Williams, J., and Netten, A. (2003) *Residential and Nursing Home Closures in England: Characteristics of Homes that Closed and the Implications of Closures*, poster presented at The Gerontological Society of America's 5^{6th} Annual Scientific Meeting, San Diego, November 21-25, 2003.

Williams, J., Netten, A., and Ware, T. (2003) *Care Home Closure: Residents' and Relatives' Views of Process and Practice*, paper presented at the British Society of Gerontology Annual Conference 2003 'Unsettling the ordinary: changing ideas about ageing', Newcastle upon Tyne, 4-6th September 2003.

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The research was part of a wider study investigating the causes, process and consequences of care homes closures, which was commissioned from the Personal Social Services Research Unit (PSSRU) at the University of Kent and funded by the Department of Health. Many thanks are due to Dr Patricia Ware for her contribution to the case study fieldwork, and valuable comments on drafts of reports and journal articles, Kate Henderson at PSSRU at the London School of Economics, who conducted some of the interviews with relatives, and Julie Prudhoe who transcribed the audio-tapes. The thesis also benefited from discussions with and comments on draft chapters by Professor Jennifer Beecham and from comments from anonymous referees about the two papers submitted to the British Journal of Social Work.

I am grateful for the support of family and friends. First and foremost, I thank Simon for his absolute support, encouragement, good humour, patience, and understanding, and to whom, along with Jim and Glenda and my daughter Alexandra, I am indebted for putting up with my long-drawn-out evening and weekend absences and for the good times away from the thesis. Thanks are also due to my Dad for his continuing confidence and support. I should also like to thank supportive colleagues at the PSSRU, especially Jennifer Beecham for her encouragement and copy-editing, Andrew Fenyo for the loan of a laptop, Nick Brawn for formatting the feedback summaries, and Lesley Cox and Jane Dennett; their timely help and support, especially during the final stages, were very much appreciated.

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Part I

Introduction and General Context

Chapter 1

Introduction

A substantial number of older people live in care homes and they provide the main form of housing and care for older people with complex and multiple health and social care needs. The thesis reports empirical research that set out to explore the process and consequences of the closure of independent care homes for older people in England. The way in which a care home is closed is likely to affect the way in which people cope with this form of involuntary relocation and in turn impact on residents' outcomes, including their health, psychological well-being and quality of care. Little is known about what happens when a care home closes in terms of the activities or the experiences, feelings, views and preferences of residents, relatives, friends and carers, care home staff or social services staff. This is the first in-depth study to explore what happens and to do so from the perspective of the people directly involved.

There are two distinct ways in which a care home can close. Closures brought about by the owner are known as voluntary closures. De-registrations brought about by the regulator are known as enforced closures and are compulsory. De-registration is sought by the regulator when it considers a registered provider unfit, criminal offences have occurred, or certain legal requirements are not met. The study focuses on the former, voluntary type of care home closure.

The study period spanned 2002-2007 and the start of this period was characterised by an increase in the number of independent care home closures in England. Prior research on the rate and causes of closures provided the context and motivation for developing a greater understanding of the closure process (further details on the origins of the work are provided in the Preface). In the early 2000s around five per cent of care homes in England closed voluntarily, which represented hundreds of homes. This resulted in an overall reduction in the level of supply and the relocation of thousands of older people. Although the closure rate is considered to have dropped after peaking in 2000 closures, and the resulting forced relocation of large numbers of older people, are likely to

continue in the long-term as a result of both the market mechanism and regulatory action. Closures are also likely to continue in the short-term as a result of the withdrawal by local authorities from the direct provision of accommodation and care.

Being forced to move from a care home is not only of considerable importance to current residents, but if closures affect the nature and level of supply, they may also have a negative effect on prospective residents looking for a care home by reducing the number and type available. Better understanding of the ways in which people cope with, and manage relocation due to, home closure might also have implications for the management of other types of relocation between care homes. This understanding may in turn benefit from good practice knowledge about relocation and admission per se.

The investigation of care home closures raises questions: about the policy and legal context of closures, including the statutory and non-statutory powers; about the duties and obligations of central and local government; about the role of regulation; about and the rights and responsibilities of service users and their families. Broad issues of relevance include the responsibilities of the state towards publicly-funded and self-funded residents and towards private providers. Policy and practice issues arise in relation to duties of care and protection, and fair access to good quality social care, including the provision of useful and timely help and support.

The thesis presents data from multiple sources and included two main strands. First a national survey of councils to establish the prevalence of local guidelines for voluntary care home closures to complement a review of the powers, responsibilities and guidelines in place at the national level. Second, a study involving multiple case studies to explore the experiences and views of those directly involved in home closure. The greater part of the case study work involved qualitative interviews with residents, relatives, care home staff and social services staff. Data collection around these closures also included the completion of 'activity and time use logs' about closure related work by care managers, some follow-up information from care managers about residents' short-term outcomes, care home staff reports of their job status about three months after home closure, and a review of the care management documentation used by care managers during home closures.

Chapter 2 provides background information about the general context in which care home closures occur, including the focus of contemporary interest in the issue, the characteristics of care homes, care home residents and the social care workforce and the nature of social care. Chapter 3 reviews the policy and legal context of care home closures. It discusses the emphasis on market principles within policies on the provision of housing and social care for older people and highlights the introduction of national regulation. It identifies a lack of specific national legislation and guidance on the management of voluntary care home closures in the independent sector and outlines the roles and responsibilities of councils, the regulator and residents and providers. Councils' aims and obligations during closures are extrapolated from reviewing their broader aims, duties and powers. The possible relevance of the Human Rights Act during closures is described along with the exclusion of the independent sector care homes from the Act. The existence of greater process regulation of care home closure in other countries is highlighted, drawing on the Unites States as an example.

Chapter 4 highlights the lack of literature on the closure process. It reviews what is known about closures, existing good practice recommendations and the research on moving to a care home for the first time of relevance to relocation between homes due to home closure. The research aims, method, rational and ethical considerations are described in Chapter 5. Chapter 6 presents information about the data collected, including the response from the survey of council guidelines and the number and characteristics of the homes and research participants.

The findings are organised into five chapters. The prevalence and content of the council closure guidelines are described first in Chapter 7. Chapters 8, 9 and 10 present descriptive analyses of the accounts of residents and relatives, care home staff, and care managers respectively. The reported outcomes and consequences of the closures for residents, relatives and friends, care home staff, providers and social services are discussed together in Chapter 11.

Interpretation and discussion of the research findings are presented separately from the analysis and organised into two chapters. Chapter 12 looks across the findings presented in previous chapters. It discusses the results in relation to previous literature and draws out the common characteristics of closures and the structural and individual

level influences on the main phases of closure, identified from looking across people's reported experiences and the review of local guidelines and national policy. The reported risks and opportunities are considered and participants' good practice recommendations summarised. Issues to take into account when considering how to improve practice during care home closures are highlighted and discussed. Some areas in need of development work are also highlighted. The chapter ends with some concluding remarks and suggestions that care home closures should be recognised as a situation of risk and that there is a need for improved guidelines.

Chapter 13 discusses the implications of the findings at the national policy level. It argues that voluntary care home closures are a neglected issue and suggests some of the reasons why this is the case. Policy and legislative developments are discussed, including proposals to strengthen the powers of the regulator, the Single Assessment Process, the new emphasis on outcomes-focused services within social care, the Mental Capacity Act, and the likelihood and possible consequences of any change to the exclusion of independent sector care homes from the Human Rights Act. The strengths and limitations of the research are discussed before suggestions for further research are identified.

Chapter 2

General background

2.1 Introduction

This chapter sets the scene of the study by identifying the general background context of home closures. It highlights the primary focus of policy and media interest in care home closures and identifies important structural features of the setting and environment in which voluntary closures occur. These include the nature of the care home industry in England, and the fees and funding system for residential care. Another important contextual factor of closures noted are predictions that demand for care homes will increase and do so on a large scale. Next the characteristics of care home residents, and what is known about the prevalence and input of relatives are described. Some key characteristics of the care workforce in terms of demographics, conditions and recruitment and retention problems are highlighted to draw attention to the wider working environment in which staff involvement in closures occurs. Finally, the nature of social care is briefly discussed. The chapter provides an overview of these issues; further discussion of data and statistics are provided in Appendix 2.

2.2 Policy and media interest

Around the start of the study, the policy concern about home closures focused primarily on changes in the rate of closure, understanding of the causes of closures, and the impact on the overall capacity of the care home market, as well as whether closures were resulting from the successful and efficient operation of a social care market or signified performance problems (Netten et al., 2005; Office of Fair Trading, 2005). A specific concern at the national policy level was whether closures were having a negative impact on older people's ability to find a care home to move to when they were in hospital and needed residential or nursing care (HC 617-I, 2002) (National Audit Office, 2003). Further information about the wider policy context of closures is provided in Chapter 3.

Care home closure is an emotive issue. Media reports identified a 'closure crisis', and suggested evidence that showed closures put older people's health and lives at risk. Closures were assumed to lead to untimely and preventable deaths amongst residents, as well as to cause distress and anguish. Newspaper articles portrayed poignant personal stories about residents facing relocation who did not want to move and emphasised the apparent absurdity of the situation of an ageing population and a loss of long-term care provision (Wainwright, 2002):

> 'Every week scores of old people are evicted from familiar care homes and decanted into new, invariably cheaper, accommodation, despite warnings that the shock and distress will cause them terrible suffering.' (Bain, 2003)

> 'The plight of 102-year-old Rose Cottle, who this week led a delegation to Downing Street to protest against the planned closure of her care home, graphically highlighted the growing crisis in long-term care for the elderly.' (The Guardian, 2002)

> 'She was stripped of her dignity, robbed of her last few emotional comforts and deprived of the will to live... Mrs Knight is among thousands of elderly people betrayed by the wholesale closure of care homes.' (Clarke and Seamark, 2002)

> 'On Saturday the Daily Mail told how five women forced to leave their care home in Birmingham had died within a month of moving out... Research suggests those forced to move from homes where they are comfortable and secure are twice as likely to die within 12 months as those in a stable environment.' (Utton, 2002)

> 'Information unearthed by the Liberal Democrats indicates that by 2005, more than 459,000 elderly people will require care. Yet the latest forecast for the number of care beds suggests there will be only 458,100 available.' (Hughes, 2002)

2.3 The nature of the care home industry

The care home industry provides housing and care for a large number of older people. There are a large number of care homes, and although market capacity fell for about a decade from 1998, it appeared to stabilise and rise again in 2006 (Laing & Buisson, 2007). The vast majority of care homes for older people are in the independent sector and the majority provide residential care. A distinctive feature of the industry is that is a 'cottage' industry, largely composed of small providers, rather than large corporate firms owning multiple homes, who provide relatively small numbers of places. The care home market is sizeable in terms of the overall market value and the amount of public expenditure on care home places, as well as in terms of the number of homes. Large numbers of older people receive state funding via social services for residential care. During the period of fieldwork (2002) there were 207,100 council supported residents aged 65 and over (Department of Health, 2002).

2.4 The funding system, fee levels and funding gap

The state funding of long-term care is complex, and eligibility criteria differs depending on source of funding. Older people may pay for their care themselves, or be funded by local authority social services departments or the National Health Service (NHS). Eligibility for funding of residential care by social services is means-tested and based on income and assets. Older people living in care homes who do not receive any funding from the local authority or NHS (other than on a temporary basis while their home is being sold) are commonly referred to as 'self-funding'. In some cases, contributions over and above those paid by the resident or state, are made by third parties such as relatives or charitable organisations. These are generally known as 'top-up payments'. Self-funded residents comprise a substantial minority within the population of care home residents.

Fees for places in care homes for older people are high (although not in comparison with care home fees for other service user groups), and vary regionally. In 2002-03 they ranged between £200 and £400 per week (Dalley et al., 2004). The median fee level was reported to have risen to £426 per week in 2004-05, representing an annual

increase in some areas of more than 50 per cent (Commission for Social Care Inspection, 2005).

Top up fees mask the funding gap between care home fees and the level of state funding available. Around the start of the present study the care home industry led a *Fair Rate for Care* campaign calling for a review of national policy on pricing and performance (Carter, 2002). One study estimated that local authority fees would need to increase by £75 to £85 per week to cover the reasonable costs of care homes that comply with regulatory and commissioning requirements (Laing, 2002).

2.5 The characteristics of care home residents and their relatives

Care home residents are often referred to as the 'oldest old'. They usually have multiple health and social care needs, and can be relatively isolated from or lack relatives or close friends. Older people living in care homes are likely to be widows, in their mid eighties, admitted following a hospital admission, with high levels of physical disability and self-care needs. In general, older people do not live for much longer than a year after moving to a nursing home, or for not much more than a couple of years after moving to a residential home.

Relatives and carers may play an important role during residents' relocation when a care home closes and may be affected by the event themselves. Relatives and friends provide considerable support and care for older people living in private households, and contact does not cease when an older person is admitted to residential care and the same level of informal care is no longer needed. Little is known about the number or characteristics of relatives and friends of older people living in care homes, or the number of care home residents who are without a relative or close friend. It is known that relatives might themselves be over 60. Clearly residents without relatives will be more dependent on help from care managers or home staff during a closure.

2.6 Demand for care homes to increase in long term

Not only are care homes likely to remain a feature of social care provision, demand is predicted to increase in the long-term given the ageing population and assumptions about rises in rates of dementia. The number of people aged 85 and over is predicted to rise to 1.7 million in 2031 (Wittenberg et al., 2001). The number of people likely to need residential places in care homes or long stay hospitals is predicted to rise by about 150 per cent over a 50 year period (Wittenberg et al., 2004), to 450,000 by 2010, and to 670,000 by 2031 (Wittenberg et al., 2001). Projections for the 30 year period between 1998 and 2031 estimated that demand for institutional care among people with cognitive impairment is likely to increase faster than among those with functional disabilities and, in turn, faster than the rise in overall demand for long term care (Comas-Herrera et al., 2003).

2.7 Relocation between homes a feature of the market

Good practice related to the transfer of older people between homes due to care home closure may be relevant to other types of relocation and vice versa. Relocation between care homes is a feature of long-term residential care in England. Older people tend to have to move between homes when their care needs change, particularly older people in residential care homes who develop needs that require nursing care. There is also a policy expectation that, as consumers, care home residents move homes when they are dissatisfied with the service provided (Policy assumptions about consumer power are discussed further in Chapter 3).

Unfortunately, little is known about the scale of relocation generally, in terms of the prevalence of moves between homes due to home closure or for other reasons. Some one-off studies provide insight into the scale of moves between homes by either identifying those who have moved from another home amongst new admissions or by noting the number who have moved in longitudinal follow up data (Bebbington et al., 2001) (Allen et al., 1992) (Challis and Bartlett, 1988; Reed et al., 2003). Findings about the proportion of residents who move between homes vary considerably, ranging from about ten to thirty per cent. There is no regular long-term data that allows identification

of the prevalence of moves between care homes in England. Research on the circumstances of moves between care homes is described in Chapter 4.

2.8 Care home staff and workforce issues

The closures investigated during the study took place in a context of longstanding recruitment and retention problems; high turnover rates were identified as posing a threat to achieving improvements in social care (Department of Health and Social Services Inspectorate, 2003), having a knock-on effect on quality (Meyer, 2007), and causing problems for employers (Chapter 4 highlights that some providers identified workforce problems as a factor contributing to home closure).

The social care workforce is historically female, and perceived as unskilled (McFarlane and McLean, 2003; Roche and Rankin, 2004; Commission for Social Care Inspection, 2005). Care staff who work in independent care homes range from qualified nursing staff to unqualified care assistants. Care assistants working in care homes are low paid and tend to be older than those working with other client groups. Around half work part-time and shift-work is common. Another important feature of the independent care home sector workforce is the prevalence of agency working.

It has been noted that 'ironically, concomitant with these challenges is the recognition that these workers are central to resident quality of life, and that the relationship between the resident and caregiver is a central feature of this quality' (Zimmerman et al., 2005 p96). It has long been recognised that staffing levels and practice exert an important influence on service quality and service users' perceptions of quality as well as their quality of life; standards developed in relation to residential and home care settings often highlight process related issues concerning workforce service delivery, such as continuity of care and the nature of relationships between care staff and service users and staff and relatives or carers (Centre for Policy on Ageing, 1996; The King's Fund, 2000; Department of Health, 2001a; Malley et al., 2007; Netten et al., in press) (see Chapter 5 for an overview of policies introduced to professionalise, train and regulate the workforce).

Closures are likely to be a stressful event and it is possible that if they are a source of job-related stress or have a negative impact on job satisfaction this might in turn effect the ability of care staff to provide residents with appropriate support at the individual level or exacerbate existing retention problems within the industry more generally. Satisfaction with patient contact has been found to be the strongest element of job satisfaction amongst care staff (Zimmerman et al., 2005). Other issues found to be important to nursing assistants' job satisfaction include the loyalty of management, employee information from management and workload (Parsons et al., 2003), which are all issues that may be particularly pertinent during a home closure.

2.9 The social worker workforce and practice issues

Around the period of fieldwork there was a national shortage of social workers and concerns about recruitment, retention, and burn out. The 'poor image, low status and lack of public recognition, years of high-profile harsh criticism in the media, low pay compared to other professions, and increasing competition from more attractive careers and training opportunities' have been identified as factors that adversely affect recruitment to social work (Eborall and Garmeson, 2001 p7).

The wider context of social workers' and councils' work was one of ongoing reform and change since the introduction of the current government's new vision to promote independence, raise standards and improve protection in the White Paper *Modernising Social Services* (Cm 4169, 1998). It has been argued that the policy emphasis on person-centred services (Cm 4169, 1998; Department of Health, 2001b) has required social services staff to undergo a culture shift away from a service-led approach and paternalistic mindset of 'looking after' people to a needs-led approach, which supports individual choice and empowerment (Bainbridge, 2003).

The provision of support and advocacy has long been emphasised in policy guidance (Department of Health and Social Services Inspectorate, 1991), and service users identify advocacy as an important service to help them express their wants and needs, their preferences and anxieties, and their complaints and objections (Harding and Beresford, 1996). Research has shown that service users value the quality of

relationships with social workers, and their knowledge and skills, as well as the service they provide (Harding and Beresford, 1996). People want to trust that social workers are honest, reliable and credible, to be able to talk to them in confidence and influence decisions, and to be shown respect, courtesy and empathy. They value being listened to and would like social workers to be able to communicate sensitively and offer advice and support as well as specialist information. However, research has emphasised a shift in the balance of activities carried out by care managers, away from counselling towards administration (Lewis and Glennerster, 1996). Some have asserted that care managers are unable to provide ongoing emotional and psychological support to service users (Scourfield, 2004). If care managers are unable to fulfill a supportive role during care home closures, this is likely to be a serious loss to older people.

2.10 The nature of social care

In general, social care work is an ill-defined concept, which has been used in a disjointed way (Daly and Lewis, 2000). One defining characteristic is the way in which it belies common classification; Cameron noted Kroger's useful observation that social care assistance 'transcends the conceptual dichotomies between the public and the private, the professional and the non-professional, the paid and the unpaid' (Kröger, 2001 p4; Cameron, 2003 p4). Daly and Lewis have also emphasised this intersection of relationships between the state, market and family and argued for a re-conceptualisation of social care as a three-dimensional concept; they argue that for the concept to better reflect the shifting of responsibilities among institutional domains and its contemporary place at the 'centre of welfare state activity', caring needs to be thought of as an activity or labour, a set of social relations within a normative framework of obligation and responsibility, and as an activity with financial and emotional costs (Daly and Lewis, 2000 p282).

As an activity social care work is personal, social and physical and as a set of relations it can also require emotional work. Care assistants provide a high proportion of the direct care provided to older people, including personal care, social care and emotional and physical support; of the staff in a care home, care staff are likely to communicate with residents and relatives the most and sometimes provide a link between relatives and

residents (Pearson et al., 2003). Care assistants are expected to develop friendly, caring and trusting relationships with the people they work with. LearnDirect (an organisation set up to offer impartial advice about careers, courses and qualifications online) highlights numerous personal skills and qualities as desirable, including the ability to be sensitive, sympathetic, patient, reliable, flexible, to communicate well, and to remain calm under pressure (LearnDirect, 2007). Standards of professional conduct and practice for social care workers have specified numerous obligations and responsibilities towards service users and the public, including responsibilities of protection (General Social Care Council, 2002).

Many of the qualities associated with the quality of care work are dependent on the motivations, commitment and personal characteristics of workers. However, other aspects of staff quality, such as continuity of care, are dependent on organisational factors, such as recruitment practices, time management, and time spent with users as well as the quality of the interaction with users (McFarlane and McLean, 2003).

2.11 Summary

This chapter has highlighted the nature of contemporary policy and media interest in care home closures around the start of the present study. It has noted that the care home industry in England provides housing and care for large numbers of older people and outlined some of the significant features of the industry. It is important to recognise that while independent sector provision dominates, the state is the major purchaser and considerable public expenditure is spent on residential care.

The characteristics of care home residents and their relatives are noted to highlight their potential need for help and support during care home closure and the likelihood that involuntary relocation caused by home closure would cause considerable disruption and do so for some during what might be the last years of their lives. Two general context factors were highlighted that might indicate better understanding of care home closures and relocation in general is needed: predictions that demand for care homes is likely to increase; and the situation that most residents of homes that provide personal care have to move homes when their needs require nursing care. Consideration of current and

future care home closure policy and practice, at the staff level, should also take into account the general characteristics and problems within the social care workforce. The view that social care encompasses a set of relationships, as well as activities, and relationships that span the state, the market and the family is highlighted as a useful conceptual starting point.

Chapter 3

Policy and legal context

3.1 Introduction

This chapter is organised into five main sections. First the policy context of long-term care in England is described, drawing attention to key characteristics and policy assumptions, including complications and caveats, and the central policy agenda of independence. The broad responsibilities of local authorities towards older people with long-term care needs are also outlined. The second section describes the national regulation of social care, which was introduced during this study. The third section identifies and reviews the legal and policy context of voluntary independent care home closures in relation to the roles and responsibilities of councils, independent providers and service users. The relevance of the Human Rights Act during home closure is then highlighted, along with the exclusion of independent care homes from it. Lastly, the existence of tighter regulation of home closures in other countries is noted, drawing on the United States as an example.

Government policy documents, official reports (including inquiries, Green Papers and White Papers), guidance and grey literature (material that is not commercially published or generally available such as internal documents from particular organisations) were identified by searching the websites of key government departments, producers of good practice guidance for social care, such as the Social Care Institute for Excellence (SCIE), research authoring organisations such as the Joseph Rowntree Foundation and the King's Fund, charities, such as Age Concern, Help the Aged, the Alzheimer's Society, and Counsel and Care, and the references cited in other publications.

3.2 Residential care and older people policies

This section describes the established policy of promoting market principles of choice and competition in the provision of long-term care for older people in England, and

considers arguments and evidence about assumptions that this drives up standards, and achieves cost efficient services that are responsive to demand. The centrality of promoting independence in policies for the social care of older people, and in turn the way in which this focus is associated with policies aimed at developing alternatives to care homes are also noted. The general roles and responsibilities of local authorities towards older people with long-term social care needs are then outlined because of their potential relevance during closures.

3.2.1 Market principles and assumptions

The care home market in England is known as a 'quasi-market'. It is characterised by state funded services that are purchased from competing private, voluntary and public providers (Le Grand, 1991). The Community Care reforms (1990), implemented in 1993, intended to help people who need care and support to live in the community and maintain their independence, introduced what is called a 'purchaser provider split' and changed the role of local authority social services departments (Lewis et al., 1996; Lewis and Glennerster, 1996; Bailey and Davidson, 1999). The reforms were introduced in part to reduce reliance on the use of institutional care, and to ensure the efficient use of public funds. In the period before 1993, social security payments were available to people who needed state funding towards the cost of independent residential or nursing home care via means tested income support, and there were policy concerns about the expansion of independent sector residential care homes, the rise in social security spending, and the possibility that people were being placed inappropriately (Lewis and Glennerster, 1996).

The shift in policy was in line with a wider political approach towards social policy, which has been characterised as welfare ends through market means, whereby the focus is on ensuring that welfare policy supports, rather than obstructs, the operation of the market system, and 'contributes to the economic goal of competitiveness ... but at the same time ensures that the needs of citizens are effectively met' (Taylor-Gooby et al., 2004 p574). The three main arguments in favour of harnessing choice and competition in public service delivery are that it 'fulfils the principle of autonomy, and promotes responsiveness to users' needs and wants; it provides incentives for providers to provide both higher quality and greater efficiency; and it is likely to be more equitable than the alternatives' (Le Grand, 2007 p42).

The Community Care reforms also emphasised consumerism, and widening and increasing choice (National Health Service and Community Care Act 1990). An intention to enable service users to exercise the same power as consumers of other services was stated explicitly (Department of Health Social Services Inspectorate, 1991).

Debate about the application of market principles to social care provision focuses around the consequences of prioritising individual choice, which can produce tensions between collective provision, individual freedom, competition, protection and security, and rationing. The classic dilemma for 'consumers' between competition and co-operation is whether to co-operate so that everyone 'wins' or to compete to ensure a potentially bigger or better win as an individual. Microeconomic theory assumes that consumer choice is a rational decision where the consumer chooses the option that will give most utility, or maximise the benefit gained, subject to his/her budget constraints and preferences. There is an assumption that choice is a considered and deliberate judgement (Barnes and Prior, 1995). To make a choice between things there needs to be a range of options and information about them and how they differ. If a consumer is dissatisfied with a service, they should be able to withdraw their custom and take it elsewhere, again choosing from a range of suppliers who will compete for their trade.

Consumers in the care home market may have a number of opportunities to act as consumers: to move to a care home or not; to select a particular home, including consideration of its location and sector of provision (public, private or voluntary); and after admission, to stay or leave (Challis and Bartlett, 1988). They are thus presupposed to be competent to make decisions and choices between services.

To choose prospective care homes residents and their family or friends need good information about their needs, the ability of care homes to meet those needs, the funding system and information about the role of councils and care managers. Market principles suggest that care home providers should be assumed to be competent unless proven otherwise, and that they should be responsive to drops in demand and to current residents' needs and preferences. This in turn, assumes that current residents are able to

make their preferences clear and to complain if they are dissatisfied and ultimately to withdraw their custom and take it elsewhere. During the period of study moves were made to improve service users' awareness of how to report incidents and to complain. These included central policy guidance on balancing risk and independence (Department of Health, 2007). However, the set of principles advocated are framed in relation to people making choices when living in their own homes (Department of Health, 2007).

3.2.2 Caveats and complications

The care home market is termed a quasi-market to acknowledge that there are a number of features, primarily the dominance of statutory sector purchasing, that preclude it from operating like a normal market. In addition, there are a number of other caveats, complications or limitations related to the nature of provision, the routes to securing a care home place, the nature of the service user group and the nature of choice. There are also uncertainties about how well the market mechanism works.

Quality within care homes is an ongoing concern. The information care homes provide to prospective residents about the price, services, terms and conditions have been found to be inadequate (Office of Fair Trading, 2005). The regulator has also found that such inadequacy was relatively widespread; 20 per cent of a sample of homes failed to meet the national minimum standards for information provision (Commission for Social Care Inspection, 2007a).

There is evidence to suggest that there is considerable room for improvement within the care home industry, which arguably suggests that the current mechanisms of consumer power, including social services contracting and commissioning, is not ensuring high quality adequately. In its first year of operation, the national regulator received 12,685 complaints about regulated services for older people, younger adults and children, ten per cent of which involved allegations of abuse (National Care Standards Commission, 2003). The majority of the other complaints related to poor practices or neglect, which a Select Committee argued should be considered forms of abuse (House of Commons Select Committee on Health, 2004). In the same period 12 per cent of care homes for older people failed to meet the national minimum standard for administering and handling medication, which equates to about 1,500 homes (Davies et al., 2004).

Analysis of the first 100 referrals to the Protection of Vulnerable Adults (POVA) list found that just under two-thirds were made by private care homes, and of these the largest proportion came from chains (42%) (Stevens and Manthorpe, 2005). Disconcertingly, staff working in residential settings were more likely to be referred to POVA for direct forms of abuse, such as physical, verbal and psychological abuse, rather than less direct forms, such as financial abuse.

Another caveat concerning the application of market principles to care homes is that the type of consumer behaviour possible in the care home market is modified by features of the 'quasi- market' (Le Grand, 1991). Those in receipt of public funding might select a home in relation to their preferences, but the council largely determines the budget. Similarly, for publicly-funded people choice effectively means 'the right to make an application' for a particular provider, rather than a definite decision (6, 2003). For self-funded people the choice of home may be restricted by a lack of information, a limited range of local services, or the requirement of a substantial top-up payment (Commission for Social Care Inspection, 2007a).

Various professionals act as gatekeepers to care homes. Care managers or home managers decide whether someone needs to move to a care home, and the type of care they require, and the older person or their relatives may have different views (Tanner, 2003); care home staff choose consumers, as well as vice versa, when they assess the degree of 'fit' between the prospective resident's needs and the services they provide.

It can also be argued that choosing a care home differs from choosing other types of services; it is about choosing a place 'to live', rather than, for example, choosing a hospital, which is about choosing a place for 'receiving care' (Reed et al., 1998 p164). Clearly, this also means that changing care homes involves changing your housing or home and not just social or health care provider.

Another important caveat is that it is an oversimplification to assume that choice is merely a rational decision; purchasing decisions are influenced by habit, values and emotional responses, as well as reason. The ability to make rational decisions may be

complicated by psychological stress (Janis and Mann, 1977; Dellasega and Mastrian, 1995), or voice or loyalty (Hirschman, 1970). As mentioned in Chapter 2 (section 2.7), transfers between homes are not monitored routinely so it is difficult to establish whether older people are exercising their consumer power to take their business elsewhere.

An older person living in a care home should be able to raise criticisms and complaints to ensure the quality they expect, and to feed into decisions about remaining or taking their business elsewhere. Thus, a lack of awareness about how to make complaints would hinder 'consumer power'. Although, national minimum standards were introduced about complaints procedures, the National Care Standards Commission found that only 50 per cent of care homes for older people met or exceeded these standards in 2002-2003, their first year of operation (Dalley et al., 2004). Recently, the Better Regulation Commission urged consumers to take responsibility for ensuring that the standards they expect are delivered, rather than relying on rules and regulations set and enforced by others (Better Regulation Commission, 2006).

While people are likely to want to have some choice, the value placed on being able to choose a service may differ depending on the service. Service users in the community, for example, have been found to place more importance on having a choice about the content, timing and duration of services than on choice of provider (Hardy et al., 1999). Other issues may be more relevant than choice: getting what one wants is probably more important than the opportunity to engage in 'shopping around' (Dowding, 1992 cited in Barnes and Prior, 1995); 'confidence, security and trust may be more appreciated by users than the opportunity for choice' (Barnes and Prior, 1995 p58). Having to choose may itself be beside the point. Older people have been found to emphasise that 'they want standardised, reliable local services of a good quality rather than having to shop around a wide range of homes for the best deal' (Commission for Social Care Inspection, 2007a p7).

Consumer behaviour and consumer competence in the care home market may be limited further by an individual resident's characteristics, situation and views and beliefs about care homes: they may be unable to express their preferences or lack capacity to decide where they want to live (Royston, 2002); the choice of moving to a care home may be

against their wishes and the involuntary nature of such a move mean it has little to do with their preferences.

The practice of independent care homes charging what are termed 'top up payments', over and above the fees paid by local authorities, further complicates the issue of funding and fee payment and may act as a serious price barrier for some – especially those without relatives who may be reliant on charitable or other sources to meet such charges (top up payments are explained in the Chapter 2).

3.2.3 The promotion of independence

At the time of the study, the main focus within social care policy for older people was the promotion of independence and people's ability to live at home. There was no positive agenda for long-term residential care, rather the focus was on developing alternatives to residential care and ways of avoiding unnecessary hospital admission. Interestingly, analysis of the British Household Panel Survey found a reduction in the rate of institutionalisation after 1994, but no evidence that increased use of domiciliary services was preventing admission to care homes (Scott et al., 2001).

Extra care housing is being promoted as a form of housing and care that may provide an alternative to care homes. This may widen choice but it is also being championed as the principal form of residential care in the future (Ladyman, 2004b; Ladyman, 2004a). It would, therefore, act as a substitute for care homes, rather than an alternative.

3.2.4 Responsibilities of local authorities to older people with long-term needs

The roles and responsibilities of local authorities of relevance to older people moving into or between care homes include a duty to assess a person's need for social care, a of 'duty of care' and an obligation to promote well-being, an obligation to provide fair access to social care, to strive for quality services and promote individual choice and control. The need for local government to balance the demands of choice, fairness, quality and value for money in service delivery is recognised by central government, but few suggestions have been offered as to how councils should go about achieving this balance (Office of the Deputy Prime Minister and H M Treasury, 2005). Similarly, councils need to promote people's rights and freedoms, while also protecting them from harm is recognised as a difficult balancing act (Department of Health et al., 2004).

3.2.4.1 Duty to assess need and arrange care

Local councils have a responsibility for arranging and funding social care services that meet the needs of their local population (National Assistance Act 1948). The Community Care reforms made councils responsible, and later obliged to carry out a community care needs assessment for any person for whom it appears the council may provide, or arrange, community care services, and for encouraging the development of private, and voluntary provision of services (1990 NHS and Community Care Act, chapter 19, section 47, paragraph 1). However, councils have merely a power, and not a duty, to provide services to those assessed as needing them. Moreover, before admission to a care home the only duty councils have is to conduct a full assessment of publicly-funded service users: there is no obligation on councils to assess self-funded service users (Department of Health, 2001b Standard 3).

3.2.4.2 Duty of care

There is considerable uncertainty and confusion about the breadth of councils' duty of care. The National Assistance Act 1948 conferred duties on local authorities to provide accommodation for adults in need of care due to age, illness or disability, and section 21 placed a duty on local authorities to offer resources and protection to residents it funds (Grose, 2007). The Local Government Act conferred a broader duty on local authorities to promote the social, economic and environmental well-being of people living locally (1999). Local authorities also have a duty of care to those whom they provide services and legislation under the Care Standards Act 2000, which defined adult service users as 'vulnerable' people in need of protection (Care Standards Act 2000; McLaughlin, 2007).

Recent policy guidance aims to clarify legislation around councils responsibilities, and duty of care to individuals for whom they provide services, within a wider discussion about risk and independence (Department of Health, 2007). However, it fails to discuss whether local authorities continue to have a duty of care to individuals for whom they commission and fund care as opposed to those for whom they provide services. To add to this confusion it reiterates the current situation in relation to human rights; private care homes are excluded from the obligation to not act incompatibly with the European Convention on Human Rights because they are not carrying out functions of a public nature. This situation is discussed in more further detail below in section 3.5 below.

When considering mental capacity the document notes that while people have the right to choose, the local authority 'remains accountable for the proper use of its public funds' and can refuse to fund degrees of risk it considers unacceptable (Department of Health, 2007 p22). This acknowledgement of their responsibility for how public funds are used clearly has implications in relation to their roles and responsibilities in relation to paying for places in independent sector care homes.

3.2.4.3 Fair access to social care

During the period of fieldwork for this study new guidance was implemented to remove the variation in councils' eligibility criteria for services (Department of Health, 1998) (Department of Health and Social Services Inspectorate, 1999). A national framework to promote fair access to social care was published the year fieldwork was conducted (Department of Health, 2002d). An important aspect of the policy around access to social care is that councils are allowed to take account of their resources when assessing people's need by considering their need in relation to the needs of others, and available resources.

3.2.4.4 Quality services

Local authorities are required to make continuous improvement in all their services and the way their functions are exercised. A performance monitoring framework was developed that includes the Best Value regime (from 2000/2001) and the Comprehensive Performance Framework (from 2002). The mechanisms through which good quality are to be achieved include commissioning, developing markets, competition, and user choice. Market management is an important aspect of councils role in ensuring 'a healthy range of providers offering diversity and good quality services in order to make individual choice a reality' (Department of Health, 2006 p11). There is a clear and ongoing emphasis on an economic definition of quality services, that is, they should be effective, efficient and represent value for money (Department of Health, 2006). Unsurprisingly, given the policy emphasis on helping older people to live at home Best Value Performance Indicators (BVPIs) for Social Services in 2001/02 include no service delivery outcomes concerning the commissioning or purchasing of care home placements (Department for Communities and Local Government, No date). Councils also have an obligation to monitor for effectiveness and efficiency and do this

via contract specification and monitoring and other means, such as user experience surveys.

3.2.4.5 Choice and control

Enabling service users to be involved in decisions about their care and strengthening their choice has been repeatedly emphasised as a key priority in national policy guidance (Department of Health, 1992; Department of Health, 1998; Department of Health, 2001a; Department of the Environment Transport and the Regions and Department of Health, 2001; Department of Health, 2002b; Department of Health, 2003a). Similarly, plans for modernising social services set out in the 1998 White Paper, focused on developing services that promote independence, are person-centred and needs-based, with clear standards, have consistent and fair eligibility criteria and protect people from abuse and neglect (Department of Health, 1998). The *National Service Framework for Older People* includes a standard for person-centred care; services should treat older people as individuals and enable them to make informed choices about their own care (Department of Health, 2001c: Standard 2).

3.3 Introduction of national regulation

In April 2002, during the fieldwork period, the National Care Standards Commission (NCSC) became the first national organisation responsible for regulating care homes in England (and boarding schools and adoption agencies), and for providing the government, and the public, with information about the state of the sector (2000). This section describes the introduction of the national minimum standards and the policy change that occurred, which appeared to be in response to the reaction within the care home industry. It also highlights the new workforce regulation, focusing on policies introduced to prevent abuse and neglect.

3.3.1 National minimum standards

Prior to 2002 local authorities regulated care homes under the Registered Homes Act 1984 (1984), but councils were found to apply standards inconsistently across homes and areas (Burgner, 1996). Greater independence and consistency were recommended, and the government set out proposals to overhaul the regulatory framework in 1998

(Department of Health, 1998). The NCSC later became the Care Standards Commission for Inspection (CSCI). There are plans for it to merge into another new organisation in 2008 covering both health and social care.

In September 1999, the government published for consultation proposed standards for care homes for older people, and the first national minimum standards were published in March 2001(Department of Health, 1999b; Department of Health, 2001b). The standards related to seven broad categories: choice of home; health and personal care; daily life and social activities; complaints and protection; environment; staffing; and management and administration. Many were to apply from April 2002, although some did not have to be met for five years.

There was much confusion about the nature of the standards, particularly in terms of whether non-compliance would lead to enforcement action, or de-registration. In January 2002 Jacqui Smith, the Health Minister, issued guidance to the NCSC clarifying the approach as 'a pragmatic but timed one', and announced a Helpline for providers (Department of Health, 2002g). Smith emphasised that the standards were not enforceable but intended to lead to improved quality. The NCSC was 'not in the business of shutting care homes' (Kerr, 2002). Homes that opened after April 2002, however, were expected to comply with the standards in order to be registered.

Throughout 2001 and 2002 care home closures were commonly attributed by the press to the proposed national minimum standards, as well as to longer standing issues including low local authority fee levels and rising costs (Steele, 2001; Batty, 2002; Morris, 2002). Chapter 4 highlights reports of closures occurring due to anticipation of the costs of compliance with the new standards. Estimates of the number of home closures in 2001 were said to signal the 'collapse' and 'meltdown' of the sector (Carvel, 2002b).

The industry protested, particularly about the feasibility and cost of implementing many of the physical environmental standards. Some argued that the standards were more of an aspirational wish-list than a statement of the minimum quality of care that should be provided. Some care home owners responded by refusing to accept publicly-funded residents and others increased their fees (Batty, 2002; Winchester, 2002).

Another consultation was announced and conducted in the summer of 2002 (Department of Health, 2002a). The Health Secretary said:

> 'The size of rooms and doors, availability of single rooms and the number of lifts and baths are important but they should not mean good local care homes having to close.' (Milburn, 2002)

The standards were re-published with revisions in 2003 (Department of Health, 2003b). Most of the changes related to environmental standards, such the proportion of places in single rooms and the width of doorways, and made them applicable to new build and first time registrations only. Existing homes were now expected to maintain the level of quality achieved in 2002, and to highlight their level of compliance to help prospective residents 'make an informed decision for themselves' (Milburn, 2002).

The press reported that this 'retreat' or 'concession' followed the death of Alice Knight who went on hunger strike over the closure of her care home (Carvel, 2002a). Reactions to the consultation and revisions were mixed. Ann Parker, the new chairwoman of the National Care Standards Commission, welcomed the changes in so far as they were likely to help stabilise the market and stop providers closing because of the standards (National Care Standards Commission, 2002). Age Concern, however, warned of the possible development of a two-tier system of homes (Age Concern, 2002a).

3.3.2 Prevention of abuse and neglect in care homes

As a care home closes there is a possibility of abuse or neglect just as there is during the normal day-to-day delivery of the service. During the period of fieldwork there were a number policy developments, some linked to organisational changes and wider regulatory developments, in the area of what became termed 'Safeguarding Adults'.

The national guidance, *No Secrets*, aimed to set out a framework of action for responsible agencies, with social services departments taking the lead in co-ordinating policies and procedure for the protection of vulnerable adults from abuse (Department of Health, 2003d). It highlighted both personal forms of abuse (for example, physical, sexual, and financial) as well as institutional abuse (such as poor care standards, and an

insufficient knowledge base within a service) and defined harm widely as including the 'impairment of, or an avoidable deterioration in, physical or mental health' (Department of Health, 2003d p12). The concept of significant harm was to be used when considering whether abuse warranted intervention.

In 2005, a national framework of standards for good practice and outcomes in adult protection work emphasised that the focus on adults who are, or might, be eligible for community care services specifically included 'those people who are assessed as being able to purchase all or part of their community care services, as well as those who are eligible for community care services but whose need – in relation to safeguarding – is for access to mainstream services such as the police' (The Association of Directors of Social Services, 2005 p5). Local authorities were made responsible for setting up a multi-agency 'Safeguarding' Adults Partnerships of statutory organisations, such as the CSCI, Primary Care Trusts and the police (Department of Health, 2000); care home providers were identified as potential members (The Association of Directors of Social Services, 2005).

The Care Homes Regulations 2001 (2001 Regulation 22) require care home providers to have complaints procedures in place, and these are subject to review by the regulator (Department of Health, 2001b Standard 18.2). Nonetheless, some of the problems highlighted by the Office of Fair Trading (1998) appeared to have persisted, namely the different complaints routes possible for differently funded residents depending on whether they are funded by local authorities, the NHS or themselves. Individual providers are responsible for dealing with complaints about their service; local authorities, the NHS or the police are responsible for responding to allegations of abuse or criminal behaviour; and the regulator is responsible for ensuring that providers comply with regulations and improve their services. There is also some confusion in policy documents about who is responsible for investigating complaints concerning self-funded care home residents (Commission for Social Care Inspection, 2006a; Commission for Social Care Inspection, 2007b, p12) (Department of Health, 2004b).

There is an expectation that care homes should encourage staff to raise concerns about poor practice and 'whistleblow', and be supported in doing so through the Public Interest Disclosure Act (1998) provision of employment protection for staff who allege

malpractice in their workplace. The CSCI also monitor evidence about whether staff in homes are encouraged and enabled to report bad practice as part of their interpretation of Standard 18.2 (Commission for Social Care Improvement, 2006).

It is also worth noting that the legal basis and rhetoric around protecting adults differs considerably to that for protecting children. In relation to children, the CSCI clearly refers to enforcing improvement 'as part of our duty to safeguard, and promote their rights and welfare' (Commission for Social Care Inspection, 2006b p5). The regulator has no equivalent legal duty to safeguard and protect the rights and welfare of 'vulnerable adults'. Rather, they have a goal of 'safeguarding the interests' of adults who cannot act themselves to get things improved.

As part of the modernisation agenda the government set up a number of organisations under the Care Standards Act to regulate the workforce and promote evidence based education and training (2000; see also Department for Education and Skills and Department of Health, 2006). The Care Standards Act 2000 established the General Social Care Council (GSCC) as an arms' length body (i.e. an executive non-departmental public body) to regulate the social care workforce, champion social care and regulate and support education and training. The GSCC launched a *Social Care Register* in 2003, and TOPSS (renamed Skills for Care from April 2005) was created to develop a national training strategy. In 2002 it published National Occupational Standards for Social Work (Topss UK Partnership, 2002), which formed the basis for a new social work degree and National Vocational Qualifications (NVQs) for social care workers (Topss UK Partnership and Skills for Health, 2005). The Social Care Institute for Excellence (SCIE) was also established to improve social care for adults and children by identifying, developing and communicating good practice knowledge in the social care sector.

Since the study started the Protection of Vulnerable Adults (POVA) scheme was introduced. It requires employers (local councils, care homes, agencies) check a list, operated by the Department for Education and Skills, when recruiting staff or volunteers in regular contact with vulnerable adults (Department of Health, 2004c). Employers are also responsible for referring to the list people who have abused or harmed vulnerable adults, or are considered to have placed them at risk of harm. Those named on the list

face prosecution if they apply for care work. Employers are also legally required to obtain Criminal Records Bureau Checks before appointing new staff.

3.4 Roles and responsibilities during closures

This section reviews the roles and responsibilities of councils, the regulator, and residents and providers during voluntary independent sector care home closures. There is a lack of legislation aimed specifically at defining councils' powers and responsibilities during closures. Consequently it is necessary to review what is of relevance in the wider legislative framework, and to consider how it may be applied to the specific context of home closure.

3.4.1 Councils' responsibilities

That councils are responsible for making sure closures are planned is indicated in a concordat between the government, local authority and independent social care, health care and housing sectors (Department of Health, 2001a). In 1993 councils were advised to draw up plans for nursing home closures to ensure that residents are helped to find accommodation, and offered help irrespective of their funding (Department of Health, 1993) but this has not been updated to cover residential care homes. The most detailed national guidance about relocating older people relates to the closure of hospitals and wards (NHS Executive, 1998). The recommendations cover consultation, a project plan, the needs of the individual and their relatives or carers, the process of transfer and role of the receiving setting, and arrangements for follow-up and monitoring. Councils have used local government overview and scrutiny committees, introduced under the Local Government Act 2000, as a means with which to investigate or review the closure of council run and independent care homes (Gloucestershire County Council Personal Care Scrutiny Committee, 2003; Prasad, 2003; Director of Social Services, 2004; 2005).

Wider policies of relevance to councils during a closure are reviewed. They primarily concern care management tasks because during a closure these are likely to mirror those that apply when an older person moves to a care home for the first time, namely the assessment of need, provision of information, help and support, and monitoring.

3.4.1.1 Information and assessment of need

Community care assessments are likely to be of central importance during relocation due to home closure. The health and social care needs of an older person living in a care home may have changed since admission. Similarly, the financial circumstances of a self-funded resident may have changed, perhaps to the extent that they are eligible for state funding. Ordinarily, assessments should be offered to older people irrespective of their eligibility for state support; 'financial circumstances should have no bearing on whether a council carries out a community care assessment' (Department of Health, 2002e p14). Assessments should be a participative process and provide clear information about health and social care needs and help residents and their families select care (Department of Health, 1990, Appendix B Glossary). Care plans based on assessments should be drawn up by care managers, agreed with service users and a copy given to service users (Department of Health, 2002d).

However, as highlighted in section 3.2 self-funders do not have to have a community care needs assessment before moving to a care home, although there is a legal requirement within the Care Homes Regulations that their needs should be assessed by a care home before admission (2001). Wright (2003 p 607) has noted that an assessment conducted by a care home is likely to be conducted by the care home provider who has 'a vested financial interest in admitting a self-funding resident'.

There is a proviso in the regulations that allows councils to arrange placements without a prior assessment if they consider a move to be a 'matter of urgency' (National Health Service and Community Care Act 1990). Assessments should then be carried out as soon as possible after such a move. This suggests that, during a home closure, which may require urgent relocation, a resident may be moved without first having had their needs assessed.

A new Single Assessment Process (SAP) for older people was initiated by the *National Service Framework for Older People* (NSF) (Department of Health, 2001c). The aims were to introduce a coherent, co-ordinated and effective approach across health and social care services, to prevent the duplication of information asked and held about individuals, to help ensure services are provided appropriately and promptly and to ensure the scale and depth of assessments are appropriate to older people's needs.

Central guidance published in January 2002 included detailed information about local implementation, key implications for service users and care staff, a seven stage process with four types of assessment and compulsory domains, including the service users' perspective and relationships (Department of Health, 2002f).

The SAP highlighted the publication of information about services as key to the delivery of appropriate and timely services (Department of Health, 2002f). The provision of good information about individuals' needs and local care services for older people from councils has long been a policy objective (Department of Health, 1990; Department of Health, 1999a; Department of Health, 2001c; Department of Health, 2002f). The need for appropriate information for service users, in terms of accessible language and formats has also been recognised for some time (Department of Health, 2001c; Department of the Environment Transport and the Regions, 2001).

3.4.1.2 Help and support

Policy guidance on care management suggests that care managers should offer help and support to service users. Negotiation, clarification and agreement were repeatedly mentioned in initial guidance and practitioners urged to establish relationships of trust (Department of Health Social Services Inspectorate, 1991). One of the main advantages of introducing care management was the improved opportunities for representation and advocacy (Department of Health Social Services Inspectorate, 1991). The more recent *National Minimum Standards for Care Homes for Older People* include a relevant standard, but there is no corresponding statutory requirement: access to available advocacy services should be facilitated to ensure the protection of legal rights (Department of Health, 2003b).

Care managers may get involved with helping self-funders find and select a home if they are unable to make decisions themselves, or are without relatives to help them. Councils may even take responsibility for managing their financial affairs, if older people are unable to do so themselves because of mental incapacity.

3.4.1.3 Monitoring of needs

The possibility of residents being relocated due to home closure without an assessment suggests that monitoring and review may be all the more important; they 'are critical to

ensuring services remain appropriate' (Department of Health, 2002d p3). In general, councils are only obliged to review the needs and service provision provided for residents whose care they are responsible for arranging and funding. The progress of self-funded residents would not normally be monitored.

A review should serve a number of purposes, each critical to a good outcome following a home closure. These include:

- Re-assessment of the service user's needs;
- Review of the service(s) provided to them;
- Consideration of how far the support and services have achieved the outcomes stated in the care plan;
- Confirmation of their eligibility for support and services;
- Confirmation or amendments to the care plan (Department of Health, 2002f; Department of Health, 2003c).

Like assessments, reviews should involve service users and their carers where appropriate, and providers of services. An initial publicly-funded care home placement should normally be reviewed 'within three months of help first being provided or major changes made' to services and at least annually thereafter, and one would expect involuntary relocation due to home closure to count as a major change (Department of Health, 2002e p12). The need for unscheduled reviews from time to time was anticipated and service users, providers and other appropriate agencies or individuals can request a review (Department of Health, 2002e).

3.4.2 The regulator's role and requirements

One might expect the regulator to play a part, or to have a say in how care homes close, as part of their monitoring of standards of care, adult protection function or policing role. The main requirement, however, is that providers give notification of their intention to close to residents and to the regulator (this is discussed below in relation to providers' responsibilities). Other than this, there appears to be no process related regulation of voluntary care home closures.

The legislation and policy guidance in place at the time of the study placed no requirement on the regulator to visit, monitor or inspect care homes during a closure period and this does not appear to have changed. There is no information about reasons for voluntary closure in either routine or special reports published by the regulator.

None of the National Minimum Standards for care homes in England relate specifically to the process of relocating residents between care homes. The Scottish National Care Standards, however, include a standard on 'Moving on'. This states that the resident should be involved 'in plenty of time' in planning and discussing the 'best way to prepare' for the move. It also gives residents the right to keep up friendships, be involved in assessments of the risk of a move and to have their records given to the new home promptly. There is no equivalent right to the first and last of these in the English standards. Moves due to closure or a home's inability to continue to meet a resident's needs are mentioned explicitly and are said to have to 'involve the least amount of risk and disruption' to the resident' (Scottish Executive, 2003 p 50).

The National Minimum Standards for care homes in England (Department of Health, 2003b) do include a standard relating to trial visits providing an opportunity for people to assess the quality, facilities and suitability of homes, or to move in on a trial basis before they make a decision to stay (standard 5). No detail, however, is given about what the visits should or might include, although interestingly the standard also suggests that prospective residents could meet care home staff in their current home. Presumably so care staff can tell the service user how the home would meet their needs.

The good practice policy guidance on transferring older NHS patients from hospitals to other care settings further emphasises the importance of communication between current staff, in this case hospital staff, and staff at the receiving care setting (National Health Service Executive, 1998). While such policy recommendations for good practice are possible in relation to moves to local authority run care homes, it may be less easy for central government to make such recommendations in relation to staff employed in independently run care homes.

3.4.3 Residents' rights and providers' responsibilities

Residents' rights and providers' responsibilities are discussed together as they are often two sides of the same coin. What residents should receive or obtain, for example, is often established by what owners are advised or obliged to do. This is the case for the length of notice of closure provided to service users, and the information provided by prospective homes. Council-funded residents right to choose accommodation of their choice is discussed first.

3.4.3.1 Right to a choice of home

Older people whose care is being arranged by local authorities have the statutory right to be placed in a care home of their choice in the UK (Department of Health, 1992; Department of Health, 2004a). This right has always been subject to certain conditions:

- The individual expresses their preference;
- The preferred home is suitable in relation to their assessed needs;
- The accommodation is available; the home will meet the councils' usual terms and conditions;
- The placement costs no more than the council would normally expect to pay for someone with the same assessed needs.

People can choose to move to a home that is more expensive than usually paid for, if there is a third party willing and able to pay the difference. Guidance also notes that waiting for a place in a preferred home is occasionally inevitable, although people in hospital ready for discharge may have to move to a temporary alternative (Department of Health, 2004a p6). Specific guidance on discharge from hospital states that 'the definition of choice must be qualified by choice of what is suitable and also available' (Department of Health, 2002c p5).

3.4.3.2 Absence of tenancy rights

Care home residents have no formal tenancy rights akin to people living in mainstream rented housing. Tenancy rights, conferred by various laws include protection from threats of eviction, uninvited visits by landlords, threats from other tenants and the prevention of visits from friends. The absence of tenancy rights is a particular characteristic of the historical development of residential care in England. It is linked

to the view that care homes are not associated with the exclusive possession of part of a building (Law Commission, 2003). In 2003 a Private Members' Bill, presented to the House of Commons by Paul Burstow, a Liberal Democrat, attempted to establish tenancy rights to ensure continuity of care when a home is closed. The bill was dropped before its second reading that November.

3.4.3.3 Notice requirement

The length of notice influences the extent to which a closure can be managed. Since April 2002 providers have a legal obligation to cancel their registration with the national regulator three months in advance (The National Care Standards Commission (Registration) Regulations 2001, Part V Regulation 15). They should then notify service users, their representatives and the local council no more than seven days later. Notice periods should also be specified in residents' written contracts (Department of Health, 2003b). When a home is closed due to financial difficulties or bankruptcy, three months is unlikely to be practicable but a reduced period might restrict the options available to current residents and their families.

The eviction of an individual resident, as opposed to de-registration of a home, is regulated separately under the Care Homes Regulations (2001). These state that the registered person shall not terminate an individual's accommodation without giving reasonable notice of his intention to do so.

3.4.3.4 Residents' rights when living in local authority run homes

Residents of local authority run homes are likely to be in a relatively stronger position during a closure than those in independent homes because case law judgements have established that councils have a duty to consult permanent residents about the possibilities of a closure (R v Devon County Council ex parte Baker and Durham County Council ex parte Curtis and Others, 1995 cited in Age Concern, 2002b). Council-run closures therefore tend to occur over longer periods and councils are likely to be more responsive than private providers to local campaigns and media pressure. Age Concern recommended that councils set up independent complaints review panels to investigate complaints, claims and risks posed by council closure decisions as a matter of good practice (Age Concern, 2002b). However, it also raised the importance of establishing exactly the date a closure decision was made by a council since any

challenge taken to the level of judicial review must be done so within three months of the decision

3.4.3.5 Providers subject to information requirements

From January 2002 care home owners have been obliged to provide various pieces of information to help people choose an appropriate home. These include: a statement of purpose, which includes the facilities and services provided; a service user's guide to the home, which includes the terms and conditions (including the amount and method of payment of fees); and the most recent inspection report.

The National Minimum Standards include some good practice recommendations around the format and content of this information but they are not enforceable (Spoerer, 2002; Department of Health, 2003b; The Care Homes (Amendement No. 2) Regulations 2003). Inspection reports are publicly available from the national regulatory body. There is no requirement to date, however, to make sure these are written in a way that is accessible to a lay reader.

3.5 The Human Rights Act and independent care home closures

Within public policy the focus on human rights has been relatively new given that the Human Rights Act was enacted in 1998, and came into force on 2nd October 2000. The Human Rights Act 1998 incorporated the European Convention of Human Rights (ECHR) into UK law and thereby provided a route for individuals to seek redress within the domestic legal system by bringing breaches of the ECHR to UK courts. The UK has been signed up to the ECHR since 1951 and the Council of Europe adopted it in 1950.

The Human Rights Act includes a number of provisions of particular relevance to care homes for older people, some of which have been interpreted as strengthening rights of access to social care. Provisions of particular relevance to care home closures include:

- Article 2: the right to life
- Article 3: the right not to be subject to inhuman or degrading treatment
- Article 6 (i): The right to a fair and public hearing within a reasonable time by an independent and impartial tribunal

- Article 8: the right to respect for private and family life, home and correspondence, although Article 8 (2) states that this must be balanced against the rights of others, and might be overridden in a number of circumstances.

The Human Rights Act has been drawn on in legal cases concerning care home closure, some brought by residents. Article 8 has been raised in relation to arguments about expectations of a 'Home for Life'. Article 2 has been drawn on in relation to the risk posed by closures to residents' health. Article 6 has been used 'to support demands for transparent and rational decision making and for procedures that enable people to make representations or complaints regarding decisions.' (For a review of some of the legal cases see Age Concern and The National Council on Ageing, 2002 p5).

In what became a critical case, long-term publicly-funded residents of a care home for people with learning disabilities, run by the voluntary sector housing association the Leonard Cheshire Foundation (LCF), fought against a home closure and relocation to community based units using section 6(3) of the HRA. Their case was dismissed and the court of appeal upheld the dismissal on the grounds that Leonard Cheshire did not constitute a public body and so did not fall within the remit of the HRA (R v Leonard Cheshire Foundation, 2002).

Subsequently, and despite pressure from the British Institute of Human Rights (BIHR), case law has re-confirmed that private care homes, where local authorities place residents, do not exercise functions of the state, and are therefore not a public authority.

Other challenges against councils' decisions to close care homes, were brought to court but later dropped. For example, three legal challenges to Lancashire County Council's decision to close 32 of its 48 care homes were withdrawn when the council agreed to include a medical assessment of the risk of transfer in residents' assessments and to consider postponing transfers until any risk could be minimised or managed (Lancashire County Council and Chorley Borough Council, 2003). Yet, a previous judgement said that assessments of need should take place before the decision to close is made (Community Care, 2001). Clearly the timing of such risk assessments influences what they might affect: if conducted before the decision is made they could conceivably be

used to prevent or postpone a closure; if conducted after the decision to close such assessments can only inform the choice of alternative accommodation and possibly the way in which the process is managed.

Section 6 of the Human Rights Act (HRA) places duties on public authorities to ensure policies, procedures and practices are compatible with the ECHR. Independent sector care homes and their residents have been excluded from the HRA because it does not clearly define public authority, or their positive obligations. The Act does not provide a list of public authorities. Section 6 merely states that public authorities include 'any person certain of whose functions are functions of a public nature.'

The specific meaning of 'public authority' has been the subject of considerable argument based on interpretation of the ECHR, as well as contested in UK case law. The current situation, upheld by the Law Lords judgement, is that the housing and care provided to the residents of such homes are a private matter between them and the private providers and not part of the public system. However, while the House of Lords decided, in a narrow majority of three to two, that private care homes do not perform a public function, the relevance of existing common law or other protections for care home residents was much debated and even those who voted against noted that it might be desirable for residents in privately owned care homes to be given Convention rights and that it be made clear whether such rights would be 'enjoyed by all residents of such care homes, or only certain classes (e.g. those whose care and accommodation is wholly or partly funded by a local authority)' (House of Lords, 2007). Press reports in the summer and autumn of 2007 stated that the government was about to act to close the 'loophole' created by court rulings and bring independent care homes within the remit of the Human Rights Act (Morris, 2007; Thomson and Sylvester, 2007).

3.6 Care home closures in other countries

Care home closures occur in other countries and examples of greater regulation of the closure process exist. Literature from the United States gives some idea of the scope of the problem and the nature of potential alternative policy responses. In the late 1990s and early 2000s concerns were raised about nursing home bankruptcies in the United States. National data suggested that between 1992 and 2000, 8.7 per cent of nursing

homes voluntarily closed and 2.4 per cent closed involuntarily (Angelelli et al., 2002). The likelihood of both types of closure was linked to deficiencies in the standards of care provided as well as low occupancy. In California, between 1995 and 2001 over two thousand nursing home places were lost due to the closure of 32 homes. Public concern was raised by two cases of sudden closure and the considerable costs incurred by the state from providing temporary management at three facilities, one of which closed. This amounted to over $2 million in 2001.

However, such public and official anxieties could be balanced against the wider context of spare capacity overall within the care system in California and the knowledge that the closures were generally linked to poor quality performance (Kitchener et al., 2002; Kitchener et al., 2004). Kitchener and colleagues recommended that states should consider requiring nursing home providers to keep a bond for use in the event of sudden closure. They also noted that an 'early warning system' style of monitoring was recommended by the Institute of Medicine in 2001, and being developed in Florida (Kitchener et al., 2004). Other recommendations included that owners be required to declare bankruptcy status when applying to renew their licenses, to enable consumers, and relatives to identify whether individual homes are in bankruptcy.

The nature of the care home market in the United States differs considerably to that in England in terms of the size and corporate nature of provision and it may be that such structural features underpin the motivation and implementation of greater regulation of closures. Over half of the nursing homes for older people in the Unites States are part of large organisations. Some are multinational corporations, which operate homes in the UK and Europe as well as the US. The largest provide tens of thousands of places in the US alone (Harrington, 2001). State agencies license and inspect nursing homes that have contracts with the federal government against federal regulations and standards. Intermediate sanctions for non-compliance include fines, refusal to pay for newly admitted residents, and the power to bring in external managers (Harrington, 2001). Inspection and enforcement are conducted by state survey agencies. State variation in performance has been attributed to differences in levels of resources, a lack of central support and oversight from federal government and the overall low level of funding. In 2000, total state agency expenditure on the regulation of nursing homes was

found to be less than one per cent of the total expenditure on nursing homes (Walshe and Harrington, 2002).

In the United States providers must record the reason for transferring residents in their clinical record and include in notification of closure the name of the responsible protective agency, residents' right to appeal and the date by which they have to leave (Nursing Home Reform Act, 1987: 42CFR483.12). Different closure notice periods are specified within different states. Federal law states that a resident of a nursing home, and their family, or guardian, has the legal right to at least 30 days notice of an involuntary transfer or discharge (Nursing Home Reform Act 1987: s. 483.12), but some state laws require longer notice periods. In Washington, for example, the licensee of a nursing home must give written notice of closure sixty days in advance (Washington Administrative Code: Chapter 388-97 Nursing Homes).

3.7 Summary

Long-term care in England is characterised by independent sector provision, largely commissioned and funded by local authority social services departments. Individuals, both those funded by the state, and those who are self-funded can 'choose' homes and in theory providers respond to this consumer choice and competition for custom by providing high quality, effective and efficient services. Theories about consumer behaviour, competition, quality and effectiveness in the care home market are qualified by a number of factors, including features of the 'quasi' nature of the care home market, ongoing concerns about the quality of care homes, and factors that limited or qualified older people's power, ability or willingness to act as competent consumers.

Councils have various duties and obligations towards older people with long-term social care needs. These include a duty to assess people's needs, although not a duty to provide care, a general and somewhat ill-defined duty of care and a duty of protection, an obligation to provide fair access to social care services and to secure high quality services, while supporting service users' choice and control.

Recent policies have focused on introducing national regulation and supporting people to live at home and actively avoid or put-off moving into long-term residential care settings. At the same time as the care home industry was being registered and inspected against national regulations and standards, there were considerable developments in the regulation of the social care workforce, including the creation of several new national bodies to oversee professional registration, the promotion of codes of practice, staff checks and training and good practice communication.

There is no national legislation or guidance on how councils may help to manage the relocation of older people from care homes that close voluntarily in the independent sector. In the absence of clear and specific guidance, it is necessary to identify and review wider legislation and policy of relevance to care home closures. The legal framework suggests that councils have an obligation to assess publicly-funded residents' needs and to offer to assess self-funded residents' needs before they move. Prospective receiving homes should assess self-funded residents' needs. There is a 'loophole', however, whereby councils have the power to arrange placements without an assessment if the move is considered urgent.

Considerable good practice guidance is available around how local authorities should approach assessment with the aim of promoting a coherent and effective person centred approach. Guidance also suggests that care managers should offer information, help and support to care home residents and their families during a voluntary home closure. In terms of reviewing residents once they have moved it appears that councils are only obliged to monitor those who are publicly-funded and to do so within three months. Councils have the option of conducting reviews on request.

One might expect the regulator to play a part in how care homes close as part of their monitoring of standards of care, adult protection function or policing role. The regulatory framework, however appears to focus on providers' obligations, rather than also on what the regulator might do. They state that care home providers should 'apply' to the regulator to close, and give three months notice of their intention to do so. The new regulations confer on 'receiving' homes certain obligations around information provision of relevance to those looking for a new care home during a closure.

Residents' rights may be inferred from their rights in general when moving to a care home: the right to a choice of home; and the right to visit homes. Some general good practice recommendations were found in relation to care home staff practices when welcoming new residents. When closing their own homes case law confers on councils an obligation to consult permanent residents about any decision to close and make clear specifications about the nature of any such consultation.

A number of provisions within the Human Rights Act have been drawn on in numerous high profile legal challenges against care home closures and involuntary relocation. A key issue is whether the Human Rights Act covers care home residents living in independent care homes. Case law has concluded that independent care homes are excluded from the HRA because they do not constitute a 'public authority'.

Voluntary closure by independent sector providers occurs in other countries. In America, the nature of provision, particularly the predominance of multinational corporations in contrast to small single businesses, and the established rights based approach appears to have resulted in a very different relationship between statutory agencies and providers. For example, a collaborative and proactive approach is evident in California where the state actively adopts a role of looking for new operators to prevent closures occurring.

Chapter 4

Review of the research literature

4.1 Introduction

This chapter reviews the research literatures relevant to care home closures in England. There are a number of areas of literature of relevance, although little that focuses directly on the process of closure. The chapter begins with a review of the research on the number and causes of home closures in England and the type of home that close before reporting available findings about the closure process. This work includes information about the closure process from the perspective of regulators and providers and a review of good practice recommendations, which are not always evidence based. Much of the research relevant to closures focuses on the consequences of closures and the fifth section identifies consequences for the supply of care homes, as well as what is known about the consequences of relocation for residents and staff and providers. Section six highlights work on factors identified as influencing resident outcomes after moves between care homes because of their potential relevance to moves necessitated by home closure.

Research on the elements of moving to a care home for the first time that are relevant to relocation between homes is then reviewed, before work on the circumstances of other types of transfers between care homes. Moving to a care home for the first time covers many issues and processes likely to be relevant to relocation due to closure because some of the activities and processes involved may be similar. These include the circumstances of initial moves to residential care, including the timing, reasons and degree to which such moves may be considered voluntary, the choice of care home, and the meaning and consequences of moving to residential care for older people and their relatives[1].

Work has been conducted on other types of closures, such as the closure of hospitals in

[1] Some of this literature review has been published previously as part of a literature assessment conducted for the Office of Fair Trading. For publication details see list of Publications and Presentations at the start of the thesis.

the 1980s (Korman and Glennerster, 1985; Korman and Glennerster, 1990). This work is not reviewed in-depth because although it sought to understand process activities from the viewpoint of those involved the situation of hospital closure differs considerably to that of care home closure by independent sector providers, for example in terms of the powers, roles, responsibilities, and degrees of planning possible by health authorities and social services departments in relation to the redeployment of staff and provision of consultation (Chapter 3 highlighted the existence of more detailed guidance for the closure of hospitals and wards and contrasted this with the guidance related to independent care home closures).

Research was identified via bibliographic searches of research databases and reviews of references in the publications found. These included the Social Science Citation Index, PsychInfo, PsycArticles, Applied Social Science Index and Abstracts, Westlaw UK, Caredata (National Institute for Social Work), and AgeInfo (Centre for Policy on Ageing) databases. Keywords used included care or nursing or residential home(s), older or elderly people, closure or relocation or move(ing) or transfer or transition, choice or decision, admission or placement, and adjustment.

4.2 The prevalence and causes of care home closures

This section presents the research evidence about the prevalence and causes of care home closures.

4.2.1 Number of home closures

Prior to the introduction of national regulation there was no routine data on the number of care homes closures nationally. Transfers between homes due to home closures were not counted in councils' routine data returns to the Department of Health (Department of Health, 2004) and even if they had been, they would have excluded the transfer of self-funded residents. A survey of Registration and Inspection Units in 2001 found that, in the year ending March 2001, 5 per cent of care homes in England closed, with rates varying regionally between 3 to 7 per cent (Netten *et al.*, 2002). For the 15-month period January 2002 to April 2003, which includes the period of fieldwork, the market analysts, Laing & Buisson, reported the closure of 745 homes for older and physically

disabled people (Laing & Buisson, 2003). This represented a loss of about 15,000 places. The introduction of a national regulation of social care (highlighted in Chapter 3) meant that data began to be collected on a national level on a more consistent and regular basis and this showed that de-registrations continued to be a feature of the market. The National Care Standards Commission reported 2,160 de-registrations of care homes for older people for the 18-month period between April 2002 and October 2003 (Dalley et al., 2004). The reasons for closure were not provided, but it was clear that most were voluntary since only 26 enforced closures were reported[2]. By the year ending April 2006, the closure rate had dropped, however, Laing and Buisson reported that 323 for-profit and not-for-profit care homes for older people and physically disabled people closed, which represented the loss of nearly 7,500 places (Laing & Buisson, 2006).

4.2.2 Causes of closure

A survey of Registration and Inspection units (R&I units) in England asked R&I unit managers or inspectors to indicate whether recent home closures resulted from business failure, enforcement action, or other reasons (Netten et al., 2002).[3] Inspectors attributed 46 per cent of the independent residential home closures, and 58 per cent of the nursing home closures during 2000-2001 to business failure.

When asked to identify general issues associated with closures in their area from a list of potential factors, the R&I unit managers emphasised local authority pricing policies, and staff recruitment problems. Local authority pricing policies, for example, were identified most frequently as a factor associated with closures in their area by the local authority units (66 per cent) and as the second most commonly cited factor by the health

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[2] Unfortunately, the number of enforced closures were not found in subsequent annual reports Commission for Social Care Inspection (2005) *The state of social care in England 2004-05*, Commission for Social Care Inspection, London, Commission for Social Care Inspection (2006) *The state of social care in England 2005-06* Commission for Social Care Inspection, London..

[3] The author was involved in a number of investigations immediately before this study that investigated the causes, scale and consequences of independent care home closures, as highlighted in the Preface Netten, A., Darton, R. and Williams, J. (2002) *The Rate, Causes and Consequences of Home Closures*, PSSRU Discussion Paper 1741/2, Personal Social Services Research Unit, University of Kent at Canterbury, Canterbury, Williams, J., Netten, A., Hardy, B., Matosevice, T. and Ware, P. (2002) *Care Home Closures: The Provider Perspective, Discussion Paper 1753/2*, Personal Social Services Research Unit, University of Kent, Canterbury, Netten, A., Darton, R. and Williams, J. (2003) Nursing home closures: effects on capacity and reasons for closure, *Age and Ageing*, **32**, 3, 332-337, Netten, A., Williams, J. and Darton, R. (2005) Care-home closures in England: causes and implications, *Ageing and Society*, **25**, 3, 319-338..

authority units (72 per cent). Overall, the inspectors linked to health authority units most frequently (81 per cent) cited a shortage of nurses of as a factor influencing local nursing home closures. Oversupply of homes in the area was also identified by one-third of the inspectors in relation to residential home closures and by one fifth in relation to nursing home closures.

Follow-up interviews with a sub-sample of inspectors found that when asked to specify the main reason for the two most recent closures in their area (69 closures) the emphasis differed, with inspectors typically indicating financial reasons (identified for one-quarter of the closures), personal circumstances (also identified for one-quarter of the closures), and factors related to existing care standards and the forthcoming national minimum standards (Netten et al., 2002). Change in personal circumstances, staff retention problems, low local authority fee levels, and low demand/occupancy levels were also frequently identified as contributing factors. The financial reasons described included foreclosure by the bank, the refusal of a loan, and a lack of financial viability in general. Many of the financial reasons were inter-connected. The refusal of a loan, for example, could be linked to the perceived need to invest in improvements to meet the anticipated national minimum standards. Other reasons could also be linked to financial issues, including costs associated with running a care home such as staff costs, and the anticipated costs of meeting the new national minimum standards, particularly the physical environment standards. Other problematic financial factors pointed to by inspectors included low occupancy rates, local authority contracting arrangements and fee levels and the value of the premises if sold (the introduction of the National Minimum Standards is discussed in detail in Chapter 4).

A linked study explored independent care home providers' views about their reasons for recently closing a home (Williams et al., 2002). The great majority of those interviewed (n=20) reported having closed to avoid further losses, or because the financial return on the business was now inadequate, or expected to become so in the near future. The main factors leading to closures identified from a list of potential factors were local authority pricing policies, care standards, the type and level of demand, staffing problems, the property market and the commissioning and regulatory environment. Factors typically identified as decisive were the cost implications of the national minimum standards and local authority prices not covering costs. Recruitment and

retention problems were identified as background factors which contributed to their decision to close (Netten et al., 2005). Few described a decisive event or moment, but catalysts did appear to have existed in the form of sudden or unpredicted changes in circumstances. These included the loss of a key member of staff, drops in occupancy, the opportunity to sell provided by high property prices, and having 'had enough'.

It was possible to compare providers' perspective on the reasons for closure with the view of the R&I unit managers in seven cases. This highlighted a difference in emphasis and, in a few cases, indicated that there might have been issues that providers were unlikely to discuss. In one case where a provider reported a lack of demand, it was apparent from information from the regulator that they had concerns about the quality of care. The council was probably aware of these concerns and might have avoided using the home, which in turn would have contributed to the lack of demand identified by the provider. In two further cases the R&I respondents reported outstanding compliance notices, which again suggested that there were concerns about the quality of care.

4.3 Types of home that close

Research shows that homes that closed in the year ending March 2001 were smaller than the national average, and less likely to be part of a chain than homes nationally (Netten et al, 2002). In terms of quality, there is evidence to suggest that homes that close include 'good' quality homes, and that good quality homes have closed voluntarily, more often than poor quality homes. When asked to rate the quality of care provided at the two most recent homes that closed R&I unit managers rated 61 per cent as good or OK, and less than 19 per cent as having provided poor quality of care (Netten et al., 2002). This suggests that their exit was *unlikely* to have resulted from the market mechanism promoting the survival of good quality homes and the closure of poor quality homes due to a lack of demand; good quality home closures suggest that closures were resulting from something other than the market mechanism

Comparison of the characteristics of homes that closed between 1996 and 2001, with those that remained open, found that closed homes tended to be smaller than the

national average, less likely to be part of a chain, and more likely to be in converted premises, with lower occupancy rates than those that remained open and associated with a positive social climate (Darton, 2004). Another study (Darton et al., 2003) investigating the social climate of homes found that those with a more positive social environment were smaller, had lower occupancy rates and were in converted premises, 'exactly the types of home most likely to have closed' (Darton, 2004 p261).

4.4 The home closure process

There is little research literature on the care home closure process. No published research was found that deals directly with the way in which independent care homes are closed, or the consequences from the perspective of residents, relatives, or care staff employed by closing homes. The following findings about process issues identified in regulators' and providers' accounts of home closure are from research that the author contributed to and which directly preceded and informed the work of the thesis (as described in the Preface). Interviews with home owners and managers which focused on the reasons for closure (reported in Section 4.2.2 above), also identified some interesting information about the process from their perspective, which have implications for the way(s) in which a closure might be managed or regulated, such as the possible scope for planning and forwarding of residents' care plans and for forewarning families about the possibility of closure. This section also reports findings from a telephone survey of Registration and Inspection (R&I) Unit managers (also identified in Section 4.2.2), which included several process related questions about the two most recent voluntary independent sector closures that occurred in respondents' areas.

4.4.1 Regulators' experiences

Interviews with inspectors identified the length of notice given to R&I units, and inspectors' perceptions of whether closures were planned, ran smoothly or were well managed (Netten et al., 2002). The findings suggest that compliance with the new requirement for three months notice to the regulator, which came into effect on the 1st April 2002 (The National Care Standards Commission (Registration) Regulations 2001, Regulation 15), would represent a considerable break with the recent past for providers

(see Chapter 5 for details of the notice requirement).

The inspectors' recent experience was that one month's notice was typical, although twelve recently closed homes had given three month's notice and five longer still, ranging from four months to a year. There was evidence too of the other extreme, homes having given less than one month's notice. Seven homes gave only 14 days notice or less, and three had given notice of one week or less (Netten et al., 2002; Williams et al., 2002; Netten et al., 2003). There was one case where the regulator received no notice and where residents were moved in the middle of the night to a sister home belonging to the same owner. A couple of inspectors offered explanations as to why providers did not give more than four weeks notice and suggested that it was beyond owners' control: longer notice periods would lead to 'staff drift' and some had to pay bonuses to persuade staff to 'stay on'.

Inspectors examples of well-planned closures or closures they considered to have gone 'well' drew on a variety of issues, and did not necessarily include reference to the degree of planning:

- Residents were given a range of homes to choose from;
- There was a protocol in place;
- Communication was good;
- There were few residents to relocate;
- Relocation was easy due to over-capacity in the area;
- Many of the residents moved to another home owned by the same owners.

Inspectors sometimes described closures as having gone well because they were relatively unproblematic or effortless, rather than particularly well-executed in terms of process or outcomes. Somewhat worryingly the ease or difficulty of finding placements could be cited both as an example of a poorly-managed closure and a well-managed one; the relocation of large groups to the same home could indicate that too little attention had been given to ensuring placements were found in homes that would meet individuals' needs. A closure could be said to have gone well in some respects while still having negative consequences for residents: 'Relocation of residents went OK, although some patients were quite traumatised by the move' (Registration and

Inspection Unit manager, unpublished findings. For description of study see Netten et al., 2005).

Inspectors identified some process related problems: deterioration in service quality; non-payment of care home staff; and residents and relatives experiencing difficulties when collecting personal possessions and money.

4.4.2 Providers' accounts of closure

Interviews with independent providers about their reasons for closure provide some insight into the closure process from the provider perspective (Williams et al., 2002). For example, some owners reported spending considerable time, including a year or as much as five years, on the decision to close. One provider reported having attempted to sell the business as a going concern for over two years before closing. However, once a decision had been made, closures could occur very quickly: one nursing home closed only two weeks after the decision was made and three others within four to six weeks. This research highlighted other process related issues, which have not been published to date. These include provider reports about having sought advice about closure, the timing and order in which they gave notification, their involvement in the relocation of residents, and their views about how the process might be improved.

Seeking advice about the process of closure was relatively uncommon among the 20 participating providers: about half said they had approached one, two or three organisations for advice; five reported talking to business advisors or council commissioning departments and three mentioned approaching Registration and Inspection Units; other contacts approached less frequently included care managers, the National Care Homes Association, and a legal Helpline for advice about staff redundancy. Advice sought included ways to minimize the impact of the closure on residents, and of finding appropriate new placements. Some providers said the advice was helpful, but others said it was of little help.

Reports of arrangement of support to help oversee the management of the closure varied and support often appeared to be minimal, for example a phone call from social services to see how the home was getting on, followed by help from a care manager to find new accommodation for one resident, or the appointment of a 'closure co-ordinator' within a

home, or the appointment of a team leader by the social services department. There was one report of the appointment of a task group by a council.

Providers' accounts of giving notification of closure showed variation in timing and order in terms of who was told: just over half reported telling either their staff, or the R&I unit or local authority first; just under half reported notifying relatives, residents, staff and the R&I unit or the local authority at the same time, or within a week or so; a couple of owners reported telling staff first, one twelve months before notifying residents; five said they told the R&I unit and local authority between one and six months before anyone else; two reported telling the R&I unit and home staff at the same time but sooner than they told the residents; and one provider said he told staff and residents before informing the R&I unit. One provider said he did not tell staff 'too soon' because of a concern that they would leave before all the residents were relocated.

About three-quarters of the providers reported the time relocation took and of these the majority said it took less than six weeks. Several noted that some relatives made plans to move residents immediately. Providers' reported a range of reactions to notification amongst residents and relatives, including distress, shock, sadness, disappointment, sympathy, and anger.

Just over half of the providers reported managing the relocation of residents themselves and said they identified vacancies, for example by phoning around homes, and matched residents to vacancies. Of these only a few noted that families or a general practitioner were helpful. Three providers said residents moved to vacancies in sister homes. In contrast, four providers said the social services department mainly managed the relocation process. Only two providers described a partnership approach, where the management of the relocation was shared between home staff, social workers and families. One provider noted that close involvement in finding new placements was inappropriate for providers because it would lead them open to criticism if they placement 'broke down', or the new home closed.

Ten providers commented on how the closure process might be improved and of these about half said nothing would have made it easier for them, or the closure had gone well and so by implication nothing needed improving. Three, however, highlighted that they

would have found it helpful if social services had done more. Examples of what would have been helpful included being notified that residents no longer had designated care managers, a central help point for families, transport to take residents to their new accommodation and social services taking more responsibility in general. One owner recommended that providers ensure they take control of the process, even though the local authority would want to be seen to be in charge. Suggestions as to how to improve the process for residents included 'proper' follow-up by social services and more choice of homes.

4.4.3 Existing good practice recommendations

Very few evidence-based recommendations for care home closure and relocation were found, and they rarely covered the actions of all likely participants. Some practice recommendations were found for care staff. Other practice recommendations found which are likely to be of relevance relate to the closure of local authority run care homes and the relocation of sheltered housing residents. A professional handbook for social care staff working with all user groups in a variety of settings, including residential, day, domiciliary and community care emphasizes careful planning, provision for the support and involvement of staff, residents and relatives, a charter of rights for service users to promote informed choice and involvement, the retention, ideally, of a full complement of existing staff, and a time-scale of two to six months (Leonard Cheshire and Social Care Association, undated). It also warns against allowing closures to 'slide into unstructured winding down' (p 10).

Lane (1987) provides some of the earliest relevant commentary in relation to the closure of local authority run homes, suggesting that all individuals, staff and residents should be encouraged to avoid panic inspired precipitate moves during the countdown to closure, and that ideally a target of not less than three months and not more than six months should be set.

Good practice guidelines about relocating sheltered housing residents identify the need to ensure that consultation is effective: guidelines suggest that consultation should provide residents with 'an opportunity to influence the eventual outcome of the decision making' (Age Concern England undated: 11). Although there is no legal definition of what consultation in this context should comprise, sheltered housing residents do have a

legal right to be consulted when moving involuntarily. This contrasts with the position of residential home residents who have no legal right to consultation (Care home residents' rights are discussed in Chapter 4).

There is evidence to suggest that residents with cognitive deficits should be included in any resident preparation before a move, such as counseling: except for those with severe impairments, residents with dementia can recall factual information, and express appropriate emotional responses (Dickinson 1996). A need for better understanding of how pre and post-relocation preparation might benefit residents and staff has been highlighted in relation to the relocation of older people from the NHS to the independent sector (Lee, 1998).

In his review of good practice guidance for home closure Woolham (2001) highlighted the limited nature of the evidence base, and a focus within recommendations on a need to minimise resident disruption and distress, familiarise residents with their new care setting, and provide continuity. Specific recommendations from this literature identify the need to:

- identify and attend to residents who are predisposed to stress and show signs of stress after the closure announcement;
- prepare residents via discussions and visits to their new home;
- allow a time-scale of three months;
- minimise the degree of environmental change;
- ensure the transfer of resident information;
- support the care staff;
- move staff and residents together where possible, and if not, have a key worker from the new home visit beforehand;
- ensure residents are accompanied by someone familiar on the day of the move.

The importance of early notification to support choice has been emphasized, 'Six months to a year is not too long for many residents to be able to retain the information' (Amenta et al 1984: 360).

Staff retention, communication and timescale have also been identified as central issues

in a study which compared four models of temporary relocation due to refurbishment (Wyld et al 2002). The least problematic alternatives were found to be to let residents stay put during a refurbishment, or to move every resident to a newly built home. The objectives of increasing residents' familiarity with a new facility, minimising residents' stress, and staff preparation were also pursued in a Canadian study, which recommended that planning and outcomes benefit from evaluation (Grant 1997). The benefits are said to include:

- accountability information;
- specific and measurable goals, objectives and activities;
- practical information that can be drawn on by others.
- If implemented routinely, evaluation information about resident outcomes might also be compared across home closures, by resident characteristics, and closure procedures and processes.

Box 4.1 summarises the activities, objectives and considerations found in the guidance literature; most are aspirational in character and there are clear gaps as to how actions should be implemented.

Box.4.1: Good practice literature recommendations, objectives and considerations during home closures

Aims and objectives	***Actions and issues***
Promote resident and relative involvement	Consult
Preparation	Notify
Maintain ongoing care Provide continuity of care	Retain existing staff
Minimise resident stress and distress Promote understanding Promote predictability and support choice Protect choice and decision-making	Prepare residents, for example via: • Ongoing discussions • Counselling • Visits to new home • Charter of Rights How might residents with dementia be supported?
Promote sense of control and decision making and minimise stress	Support and involve staff
Ensure new accommodation is suitable	Assess residents' needs
Promote sense of control and decision-making	Involve residents in finding new homes
Respect personal and social needs	Consider protecting friendship groups
Provide support Avoid problematic days or times of day	Ensure residents are accompanied by someone they know when they move
Support continuity of care	Transfer information about residents
Provide continuity of care	Care staff should have the opportunity to visit residents in new homes
Ensure suitability of placement	Ensure monitoring and follow-up

4.5 The consequences of closures

This section provides an overview of research on the impact of closures on supply, before briefly reviewing the considerable research literature on the consequences of

relocation for care home residents, along with what is known about the consequence for others, such as care home staff and employers/ providers. The types of impact and consequence of closure for people other than residents, such as relatives, carers, and care home staff have been identified as a relatively neglected area (Smith and Crome, 2000), as have types of impact for residents other than mortality or morbidity effects, such as the social consequences of relocation (Castle, 2001).

4.5.1 Consequences of home closure for supply

Research into the number of home closures, new registrations and changes in registration status found that there was an overall loss of capacity across most of England, particularly in the South East and South West between 1999 and 2001 (Netten et al., 2002). The picture was complicated and in some areas, such as London, there were net gains in the number of places. Homes that closed could be smaller than homes that opened. The reduction in places was found to be greatest amongst nursing homes (Netten et al., 2002); the number of nursing homes reduced by 6 per cent and the number of nursing and dual registered placed fell by around 5 per cent in 2000-2001 (Netten et al., 2003).

4.5.2 The impact of relocation on older people

The consequences and impact of the relocation of older people have long been the subject of quantitative research, mostly in the United States and Canada. Empirical research on relocation effects on older people is extensive and complex and includes considerable disagreement and debate. A number of reviews have appraised investigations into various types of relocation, including the relocation of older people from home or hospital to residential care (Mikhail, 1992), the effects of psychiatric hospital closure (Jackson and Whyte, 1998), as well as transfers between residential homes and nursing homes and relocation brought about by home closures (Schulz and Brenner, 1977; Coffman, 1981; Horowitz and Schulz, 1983; Smith and Crome, 2000; Castle, 2001). There is a concern that moves affect older people's morbidity adversely and may cause distress, 'relocation stress syndrome', trauma or death. Effects studied include mortality rates (Pruchno and Resch, 1988; Danermark et al., 1996; Jackson and Whyte, 1998; Aneshensel et al., 2000) and morbidity effects (Danermark et al., 1996), including mobility and fall rates (Friedman et al., 1995), hearing, vision, communication, daily functioning and self-care, and mental health. Debate has centered

around whether relocation causes mortality rates to increase or has any negative effect on residents.

Some studies have found no effect on residents following inter-institutional relocation (Grant, 1992) and others have identified positive outcomes following relocation, including a decrease in mortality rates (For a review see Castle, 2001). An English longitudinal study of care home residents has also reported the unexpected finding of greater survival rate amongst residents who moved to a different type of home or placement (for example from a residential placement to a nursing placement but also vice versa); such residents were more likely to have survived to 42 months than were those residents who did not move between types of home or placement (Bebbington et al., 2001). However, those that moved from a residential placement to a nursing placement were also more likely, than those who remained in a residential placement, to have experience increasingly high dependency levels and to suffer cognitive impairment.

The ambiguity of the relocation literature can be attributed partly to the numerous methodological difficulties encountered when trying to establish causation as well as factors which make it difficult to compare the research evidence, including the use of a variety of measures, small sample sizes, a lack of or ill-matched control groups, and samples biased towards the most healthy residents, due to the exclusion from interviews of older people with cognitive impairment. Some researchers have cautioned that because much of the research is limited by sample bias and findings that do not reach statistical significance, it is better not to reject the hypothesis that relocation does not result in increased mortality (Horowitz and Schulz, 1983). Others have recommended that attention shift towards understanding conditions that are 'causal to an individual's vulnerability to mortality when relocating' (Borup, 1983 p 241). Two reviews of the relocation literature conclude that research which has sought to demonstrate a causal link between involuntary relocation and deterioration in residents' health, well-being or increased mortality is ambiguous and contradictory (Smith and Crome, 2000; Castle, 2001).

4.5.3 Consequences for staff and providers

Very few studies have examined the impact of closures of care homes, or hospitals, on

former staff, so little is known about the nature, force or prevalence of such consequences. However, two American studies have investigated the impact of hospital closure on staff. MacAuslane and Sperlinger (1994) found that nurses who moved to a nursing home with residents relocated from a hospital reported higher levels of satisfaction after the move than before, and that they were more satisfied with certain aspects of their new jobs than their old jobs. However, the findings are limited: the study was a small scale study; the pre-measure was taken close to the time of the move, which was likely to influence levels of anxiety among staff; and the move was considered to be to a 'better quality' and more appropriate environment.

The second study measured the potential physical, psychological and attitudinal impact of the closure of a psychiatric hospital on staff in 1994 (Mesch et al., 1999). After the move staff were less stressed and depressed than when anticipating the closure and reported using more coping strategies but greater pessimism about the future. The finding that they were stressed during the closure may have implications for the ability of care home staff to provide extra support to residents during a closure process.

The study of provider's reasons for closing described earlier provided some insight into the potential consequences of care home closures for providers (Williams et al., 2002). Providers were asked what they did following the closure of their home: four had retired and two were starting a new business venture (such as a Bed and Breakfast) or returning to Higher/Further Education. The majority continued to work in the industry, which suggests that, at least for these providers, the experience was not so negative that they decided to work in a different field altogether. The sample was a voluntary one (although drawn up by the R&I unit managers) and so might have been biased towards providers who were particularly dedicated and had a story to tell; they might have been more likely to continue working in the industry than other owners/managers less inclined to agree to take part in such research.

4.6 Influences on resident outcomes after transfer between homes

Section 4.4.3 reviewed existing good practice recommendations relevant to care home closures and noted that much of it was not linked to research evidence. This section

briefly describes the research on relocation effects that identify factors likely to exert a positive influence on resident outcomes following relocation between care homes. A variety of influences have been explored, including resident characteristics, situational factors and the quality of the new environment (Castle, 2001). Resident characteristics that have been examined include age, gender, health, cognitive status and personality factors such as life satisfaction and coping styles. These studies are not reviewed here in-depth because the focus is on processes and activities that are subject to change within policy and practice during closures, rather than on relocation effects per se or psychological influences on them.

However, it is interesting to note here that situational factors including the timing, duration and voluntary nature of relocation have been highlighted as important. Schulz and Brenner have argued that the perceived predictability and controllability of events, as well as the controllability of the pre and post-relocation environments affect resident outcomes (Schulz and Brenner, 1977). A small-scale American study also attributed the successful transfer of nursing home residents to a larger facility to careful preparation (Amenta et al., 1984). Research which reports an implementation evaluation of a relocation plan in relation to a nursing home relocation that involved residents and staff, usefully highlights some practical difficulties associated with implementing relocation plans, mainly associated with pressures on staff time, but does not report the associated outcomes (Grant, 1997).

The issues of control and the voluntary nature of moves have long been discussed in relation to residents' adaptation to initial admission to a care home, and this is discussed further below in section 4.7.2.

4.7 Moving to a care home for the first time

Given the lack of studies focusing on the specific circumstances and processes involved during a care home closure, it is useful to review what is known about the process of moving when older people move to residential care for the first time. Rather than review this literature in full, the elements of potential relevance to relocation between homes are discussed. Relocation due to home closure is likely to involve activities

which are similar to those that occur when older people move to a care home for the first time, for example the move might represent a similar form of upheaval, involve similar or contrasting circumstances, in terms of the decision to move, the timing and reasons for the move, the choice of care home, and the role of professionals including care managers and care home staff. Other stages have been identified including prior discussion of the option, and the actual placement (Gonyea, 1987 cited in Naleppa, 1996). Evidence about information and advice provision at each stage is highlighted where available.

Considerable research has looked at the experience of moving to a care home from the perspective of those involved. Since the mid-1990s about 12 studies have conducted in-depth interviews with older people and/or their relatives/informal caregivers about processes related to moving to or from care homes (Nolan et al., 1996b; Ryan and Scullion, 2000a; Wright, 2000b; Davies and Nolan, 2003; Reed et al., 2003), with seven involving interviews with thirty or more people (Myers and MacDonald, 1996; Reed et al., 1998b; Hardy et al., 1999; Reed and Morgan, 1999; Davies et al., 2000; Nolan and Dellasega, 2000; Williams et al., 2003).

4.7.1 The circumstances of initial moves to residential care

The move to a care home often occurs at a time of crisis. This is related to two common features, admission via hospital, and a lack of planning or anticipation of the need for such a move. It has long been demonstrated that around half the older people who move to a residential or nursing home do so after having been in hospital (Bebbington et al., 2001; Netten et al., 2001; Laing & Buisson, 2004). These findings from large scale studies are reflected in many smaller studies (Reed et al., 1998b; Davies et al., 2000; Wright, 2000a; Davies and Nolan, 2003; Reed et al., 2003; Stilwell and Kerslake, 2004), often showing that admission from hospital can be associated with relatives feeling pressured and/or that they have to select a home quickly (Davies et al., 2000; Nolan and Dellasega, 2000; Wright, 2000a). Qualitative research also suggests that relatives rarely discuss the move to a care home with older people, and that this contributes to the sense of being unprepared (Nolan and Dellasega, 2000).

Another consequence of being in hospital, perhaps similar to many relocations between homes, is that prospective residents may be physically unable to visit homes themselves

and this can mean the move is very much a 'step in the dark' (Reed and Morgan, 1999). It may also mean they are unable or unwilling to take part in decision-making (Commission for Social Care Inspection, 2004a).

Moving to a care home from hospital is thought to be associated with the least positive type of admission process, the fait accompli. This worst-case scenario is characterised by a lack of anticipation of the need to move to a care home, older people not being involved in the decision to move, a lack of opportunities to discuss alternatives or express and explore emotional reactions, and a lack of information (Nolan et al., 1996b). A small-scale study of older people's experiences of living in a temporary hospital bed concluded that this transitional state led to anxiety, and that the patients might consider themselves as having no future or fear having to start again in an unknown environment (Kydd et al., 2002). Clearly, moving to a care home after such a stay would be the worst 'worst case' scenario.

Given the role that care homes have, it is concerning that some commentators have concluded that in England moving to a home for residential care is viewed as less legitimate than moving to a home for nursing care; there 'appears to be an almost universal antipathy towards residential care (Peace et al., 1997 p41). Much of the literature notes the likely impact of the negative image of residential care on people's lack of anticipation of the possibility of having to move to a home, and the consequent lack of planning and reluctance to choose such a long-term care option (Espejo et al., 1999; Oldman and Quilgars, 1999; Nolan and Dellasega, 2000).

One feature of this negative image is the way in which care homes are contrasted unfavourably with living at home (Oldman and Quilgars, 1999). Some commentators have noted the contribution of government policy and rhetoric towards the negative image of care homes. Sumner (2001), for example, notes that the framework for housing for older people (Department of the Environment Transport and the Regions, 2001) focuses on mainstream housing and almost entirely neglects the 'positive role for residential forms of care as part of this spectrum'. The negative image of care homes is thought to be related to a belief that poor standards of care are provided (Nolan et al., 1996a). A longitudinal cohort study of new users of community-based services, and those experiencing a change in their care package, asked older people how they felt

about the possibility of moving to a home (Davies and Baines, 1994). It found that 29 per cent of the sample of 589 considered a home to be a place to die, or to represent the end or being unwanted. Twenty seven per cent associated care homes with a lack of privacy. An American study of people aged 60 and over living in the community found that 60 per cent 'somewhat' or 'quite' feared moving to a care home and 16 per cent feared it in the extreme and more than half anticipated difficulties maintaining aspects of their quality of life, such as their control, dignity and self-respect (Biedenharn and Normoyle, 1991). These beliefs were held despite 50 per cent of the sample reporting having had good experiences of nursing homes.

4.7.2 Involvement and control during admission

The forced nature of a home closure might not be entirely dissimilar to the experience of moving to a care home for the first time because such moves themselves are often experienced as unwished for and as involving compulsion. Nay (1995) argues that no distinction should be made between voluntary and involuntary moves because every admission to a care home involves factors that are beyond an older person's control.

Numerous studies have concluded that older people and their relatives are rarely involved in the decision to move to long-term care (Allen et al., 1992; Espejo et al., 1999; Davies et al., 2000; Nolan and Dellasega, 2000; Davies and Nolan, 2003). Much of this research is small-scale and does not report the extent to which different people made the decision. Interviews with twelve residents conducted in 2000-2001, however found that only two had positively opted for residential care (Ware et al., 2003).

Research into the assessment process, that included interviews with 16 older people moving to long-term care in 1996, found that participants felt they had no choice but to move due to their situation or needs (Hardy et al., 1999). An earlier study of assessment and care planning conducted in four regions in Scotland found that some service users interpreted a suggestion to move to a care home made by a doctor as final, implying that they did not discuss the decision (Myers and MacDonald, 1996). Another earlier study in England reported that about one-third of the publicly-funded residents interviewed, and a quarter of the self-funded residents, said that someone else had made the decision that they needed to move into residential care (Allen et al., 1992). By 1999, this had increased to 58 per cent among self-funded residents (Netten et al., 2001).

A comparison of relatives' experiences in the UK and United States found that older people were more likely to play an active role in the process in the UK than the US (Nolan and Dellasega, 2000). However, many patients and relatives still complain about being insufficiently involved in decisions to move to a care home (Health Service Ombudsman for England, 2003), and across many countries the choice is frequently 'expert driven' (Office of Fair Trading, 1998; Nolan and Dellasega, 2000; Davies and Nolan, 2003) or influenced by professionals (Reinardy, 1992; Myers and MacDonald, 1996; Hardy et al., 1999; Tanner, 2003).

Four main types of admission process have been identified: the positive choice; the rationalised alternative; the discredited option; the fait accompli (Nolan et al., 1996b). This typology has been drawn on by others working in the field (Davies et al., 2000) and resonates with findings about relatives' experiences reported here (see Chapter 8). Research has highlighted that identifying who made a decision to move to a care home and whether choice was supported are complex issues. A study that involved interviews with older people and care managers, and an audit of case notes found that only one of the 15 older people, or their relatives, said that they were the one to suggest moving to a care home, and yet the case notes or care managers attributed each of these 15 decisions to the service user or their relative (Stilwell and Kerslake, 2004). Relatives might distance themselves from the decision and say it was a hospital doctor or General Practitioner (Ryan and Scullion, 2000b). Qualitative evidence also confirms a theory that older people may sometimes prefer others to make choices on their behalf (Hardy et al., 1999).

Research published in 1997 concluded that relatives and carers have to make difficult decisions about care home placement in the context of numerous uncertainties and concerns, which span the process of moving in:

- 'Lack of familiarity with the care options available;
- Not knowing how to find a suitable home;
- Not knowing how to evaluate a home;
- Concerns about the quality of care;
- Concerns about finances;

- Lack of support systems.' (Dellasega and Nolan, 1997 p445).

Research on the influence of control on older people's well-being following relocation to a care home dates back to the 1970s and Schulz's (1976) influential experiment. He found that visits by undergraduates that were either controllable or predictable were associated with positive effects on the well-being of institutionalized older people. From this it could be extrapolated that older people experiencing increased unpredictability and lack of control may experience relatively more psychological, and possibly physical, deterioration than those able to maintain a more predictable and controllable environment.

The way in which an older person has control over how they move into a care home is thought to influence, and be a part of their process of adjustment. Chenitz (1983) is widely cited in the UK literature, arguing that acceptance of the move to a care home is shaped by an older person's view of their control during the process. In turn, their sense of control and acceptance is influenced by the move being seen as important, as desirable, for legitimate reasons and for a short time. Espejo and colleagues (1999), who identify six types of acceptance, use a similar typology to Chenitz: positive, pragmatic, passive, worried, reluctant and a lack of acceptance. The researchers found the degree of acceptance or rejection was linked to the process; those who were ambivalent or reluctant were found to have had little control or autonomy over the situation and those who had been allowed to come to the decision themselves and who had been given emotional support were more likely to accept it.

Drawing on the work of Collopy (1988), Nolan and colleagues (1996a) argue that while older people may not be able to carry out actions based on their decisions, their ability to make decisions should be supported. They suggest that it is useful to think of autonomy as a continuum; it may be direct, consultative, joint, delegated, or handed over to a third party. Boyle (2004) argues that while *Caring for People* (Department of Health, 1990), emphasised the importance of choice and control, it failed to advance the need for staff and relatives to support older people's decisional autonomy.

This notion of control links five further studies. Smider and colleagues (1996) found

that the difficulty of moving into a care home may be buffered by the older person's psychological resources, such as environmental mastery and sense of autonomy before the move, but that for those with lower psychological resources the contextual characteristics of a move could be particularly important for adaptation. Moves experienced as difficult were associated with higher than expected feelings of aggravation afterwards.

A longitudinal study of 50 residents admitted to a nursing home in British Columbia investigated the effects of perceived control over the decision to move on physical health and morale (Davidson and O'Connor, 1990). It concluded that perceived control over the relocation decision had short-term benefits but longer-term disadvantages, as it was associated with negative effects on health and morale between the second and fourth months. They suggest that this negative effect may be due to residents having moved to an environment where they had little privacy or control over their daily lives. Acceptance was found to have positive effects on health and morale in the medium term and was thought to be linked to coping. Relatives also appear to find the transition easier if they find the home acceptable (Morgan and Zimmerman, 1990 cited in; Naleppa, 1996).

Another large-scale study of newly admitted residents to a nursing home in the US found links between decisional control and adjustment and well-being (Reinardy, 1992). 59 per cent of the sample reported not having made the decision to move to a care home. Those who were not looking forward to the move were also most likely to have not made the decision. Those who felt they had taken part in the decision to move experienced positive changes in their activities of daily living abilities.

Some distinguish between whether the decision to move to residential care was made, reached or merely accepted. Allen and colleagues (1992) found that two-thirds of their sample said that they had ultimately made the decision, but 68 per cent still reported that they had insufficient control over the decision. The Office of Fair Trading also found just 40 per cent of residents reported having had a choice about moving into a care home (Office of Fair Trading, 1998). Reluctant acceptance was described by ten of twelve residents who described feeling they had little choice but to move to residential care as recently as 2000-2001 (Ware et al., 2003). This may have been related to their

health care needs.

4.7.3 Choice and selection of individual homes

Evidence about whether older people have a choice of individual care home is similar to that about their involvement in the decision to move to residential care, and is of relevance when looking for a home because of closure. The consensus appears to be that a significant proportion, around 50 per cent, of older people who move to care homes have no choice about the home they move to (Office of Fair Trading, 1998; Davies et al., 2000).

Relatives are often involved and older people are often pleased and relieved that someone else had made this decision for them (Allen et al., 1992; Reed and Roskell Payton, 1996; Office of Fair Trading, 1998; Davies et al., 2000). Such findings about the involvement of relatives, rather than the older person, suggest that there is a need to guard against assuming that a lack of choice on the part of an older person is necessarily the worst-case scenario. A researcher in Australia, however, found that relatives attributed the fact that the process of searching for and selecting a care home had 'worked out' in the end to good fortune and suggests that this indicates a perceived lack of control (Cheek and Ballantyne, 2001).

Various types of factors have been identified as possible constraints on the selection of an individual care home. Structural constraints include the availability of services in general, their cost, the speed of funding arrangements and the demand for hospital places (Ware et al., 2003). There is some evidence that choice of home is likely to be affected by local supply (Darton, 2004). This is described in more in the section on the types of home that are closing.

At the home level, the characteristics of vacant rooms and admission policies have been highlighted as potential restrictions on choice (Corden, 1989), as well as the lack of vacancies (Myers and MacDonald, 1996; Nolan et al., 1996a). The amount of time available may restrict choice (Nolan et al., 1996a). The time-consuming nature of the task was highlighted in interviews with relatives who had spent as much as an hour a day for 26 days telephoning homes and visited up to 25 homes (Cheek and Ballantyne, 2001). This was said to have a negative affect on family relations.

Choice of home can also be hampered by a lack of information; service users should be able to draw on useful, reliable, appropriate and timely information. A study of older people moving to care homes from hospital concluded that older people did not consider themselves to be informed consumers (Reed and Morgan, 1999). One study found that 65 per cent (of 48 carers) had not been given all the information they wanted and that 50 per cent had not received all the help they would have liked (Nolan and Dellasega, 2000). More recent evidence suggests that there still remains scope for improvement in the provision of information to users generally. In 2003-04 only 62 per cent of councils achieved the performance indicator, and aspirational Best Value target of giving '90.85 per cent' of people a statement of their needs and how these will be met after an assessment (Commission for Social Care Inspection, 2004b: Indicators AO/D39 and BVPI 58, p161). This target relates to all adult service users. More worryingly, however, a recent survey of carers of older people involved in assessments found that only 38 per cent had been given any written information about the results of the assessment (Audit Commission and Better Government for Older People, 2004). Such information should be available to help people understand the needs of the older person, so that they can find a home that is appropriate. In terms of informing service users more generally, a survey of eight councils in 2001-02 concluded that the levels of information provided to social services staff working in information-giving roles were 'alarmingly low' (Rhodes, 2003 p48).

A lack of prior discussion between relatives and older people may explain why relatives lack criteria to select a home that the prospective resident would like (Nolan et al., 1996a). Research also suggests that relatives and residents lack criteria on which to compare homes. Some resort to relatively superficial criteria, such as appearance or décor, because they lack advice about what they should be looking for, 'I mainly went on how they looked from the outside.' (Nolan and Dellasega, 2000). Décor, furnishings and the 'feel' of a home have also been identified (Davies and Nolan, 2003). People would value expert advise on the quality of particular homes: 'No one would tell me which was a good home or which was a bad one.' (Nolan and Dellasega, 2000). Some have described relatives as desperate for 'insider knowledge'(Davies and Nolan, 2003), with a high value placed on personal recommendation (Davies et al., 2000; Davies and Nolan, 2003; Williams et al., 2003).

Relatives and residents have been found to select a home based on its familiarity (Reed et al., 1998a; Davies et al., 2000). The basis for 'knowing' a particular home, or its location, may at first appear tenuous, such as having driven past a home on the way to work or having known the village when a child, but indicate links to personal histories that may help establish an important sense of continuity (Reed et al., 1998a). Practical criteria include the distance to the home (Davies et al., 2000; Davies and Nolan, 2003), the cost (Davies and Nolan, 2003), an absence of odour (Davies and Nolan, 2003), and closeness to amenities, town centre or public transport to enable residents to visit others or allow them to be visited by friends and neighbours (Reed et al., 1998b). Relatives have also reported looking at other residents living in homes, presumably to gauge if they are similar to the prospective resident (Davies and Nolan, 2003).

A cross-sectional survey confirms the importance of local knowledge for self-funded residents (Netten et al., 2001). Twenty seven per cent knew of the chosen home because it was close to where the resident had lived. A further 16 per cent knew of its existence because it was close to where a member of the resident's family lived. The survey also found that 31 per cent had considered the distance from the resident's former home and 57 per cent the distance from family and friends, when selecting a home. The general atmosphere was identified most frequently as a factor that influenced the selection of a home (cited by 77 per cent of respondents) and as typically having been the most important reason (identified by 31 per cent of respondents). The availability of a place was the next most frequently cited factor (identified by 65 per cent of respondents).

Little is known about the degree and nature of communication between prospective residents and their representatives and prospective homes. An OFT survey (1998) found that only 35 per cent of relatives/friends and 23 per cent of residents received written information via a leaflet or brochure prior to staying at a home. The regulator similarly reported that only 25 per cent of homes met or exceeded the information standards in 2002-03 and 24 per cent failed it, and concluded that information 'provided by the care sector in England is often deficient' (Unsworth et al., 2004 p18).

It appears that the content of information could also be improved. For older people,

information is a means to an end (Quinn et al., 2003). A lack of information may not indicate a lack of provision, but rather a lack of useful information or awareness of the existence of information. There are, however, many sources of information and advice about what people might ask when visiting homes from various organisations, which suggests that to some extent the problem is one of access, rather than availability. For example, none of the 30 relatives who were interviewed in one council were aware that they could look at inspection reports (Davies et al., 2000).

A summary of the factors identified as influencing the nature and degree of individual choice and control in the care home market is presented in Box 4.2.

Box 4.2. Factors that facilitate or impede the nature and level of choice and control in the care home market

Supply factors
- Availability of homes in preferred location
- Availability of homes that can meet the older person's needs
- Suitability of rooms within homes
- Availability of vacancies in suitable, or any, homes

Structural factors (organisational, professional)
- Eligibility criteria for services/needs assessment (Council, NHS, providers)
- Demands and priorities of practitioners (care managers)
- Gatekeeping procedures of care home providers

Economic factors
- Care home fee levels
- For publicly-funded residents – councils' fee threshold and the willingness and ability of a third party to pay a top-up
- For private payers – their ability and willingness to pay

The nature of the process of moving
- Circumstances of the move (acute ill-health may mean person temporarily unable to make a decision. Hospital is not the best place to make major decisions)
- Degree of involvement of older people and relatives in process by practitioners
- Who is involved in decisions
- Time available to search for, compare and select homes (and possibly to wait for a vacancy)
- Access to information and support/advice (to discuss feelings, advise on selection)
- Ability to visit prospective homes (influenced by availability of transport, possibly specialist)

Personal factors/Characteristics of consumers
- Presence of relatives or close friends
- Functional ability, dementia may mean person unable to participate in initial choice or to judge/indicate dissatisfaction with home
- Presence or absence of relatives, informal carers or close friends to help
- Degree of anticipation and planning
- Attitudes and expectations
  - About care homes (may contribute to a lack of planning; beliefs may hinder willingness and ability to anticipate and engage in process; rationalise and plan)
  - Perceived role as consumer (may find active and personal interaction with others different to past experience as consumer)
  - Willingness to be consumer (may prefer to hand over responsibility)
  - About moving and ability to cope (life histories, prior experience of relocation/ number and pattern)
  - Initial move perceived as unchangeable
- Knowledge about what they want/criteria to select a home
- Emotions
  - Distress of older person
  - Reactions of carers (turmoil, ambivalence, sadness, failure, loss, guilt)

4.7.4 The significance of moves to residential care for older people and their relatives

Relocation to a care home is recognized as a major life event and a stressful life change. It can result in changes in geographical location, lifestyle, daily activities, routines, social networks, relationships and roles, as well as living arrangements (Nay, 1995; Morgan et al., 1997). Moving to a care home was described by older people in one study as 'breaking up the home', suggesting a very different nature to previous house moves (Reed and Roskell Payton, 1996 p49) with the experience as one of loss being widespread (Nay, 1995). It can involve the selling of a home, and almost always the downsizing of possessions, losing links with community and a number of trade-offs between security and privacy, company and solitude, and warmth and regular food versus familiar places and objects (Corden and Wright, 1993; Peace et al., 1997).

It is not of course, a universally negative experience as residents can report important positive aspects, such as being less lonely or depressed than before, or being free from dependence on relatives for their care (Oldman and Quilgars, 1999; Reed and Morgan, 1999).

The meaning of home and place have been conceived as encompassing more than accommodation/domestic space but also access to amenities, public transport, the wider locality, community, and region and defined in terms of relationships and experiences (Regnier, 1983). Place is thought to be connected to developing and maintaining a sense of self (Reed et al., 1998a). UK and US policy have long prioritised 'aging in place', an idea which assumes that it is desirable to remain in your current setting as you grow older because such residential stability is associated with greater independence and a set of beneficial attachments (Rowles 1993). Rowles (1993) has identified three types of affiliation to place that may be adaptive and increasingly important to our sense of identify as we grow older: physical attachment/familiarity; social affinity; autobiographical 'insideness'. If care homes become 'home' involuntary relocation such as that necessitated by a home closures may have negative effects on older people's sense of self by disrupting such affiliations to place.

The move of an older relative to a care home may be stressful for family and informal caregivers too, as they experience feelings of loss, guilt and sadness (Nolan et al., 1996a; Dellasega and Nolan, 1997; Nolan and Dellasega, 2000). Literature in the UK

(Nolan et al., 1996a) and the US (Dellasega and Mastrian, 1995; Naleppa, 1996) highlight that placing an older relative in a care home signifies the start of a new, but still involved, stage in the care-giving relationship. It might involve financial consequences such as paying the care home fees, a top-up or additional costs in terms of meeting extra charges made by the home, or even the loss of a future inheritance (Wright, 2000a). Relatives may also take on the role of advocate, or try to be an arbiter of the standards of care provided by the home (Nolan et al., 1996a; Davies et al., 2000). US literature similarly identifies the evaluation and monitoring of care as a task taken on by families (Naleppa, 1996). Studies have also shown that the *process* of helping an older relative move to a care home is stressful for their relatives and informal carers (Reed and Morgan, 1999; Ryan and Scullion, 2000b; Davies and Nolan, 2003; Davies and Nolan, 2004).

4.7.5 The role of care managers

No research was found that explored directly the way in which care managers' support older people during involuntary relocation due to independent sector care home closure. Research on what service users and relatives value in general in their contact with Social Services staff is likely to be of relevance. For example, the quality of relationships with social workers, and their knowledge and skills, are valued as well as the service they provide (Harding and Beresford, 1996). People want social workers to be honest, reliable, credible, and confidential, and to be shown respect, courtesy and empathy. They value being listened to and would like social workers to be able to communicate sensitively and to offer advice and support, as well as specialist information.

The level and significance of care managers' help and support can be difficult to measure. Studies of the care management process have found uncertainty amongst relatives (Myers and MacDonald, 1996; Abbott et al., 2001) and patients (Abbott et al., 2001) about how or why social workers were involved, although the reasons might be more clear during a home closure. Dellasega and Mastrian (1995) found that relatives perception of having to make the decision in isolation was reported even when the older person and/or professionals were involved. A large-scale study that looked at satisfaction with the assessment process and help provided by social services among older people in receipt of community-based services found that users reported greater

satisfaction if their care manager was a qualified social worker, the more hours the care manager had spent arranging the service and if they had were more satisfied with life in general (Chesterman et al., 2001)

A study of self-funded admissions found that half were assessed by social services, and so received some help in identifying the type of care required (Netten et al., 2001). A smaller-scale study, however, found that only about one in three self-funded residents had spoken to a social services care manager about finding a home (Wright, 2003).

4.7.6. The role of care home staff and management

Existing research into staffing issues relevant to closures includes work that has looked at how staff might help residents adapt to moving to a care home for the first time via their admission procedures, daily care practices, values and philosophies. It would seem sensible that general recommendations for supporting the adaptation of newly arrived residents should be followed by staff at homes receiving older people who have experienced a closure.

Such recommendations include good record keeping, including the recording in care plans of how care staff might help someone adapt, the recognition among staff of the importance of and need to support the development of relationships between residents (Reed and Payton, 1997), and residents' adaptation strategies such as the construction of familiarity and minimization of difference or dis-location (Reed and Payton, 1996). Others have emphasized the need for care staff and relatives to work together, and that staff, in particular, should value the knowledge and expertise of relatives and carers, and the opportunity it provides for finding out about the older person's life and building a connection with them (Milligan, 2003). An empathetic awareness among staff towards relatives' concerns and the development of a shared understanding of how this might be incorporated into daily caring practices has been identified as key to building of collaborative relationships between staff and relatives (Sandberg et al., 2002). An admissions protocol that identifies the needs of relatives as well as those of new residents to be met by a home has been identified as key to good practice (Pearson et al., 2003). The Relatives and Residents Association similarly recommends the drawing up of life histories or story books and that staff involve relatives throughout the admission process and in the older person's day to day care (Burton-Jones, 2001).

4.8 The circumstances of other types of move between homes

Four types of subsequent relocation between care homes have been identified, based on the degree of resident participation involved and the reason: preference, strategic, reluctant or passive (Reed et al., 2003). From their qualitative interviews with 12 residents Reed and colleagues noted relocations where residents exercised choice, where relocations were planned, perhaps to pre-empt changes in circumstances, where residents disagreed with or resisted the move, and where they accepted the decision, which had been by others. Of the twelve residents interviewed, three experienced moves due to home closure. Nearly all of these reasons were related to some degree to changes in residents' needs, perhaps because the existing home was not registered to provide for reassessed needs. At the time of the study (1999-2000) such moves could be attributed to the structure of the care home market because people had to move, rather than care moving to them (Reed et al., 1998b). An analysis of care home managers' experiences of relocation in eight homes similarly found the majority of relocations were professional or service driven and Cook suggests that moves should be made unnecessary for those who do not want to move, and easier for those who do (Cook et al., 2001).

Professional decisions about the need for someone to move can involve judgments about what is in the best interests of the other residents and unrelated to the specific needs of the individual resident (Reed et al., 2003). These features of relocations are not mutually exclusive and the authors highlight the mixture of 'push' and 'pull' factors behind moves. An earlier study also noted that people 'voluntarily' moved home due to dissatisfaction with the home and/or a desire to live nearer a relative (Allen et al., 1992). Other reasons for moving out of a home might include a return to mainstream housing, or other forms of housing with care.

A number of constraints have been identified as potentially limiting older people's ability to choose whether to stay in a particular home: they may be unable to judge or indicate their dissatisfaction or unhappiness; they may have no-one to help them find another home; there may be no vacancies in appropriate homes; older people may fear reprisals if they say that they want to leave (Challis and Bartlett, 1988).

4.9 Summary

The literature review shows the paucity of evidence directly related to the home closure process, but a considerable amount of literature that has been useful to set the context for the study, to aid its implementation and design and to interpret the findings. No studies were found which focused primarily on the process of voluntary care home closure. It is an under-researched area, and one where it is important to understand more about the context and conditions of such situations, and the ways in which these might interact with other factors. The literature does suggest, however, that processes and procedures used to close homes and relocate residents are likely to affect the impact of a closure. Some previous work has identified good practice recommendations during relocation. However, they are not always linked to an obvious evidence base and relatively little attention has been paid to implementation issues.

There is a considerable literature on the consequences of involuntary relocation of older people between care homes, in terms of impact on residents' health, psychological well-being and mortality. The evidence, however, is ambiguous. The consequences of home closure for care home staff and relatives are relatively neglected areas, as are types of resident outcome other than those related to residents' health, well-being and mortality.

Less is known about the process of care home closure, although preparation has been highlighted as an important factor associated with successful transfers. Regulators' experiences have highlighted a number of process related issues. Providers' reports suggest that they feel responsible for the relocation process but may not seek information and advice from external sources. They may notify stakeholders at different times, and resident relocation may be rapid.

The literature on moving to a care home for the first time is a useful starting point when considering what a closure may be like for residents and their families because a closure may share similar conditions and processes. The literature review found considerable conceptual uniformity and consensus about what promotes a 'good' experience when moving to a care home in the first instance and the problems people face when moving to, or between, care homes. Importantly, there also appears to be consensus about the

context in which older people and their relatives make choices about care homes:

- Some people lack information on which to base selection decisions and would value guidance on how to choose an individual home;
- People have low expectations of the care that will be provided by care homes;
- Decisions about moving to residential care are often made during a crisis;
- The decision to move to a care home is often 'expert driven';
- Moves are often perceived as pressured and hurried;
- A significant proportion of older people report little, or no choice about the home they move to, although many have delegated the choice to a relative;
- Whoever makes the choice is likely to find it difficult and stressful.

Various processes have been identified as promoting a positive experience of moving to a care home. Control is thought to be important for acceptance and adaptation. Conditions identified as promoting resident choice in subsequent moves include awareness among residents of their rights and choices, an ability to communicate and debate their choices with others, and the ability to access and evaluate information (Reed et al., 2003). Factors thought to improve the experience for relatives include the opportunity to explore their feelings and emotional reactions.

Part II

The Study Methodology

Chapter 5

Aims and method

5.1 Introduction

This chapter describes the aims of the research, and the research strategy. The methodology is discussed in terms of the methods and techniques used to collect and analyse the data, and the rational for particular methodological decisions, as well as the way in which the research project was designed.

The chapter is organised into five main sections. The first describes the aims and objectives of the research, the second the overall research design and methodology, including the instrument design. The third section describes sample selection, recruitment and data collection processes, and the fourth the method of analysis. The last section considers some of the ethical issues of the study.

5.2 Aims and objectives

The research sought to develop a better understanding of the process and consequences of voluntary closures of independent care homes for older people. The study focused on voluntary closures rather than enforced closures. A major reason for this was the rise in the number of voluntary closures and policy interest in their causes and consequences (For an overview of the policy and media interest see Chapter 2) It was also felt that the inclusion of enforced closures would have broadened the focus of the research considerably and a number of ethical and practical reasons suggested that investigation of enforced home closure would be extremely problematic. Enforced closures often necessarily occur in extremely short-time periods and in distressing circumstances, and any research at such a time would have to consider very carefully whether it was appropriate or possible to talk to people close to the event without causing unreasonable intrusion.

The study had five broad aims. To better understand:

1) The national context, and local circumstances and conditions of voluntary closures;
2) The processes and activities involved during closures;
3) The nature of any constraints, challenges, and opportunities
4) The ways in which closures, and policies and approaches to their management might be improved; and
5) The impact, outcomes and consequences for residents, their relatives, care home staff and social services.

Questions linked to the overarching aim of understanding what happens when care homes are closed included how and by whom closures are managed, and the aims, goals and concerns of key participants. A variety of process related issues were likely to influence residents' well-being during and following a care home closure: the length of closure periods; the tasks required to achieve relocation; the information, help and support available; the feelings brought about by home closure; the nature and level of their involvement in the process; the degree to which they could choose where to move or were asked about their aims; where they moved to and whether it reflected their preferences and how it compared to the closed home. Whether they moved far from their present geographical area was also considered potentially important.

The fourth aim of examining potential improvements was concerned with identifying how such involuntary relocations might be made easier, and the potential stress, distress and negative effects on residents' well-being minimised. The study sought to produce evidence useful to providers, commissioners, and those actively involved in managing future home closures about the advantages and disadvantages of particular approaches from the perspective of those involved. It was hoped that the study might be useful to a practitioner audience and a series of short summaries of findings were circulated to research participants, and social services departments in England to communicate some of the main findings (see Appendices 3 – 5).

Identification of the range of potential positive and negative impacts, outcomes and consequences of care home closure was the final aspect of the study. The focus was on immediate and short-term changes and impacts, such as changes experienced by residents associated with change of care home, and the potential impact on care staff

morale during closures and on attitudes towards working in the care home sector more generally.

5.3 Research design and methodology

The aim of understanding the nature of the closure process suggested a mainly exploratory and descriptive piece of empirical research, which would need to draw on multiple sources of data, and different methods of collection and analysis. The research included two main components: a survey of councils' closure guidelines; and a qualitative investigation of the process of closure via interviews with key participants around multiple 'case study' closures.

5.3.1 National survey of council closure guidelines

To identify councils' powers, responsibilities, plans and any existing good practice concerning the management of voluntary care home closure, it was important to establish whether councils had guidelines for managing independent care home closures. Consequently a national survey of councils was conducted to establish the prevalence of closure guidelines, and the nature of any policies, including their aims and objectives, how roles and responsibilities were allocated and recommended approaches, policies and procedures.

5.3.2 Case study approach

An in-depth qualitative case study design based around closures as they were occurring was chosen because it allows exploration of the way in which homes are closed, and focus on the views of those involved, while also allowing for the possibility of some short-term follow-up of consequences.

The exploratory nature of the research aims and the focus on people's experiences suggested that a qualitative approach, which focused on talking to those with direct experience was appropriate. People with recent and direct experience of closure are well placed to identify what happens during a home closure, to discuss their own actions, feelings and views, and also to consider how such events might be improved in future. Consequently, the focus of the main data collection and analysis was the

narratives of people with first-hand and recent experience of care home closure. These included older people living in homes about to close, their relatives and carers, the care staff working at these homes, and local authority social services staff charged with helping relocate the residents.

Both the nature of the research questions and the nature of care home closures as a complex contemporary event suggested that case studies of care home closures were appropriate:

- They were an event that could not easily be controlled (as required by an experiment);
- The aim was to understand both the process and meaning of such events and the context and conditions in which they occurred (Yin, 2003).

Case studies are used in a number of fields, including sociology, psychology, political science, social anthropology, education and economics, but there is no agreed single definition. Some define them in terms of the topics explored, the data collection techniques used, the kind of data collected, the type of findings supported, or as a research strategy with a logic of design, data collection and approach to analysis (Yin, 2003) (Mitchell, 1983; Stake, 2000a). In general, however, they are understood to signify an in-depth study, which produces detailed information that it would be difficult to collect on a larger scale. Yin argues that case studies can usefully draw on multiple sources of data (Yin, 2003).

A multiple case study approach was used because it would allow different perspectives of a small number of situations to be compared. Views differ about the type of analysis and knowledge supported by case study research, particularly about whether case studies can support generalisation or theory testing and this issue is discussed in Chapter 13.

Alternative ways of identifying residents with experience of closure were explored but found to be unfeasible. Residents about to experience a home closure could not be identified easily in advance of a closure and neither can they be picked up easily retrospectively. The information routinely collected about residents by local authorities

in England did not permit the identification of residents about to experience a closure, nor allow the large scale tracking of residents who have moved between homes. Home closure was not necessarily recorded as a reason for a move on councils' records, and even if it were, such records would be available only for publicly-funded residents and so exclude self-funders. The timing of identifying closures in advance was itself made problematic by the variation in the timing and source of closure notification: care management departments may be the last to be notified officially about a closure, although they may also be one of the first to hear unofficially.

Even if residents about to experience a home closure could be identified well in advance, there are ethical issues around doing so. It would seem inappropriate for researchers to have forewarning of an event that residents might not be aware of. Systematic selection of closures was also unfeasible on a number of grounds. For example, no sampling frame of closures existed and the characteristics of the closure process could neither be predicted, nor assessed for representativeness beforehand, since the nature and scope of the closure process was largely unknown and the very focus of the study.

5.4 Sample selection, recruitment and data collection

This section describes the sample selection, recruitment and data collection processes. Most of the case study fieldwork took place over a five-month period in 2002. First it describes the survey of councils' guidelines. Next the selection and identification of the case study closures, and the collection of recent inspection reports about the closing homes are described before the rational and design of the qualitative interviews. The recruitment and data collection with the main participants are described in turn, starting with the residents and relatives and the additional sample of relatives, followed by the care home staff and social services staff.

5.4.1 National survey of council guidelines

The total population of councils in England were contacted about closure guidelines. All social services departments were asked if they had a protocol for home closures in March 2002, and if so to provide a copy. Since authorities with a considerable number

of homes were more likely to have experienced closures, and as a consequence were more likely than other authorities to have guidelines, a follow-up letter was sent to authorities with 100 or more independent residential or dual registered care homes, as at March 2001 (Department of Health, 2001).

5.4.2 Local authority selection and identification of closures

Local authorities were approached to identify impending or ongoing closures using a mixture of opportunistic and selective sampling techniques (Luborsky and Rubinstein, 1995; Coyne, 1997). The main criterion for choosing local authorities was that they had sufficiently large numbers of care homes to make a home closure during the period of fieldwork likely. To increase the likelihood of including a range of contexts and closure circumstances and to avoid a geographical imbalance different types of local authority, , were approached in different regions of the country. Local authorities are the administrative units of local government below regions and include counties, metropolitan boroughs, unitary authorities and London boroughs.

A mixture of opportunistic sampling and purposeful sampling was used to identify closures. The initial aim was to conduct four or five studies around particular closures in two local authority areas. It became clear, however, that additional councils needed to be approached to obtain permissions at a time that would permit involvement when participants could be contacted. For example, once a home had closed, residents would no longer be a collective group that care managers or care home staff would be in contact with, and no central 'gatekeeper' at the home would be available to forward letters to staff who would have left. It became apparent, however, that closures were at different points of the closure process when identified, and this meant that involving social services staff in recruiting residents and relatives was not always possible and identical sets of data could not be obtained across all closures (see Chapter 6, Table 6.1). The number of councils approached was increased; a further two local authorities were approached and existing councils asked to look for additional closures

The study involved sampling of locations, events, people and documents. Securing informed consent involved negotiation with numerous 'gatekeepers'. Directors of Social Services were asked if they were happy for the research to occur in their areas, both because they were the main source of information about impending closures and

the employers of the care managers who would be involved in helping residents to relocate and whose participation would be sought. Once permission was sought from the Director of Adult Social Services a district manager or team manager who was likely to be interested in the research or to know of closures, was usually recommended. In turn, they identified or suggested closures or impending closures. Sometimes District Managers identified homes located in other areas within an authority, which were managed by their own district teams of team managers (for description of the organisation of care management teams by local authority see Chapter 10). The identification of closures occurred fairly sequentially and over a number of months, which allowed the achieved sample to be reviewed and contacts to be told that a nursing home closure was wanted, because most were residential homes. Only one nursing home closure was identified despite such efforts to include more. The achieved sample is described in Chapter 6.

The use of social services care management staff to identify closures and pass on requests had some unexpected consequences. One care home provided care for older people with mental health needs and the care manager considered informed consent from these residents inappropriate and unachievable. Permissions had already been sought from the owner and it was decided that it would be useful to see if and how the process of closure differed in relation to this client group, even though interviews would not be carried out with residents. It also became apparent that some care home staff 'vetted' lists of residents before passing on requests for interviews and care home providers sometimes declined from passing on information about the study to care home staff.

The inclusion criteria for the closing homes were that they provided for older people, were in the independent sector and closure was voluntary. The practicalities of the research timetable, which meant that fieldwork needed to be conducted within a year, meant that cases could not be rejected once identified, even if they only offered the possibility of involving some potential participants. A closure would have been rejected if gatekeepers indicated that neither care home staff, residents and relatives, nor care managers could be involved.

The requirement that those with responsibility for managing the closures agree to take part in the research was likely, to some extent, to have biased the main sample towards

closures that were likely to be managed 'well'. However, additional interviews were sought via other mechanisms with relatives unconnected to the case study closures, and these were likely to widen the range of closure processes and contexts described.

5.4.3 Inspection reports of sample homes

The regulator was telephoned and asked for copies of the most recent inspection report for the nine closing homes. It was anticipated that the reports would provide descriptive information about the homes, as well as an indication of their quality, and the nature of any problems or concerns. Prior to the closures, Registration and Inspection Units at the local authority level carried out inspections of nursing and residential homes to ensure compliance with the Nursing Homes and Mental Nursing Homes Regulations 1984, and the National Health Service and Community Care Act 1990 and inspections involved Lay Assessors. National minimum standards for homes, and standard inspection methodologies were about to be introduced (see Chapter 3).

5.4.4 Qualitative interviewing

Qualitative interviews were chosen as the most appropriate form of data collection with the participants because the topic was a complex event, and the research questions sought to understand the experience from the perspective of those directly involved. Interviews can provide 'rich insights into people's biographies, experiences, opinions, values, aspirations, attitudes and feelings' (May, 2001). They can also establish the range of opinion about something, and the dimensions of attitudes (Fielding, 1993). Interviews are also useful when collecting sensitive or detailed or complicated information, which the topic of involuntary home closure and relocation was likely to involve, or when sampling a population that is likely to respond poorly to self-completion questionnaires, which older people and their relatives and carers might (Fielding, 1993).

The methodological approach taken was one that acknowledged that interview data are inescapably social constructs, but stopped short of regarding it as entirely subjective or unrelated to external facts and events beyond the interview situation. In this way language can be viewed as a social medium, rather than as merely referential, but what is said can remain the focus of analysis. Semi-structured interviews with open-ended questions were used because they enable data to be collected in a way that allows the

culturally defined and situated nature of the situation and of the data to be acknowledged; research interviews are acknowledged as socially situated, 'joint accomplishment(s) of interviewer and respondent' (Cicourel, 1964; Silverman, 1993; Dingwall, 1997 p.56; Fontana and Frey, 2000); and the 'inter-subjective construction of reality through accounting is a social fact. It is there; it is observable; it is reportable' (Dingwall, 1997 p.64). The approach was akin to Silverman's 'realist' standpoint which regards interviews as displays of perspectives and cultural realities, as well as displays of how people construct those realities (Silverman, 1985).

The interviews were mainly one-off; the topic was a distinct event so a sequence of interviews was considered unnecessary. Flexible, open-ended, semi-structured interview schedules were designed and used like a topic guide. General topic areas were outlined as well as specific questions, probes and prompts for further details. To some extent the guides were more detailed than might be expected for open-ended, semi-structured interviews. This was in part due to the use of multiple interviewers and to ensure that similar topics were introduced or covered. One of the advantages of semi-structured interviews is that they allow participants to respond in their own words and to use their own frames of reference while also allowing the collection of similar kinds of information, making comparison easier than when using unstructured interviews (Burgess, 1988; May, 2001).

The guides indicated the topics to be covered rather than a set of questions to be read out in exactly the same way. The sequence of topics and issues was not fixed but organised logically to follow the likely chronological sequence of events. The guides were designed for flexible use to allow respondents to take the lead and give their account of what happened in their own words, with the interviewer interjecting to ask follow-up questions. Questions were mainly open ended/non-directive and wording intended to be non-standardised but neutral. Follow-up questions were designed to ask for more detail or clarification of particular issues or points, for example: What happened? How did you feel about that? What was that like? What would have been helpful? Anything else? The interview guides were also designed to allow some factual information to be recorded to aid information retrieval and data analysis.

The residents, relatives, care staff and social services staff were asked roughly parallel questions about the process of home closure, as well as questions more particular to their position and role (see Appendices 6- 13). Common topics included:

- How they found out about the closure
- The sort of support or preparation that was offered to residents
- What finding and selecting alternative accommodation was like
- What the actual move was like
- Whether residents had settled in and adjusted to the new home
- Their feelings and concerns during the closure
- What might have helped or been valuable
- The effects and consequences of the home closure

Additional topics discussed with care home staff included their feelings and motivation during the closure, concerns, and plans for the future. Care management staff were asked about the availability and usefulness of closure guidelines. Senior managers were also asked about the commissioning context and whether and how the council was managing the long-term care market.

The influence of the physical context and style of interviews on the type of information gained has been highlighted in the field of education research (Burgess, 1988). An informal style was fostered as far as possible given that a semi-structured guide was being used. Interviews in people's homes, offices or rooms were on their territory, although the care staff might not have regarded a closing home in this way. Seating arrangements tended to be less formal than sitting across from each other at a desk. Details such as informal seating arrangements are thought to go some way to reducing the formality of interviews and towards conducting 'conversations with a purpose' (Burgess, 1988 p.153). Interviewees were hospitable and invariably offered tea/coffee and biscuits. Interviews were always private, although some were more private than others. For example, on several occasions a husband walked in and out of the room while his wife was taking part in an interview as a relative, sometimes joining in the conversation, and one resident had a friend present.

5.4.5 Residents and relatives recruitment and data collection

With the locations and events, that is, the closures, selected, a volunteer sample method was used to recruit residents and relatives. Residents and relatives linked to the closures were invited to take part without any inclusion criteria specified by the researcher. Participants were 'chosen' in the sense that the closure of their particular home had been identified as an event to ask them about. As mentioned in section 5.4.2 above, residents were invited to take part in all but one of the case studies. Potential participants were contacted only once to avoid intrusion at a difficult time. For the same reason, the residents and relatives were not approached directly, but forwarded information about the research by a third party, such as the home manager or care manager.

This indirect method of recruitment had a number of consequences in addition to those already identified. For example, where social services staff forwarded information, only residents they were aware of, or were actively helping were contacted. Self-funded residents not in receipt of help from a care manager, and residents funded by other authorities were not always approached. None of the 'gatekeepers' put any formal conditions or restrictions on access, but practical issues such as the care managers' workload and lack of time were sometimes given as reasons for not supplying photocopies of assessments that residents had agreed could be looked at. Another drawback of not selecting who was approached was that the characteristics of the non-respondents often remained unknown.

Residents and relatives were sent a project outline (see Appendix 13), and letter and asked to return a reply slip, or tell a care manager, if they wanted to take part and told that a researcher would telephone to arrange a convenient time and place at least 4-6 weeks after the home closure (see Appendices 14 and 15). This time was chosen in the hope that it would be less intrusive than asking people to take part when they were likely to be busy dealing with the closure, and in the hope that it would give residents a chance to 'settle' at their new home. It was also known that care managers often plan to undertake a review 4-6 weeks after such relocation.

The timing of the resident and relative interviews in relation to the date of closure varied considerably from one to three months after residents had moved. This was partly due to some of the residents having moved before the home actually closed. The

resident and relative interviews took place between June and November 2002. The interviews with residents took place in their new accommodation and relatives and carers were interviewed at the place of their choice, usually their home.

5.4.6 Additional sample of relatives

To increase participation from relatives and carers and to maximise variation in the closures discussed, several national and local relative and carer organisations were contacted to ask if they could forward study information to relatives and informal carers with recent experience of a voluntary care home closure in the independent sector (see Appendix 16). A national association and five local carer support groups in one local authority, a local carers centre in another authority and a local Alzheimer's care home and day centre forwarded information. Relatives recruited in this way were interviewed between February and June 2002. In five instances the home closure had happened within nine months before the interview. In one case the relative asked to be interviewed just before the home actually closed, and one home closed in 1999.

5.4.7 Care home staff recruitment and data collection

In six of the closures, the home manager or manager and owner agreed to circulate information and invitations to take part to staff (see Appendix 17). This meant that ideally the home needed to be identified and the approach to staff agreed by the manager/owner before the home closed, which was not possible at three of the closures. Despite this, all but one of the staff were interviewed just before the homes closed, and the interviews occurred between April and August 2002. Staff were sent follow-up questionnaires, or telephoned if requested, between October 2002 and February 2003.

Self-completion questionnaires (see Appendix 18) were left with accompanying letters (Appendix 19) for circulation among care staff at the homes where care staff volunteered to be interviewed. It was hoped that this would encourage participation and provide a way of asking if they could be contacted later to find out where they were working. Interviewed staff were asked to complete a questionnaire. Staff who did not respond to the follow-up questionnaire (see Appendix 20) were chased once after three weeks. The follow-up of staff occurred between four and seven months after the homes had closed. Interviews tended to be shorter than those with other participants.

Leaving self-completion questionnaires in a general office appeared to be regarded with suspicion by care staff at least one of the care homes, where there was mistrust, resentment, and shock:

> 'Because staff are very wary of what's happening nobody has actually took any at the moment. It is like we get these envelops and it is like "Here you are. Can you get staff to fill them" and we look through them and think, "What's this?"' (HC7, care staff 2)

Contact via letters did not appear to be a successful way to convey information about the research to this group and given more resources a personal visit in advance of any data collection might have been more productive. There was some indication that despite assurances of confidentiality and anonymity, staff were reluctant to share negative views or comment on management decisions and that the purpose of the interviews, if not unclear, were unfamiliar.

The care home staff questionnaires were designed to gather slightly different information to that from residents, relatives and care managers. The interviews focused on their experience, role and views of the closure process. The pre-closure questionnaire asked for additional personal information including qualifications and training, experience, current job, and future plans and whether they had started to look for another job (see Appendix 18). The follow-up questionnaire asked what they were currently doing, their reasons for no longer working with older people in a care home if they were no longer doing so, and their views about how care staff ought to be involved in home closures (see Appendix 20). The questionnaires consisted of mainly closed questions.

5.4.8 Social services staff recruitment and data collection

Care management teams were identified in four councils. In most cases a researcher met care managers to discuss the various invitations to be forwarded and data collection instruments before the homes closed. Interviews and discussions with social services staff were conducted flexibly across the case studies at times convenient to them. This meant that interviews were sometimes one-off and with individuals, sometimes the same staff were interviewed twice, and sometimes they met with researchers and

discussed the closure(s) less formerly on numerous occasions, sometimes in groups of two, three or more. Three asked to be interviewed as a group about the closure they were working on, and had booked a room and allocated time away from their desks so that they could be interviewed together. Another team of two also requested to be interviewed together. Of the participating care management staff responsible for managing four of the closures, two, including the team manager who was interviewed more than once, were interviewed 'formally' using a topic guide and tape-recorder. Telephone or face-to-face conversations mostly held during pre-existing meetings with a further nine of these care managers were recorded in field-notes.

The interviews took place at different points in time in relation to the closures. Some occurred while the care managers were still involved with the residents, and some took place several months after the closure. They took place during the day in a variety of workplace settings including an office on loan from a manager and pre-booked meeting room. The care managers tended to have desks in open-plan areas.

To complement the interview data, activity and time use logs were designed for completion by care managers to identify the nature and extent of their closure related activities before and after a home closes. It was assumed that care managers were likely to be involved in other tasks as well, so a diary was considered inappropriate and probably too burdensome. Instead, headed sheets of paper were provided for care managers to describe their closure related activities under three broad categories: face-to-face interaction, telephone calls, and administration (See Appendix 21). Space was provided to note any particular issues or concerns. Care managers were asked to note the date of an activity, the nature of the activity and the time taken. A similar, more detailed diary, differentiating more activity categories and half-hour slots, has been used to identify the general working practices of care managers (Wienberg et al., 2003).

A range of additional information was sought from care managers:

- Resident details form (see Appendix 22);
- Resident follow-up information (Appendix 23); and
- Copies of example or anonymous assessment and review forms.

5.5 Methods of analysis

The home closure guidelines and protocols were analysed using a combination of quantitative and qualitative approaches to content analysis. Protocols were reviewed to identify the format, length and scope before the number in each category was quantified. Similarly, the content of the documents was reviewed to identify the nature of recommendations before quantifying the prevalence of particular subject matter and suggestions. Issues and recommendations were then compared in more detail to identify common views of best practice and any variation or agreement.

The characteristics of the case study home closures were summarised and compared to national statistics, as were the characteristics of participants where possible. A mixture of qualitative and quantitative content analysis was used to analyse the care manager activity and time use logs.

The interview findings were analysed primarily by perspective rather than by home closure. Perspectives were analysed by looking at interviews individually and then cross-closure comparisons were made within perspectives. Cross-perspective comparisons were then made to see if this identified any additional issues and to review common patterns, processes, and constraints as well as variability. This analytic approach was considered the most appropriate because the purpose was not to produce conclusive accounts or typologies of particular home closures, but rather to better understand the process from the perspective of those involved. This approach was also considered necessary in order to protect the anonymity and confidentiality of the homes that closed, and in turn the research participants. For this reason, linkages between home characteristics, reasons for closure and details about the way in which they were closed have been kept to a minimum. One disadvantage of this is a limited overview of individual homes and sense of their individual identity. This does not mean that the analysis of different perspectives was unconcerned with the cases/settings of the individual closures experienced; the case study approach was essential to developing detailed insight into multiple perspectives of such a complicated event and process as a home closure.

Interviews were transcribed verbatim. Transcripts were coded using a qualitative data analysis software package, Q.S.R. NUDIST (Non-numerical Unstructured Data Indexing Searching and Theorizing). A broadly grounded theory approach was used (Dey, 1993; Charmaz, 1983); codes and themes were developed both deductively and inductively (Gilbert, 1993). They included descriptive characteristics of events and aspects of interviewees' accounts of what they did and how they felt, and more theoretical ideas about their perceptions, views and strategies. All data were coded until no new codes, themes or topics emerged. These were then analysed within the context of the broad research questions.

Verbatim quotations were used throughout the findings chapters to illustrate the themes and issues discussed, strengthen understanding of participants' perspective by highlighting the real words, terms and concepts used by people, to promote participants' voice, indicate the variety or commonality of opinion, illustrate the spread of interviewees comments and to allow the reader to consider the validity and accuracy of the interpretations made. Quotations were labelled in a way that aimed to ensure anonymity while indicating broad attribution; the labels at the end of quotations include a code for the care home, indicate the role of the speaker (resident, relative, care manager, care assistant) and specifies a code designated to that individual.

5.6 Ethical considerations

Empirical social research with individuals necessarily raises ethical issues. Qualitative methods are also thought to potentially involve a wider range of ethical dilemmas than quantitative research since:

> 'the ethical dilemmas facing the qualitative researcher are sharper and the freedom of action in research greater, so that the consequent ethical problems that may be encountered are more varied.' (Bulmer, 2001 p.55)

This section outlines the ways in which ethical standards and principles were considered and addressed. The research design was undertaken before the creation of the internal

ethical review panel of the School of Social Policy, Sociology and Social Research at the University of Kent and so was not subject to formal peer review.

A number of professional associations have produced ethical guidelines to inform and advise researchers, such as the Social Research Association (SRA), the British Sociological Association and the Social Policy Association. The Social Research Association guidelines describe four types of research obligation, obligations to: society; the funder and employer; colleagues; research subjects (Social Research Association, 2002). The first and the last of these are the main focus of the issues considered here and obligations to research subjects are discussed in detail. The British Sociological Association's statement of ethical practice more briefly summarises similar basic principles and obligations (British Sociological Association, 2002).

In terms of obligations to society, the research did not contravene legislation, such as data protection or human rights. Regrettably the use of the data for the purpose of a PhD was not anticipated during the fieldwork stage and so was not explicitly identified as a purpose of the research when inviting participation. This is not a contravention of the Data Protection Act since data collected for research purposes is exempt from the principle that personal data cannot be used for purposes other than that for which they were originally obtained (1988). However, it would have been preferable to uphold this principle. The SRA (2002) argues that the main concern is whether additional analyses have consequences for research participants and the use of the research for the purpose of a PhD should have no consequences for those who participated.

The 'worthiness' of research and particularly research with older people is considered an ethical issue (Miles and Huberman, 1994; Reed and Payton, 1996). The research focused on an under-researched event that could be associated with serious consequences for residents' health and psychological well-being. The research was not designed to have immediate benefits for those involved. Participants' needs and priorities, however, were respected and understanding of their views was central to the study, which was designed to produce findings of relevance to practitioners, service users and the wider academic community. It was possible to predict one beneficial outcome if not its impact on policy or practice: improved understanding of how home

closures are experienced and might best be managed. The research design, fieldwork and analysis sought to produce valid and rigorous research.

Inevitably the research was not devoid of possible harm to group interests. The research into care management practice during closures, for example, was concerned with what councils were able to achieve, care managers' goals and views of good practice and the barriers and constraints to achieving those goals. It was unconcerned with judging the overall performance or work of any individual or group and hopefully the focus of the findings should guard against them being used to bring about any misplaced detrimental consequences.

Findings were communicated to research participants, the funder, academic journals, and the press, with a view to communicating them as widely as possible. Research participants were sent research summaries as data were analysed, told that they could be sent copies of the full reports, and that these were available on the PSSRU website.

Issues central to upholding obligations to research subjects include gaining informed consent, avoiding undue intrusion, protecting the interests of participants, and enabling the participation of those people who might like to take part. Judging the ethics of qualitative research has been described as problematic when using the health/medical model because qualitative research design is often emergent and the risks and benefits are consequently difficult to predict (Ramcharan and Cutcliffe, 2001). However, unlike health research, social research is usually unconcerned with studying a particular physical treatment or intervention that might cause physical harm (Ramcharan and Cutcliffe, 2001; Lewis, 2002). Ethical issues particular to this research included the study of sensitive topics and researching 'vulnerable' people.

5.6.1 Gaining informed consent

Participation was voluntary and requested in writing. The aim of the research, the purpose of the interview, the voluntary nature of participation, that data would be treated as confidential and that people and places anonymised were also described at the beginning of interviews. It was explained to participants that their views would be reported anonymously in publications, and that their words might be quoted verbatim. Discussion of informed consent in the context of qualitative research with small

samples has emphasised the importance of reiterating participants' rights to withdraw or withhold information rather than treating consent as a one-off event (Ford and Reutter, 1990). The research did not involve multiple meetings with the majority of participants like much qualitative ethnography. Re-capping the purpose of an interview and the position of the interviewee, however, was a useful as well as ethical way to begin.

As mentioned earlier, a letter outlining the purpose of the research and what participation would entail was sent to potential participants with a one-page outline of the research project. Information to participants tended to state a hope that the research would be benefit people involved in future closures. Attention was paid to the legibility and comprehensibility of the information provided in terms of language used, length and print size. The outline was usually taken to interviews in case the information had been misplaced or was not at hand. Written confirmation of arrangements was sent if there was time. Thank-you letters were sent, again as a way of ensuring that they had a record of their participation, if they so wanted, and the contact details of the research team if they had any questions. It was hoped that this, along with the circulation of a summary of the research findings to those who indicated that they wished to receive it would mitigate against any sense that the interview had been a one-sided 'hit and run' intrusion.

While gatekeepers were consulted and asked to forward the letters of invitation, which might have resulted in some 'censoring' of who was given an invitation, consent was very much sought from individuals rather than any representative. As Lewis argues, individuals have a right to decide whether to participate 'rather than the service provider or the members of ethics committees' (Lewis, 2002 p.6). There was no reason to believe that any of the residents had been in any way coerced to take part. No incentives were offered.

Consent was verbal. For a number of reasons signed consent was viewed as unnecessary and potentially undesirable. The SRA (2002) guidelines suggest that signed consent is appropriate for longitudinal and/or intrusive studies and this research was neither. Some evidence suggests that asking for signed consent increases refusal rates and might lead to greater use of persuasion and feelings of imposition and/or distress among potential participants (Brod and Feinbloom, 1990).

Measuring the decisional capacity of residents was not an issue because the gatekeepers felt that it was inappropriate to forward invitations to any residents without decisional capacity or with cognitive impairment. What was meant by an inability to give informed consent was not explored. Residents with cognitive impairment should not automatically be excluded from research. Informed consent by people with dementia has been the focus of considerable debate and a diagnosis of dementia recognised as 'not automatically confer(ring) decisional incapacity' (AGS Ethics Committee, 1998). People with dementia might be able to understand the purpose of research and what is involved and their decisional capacity may change (Kayser-Jones and Koenig, 1994). If the focus of participation had not been the discussion of a distressing event in the recent past, which might have been stressful, the way in which the excluded residents were perceived as unable to consent would have been explored further. However, the research was neither focusing on older people with cognitive impairment or mental illness, nor trying to be representative of the care home population as a whole.

5.6.2 Avoiding undue intrusion and protecting the interests of participants

In terms of research design, observation was considered inappropriate for ethical and practical reasons, given the stressful nature of a home closure and the participants need to deal with the practical consequences.

The study of sensitive topics might put participants at risk of psychological stress from telling their stories and this is thought to be a particular problem when using in-depth interviews (Brannen, 1988). The informal nature of in-depth interviews is also thought to put research participants at risk of unintended disclosure of revelatory or personal information, which might be embarrassing or hurtful (Finch, 1984; Brannen, 1988). The relatives and residents who participated were particularly at risk of finding the interview experience stressful. Some of the participants' relatives had died within months of a home closure and interviews with them had to be handled sensitively. The nature of the topic, their experience of home closure, however, was not itself highly personal, threatening or confidential and there was little to suggest that participants did find the interview itself a stressful experience or that the interviews caused distress.

Interviewing residents and their family or friends *during* such a potentially stressful event as a home closure was undesirable as well as impractical. Consequently

interviewees were invited to arrange a date sometime after the event. To maximise their control of the experience the date, time and place of the interview was decided by them. The majority of the residents and relatives chose their home. However, interviewing in the private setting of someone's own home has the potential to increase the risk of intrusion via self-disclosure due to the informal atmosphere (La Rossa et al., 1981; Stalker, 1998). Many participants were extremely hospitable and friendly, offering tea, coffee, biscuits, cake, and even lifts to and from the train station. The research, however, was unconcerned with what was occurring in the setting, or the nature of the relationships between participants.

The only indication that any of the participants might have disclosed more than they had originally planned to divulge relate to information that was almost always signified by comments such as 'I shouldn't say this but' and generally occurred during interviews with staff and related to what might be considered 'controversial' statements, views or revelations about the way things were, rather than personal information. For example after commenting on the past reliability of the fit persons check for providers someone said:

> 'And that's not for printing...I hope there are not too many controversial things I have said that you will have to anonymise hugely.'

> 'First care manager: We could get hung for all this couldn't we?
> Second care manager: No.
> Third care manager: Well why shouldn't we be telling the truth. We are telling the truth so.'

It seems unlikely that the participants, with hindsight, would have regretted the things that they said even when they highlighted the sensitivity of such information. One relative did say that he/she had felt so angry that he/she would have liked to shoot the home owner.

The ordering of the interview questions was designed to follow the likely temporal and narrative flow of the experience of home closure and the questions were designed to be obviously relevant and salient. This seemed to work well. In some interviews it was

the interviewee who was clearly in control of the interaction with the interviewer interjecting a few specific questions about details while they described their experience at length. The nature of the topic was also such that while it might have involved stressful, upsetting, or traumatic events, it was something they were unlikely to feel responsible for since the closure decision was very much beyond their control.

A number of people said that they were glad of the opportunity to tell someone about what had happened, to reflect on events and their views about it:

> 'I have sort of appreciated the opportunity to talk about it, because when you have got something on your chest it is nice to get it off in a way isn't it?' (Additional relative 3)

Techniques for preserving the confidentiality of the data included: the use of pseudonyms in all reports and papers to protect participants' identities, neither the care homes nor local authorities were identified; data were confidential to the research team; care managers and /or home staff were asked to allocate their own codes when providing information about the attributes of individuals. Similarly, descriptions of the homes were kept to a minimum to protect confidentiality. For example where summary characteristics are provided about the closure processes they are not linked to detailed information about the homes, such as their sector of provision, whether they provided residential or nursing care, or their location in terms of region or authority type.

5.7 Summary

The research wanted to identify the extent to which councils had guidelines for managing the voluntary closure of care homes, the roles, responsibilities and powers of local and national government, what happened when a care home closure occurs and recommendations, approaches, procedures and policies for improving practice from the perspective of the key participants.

The research included two main components: a survey of councils' closure guidelines; and a qualitative investigation of the process of closure via interviews with key

participants around multiple 'case study' closures. The exploratory nature of the research aims and the focus on people's experiences suggested that a qualitative approach, which focused on talking to those with direct experience was appropriate.

A national survey was conducted to establish the prevalence of councils' closure guidelines. The greater part of the closure case study data collection consisted of in-depth qualitative interviews and a wide range of data was collected:

1. Resident interviews
2. Relative and carer interviews
3. Demographic and basic information about residents collected from care managers
4. Follow-up information on residents' short term outcomes from care managers
5. Example of councils' care management assessment and review forms
6. Social services senior manager interviews
7. Care manager interviews
8. Care manager 'Activity and time use logs' of daily 'closure' related tasks
9. Care home staff interviews (and/or questionnaires before the closure)
10. Care home staff questionnaire or telephone interview about 3 months after closure)
11. Inspection reports of homes
12. Examples of social services care management documentation

The closure guidelines were reviewed and analysed using quantitative and qualitative techniques. The interview data was analysed qualitatively by perspective before being reviewed together to identify processes and influences within and across the closures studied. The research raised a number of ethical considerations, particularly in relation to gaining informed consent, and avoiding undue intrusion and the protection of research participants' interests.

Chapter 6

Data and participants

6.1 Introduction

This chapter describes the data in terms of the response achieved, and the characteristics of the data and participants. The response to the survey of council guidelines is described first, and then the number and characteristics of the homes that closed. Next, the inspection reports received are briefly reviewed. The range of closure situations included in the sample is highlighted, focusing on process factors such as the length of notice and the ways in which people were notified. The homes described by the additional sample of relatives are also highlighted. Details about the research participants are presented, including sample sizes and demographic and other relevant characteristics. The resident information and care manager activity and time use data provided by care managers are also outlined. The scope and representativeness of the various sources of data is highlighted throughout, as is the coverage of the data across the closures.

6.2 Response to survey of council guidelines

In total, information was collected from just over one-third (55) of the 150 councils in England. Of those councils with over 100 independent care homes 68 per cent (48) responded. Thirty-three protocols or guidelines were received and analysed. They included guidelines from twenty-seven of the larger authorities and a further seven councils with fewer homes. Of the responding authorities with large numbers of homes 62 per cent said they had guidelines in place and 37 per cent said they did not.

There might have been more protocols in use than reported. Different local authority departments responded, and telephone enquiries as to the existence of protocols also typically involved being put through to more than one department. Obtaining a definite no as to the existence of a protocol was consequently difficult; knowing which

department should be contacted was far from straightforward and deciding when all relevant departments had been contacted more so. Sources of protocols or information included: Adult Services, Contracts, Commissioning, the Directors Office, Communication, and the Policy department within councils, and the National Care Standards Commission. Moreover many of the protocols received were formal policy level agreements, outlining responsibilities and resource allocation. Discussion with care managers leading closure teams highlighted that they sometimes developed guidelines, and these might not have been known about at higher levels.

Appendix 24 shows the response to the survey from local authorities with more than 100 care homes by type of authority. Shire Counties were slightly over-represented amongst the councils with over 100 care homes that responded, with a response rate of 80 per cent. The majority of councils that reported having no protocol were in the South East. Of the guidelines received almost half were from the Northern and Yorkshire region and the North West.

6.3 Home sample and characteristics

During 2002, information was collected about nine closures in five local authority areas. Dr Ware recruited two of the local authorities and conducted the interviews with social services staff, residents, relatives and care home staff linked to these closures. Four of the closures occurred within one of these authorities. She also collected the additional resident information provided by care managers and conducted around half of the additional relative interviews and commented on drafts of reports to the funder and a journal article on the care managers' experiences. Kate Henderson contributed by interviewing some of the residents, and relatives linked to other study closures.

The homes closed between May and September in 2002. The closures occurred in a range of authority types: two shire county authorities, two metropolitan district councils and a shire unitary authority. They were located in three geographical regions. Four occurred in the same local authority. The ninth closure was considered a 'mini' case study, as it involved a small data collection of interviews with a manager, one care assistant, and one resident, who had been identified and approached via a relative who

volunteered to take part. All of the case study closures were voluntary, and each closed for a combination of financial related reasons. These included: financial non-viability; the anticipated capital needed to make premises comply with the National Minimum Standards; the unsuitability of premises (one owner said that if the business was bought it could not be re-registered as a care home); business rationalisation; expiry of the building lease; staff recruitment problems; low local authority fee levels; and/or owners impending retirement.

Table 6.1 shows the distribution of sector, home type, average size, and whether they were part of a chain.

Table 6.1. Summary of closed homes: sector, type of home, size and whether chain

	Closure homes (n=8)[1]
Private sector	7
Voluntary sector	1
Nursing	1
Residential	6
Dual registered	1
Average number of places in the residential homes	22
Single home	4
Chain of two or more homes	4

[1] The ninth 'mini' closure was a residential home in the voluntary sector, and a chain of two or more homes

Table 6.2 provides a profile of the homes in terms of the number and funding of the relocated residents. Seven were in the private sector and two, including the ninth mini case study, were in the voluntary sector. The case studies included each type of care home: the majority were residential homes, although a nursing home and dual registered home were included. One was registered to care for older people with dementia, and another cared for older people with mental health problems. Three additional relatives described nursing home closures and another a dual registered home closure. The sample of homes was not untypical of the national population of care homes in terms of home type and sector (See Chapter 2 for a discussion of care home characteristics).

Table 6.2: Profile of homes: type, size, occupancy and source of funding

Home closure	*Home type*	*Number of registered places*	*Publicly funded & allocated to known care managers*	*Publicly funded by other areas or authorities*	*Self-funded residents known about*	*Total number of residents at time of closure*
1	Nursing	> 29	10	Unknown	1	23
2	Residential	<20	7	9	3	19
3	Residential	> 29	12 of 18	3	7	28
4	Residential	<20	13	0	1	14
5	Residential	20-29	15	2	1	18
6	Residential	> 29	9	0	2	11
7	Dual	> 29	22	2	6	30
8	Residential	> 29	25	1	5	31
9	Residential	20-29	Unknown	Unknown	Unknown	Unknown
Total			113	17	26	174

The case study homes ranged in size from 17 places to 38 and the average size across all home types was 25 (only including the places that were closed from the home that 'downsized'). Five of the homes were registered for 30 places or more. The average size of the residential homes was 24 places. The residential homes were slightly larger than the national average at the time, although national estimates varied (See Chapter 2 and Appendix 2). Most were small businesses, rather than large corporate firms,

although half were part of a chain of two or more homes. Of these, one was part of a national chain, another part of a chain of less than ten homes, and another part of a chain of two. Overall, the homes were not untypical of closures that were occurring nationally (see Chapter 4 for research findings about the types of homes that were closing).

6.4 Homes described by sample of additional relatives

The seven homes described by the additional relatives were also in the independent sector and closed for financial reasons. Three were nursing homes, two residential, one a nursing home for Elderly Mentally Infirm (EMI), and another a dual registered home. These homes ranged in size from 14 to 50 places and the average size was 31 places. Three homes had less than thirty places. The largest were a nursing home with over thirty places and an EMI nursing home with about fifty places. This information about home size, however, was likely to be an under-estimate, as some of the relatives knew the number of residents who had to relocate but not the number of places registered.

The accounts of the additional relatives provided increased variation in the experiences described, and covered more extreme situations, such as shorter lengths of notice, as well as closures in a further two local authorities, both metropolitan districts. One of these relative also said the home had received a critical inspection report at the same time as it was making a loss, and another said a closed home had failed an inspection due to the need for building repairs.

6.5 Inspection reports

Nine inspection reports were reviewed (see Appendix 25 for description of their nature and scope). The inspection reports of the homes generally confirmed the expectation that only proprietors of 'good quality' homes agreed to take part. This does not mean, however, that the homes were beyond improvement, or that inspectors had no concerns. A complaint was upheld at one of the homes about the smell of urine, the poor quality of the food and the lack of supper, which had consisted of drinks and biscuits. Participation from this home was relatively low; it consisted of interviews with an

assistant manager, a care assistant, a relative and discussions with the team of nine care managers and team leader working on the closure. The detrimental effect of the lack of a registered manager at another home was noted on staff moral and resident care. Other concerns about the quality of care at the homes identified in the inspection reports included a lack of awareness at two of the homes amongst residents interviewed of their entitlement to read what was written about them in their care plans, a lack of awareness amongst residents interviewed at one of these homes that they could lock their bedroom doors, and concern about the need for more social stimulation and activities at another home. The need for environmental improvements, including re-decoration and re-furnishing was identified in four of the inspection reports.

6.6 The closure processes

The closures included a range of situations in terms of length of notice, the form of closure notification, and the degree to which home staff, and social services staff were involved in the relocation process. Box 6.1 presents a summary profile of each closure process focusing in particular on the form and length of notification and perceptions of the involvement of the home staff and care managers in the relocation process. For example, in Home Closure 2 residents, families and staff were told the month in which the home would close, rather than a specific closure date as in the other closures. In another, Home Closure 3, the closure date was changed and postponed by four months. Little was known about the nature of voluntary home closures in general, or the possible dimensions of heterogeneity, so it was difficult to gauge the degree to which the closure processes were representative of closures more generally (see Chapter 4).

Box 6.1: Summary of key closure process characteristics

Home Closure 1

One month's notice was given to families and informal carers and the social services department. Relatives were notified of the closure by letter and/or telephone, and relatives notified residents. Relatives described the manager of the home as having helped actively to find potential new homes and liaised closely with social services.

Home Closure 2

The amount of notice given to social services was unclear, as the date of notification was not established. A social worker was allocated to the closure at least six weeks in advance of the initial closure date and the owner decided to stay open for a couple of extra weeks until suitable accommodation was found for all residents. The proprietor worked with the social worker to find and select suitable homes. Few of the residents had relatives.

Home Closure 3

Families and informal carers were given six months notice, and no specific date was set. Relatives and some residents were told of the closure at group meetings attended by the home management. The manager of the home took an active role in helping to identify potential alternative accommodation for residents if they so wished; care staff perceived the role of care managers' as minimal. The majority of the residents moved within five months.

Home Closure 4

The owners closed the home after having extended a sister home. All but one of the residents moved to the sister home. Initially six weeks notice was given but this was put back by four months. There were rumours between residents, relatives and care staff about the possibility of closure. Relatives said they received a letter about the closure within days of the rumours.

Home Closure 5

Reports of the length of notification differed. Social services reported eight weeks notice and a relative said they were given a months notice by letter. Relatives said home staff were helpful and supportive.

Home Closure 6

Eight weeks notice was given to relatives by letter. The closure consisted of a larger home closing the places that were located in one building and re-registering the remaining places in an adjoining building as a smaller unit. Some of the residents moved before the closure date. The care managers said the home said it was their responsibility to notify residents.

Home Closure 7

Six weeks notice was given to relatives by letter. Four of the nine relatives interviewed reported either having seen an article in the local newspaper about the home being re-developed or having been told about the article or planning permission by staff in the week before being notified by letter. Care staff spoke of their preference for relatives informing residents of the closure, and of feeling that the owner had been far from honest with them.

Home Closure 8

Relatives were sent a letter inviting them to attend a meeting for all relatives, which was attended by managers and a representative from social services. They were told the home would close in about three months, once all of the residents had been relocated. After about two months, when the majority of the residents had moved and some staff had left, relatives said they were asked to 'get on' with moving the remaining residents.

Home Closure 9 ('Mini' study)

The closure of the home was discussed for two or three years, which meant that some families were told of the plans for closure when their relatives were being admitted to the home. The closing home merged with a neighbouring home, which was being extended and refurbished. The move was delayed by at least six months.

Four of the additional relatives were given one month's notice and three were given two months. One relative was given three weeks notice during two previous closures. Their notification was typically by letter. In one case, a letter was inexplicably received more than a week after the date marked on the letter, so the month's notice was reduced to three weeks. This letter also stated that the owner wanted alternative accommodation to be found as soon as possible because he could not guarantee staff would stay to cover the impending Christmas holiday, which fell within the notice period.

6.7 Overview of case study participants

Overall, ninety-one people participated via interviews or questionnaires in the case study data collection. Interviewees included ten residents, 28 relatives, seven relatives with experience of other recent closures, six owners or managers, 16 care home staff, and 24 social services staff. Table 6.3 shows the total number of people interviewed (note: some care staff took part via a questionnaire) by the number of home closures or authorities.

Table.6.3: Total number of research participants

Participants' role	*Number of people*	*Number of home closures*
Residents	10	4 homes
Relatives or friends	28	8 homes
Additional relatives	7	-
Home owners	4	4 homes
Care home staff (including two assistant managers and two managers)[1]	18	5 homes
Social Services care managers or care manager assistants	16	3 councils
Care manager team leaders or assistant team managers	5	4 councils
Social services district managers or higher	3	2 councils
	91	

[1] Participating care home staff took part in various ways including the completion of questionnaires as well as interviews. Only 8 non-management care staff took part in interviews. Further details are described below in section 6.9 and provided in Appendix 28.

6.8 Resident and relative response and characteristics

In total, 45 residents and relatives participated: 10 case study residents; 28 case study relatives and seven additional relatives. In two instances, both a resident and one of their relatives were interviewed, so the total number of residents known about via the interviews was 43. Relatives volunteered from eight of the nine closures studies and residents volunteered from four. Unfortunately, none of the relatives from the home providing for older people with mental health problems volunteered, where the care manager considered it inappropriate to contact residents. The care manager reported that some residents had no relatives, including four of the seven she helped to relocate, and some had relatives who did not get involved in the relocation.

Appendix 26 summarises the characteristics of the residents known about via interviews. Ten residents from four of the case studies, including the 'mini case study',

were interviewed. Five lived at the same home. The average age of the interviewed residents was 81 years old, which was younger than the residents whose relatives or informal carers were interviewed, and younger than the national average (see Chapter 2). Seven were women and three were men. One resident had mild learning difficulties. Another interviewed resident had some degree of low-level cognitive impairment. Half were publicly-funded and half self-funded. One resident had previous experience of home closure.

The mean age of the twenty-eight residents who were described by relatives or friends, was 89. Three quarters of these were women, and half said to have some degree of cognitive impairment. Eighty two per cent were publicly-funded, compared with half of the interviewed residents; self-funded residents were slightly under-represented in comparison with publicly-funded residents within the homes and the wider population of care home residents.

The average age of the seven residents discussed by the additional relatives was 87. Again, three times as many of these residents were women than men. Almost all were said to have some degree of cognitive impairment and the majority were publicly-funded. Two of the additional relatives had experienced more than one home closure. Two described the same closure.

Overall, the sample of residents, either interviewed or discussed by relatives, was similar to the national population of older people in care homes: average age was 87, 72 per cent were women and 72 per cent were publicly-funded (see Chapter 2). The sample included: residents who were slightly older than the national average of 85 years; a higher proportion of men (28 per cent compared with 20 per cent nationally); an approximately equal proportion, one-third, of self-funded residents; residents who, on average, had been in the closed homes close to the estimated length of predicted stay among the population in residential care (27 months compared with between 28.9 and 30.7 months); a lower proportion of residents with some level of cognitive impairment (Bebbington et al., 2001; Netten et al., 2001).

Unfortunately, it was not possible to assess how representative participants were in terms of health and social care needs as these were not assessed or reviewed for the

research. Anecdotally, it can be stated that the residents interviewed, and discussed by relatives, included older people with a variety of illnesses and physical disabilities The majority of the relatives were the adult children of residents, although a variety of relationships were represented, with the exception of spouse or partner. Appendix 27 summarises the relatives' relationships to the residents. Chapter 2 highlighted that most care home residents are widows, so the lack of spouses is not unrepresentative of the wider population of relatives of residents. Some were retired and some were working. One adult daughter said being retired was advantageous because it meant she had more time to deal with the closure. The sample included relatives who lived near the closing home and relatives who did not. One relative lived a five to six hour drive from the closing home and the new home and said that dealing with things on the phone was more difficult than it would have been face-to-face.

It was difficult to review the typicality of the relatives, either in terms of the wider population of relatives of care home residents, in terms of how usual or rare it was for care home residents to have relatives and/or relatives that actively provided support or help to manage their affairs. The sample might have been biased in terms of the amount of social contact with residents. Relatives were not asked systematically how often they visited. Eleven of the 35 relatives, however, volunteered information about visiting their older relative on a frequent and regular basis, such as once a fortnight, two to three times a week or even everyday. Relatives with little active involvement in the lives of residents or the closure process were under-represented, but this was unsurprising given the aim of the interviews was to discuss their experience of the process.

Chapter 2 highlighted some characteristics about informal carers in the community and care home residents that allow some inferences to be made about the characteristics of the sample of relatives interviewed. For example, about one-third of informal carers caring for those in the community were likely to be 'old' themselves and the study included adult children who were themselves close to retirement age and had adult children themselves.

6.9 Care home staff response and characteristics

In total, eighteen care staff/employees participated via interview and or questionnaire, from five of the homes (including the 'mini' closure), including thirteen care assistants, one nurse from the dual registered home, two assistant managers and two managers. Twelve care assistants, one senior care assistant, one nurse, two managers and two assistant managers took part. A further four interviews were carried out with owners at two of the homes, a closure project manager at a third and a director at a fourth. Understandably, these interviews differed considerably from the staff interviews in terms of topics discussed and perspective. A different topic guide was used (see Appendix 12), which included discussion of the reasons for closure and the reasons for the length and form of notice.

Of the remaining four closures, two owners did not respond to requests to contact their staff so they were not contacted (unfortunately, this included the nursing home), none of the staff volunteered from one, and at another it was agreed that staff would not be contacted as it was too difficult a time, due to problems finding new placements for residents.

Eleven interviews were conducted with staff. Of these, nine were audio-taped and transcribed and notes were taken during the remaining two on request. Ten staff from three case studies completed the questionnaire before the homes closed, including one manager and an assistant manager. Fourteen agreed to be contacted, and were telephoned or sent a second follow-up questionnaire (including a home manager). Of these, however, only eleven provided address details. Seven staff from four case studies provided follow-up information, including three care assistants, one nurse, one manager, and two assistant managers.

Unfortunately, the response rate amongst the care staff within each home could not be established. The inspection reports provided insight into some staffing issues, but none specified the number of care staff employed. One report outlined staffing in terms of staffing hours and stated there could be up to 15 staff on duty in the morning, up to nine in the afternoon, four in the early evening and three thereafter. (The staff/patient ratio

was then highlighted as something that needed addressing). The number of care staff employed appeared to be something that owners/managers found it difficult to specify. One owner, for example, estimated there were about twenty five staff overall, of which only five were full-time.

The response from staff across the homes was low; only a few participated from each home. In two homes only one manager/assistant manager and one care assistant took part. At another two homes, participation was limited to only three or four people, and even the home where seven staff took part only two returned the follow-up questionnaire. Potential reasons for this were discussed above. However, participating staff were sometimes upset, so this in itself did not necessarily prevent participation.

Appendix 28 shows the number of participating care home staff by case study and method of participation. A number of those who took part did so in more than one way, although fewer than was hoped. For example, four of the interviewed staff completed the first questionnaire, and two completed both questionnaires. A further three of those interviewed provided follow-up information, when they had not completed the first questionnaire. Five staff in two of the homes completed the first questionnaire only.

The range and distribution of staff characteristics, backgrounds and career profiles are now described briefly in relation to their qualifications, experience, job type and hours worked. The majority of the care staff (eight of the eleven who supplied information about qualifications) had no National Vocational Qualifications (NVQs). Four staff had an NVQ in Care. Other qualifications held by care staff included a certificate in Care Practices Part 2 and a City and Guilds certificate in Family and Community Care. Other qualifications held by managers and team/assistant managers included a BTEC (Business and Technology Education Council) in Care of the Elderly, a City and Guilds Certificate in Advanced Management of Care, and a Higher National Certificate (HNC) or Higher National Diploma (HND) in Social Care, and D32/33 Assessor qualification. Four staff said that they were working towards a qualification: a care assistant was working towards a Level 2 NVQ in Care; a nurse and a team/assistant manager were working towards an NVQ Assessors course/ D32/33; and a team manager was working towards NVQ Level 3 in Customer Services.

The sample included staff with both extensive and limited experience of working in care homes for older people. Most had worked in health or social care work for considerable time; six had worked in care work for over ten years (of these two had worked in care work for over twenty years). At the other end of the spectrum, only one person had worked in the field for less than a year, and two care assistants had no prior experience of care work, and had worked at the closing home for only one-to-two years. However, most had worked in other care homes for older people. Two had worked in homes for other client groups and two reported caring for people in their own homes. Other experience of care work identified included working in hospitals, working as a nanny and looking after relatives. It is likely that most of those who took part were relatively committed to care work given the length of time they had worked in the field.

Length of time worked at the closing home ranged from seven months to over 15 years. The majority, however, of those who reported time employed at the closing home had worked there for less than three years (seven staff). Two had worked there for less than a year. Three had worked there between four and nine years, and one care assistant had worked at the closed home for seventeen years.

The number of jobs held in the last five years ranged from one to four: some had worked in the same job for the last five years; others had had two or three different jobs; and one person had had four different jobs. One care assistant had previous experience of home closure, having experienced three.

Staff had similar contracts of employment; of the eleven staff who gave contract details, ten said they had permanent contracts. One care assistant added that she had worked for an agency before becoming a permanent staff member. A nurse said she that she had no contract at the closing home and was still waiting for one in her new job. Ten staff from three homes reported the number of hours worked, and of these nine worked 30 hours a week or more. Six worked full-time, in terms of working over 35 hours a week.

The participating care staff reflected the social care workforce in independent care homes in general, in terms of gender, age, and length of time spent working in the field of social care, although not in terms of ethnicity or hours worked. The staff that took part were similar in terms of gender and ethnicity. All eighteen employees were women

and all but one were of white British ethnic origin. One care assistant was Chinese and English was not her first language. Eleven staff gave their ages. Two were in their 20s, two in their 40s, and two in their 50s. Four women were in the 30s and one was in her early 60s.

Participating care staff were less typical of the population of care staff in terms of hours worked and contract type. Ten staff from three homes reported the number of hours worked, and of these nine worked 30 hours a week or more. Six worked full-time, in terms of working over 35 hours a week, which was atypical (see Chapter 2). All were employed by the home; none were agency staff, which was atypical of the workforce (see Chapter 2). Some of the homes had employed more agency staff that permanent staff. An interview with a general manager established that about sixty per cent of the staff at one home were agency staff, albeit agency staff employed on a long term basis. The inspection report from this home also noted that it relied heavily on agency staff to cover vacancies, which at one point included eight full and part-time day care and night care posts. One of the homes, unfortunately where none of the staff participated, was reported to use no agency staff in the inspection report, which was unusual.

6.10 Social services staff response and characteristics

Across eight closures, 24 social services staff participated in four local authorities, including 16 care managers or less qualified care manager assistants, five team leaders, or assistant team managers (with responsibility for overseeing the team) and three senior managers. Eighteen interviews were audio-taped and transcribed. Appendix 29 shows the number of participating social services staff by council, home closure and job. Interviews with care managers and social services staff took place between May and October 2002. Seven care managers described their closure related activities in activity logs.

Four of the home closures occurred in the same council and were managed by the same care management team. Another two of the closures occurred in the same council, but in different boroughs and care manager(s) took part from two area offices. The three senior managers were linked to two of the local authorities (the Deputy Head of

Community Care in the authority where four of the closures took place, and the Head of Adult Services, and a District Manager at another authority). Two of the care managers said they were senior social workers, at level 3.

In most authorities the sample represented the population in question, that is, the care managers involved in the home closures took part. They included men and women, although most were women, which reflected the gender balance within the wider social worker workforce (see Chapter 2). Participating staff included staff in senior positions, as well as qualified social workers and less qualified care management staff, staff with considerable experience and staff who were relatively new to the job, and staff who had prior experience of care home closures, as well as staff form whom it was a new.

6.11 Resident information provided by care managers

Care managers provided short-term outcome information for 120 of the 174 residents relocated in the main eight closures. Care managers at three of the councils provided copies of resident care plans, assessments and/or reviews for 22 residents. Care managers at another of the authorities provided examples of the forms used. Appendix 30 shows the number of residents for whom outcome information was provided by home and number relocated. The care managers were able to indicate whether these residents changed type of placement when they moved, moved again, and whether they had died at the time of the care management reviews.

6.12 Summary

Just over one-third of councils in England responded to enquiries about closure guidelines and of these two-thirds reported having guidelines and 33 were received and analysed.

Nine case study closures were identified and investigated (including a 'mini' study which involved one care manager, once care assistant and one resident). A range of situations were included in terms of length of notice, form of notification, and the degree to which the home owner, councils and social services staff were involved.

Overall, ninety-one people participated via interviews or questionnaires in the case study data collection. The number of residents interviewed was small but not atypical of the general care home population in terms of gender, age, funding and length of stay. Assessing the degree to which the participating relatives reflected the wider population of relatives and friends of care home residents was problematic because so little is known about this group. Eighteen care home staff from five homes, including some managers, took part via interviews or questionnaires. Social services staff with a range of seniority and level of involvement in the closures took part, including District Managers, front-line care managers and team managers responsible for co-ordinating closure work. The sample included staff with previous experience of working on home closures and staff new to such work. The nature and extent of closure work carried out by care managers was investigated via records/activity logs kept by seven individual care managers and a review of the assessment, care plan and review forms used, as well as via interviews.

Chapter 7

Council closure guidelines

7.1 Introduction

All local authorities in England were asked if they had local guidelines for managing the voluntary closure of independent care homes for older people. The aim was to identify the prevalence of local guidelines, their aims and objectives, how roles and responsibilities were allocated and any recommended approaches, policies and procedures. This chapter describes the findings first, in terms of the number and prevalence of councils that had closure guidance in place in 2002, and second in terms of the nature, scope and content of the 27 plans and policies that were provided for analysis[1].

The terminology used reflects that used in the guidelines and as a result reference is made to registration and inspection units (which were subsequently replaced) and to residential homes and nursing homes, which became known as care homes with or without nursing care.

7.2 Prevalence of guidelines

Fifty-five councils responded to enquiries about the existence of local guidelines for independent sector voluntary home closure (see Chapter 6 for details). Of these, two thirds reported having guidelines in place.

Appendix 24 shows the number of larger councils (those with more than 100 homes) that reported having guidelines, and the number of guidelines received by type of authority. A further seven councils with fewer than a 100 homes also responded, and all of these reported having closure guidelines.

[1] The findings reported here were published in a journal article, details of which are outlined in the list of Publications and Presentations at the start of the thesis.

The analysis focuses on 27 guidelines, 22 of which were from larger councils, and five from councils with fewer than 100 care homes. Half covered voluntary closures only and half covered both voluntary and emergency closures. Another six guidelines were received but excluded because they did not concern voluntary closures in the independent sector: four covered enforced closures only and two related to the closure of council run homes.

A variety of different departments within authorities responded, including Adult Services, Contracting, Commissioning and the Director's office. This suggested that the process of obtaining a definitive no as to the existence of a protocol was complicated. Several of the council staff who responded in the negative attributed the absence of closure guidelines to the impending launch of the National Care Standards Commission (NCSC); five said they were expecting the NCSC to produce guidelines in the near future.

7.3 The nature and scope of the guidelines

The nature of the guidelines varied in terms of age, status, scope, length, authorship and intended audience. The organisations involved in developing the guidelines, as well as the intended audience, were characteristics of the guidelines likely to affect the breadth of their scope, relevance and capacity to support a coordinated response. Date of publication, where stated, ranged from 1994 to 2002. Just under a third were drafts or being updated. Some said they covered all aspects that might occur during a closure, and others outlined key issues or actions. Five guidelines were checklists and about half included single or multiple checklists as appendices. Appendices also included examples of relevant paperwork. Length ranged from one page to 71 pages. A third were between two and six pages long. Just under a third were developed or agreed jointly by health and social services. Some were aimed at a single main audience, such as the care management team or providers, and others at multiple audiences, such as different departments within councils, or other agencies.

Voluntary closures were generally classified as planned or unplanned and/or urgent, but definitions of planned sometimes varied. Planned voluntary closures were typically

distinguished from unplanned voluntary closures in terms of reason for closure, but were also discussed in terms of timescale. For example, planned voluntary closures were described as those with a minimum of six to eight week's notice, and urgent voluntary closures as those with less than six weeks. Such definitions of urgent differed considerably to those used in the context of emergency closures, where urgent could mean as little time as a week or even a few hours. One guideline defined unplanned voluntary closures in terms of reason for closure, that is, those caused by financial failure or staffing issues. Clearly, a closure due to financial failure might be sudden and could be considered just as much of an emergency, in terms of requiring the urgent relocation of residents, as an urgent enforced cancellation. However, providers might consider closures instigated by themselves for financial reasons as planned when compared with those forced on them by the regulator, and closures that occur within six weeks or less might still have been planned. The purpose of distinguishing between planned or unplanned voluntary closures appeared to be to indicate short timescales.

7.4 The content of council closure guidelines

The main issues, recommendations and concerns identified in the guidelines were the length of notice providers should give councils, the form of notice given to service users, the allocation of roles and responsibilities, the role of care home staff, and the councils' role in finding alternative and appropriate accommodation for residents, including the provision by councils of community care needs assessments, and help and support during relocation and review and follow-up afterwards. Resident preparation, temporary moves and resources were commented on infrequently.

7.4.1 Aims and objectives

Less than a third of the documents outlined aims and objectives. The majority of those that did identified supporting and protecting the rights and interests of residents, carers and relatives, and ensuring their safe transfer to appropriate care. Just under half summarised general principles of good practice, many of which reiterated broad aims, such as minimising resident disruption, stress and distress, and promoting independence, choice, privacy, dignity and respect. Two protocols noted that offering a choice of alternative accommodation was likely to be difficult.

7.4.2 Roles and responsibilities

The allocation of both overall and specific roles and responsibilities varied across the guidelines. The allocation of overall responsibility for a closure included a co-ordinating task group spanning different agencies, one agency, such as the regulator, or more commonly, an individual such as a District Manager within Social Services. One policy varied responsibility depending on the type of closure: councils were responsible when closure was voluntary and the regulator when closure was an enforced cancellation.

Most of the guidelines that allocated specific responsibilities identified care management staff as responsible for helping residents find alternative accommodation. Four guidelines, however, said the proprietor or person in charge of the home was responsible, although one added that they should be encouraged to work with care managers. In two of these cases the proprietor was said to be responsible for making arrangements, in the first instance, even when the closure was an enforced cancellation. It would seem particularly inappropriate to give to a proprietor of a home that is being closed by the regulator lead responsibility for helping residents find accommodation best suited to their needs.

Approaches to assigning care managers to residents of closing homes varied and included allocating: care managers who had assessed the residents before admission; an existing specialist team, such as a review team; a temporary team; or any of the above depending on the timescale.

Responsibility for many practical tasks varied. Obtaining a current list of residents, along with details of funding arrangements, and the names of GPs and next of kin, for example, was the responsibility of the social services department in six guidelines, the regulator in five guidelines, and the proprietor or home manager in another five.

7.4.3 Legal issues

Just under half of the guidelines highlighted legal issues. These included councils' legal standing in relation to communication from the regulator; councils could not expect registration and inspection staff to alert them about the likelihood of home closure, for example by sharing concerns they might have about the financial viability of a

particular home. Some guidelines noted that councils did not have the power to move residents against their will. An issue with practical implications was that permission had to be sought from proprietors to move residents' records.

Guidelines offered conflicting advice about whether councils had the power or ability to pay existing care home staff or to provide new staff on a temporary basis to keep a home open long enough to ensure that residents were found suitable alternative accommodation. Some noted that council staff must not 'meddle' with the running of an independent care home. In contrast, two guidelines discussed paying or providing staff as options. Another said that it was impossible for statutory agencies to legally pay staff in independent homes because it would require the council to adopt responsibility for being registered as a fit person to run the home and there was no such thing as a temporary registration.

7.4.4 Notice

A quarter of the guidelines discussed the preferred or required length of notice for independent sector voluntary closures. While periods varied, the typical recommendation was for around one month, or as much notice as possible. Several guidelines considered the practicality of notice periods. Two said that a month was 'probably realistic' and another recommended between two and six weeks, depending on the number of residents requiring relocation.

Recommendations about who should be involved in deciding how service users were notified differed between authorities and by type of closure. Three guidelines stated that notification and consultation with service users was the responsibility of the proprietor. One recommended that care managers discuss the form of notification with the proprietor, and that the proprietor then notify service users with a representative from the registration and inspection unit. Others recommended that homes convene a meeting for relatives and residents, either together or separately. Others suggested that the form of resident notification should be decided flexibly and on an individual basis. It was sometimes noted that care managers might have to tell residents about closure if they had not already been informed. Some recommended that residents should be notified in writing rather than told verbally.

7.4.5 Provision of assessments, information and support

During a home closure social services staff and/or relatives and carers need to be able to identify homes with a vacancy before deciding whether a home meets a resident's needs. The need for care managers to ensure that new accommodation is appropriate to residents' needs was emphasised frequently. A small proportion of guidelines referred to the need to consider the social and personal needs of residents and their relatives and carers when finding new placements. Those that did referred to the need to consider factors such as existing friendships between residents, preferred location, and the ability of relatives and friends to visit. The central government recommendation that friends should be moved together, made in the context of transferring long-stay hospital patients (discussed in Chapter 3), was referred to explicitly only once, although six recommended trying to keep friends together. One guideline highlighted the complexity of identifying friendships between residents:

> 'Sometimes relationships are observed to be positive by outsiders, but one of the partners could be experiencing some form of abuse... It should not be assumed that relationships between confused people or people with a learning disability are less important to them than between others.'

The importance of considering the needs of minority ethnic communities was identified in one document. Six recommended the use of advocacy services.

Planned approaches to providing needs assessments varied across the councils in terms of whether assessments were to be offered to:

- all residents
- residents' whose health and social care needs had changed
- publicly-funded residents only
- publicly funded residents and those self-funded residents without help or the ability to arrange a new placement themselves.

Six guidelines noted that councils have a statutory duty to assess publicly-funded residents. In contrast, eight noted that assessments should be offered to all residents irrespective of funding. In guidelines that covered both voluntary and enforced

closures, the issue of whether assessments would be carried out in both situations was often unclear. In the context of an emergency closure, one guideline said that residents would not necessarily be assessed unless their needs had changed since placement. How a change in need would be identified in the absence of an assessment was unclear.

Approaches to offering self-funding residents information, help and advice about finding a new home, also varied. One guideline referred to, and another quoted, the government recommendation that councils help all residents irrespective of funding. Two further guidelines also said that assistance should be offered to all residents. Only one guideline emphasised that assessments of self-funding residents should include a review of finances, since their financial circumstances might have changed making them eligible for support. Five guidelines, however, recommended that care managers should only offer information and advice to self-funding residents without relatives, or to those incapable of finding new accommodation for themselves. Yet another said that information and advice should only be offered to self-funding residents on request.

Written information for residents and relatives provided by councils, or registration and inspection units, included lists of homes or accredited providers, home brochures, and inspection reports. Little was said about ensuring the quality or usefulness of information. One guideline reminded care managers that they were obliged to restrict the advice they give to residents and relatives to residents' care needs. When looking for vacancies, care managers were variously advised to use a council vacancy list or to establish vacancies themselves, for example by telephoning homes or the contracts department.

7.4.6 Involvement of care home staff

The majority of the recommendations about involving care home staff were in agreement; seven guidelines recommended that care staff should be consulted, asked to help and encouraged to be involved in the closure process. Five highlighted the potential role of care staff in transfer arrangements. For example, one suggested care managers ask existing care staff to contribute to the continuity of care provided to residents by producing 'pen pictures' of residents' likes, dislikes and routines.

The importance of recognising friendships between care staff and residents was also emphasised. Recommendations included keeping staff informed about moving dates because they might want to say 'Goodbye' to residents. Three guidelines noted that care staff might be concerned about how residents settle in their new homes. Suggestions in response to this included asking staff to accompany residents to their new homes, something residents might also appreciate, and letting staff know how residents were later on. One guideline for emergency closures recommended that care staff be offered emotional support and counselling.

7.4.7 Resident preparation

Few guidelines discussed how residents might be prepared for the move other than making sure residents were told. One protocol referred to the value of encouraging residents to visit a chosen home to become familiar with the new people and surroundings, as opposed to help them choose a home.

7.4.8 Temporary moves

Few guidelines commented on temporary or second moves linked relocation due to closure and those that did offered different advice about their desirability. One suggested that temporary moves were a useful option when places are unavailable in a resident's preferred home as it allowed them to wait until one became available. Another suggested they be considered an option during emergency closures, if time were insufficient to find permanent placements. Another guideline advised that placements should be permanent rather than temporary.

7.4.9 Moving arrangements

Just over a quarter of the guidelines discussed the kinds of practical arrangements required when moving residents. Encouraging relatives to arrange or be present during moves was recommended, as was care managers' use of their own cars in preference to taxis. A pre-packed box of emergency equipment, containing secure bags for medication and parking cones for example, was mentioned in five guidelines and several referred to providing mobile phones. Only one highlighted the need to be able to identify and equip a reception centre in the event of a closure caused by a disaster, such as a fire or flood.

Advice about the way in which residents' possessions should be moved focused on ensuring the use of suitable bags. Two protocols stated that black bin liners should not be used. Another two, however, referred to ensuring adequate supplies of black plastic bags.

One guideline advised against moving large groups of people on the same day, in line with recommendations for relocating long-stay NHS patients (See Chapter 3). However, another recommended that care managers arrange for residents to move on the same day.

7.4.10 Follow-up

Approaches to following up residents via placement reviews and/or review of the closure process included informal checking of how residents were, formal review of the placement, debriefing of care managers and/or some form of evaluation. Five guidelines recommended that care managers continue to monitor resident welfare immediately after a closure. The majority of the guidelines that referred to placement reviews by care managers were in agreement about timing; seven stated that reviews should take place within four to six weeks of relocation. One suggested that residents be reviewed sooner, within two weeks. The guidelines rarely specified whether all, or only some residents, would be reviewed, although one noted that reviews should take place only 'for residents for whom we are responsible'. This appeared to have been generally assumed.

Only five guidelines recommended some sort of formal team debriefing, longer-term review of residents, or evaluation of the closure process. There was little reference to any record keeping by care managers for accountability purposes, other than one guideline, which noted that any complaints made by residents or relatives should be recorded.

7.4.11 Resources

Resource requirements and cost issues were rarely discussed, and those that were tended to relate to staffing. Four guidelines suggested how the number of care managers required might be determined: involve as few as possible depending on the time available; allocate one care manager to every three to five residents, with one care

manager to every five 'other placements' (presumably self-funding placements or 'out of area' placements); allocate a minimum of one care manager to four residents. Four guidelines noted that finding sufficient staff might be difficult. Suggested responses included the use of volunteers or extra staff, and the prioritisation of home closures over routine work.

7.5 Summary

The survey of English councils found that local plans were patchy; about one-third of responding councils had no local guidelines, and where there were plans, arrangements and recommendations differed. Substantial numbers of English councils had no guidelines for the voluntary closure of independent care homes for older people and considerable variation was found in the nature and content of the guidelines that were in place.

A wide range of inconsistencies and differences were found in councils' approaches and plans. These included differences in who was said to be ultimately responsible for helping residents find new placements (the council or home owner), policies towards providing community care needs assessments, whether councils had the legal power to pay existing staff employed in private homes, or to send in council care staff to help keep homes running to extend the length of closure periods, views about the use of temporary placements, and in good practice recommendations, such as whether to move residents quickly or gradually, the timing of placement reviews following relocation, and whether to avoid or ensure plenty of black bin bags.

Chapter 8

Residents' and relatives' perspectives

8.1 Introduction

This chapter presents descriptive analysis of residents' and relatives' experiences and views of care closure[1]. Information was collected about 43 residents linked to fourteen closures, and the analysis draws on interviews with ten residents, and 28 relatives, and friends linked to seven of the nine home closures, and a further seven interviews with additional relatives (for further details about the participants see Chapter 3). The findings are organised around issues discussed in relation to key phases of the closure process: notification; the availability of information, help and support; the maintenance of standards within the home; the moving day; and settling residents into new homes. Beliefs and views of temporary and multiple moves, and the need for measures to prevent closures are also described along with suggestions and recommendations to improve the experience from the residents and relatives perspective.

8.2 Notification

Aspects of notification discussed by residents and relatives included the length, form and content of notification. The form and experiences of notice reported by relatives and residents differed across the homes and between residents and relatives within homes. Some relatives expressed strong feelings about the order in which people are notified and about their uncertainty as to how to tell residents with cognitive impairment. The lack of security of tenure was also commented on and one relative suggested homes should be given a grant to enable them to prolong closure periods until residents were found places.

1 A version of this chapter was produced as a Discussion Paper for the Department of Health: Williams, J., Netten, A. and Ware, P. (2003) The closure of care homes for older people: relatives' and residents' experiences and views of the closure process, PSSRU Discussion Paper 2012/3.

8.2.1 Reactions to notice and views about length of notice

Some residents spoke of their shock and feelings of distress when notified of home closure:

> 'We were all shocked, surprised mainly.' (HC3 resident 3)

> 'It was a shock to learn that it was closing because we had no idea. None at all.' (HC3 resident 4)

> [I was] very upset and very worried... It did worry me.' (HC4 resident 12)

> 'So you can imagine the uproar it created. Well, for one I said 'well I wonder if he would like this done to his mother turning her out with no-one and nowhere to go'. (HC7 resident 15)

Most of the relatives described surprise or 'total shock'; some sort of forewarning was recommended to counteract this. A resident highlighted how some forewarning would have been particularly appreciated in her case because she had just spent money on new furniture for her room:

> 'I went berserk, I thought "oh no it can't be. I have just bought this furniture and a wardrobe, that chest of draws"... I thought 'well why didn't they tell me when I was talking about buying the furniture that they were going to close it down?' (HC7 resident 15)

Few residents expressed a preference about length of notice. One month was said to be too short by a resident who had experienced notice of only one month:

> 'It was panic stations for everyone. One lady was in constant tears all the time; she was in her 80s.' (HC7 resident 15)

Residents' recommendations for notice included more than six weeks, between three and six months, and as much notice as possible.

Residents identified various issues about notification length, including a couple of possible disadvantages that could be associated with a relatively long notice period, such as six months; it could pass slowly or be associated with residents developing a false sense of security, and then finding themselves being forced into accepting decisions sooner than anticipated

> 'Some (of the other residents) thought they had a long time and then they found the decision was being made for them and they had a week or a fortnight.' (HC3 resident 2)

However, another resident who experienced the same long notice period highlighted how residents reactions could vary since he said he started 'looking (for a new home) within a week' of notification' (HC3 resident 4).

One resident suggested that a less fixed notice period might help minimise residents' sense that they

> '... have got to go, because otherwise you will have nowhere to sleep'. (HC3 resident 5)

Notice periods recommended by relatives included two, three and six months. The main concern about notice identified by relatives was that it be sufficient to find vacancies and select a home: three, four and six weeks were considered too short; four months was described as a 'fait accompli'; a month was said to involve the risk of residents being placed inappropriately, or on a temporary basis; and six months was long enough for residents' names to be put on waiting lists. However, longer notice periods were not without disadvantages; residents would be living in a home in decline 'because in the run down procedure things do become neglected.'

8.2.2 Form of notification of relatives

Relatives reported finding out about closures by letter, telephone, at a meeting or via rumours; at four homes relatives or residents spoke of rumours at the home or local newspapers articles:

'We actually heard through the laundry lady' (HC7 resident 15)

'A few months ago, there was a piece in the newspaper about the owners. The owners had applied for some sort of permission to build some flats and I think it was going to be sheltered accommodation. But apparently they failed to get the planning permission or whatever they needed to do it. And then this cropped up recently, this is sort of perhaps maybe over just a week or so before we got the letter, there was something else in the paper about it being re-developed into flats.' (HC7 relative 1)

Relatives commonly identified involvement in meetings or discussions with proprietors as important and the preferred from of notification. Meetings had many advantages: they offered an opportunity to talk; notification face-to-face was described as 'more honourable' and considerate than a telephone call; and meetings meant people were told simultaneously. However, relatives highlighted that while meetings were 'an easier blow' than a letter, they were not unproblematic because the owner 'was closing it no matter what' they said. One relative reported appreciating a call from a carer who phoned everyone immediately to let relatives know the letter was in the post:

'She took it on her own back to phone everybody... That was the day that they were told and she got straight on the phone.' (Additional relative 2)

Relatives identified the order in which they, home staff and social services were notified as important, although views differed as to who should be told first; some said social services should be told first so they can contact relatives promptly, while others said relatives should be told first so they could tell residents:

'I can't emphasise too much, nobody in there should have known about it, even the staff, before the relatives had time to tell their mothers or fathers or whatever.' (HC7 relative 6)

The lack of prior consultation was identified as problematic by some relatives, who said they would have liked to have an opportunity to help find an alternative solution:

'They must have known for some time. We would have liked some communication then. We would have liked some options. It would have been interesting to know how many people would have been prepared to pay more money. Pa ended up paying £50 per week more at (new home)... I think that there were other people in there for whom it may not have been such a problem, who could have made that choice. I think it would have given us a sense of feeling of partnership – and having some sense of control.' (Additional relative 5)

'I think if each nursing home had invited relatives to a monthly meeting, put some coffee on, let us all go 'any ideas?'... But they are frightened that you will take them (the residents) away... they think you will take them away and then they have got to struggle through with no funds coming in.' (Additional relative 6)

Closures during the summer months or annual holiday periods were identified as difficult. Two of the homes closed in summer months and notification or the closure period coincided with relatives' holidays, and this caused problems such as feelings of panic, and problems contacting the 'right people' at social services in haste before departing.

8.2.3 Form of notification of residents

Interviewed residents reported notification by letter or at a group meeting. Few comments were made about this, although one resident spoke of regretting that the owner had failed to speak to residents, and said:

'They were probably too ashamed or too afraid.' (HC7 resident 15)

This resident, who was told by a care assistant, also lamented the lack of a 'proper conversation'.

Those who were told in groups on the same day said it was a good way to be told:

'I didn't see any other decent way of doing it.' (HC3 resident 4)

About two-fifths of the relatives said they told residents. Relatives from three closures and two additional relatives said home staff left notification to them. Two daughters told of putting off telling their mothers until they found new placements, because they did not want them to worry: "where am I going to go?" Some relatives described discussing or negotiating resident notification; requesting it be left to them; seeking advice from staff about timing; or requesting that a care manager tell residents with them.

Some relatives reported uncertainty about whether staff had told residents, and others said they knew residents had not been told. Residents who were not told tended to be people with a cognitive impairment. Approaches to notifying residents with a cognitive impairment differed; some relatives reported telling them, while others said they had decided not to. Some described apprehension, and fear, including being 'mortified', about telling residents. This was linked to concerns about upsetting residents and uncertainty about the best way to go about it: 'We didn't know how to'. The reasons given for not telling residents often centred on views about their inability to understand or recall the information:

> 'She wouldn't have known. You don't know whether they understand what you are saying. She can't speak any sense really.' (HC8 relative 2)

> 'She would have forgot about it two hours later.' (HC6 relative 8)

Those who told residents with dementia they were moving reported telling them it was for 'pull' factors, such as going somewhere to make them 'a bit better', rather than because of the home was closing:

> 'I asked her if she could remember the lady who had been to chat to her (the care manager) and that we felt that she needed more help, so she was going to go to somewhere new, where there would be more nurses and more facilities for her.' (HC7 relative 1)

8.2.4 Information sharing with recently admitted residents

Relatives told of owners allowing new residents to move in without informing them of the likely closure. At one home, several residents were said to have moved in only three or four months before the announcement, without knowledge of the closure despite existing residents having been told. One relative described anger that the owners 'must have known' and were motivated by money to accept new admissions: 'He knew at Christmas it was closing so why did he take Mum in? It's the extra finance. It boils down to money.' Being told admissions were likely to be temporary would have been preferable and given them the chance to choose elsewhere.

8.2.5 Content of notification and information needs

Residents and relatives identified being told the reasons for closure as important, along with reassurances that help was available, and suggested that vacancy information be provided from the outset:

> '… The reason that's important… it would be, to me, important that we know the reason why.' (HC3 resident 1)

> 'I sort of needed to know why' (HC6 relative 1)

> 'I think that the most important thing to get right at the beginning is to say that you have rooms ready to take people … to say to the people beforehand: "We are closing this place down, but we have rooms in this place, that place, and that. You can go and see them and there are rooms and you ca
> n have a choice".' (HC8 relative 3)

> 'They didn't say, "Well, we are closing, but we have got an ideal spot for you"' (HC7 resident 1)

That owners should not give false accounts of flexibility and should provide clear information about what relatives were expected to do were also highlighted:

> 'They made it sound brilliant. That places would be found for all the old people in time and there was no hurry and it would take as long as took sort of

thing. And the staff were going to stay on and look after the people and everything was just going to be honky dory. And the next thing... the story had changed... they had got to go.' (HC8 relative 3)

One relative who said she was told social services would contact her, said when they failed to do so she contacted them herself only to be asked why she had not started looking for vacancies. She concluded that the lack of contact was because her mother was self-funded:

'Maybe because mum was self-financing they weren't sort of worried... If they had just spelt it out in black and white, what I should do next.' (HC8 relative 2)

8.2.6 Security

Security, or the lack of it, was discussed explicitly and implicitly: security of tenure was identified as desirable; the ongoing lack of security of living in residential care was regrettable because future closure experiences were unwanted; it was suggested that implications for security should be discussed when people first consider moves to residential care; security was associated with 'home' and control:

'She couldn't comprehend that the whole place was closing, because at that age you think, "homes where you live don't close, you live there".' (Additional relative 2)

'We felt let down and angry. There was this sense of insecurity. We had done all we could to build up a good life for him and it was knocked back. The key thing was that there was no sense that we had any control.' (Additional relative 5)

Some relatives spoke of including consideration of whether homes might close in their criteria when selecting a new home. Large voluntary organisations were identified as a relatively secure option, and some reported asking prospective proprietors about financial viability.

8.3 Ongoing communication, support and co-ordination

Residents and relatives' identified support from the home and social services, and co-operation between the home and social services as important. Experiences of the level and nature of help and support from homes and councils varied within and across closures, and varied among both self and publicly funded residents. An inclusive approach towards residents was identified as vital; a resident said ensuring the involvement of residents was the most important thing to get right:

> 'To be made to feel that they are involved. It isn't just being done to them, "you have got to go there", you know... You have to make the residents feel that they are in on it... They are not being told "over there", like a child – they are being given a chance to participate as far as they can.' (HC3 resident 5)

Openness and timely communication from the home was identified as important by both residents and relatives; they wanted to feel in possession of the facts, to be informed of changes or developments to the closure process, and to know where fellow residents moved.

Relatives' overall judgements about how well a closure was managed were sometimes linked to the degree of support home staff offered. Relatives reported positive experiences of staff support at three of the closures, and their accounts suggested they particularly valued help that was readily available, provided opportunities to talk and promoted a sense of being supported:

> 'Any help I needed was there. They (the matron and nursing staff at the home) would have done anything. They were there to question and to talk to if you wanted to... She (the matron) managed everything and moved everybody ... I think it was all handled well really.' (HC1 relative 1)

> '(The manager) gave so much help, more than one would expect... She was wonderful.' (HC1 relative 2)

'We got the feeling that they were always there to support us and help us and that was a great factor for me.' (HC3 relative 5)

However, not all of the relatives or residents reported such positive experiences. Some described receiving little or no support from staff, and said that they hardly senior staff, staff hardly spoke or people were left to their own devices:

'Nobody [staff at the home] seemed to say much at all you know, it was funny. (HC8 relative 2)

'It was a bit vague. It was more or less left to ourselves to find the place.' (HC7 resident 14)

This situation could, according to one relative, be mediated if you had 'a good social worker', but another said they received help from neither the home nor Social Services.

Reported levels of co-operation between relatives and social services, social services and the home, and between all three differed across and within closures. Relatives who received help, or had a positive relationship with a care manager, often offered unreserved praise, and suggested that it was central to their experience:

'The two of them (the home and the council) were working very much together in terms of the future of the residents... So it was a very positive relationship from the start.' (HC3 relative 5)

'Both the nurses and (care manager) worked together very well and with me, all three of us together. And I got all the help that I could possibly have needed.' (HC5 relative 1)

Relatives of residents who were publicly-funded at six homes described positive experiences with social services staff and spoke highly of the support received:

'The social worker ... was absolutely super, she was very, very understanding... I think I was very fortunate. The social worker was

absolutely fabulous... I can't speak highly enough of the social worker.' (HC6 relative 1)

'She would give you two hours without thinking about what she has got on or when she is going to get home... She gave us all the back-up and information we needed.' (HC7 relative 2)

'He was quite passionate about his job... he did put himself out. I can't praise him enough.' (HC7 relative 8)

To the other extreme, relatives of residents who were both publicly and self-funded reported only talking to a care manager once:

'I think somebody in the early days got in touch with me... but then that's the last I heard about it...' (HC4 relative 2)

'I just saw her the once.' (HC4 relative 3)

'I think I had one conversation with her on the phone.' (Additional relative 3)

Relatives linked to the same homes reported both sufficient opportunities to talk to care managers and minimal contact, and differing levels of help and support were reported in relation to both self and publicly funded residents. There

appeared to be an expectation that social services would be proactive among relatives of both publicly and self-funded residents:

'I thought we would be invited over, but we weren't (when the care manager spoke to the resident).' (HC1 relative 1)

'You were left to your own devices really. I was rather surprised, I thought it would have been much more personal.' (HC3 relative 5)

One relative described relations with the council as combative; they 'locked horns' over his attempt to place his mother in a nursing home on a temporary basis until a vacancy became available in a small adjoining residential home, or to have the home register an additional residential place. He said he was prepared to fund the place privately and wanted to avoid moving his mother to another temporary place less suited to her needs. He reported being told both options were 'against the law', when he knew that 'the registration authority can vary any condition', and concluded:

> 'It was almost as if I was being stonewalled to the point of being lied to, because they didn't want to change anything; they didn't want to do anything. They'd got their own rules and regulations and that's the way it was going to be, quite regardless of the interests of the people that the Act is there to protect.' (Additional relative 3)

Another relative reported wasting her time looking at vacancies that the council would not fund because the care manager neglected to tell her about the need to choose from a list of providers preferred by the council.

Suggestions to improve levels of co-operation, co-ordination and communication included a series of consultations between residents, relatives and social services staff, to provide advice on appropriate care, and to identify suitable vacancies and relatives' and residents' preferences, such as location. One relative said he would have expected plans to be in place:

> 'One would have thought… the guy would have announced to the local authority that he was going to close. And that that would have swung some kind of process into motion whereby the social services would have a series of protocols. The first of which is that "this information will not come from the owner. It will come from social services" and they will swing a system into gear...' (HC7 relative 4)

Suggestions for better overall management included: a co-ordinator to help search for and select places; written information for relatives about what they should do, ask and

expect; and greater co-operation in terms of moving residents and/or residents and staff together:

> 'We found out later that one or two very good members of staff had gone to a particular residential home ... It may well have been that they could have tried to get the residents with members of staff. If we could have worked together on that, but we were all off, like bullets out of a gun, looking round, sorting out our own relatives. And staff were doing the same.' (Additional relative 5)

> 'If they'd have got the residents families round together and we could have said "Well, let's two of them go together, the two that have been friends here and two there, let's try and work in two's – because at least then they have got a familiar face at the side of them." But everybody panics and everybody runs around looking for a home thinking there isn't going to be one.' (Additional relative 6)

A couple of people said that they would have liked to have been told where other residents moved to:

> 'I thought it would be a good idea if I could have a list of where people had gone, you see. And the assistant manager of the home... when I asked this, said "we can't give it to you." It is one of these things you can't do. Tell you where people are.' (HC3 resident 1)

> 'I would have liked to have been kept informed how many people were moving and where they were all going really. I suppose they were thinking, may be confidentiality, I'm not sure.' (HC8 relative 2)

8.4 Choosing a new home

Relatives and residents were asked if a care manager assessed resident's needs, about the sources of information used to identify vacancies, and about visits to homes. Views about the availability and adequacy of information and advice differed.

8.4.1 Needs assessments

Reports suggested that care manager assessments of residents' needs varied among publicly and self-funded residents. Two-fifths of the residents and relatives interviewed reported that residents' needs were assessed before they moved, and these included self-funded residents at two different councils. However, there were also reports of uncertainty as to whether care managers conducted needs assessments and reports of non-receipt in relation to both self and publicly-funded residents. None of these residents were given less than one month's notice, so it was unlikely that any lack of an assessment was due to urgent time constraints. However, comments about care managers having 'had a natter… [with a resident] just to explain to him what was happening', suggest that some might have been unaware when an assessment had taken place.

It appeared that in some cases care managers' considered assessments unnecessary: a relative reported being told by a care manager that this was the case because his publicly-funded mother's needs were unchanged since admission. Relatives identified the importance of assessments being timely so that they can support the selection process. At a home with a six month closure period a relative reported being told by the social worker that her cousin's needs would not be assessed until she was due to have an assessment in around three month's time. However, during this time other residents 'filled in the vacancies', and waiting lists and finding somewhere became urgent.

Relatives of self-funded residents sometimes spoke of wanting a care manager needs assessment:

> 'I said to them that I needed a very clear assessment of all his care needs – his care plan. Ought he to have nursing care at this stage? The manager did ask the opinion of the GP about whether he was nursing or residential – but we would have liked something more.' (Additional relative 5)

This relative described self-funded residents, particularly those without family, as vulnerable to being overlooked:

> 'I have a sense of these people in the system as the 'Lost Boys'... because there is this sense of being like Peter Pan's lot – out there somewhere, but not really being part of what anyone cares about – not within the professional gaze at all. If they don't have family they are lost.' (Additional relative 5)

Another relative said he thought care managers should offer help and support to self-funded people:

> 'I wished the care managers had been more interested.... Just because somebody is over the £16,000 or this £18,000 now, I think care management and social services should still monitor. Because they're the ones with all the knowledge and ordinary people, like you and me, don't know anything about it. Just suddenly, we're thrust into it.' (Additional relative 1)

A couple of self-funding residents said that they supposed that help to find a placement or an assessment would have been available from social services had they wanted it:

> 'I could have had (a needs assessment by a care manager). That would have been quite nice' (HC3 resident 5)

Staff at prospective homes also conducted assessments of residents' needs and there were two reports of residents having been refused places on the basis of these provider assessments.

8.4.2 Information about vacancies and homes

As mentioned previously, relatives and residents said it would be useful to receive information about vacancies when notified. They reported drawing on various sources to identify vacancies and homes: directories or lists of homes provided by social services; lists of care homes produced by a home manager; the Yellow Pages; discussions with a care manager; personal recommendation by care home staff, colleagues, friends, or other relatives. Suggestions for potential additional sources of information included a central information bureau and a website. Awareness of information sources could be a problem; a relative reported that it was a friend, rather

than the home or social services, who told her of and provided a copy of a home directory.

Suggestions to improve care home directories included greater differentiation between care homes for different client groups and greater clarification of the type of residential care needs that could be supported, more detailed information about home characteristics, such as the number of registered places and whether they had en suite facilities, and some sort of star rating. These might include ratings of 'what they provide', such as entertainment, or transport for day trips, and draw on residents' views.

Relatives from at least three homes emphasised the need for information about homes *with* vacancies, rather than being left to choose potential homes only to find there were no vacancies, or a waiting list.

Relatives' and residents' reported seeking personal recommendations from staff about homes. Some relatives and residents appeared to recognise the potential limitations of personal recommendations:

> 'The only help and support we got was provided by the nursing staff at (closing home), who said "try this home, try that home". But their advice lacked a certain amount of direction and carried their own prejudices about which homes were good and which were bad. (Additional relative 3)

> 'I was quite close with one of the carers at [name of home] and I showed her the list and said 'what is your favourite out of that?' and she eliminated three of them immediately. I suspect because she had been sacked, I don't know obviously.' (HC3 resident 4)

However, a resident reported acting on the personal opinion of a care assistants in spite of his awareness of the potential impartiality.

8.4.3 Visits

Visits were said to be important and described as an opportunity for relatives and residents to make decisions based on criteria important to them. The majority of the

interviewed relatives and about half of the interviewed residents reported having visited homes. The number of homes visited ranged widely from one to thirteen, although one visit was common, and about one-third visited two to six. Relatives, home staff and social services staff arranged visits. Sometimes relatives reported not visiting homes if a resident had, considering visits inappropriate because they would confuse residents, and others reported not visiting homes when residents moved within the same chain as the closing home.

Suggestions about improving visits included the provision of transport, ensuring residents can influence the frequency, timing and length of visits, and ensuring that someone known to residents accompanied them; one self-funded resident identified this as the second most important thing to get right during a closure. A friend of a resident explained that this was important because two homes refused to 'take' her friend, who was usually a quiet person but caused a 'disturbance' during unaccompanied visits. One resident reported liking the opportunity to have two meals on different occasions because food was important to him and another said she wanted longer visits:

> 'It would be nice if you could go and spend 48 hours there because then you would see what it was like. The whole feeling, the food, the way people behave. You can't really tell if you just go for twenty minutes.' (HC3 resident 5)

This resident emphasised the importance of listening to and respecting residents' views about homes:

> 'And of course when you say 'I don't like that', they say 'How do you know in 10 minutes? ... Always give them (the residents) the feeling, and not just a pretend feeling, that they have got some say in the matter. So if they say they want to see this particular home three times or you say "you must go to that one it is ideal", and they don't want to go, you should respect their point of view.' (HC3 resident 5)

8.4.4 Choice

Some relatives reported that the collective search for places during a home closure felt competitive, and contributed to their sense of urgency:

> 'We felt that she ...would be left at the back of the queue because she was quite able to look after herself in a reasonable way. We just thought she could be one of the first to go... it would be in her best interest to try to get her somewhere reasonably quick and then we have got a better choice.' (HC3 relative 2)

> 'There is literally a scrap for beds in the area. You are fighting over them. It adds a tremendous burden to the burden you have already got.' (Additional relative 2)

> 'There wasn't only us, there was 28 sets of other people. And we were all looking.' (Additional relative 7)

Nearly two-thirds of the publicly-funded residents or relatives involved in the study stated that the new home reflected their preferences or choice, and over one-third said the home was suggested to them. Experiences of having homes suggested varied. Some said they vetted suggestions but others said 'there was no option' but to accept what was offered: 'If I'd have said "No" I really don't know what would have happened then.' Self-funded residents reported that the home had either been chosen by them or suggested to them. Care managers at three councils were reported to have suggested homes.

Reports indicated that having homes suggested by care managers did not necessarily mean relatives or residents were uninvolved or unhappy:

> 'She actually came up with (the new home) and then I went to look at it. She said 'it had a very good reputation for cleanliness and activities etc'. And as I say, it wasn't too far away really.' (HC7 relative 6)

'He actually gave us a choice of three... And he advised us on one that he thought would be the better one in spite of it being a slight top-up… And he more or less said 'this is the place, I do know the matron and she is a fine lady. It is run like clockwork' and it is.... And we more or less followed what he had told us, we literally took his advice.' (HC7 relative 8)

Choice of home was said to be limited by a number of factors: a lack of available places; short timescales; insufficient information about vacancies and homes; a lack of information about the process in terms of who should do what and any constraints linked to public-funding; and delays in assessments. Relatives and residents' accounts also suggested a general lack of awareness that publicly-funded residents have a right to choose where they receive residential care.

8.5 Concerns about temporary placements

Relatives' identified concern about the possibility of having to accept temporary placements and said that this added to the stressful nature of the experience of finding a new home:

'If you don't get the right thing you have to go somewhere else in-between. That would be another bit of strain. I mean we might all have to do that and then you have got to start all over again.' (HC2 relative 5)

'I didn't really want for my mum to go somewhere just as a slot before we could get her, you don't want it do you? Well not me, I don't want it, my mum doesn't want it. That's no good at all. It is too much upheaval. It is just too much.' (HC3 relative 1)

'I got panicky about not finding anywhere and that she might end up in a temporary bed somewhere. I have found it very stressful really.' (HC6 relative 1)

> 'There wasn't actually a room for mum, but they were going to put her in this matron's home next door. And I just thought "Oh no, I don't want her confused like that". So I dismissed it.' (HC7 relative 2)

One additional relative described how a temporary move was very much against his wishes. His mother had to move to a temporary place in a large residential home within the same ownership as the closing home for three weeks before moving to a residential place attached to a nursing home. He said the level of personal care and facilities provided during the temporary placement were inappropriate for his mother's needs. His mother had a fall, became incontinent, wandered and did not want to drink. Another relative also indicated that their experience of a temporary place involved inappropriate or unacceptable care:

> 'All I can say is after the first week there we would not have stayed much longer.' (HC6 relative 2)

8.6 Standards during closures

Relatives' identified the maintenance of standards of care, staffing and the physical environment during closure periods as important. Reports suggested that standards of care varied across the homes and falling standards and fears for residents' health and safety were associated with the loss of permanent staff and loss of management.

Standards of care were highlighted as good at five homes and as unpleasant, upsetting or unacceptable at three. Relatives at three homes commented on deterioration in personal care, and noted for example, that residents were washed less frequently or had become 'smellier'. Two additional relatives said they reported their concerns to the registration and inspection (R&I) unit. One said she suspected staff numbers failed requirements, was putting residents' safety at risk, and worried what would have happened 'if one of them was a double lift?' Another said standards of care were 'horrible', and so upsetting that she was unable to talk about it. Staff had left, including the matron, and while she did not blame staff because 'they are paid peanuts' she said:

'... deterioration was immense. I could really shout about this because I don't think what they realise is that even if your mind has gone a little bit, it is the pure familiarity of the carers that you have and of the continuity of the putting to bed at a certain time. And then all the routines are different...the different way that you are handled.' (Additional relative 6)

Another relative at one of the main case study closures described being worried about risks to her mother's health due to her isolation in a bedroom some distance from where remaining residents and staff were located: 'I felt if she had an accident, how would they know?' That her mother was allowed to 'stay in bed until dinner time' also concerned her 'because she lost all sense of time'. She wanted her mother 'to be got up on a morning and still live a normal life'.

Residents and relatives said they valued the retention of staff and staff who did their best to continue as before:

'(The staff) did their very up most for the residents. ... Well they simply carried on. If you went for a walk with them, that didn't stop, it carried on....' (HC3 resident 4)

'The two nurses, they stayed on right until the end ... they couldn't have been better.' (HC5 relative 1)

'They were a brick. They stayed and I know they spent a lot of time with the residents comforting them, being there for them.' (Additional relative 2)

Understanding was shown for the position of staff, that they were likely to find the closure stressful and had to look for new jobs:

'I think they were equally distressed that they were having to say goodbye to the people, plus the fact that they were worried about their own jobs.' (HC6 relative 1)

However, atmosphere within could deteriorate. In the 'mini' case study, where residents and staff from the new home moved into the closing home while the new home was refurbished, a relative said there were problems around resident and staff integration, and an 'unhappy atmosphere' for months, and poor management because the two managers 'couldn't get on'.

The preservation of the physical environment and minimisation of obvious signs of packing, or re-development of buildings were identified as important. Relatives identified the removal of furniture in communal areas as upsetting, and giving the impression that the home was being dismantled around residents:

> 'As time went by residents were disappearing, furniture was being emptied and piled up sort of around those who were still living there. It didn't seem to be a home anymore. It was sort of emptying the books and getting them packed or getting the chairs altogether and I felt that was wrong.' (HC3 carer 3)

> 'Three weeks into the process it was getting uncomfortable... Furniture was being sold and carried out and there was a sense of closure and turmoil.' (Additional relative 5)

At three of the homes relatives saw builders or planners, which was identified as insensitive:

> 'There were two men measuring up the front area, when the residents were still there. And then I found them in her room, I said: "She hasn't even gone yet".' (HC3 relative 3)

> 'Whilst the shutdown was going on he (the owner) used to come up with his entourage, they must have been planners, builders, people who were looking round to see how they could rearrange this. And he used to go into this room where the senior carers used to go …and the senior carers would be swept out and he'd close the door…' (HC7 relative 9)

8.7 Moving

Relatives identified a range of issues to consider when moving residents including timing, communication, the maintenance of routine, the need for someone known to residents to travel with them to new homes and the need for help with practicalities.

The timing of moves was something relatives described thinking about and various views were offered about good practice: residents should be moved 'the quicker the better' to minimise upset; 'a last minute rush' should be avoided; moving residents with a cognitive impairment is complex as they should be told what is happening but might be unable to understand and feel they are 'going into the unknown'. Relatives expressed uncertainty about what to do for the best in these circumstances.

One relative identified the way in which the closing home let residents 'have a normal day' and moved them in a way that allowed them to keep their meal and tea times as good. Other relatives described trying to minimise dislocation by unpacking residents' belongings in new homes before they arrived:

> 'You have got to empty one room of their belongings, get them in place so that it looks like home in the other room, without them looking as if they are in a locker room somewhere... So I thinned out her stuff and made it look as pretty as I could in the new room.' (HC6 relative 1)

Relatives emphasised the importance of residents being accompanied on the journey by someone known to them, and of having someone remain with them for a while. If they had not travelled with residents many of the relatives arranged to be at the new home for their arrival:

> 'To me it was important that someone he knew and loved was with him and (closing home manager) was. I didn't really want social services to be in charge of him. Someone goes and takes him and then they have got to rush off because they are busy, and (the manager) would not have rushed off. She would have made sure he was okay.' (HC1 relative 2)

> 'I followed in the car so I made sure I was there when she got out of the wheelchair. So I was there all the time and we stayed with her for quite a long time to get her adjusted.' (HC5 relative 1)

A couple of relatives of residents with dementia said they considered the manager or 'matron' as the most appropriate person to accompany them. One said if it was left up to her she 'had visions of dragging her outside and getting her in the thing and holding her down and having her screaming and kicking all the way.' Another additional relative with experience of multiple moves said that when the 'horrible day' came she 'couldn't face' travelling with her mother so left it to familiar home staff. The day of moving was clearly identified as a source of considerable anxiety, distress and even fear for relatives, linked to concerns about whether residents' health would deteriorate as well as their initial reactions:

> 'I would have been quite distraught if my mum had been crying and if she had been really close to one of the other ladies there and she had gone somewhere else.' (HC6 relative 8)

> 'So the day came, a horrific day... She was sitting there with all the black bags around her ... and she was utterly devastated... absolutely traumatic.' (Additional relative 6)

One relative reported an apparently direct and immediate negative affect on her mothers' behaviour; she stopped speaking in the car and for about one month afterwards.

Relatives and residents linked the quality of moves to the level of organisation and provision of support. At one home residents said that removal arrangements underestimated the task, the move was a 'shambles' because while the home arranged for help they were not professional removal men, and their belongings were put at risk of damage. The importance of clear allocation of responsibility for packing and unpacking of possessions and sensitivity about this was illustrated by a relative who said she was horrified to see a resident having 'as much as they could pushed in with

him' in a community transport ambulance. At the home where residents were relocated to a sister home a resident reported a number of problems, she said she was without furniture, medication and had:

> 'just a nightie and sponge bag and what I was standing up in.' (HC99 resident 1)

Some relatives said they would have liked staff at the closing home to help them pack, bring things to the car, or at least downstairs, or to unpack. One care assistant was said to have 'bunged everything into the room in bin bags and left.' One relative concluded that 'You move mum in, you move mum out.'

Transport arrangements varied across the homes and included the provision and payment by homes of removal vans for possessions with relatives' responsible for moving residents, all transport provided for, all transport left to relatives, community transport for residents arranged by care managers.

8.8 'Settling in'

When asked about how residents' might be supported to adjust to new homes residents and relatives tended to identify recommendations of relevance to initial admissions. Suggestions usually concerned care home staff. For example, a key worker should be 'personally involved' and introduced to residents on arrival, not two or three weeks later, or someone should be dedicated to greeting and staying with residents and families 'all day': 'a "settler" to get them settled in, and:

> '... to pay them special attention and make sure they are not sitting depressed and crying, which my mother was for a lot of the time'. (Additional relative 6)

A few commented on the lack of time taken by care staff at new homes to talk and listen to residents. A 'nice hello', a 'terrific fuss' and a smile were identified as important to give residents a sense that they were wanted and to reassure them that they would be looked after. Relatives said it was obvious to them when staff had been briefed of their

arrival and knew their circumstances as they were sensitive to what residents were 'going through'. The need for staff to respond sensitively to resident's needs on an individual basis was emphasised. A resident highlighted being shown around the home as important:

> 'They should show everything or you should be shown everything which is available in the new home.' (HC3 resident 4)

A woman with a visual impairment highlighted difficulties familiarising herself with her new room and suggested that in a perfect world she could be provided with:

> '...Someone with time to pack or unpack things with you slowly, re-arrange it, make a list in Braille so as to remember it. I have had to ask them sixteen hundred times where such and such a thing is, and if you have somebody who is new and not aware of what has been done... you would need almost a stranger just to tell you "this is there, this is there", write it all down and take all the time in the world because they know you would forget at the beginning. So yes, but it is absurd, you couldn't do it.' (HC3 resident 5)

One relative suggested the sense of security among residents who moved together to a sister home might have been strengthened if they socialised as a group in the communal areas more; a daughter suggested 'they ought to have tried to keep the residents together a little bit more ... so they had got each other.'

8.9 Need for prevention

Eleven residents and relatives raised the issue of closure prevention when asked what could have been changed or improved:

> 'The only thing that would be helpful is if they just left her where she was.' (HC8 relative 3)

> 'It would be better if they didn't happen.' (HC8 relative 2)

One resident said money should be spent on care homes rather than on the research that was being conducted, and this was the only point she wanted to convey:

> 'I think the money shouldn't have gone to you to do this. They should have given more money to the places, to the residential homes.' (HC3 resident 2)

About half of those who spoke of prevention made suggestions concerning funding, planning and co-operation by local or central government and providers:

> 'I would have expected to see a proactive system not a reactive system. I would have expected a system whereby the owner of the home ... (tried) to address issues with the local authority about the basic level of funding and all of that.' (HC7 relative 4)

> 'More money should be put into homes so that this doesn't happen... it is not a home it is their home and it is very important. The stability should be kept for them – they don't have a lot of things left in life for them.' (Additional relative 4)

Suggestions included planning for the provision of care homes in localities where older people already live, so that they can remain in their communities, and planning for future supply. A lack of co-operation, shared goals and compatible policies between local and central government was seen part of the problem:

> 'It seems on the one hand, the government is imposing new stricter standards that increases the cost to the homes, whilst at the same time, local authorities are putting more and more pressure on homes to reduce costs. And the two can't work together and this is, in many cases, what pushes homes into liquidation or closure. The whole thing is a political mess.' (Additional relative 3)

A few relatives said the care of older people should not be in the private sector. Many described understanding that providers were running a business and faced pressures.

However, they spoke of being uncomfortable with business imperatives being allowed to cause the involuntary relocation of older people:

> 'It was their business – but I just keep coming back to the fact that when it is frail elderly people, the same things don't quite apply. I know it is a business – but it just made me feel that … they just wanted their own bread and butter really.' (Additional relative 7)

> 'The state should provide good quality accommodation for our elderly people. I recognise all the problems that statement will no doubt throw up in terms of taxation and people voting for the party that taxes us least. But that is the only solution to me – the ultimate solution.' (HC7 relative 9)

> 'They shouldn't rely on private businesses – it should be about principles of care not money.' (HC7 relative 7)

Some spoke of concerns about future supply and disbelief that demand was insufficient:

> 'They shouldn't be closing homes down, they should be making more for old people.' (HC8 relative 1)

> 'But with the population, the old people, it is going to be us and if the homes are closing down what is everybody going to do when you need care in your old age? I mean, rather than closing, they should be opening more.' (HC8 relative 4)

8.10 Summary

A care home closure inevitably forces residents and relatives to make a decision about where to relocate. Many reported experiencing the process as stressful and offered clear recommendations about how the process might be better managed. Some of these had implications for councils, such as the need for plans to be in place so that councils' can offer efficient, timely and consistent help in a proactive way, which is responsive to

individual needs while also protective of their best interests, health and safety. Concerns identified by residents and relatives of particular relevance to local and central government and in turn, the regulator, included falls in standards of care, or fears about the care provided by homes during closures. Reported considerations and constraints on their decisions and actions included a lack of vacant care home places, a lack of homes providing particular services, a lack of information about vacancies and homes and their right to choose a preferred home, uncertainty about residents' ability to understand and cope with the news of the closure, and about what was in their best interests during relocation.

The main concerns identified by residents' and relatives' were to find an alternative home, to find a home that was appropriate, and for standards of care to be maintained at the closing home throughout the closure; standards in three homes were described as unpleasant, upsetting or unacceptable, and some relatives feared, or said that residents' health and safety was at risk. Concerns about falling standards were linked in participants' accounts to the use of agency staff unfamiliar to residents and, or a lack of management. The maintenance of the environment was identified as important and linked to a sense of home. Relatives also stated that they were worried about the possibility of having to accept a temporary placement, which was associated with further disruption and deterioration in residents' health.

The actual move was identified as a source of concern and distress for some relatives, who spoke of worrying about how to minimise adverse effects on residents' health. Some said they experienced well-managed 'leaving days'. Others described the move as disorganised or devoid of assistance. Some relatives described trying to cause the least amount of disruption to resident's routine. However, they identified uncertainty about how best to support residents, particularly those with a cognitive impairment, and about how quickly to arrange moves so that residents weren't the last to leave, whilst also avoiding a sense of rush.

The relatives' and residents' accounts of overall management, co-ordination and division of responsibilities varied across closures. Help and support from the provider and council staff was said to be valued, as was co-operation between the provider and councils. Some reported a general lack of communication, help and support and spoke

of managing the process single-handedly. Others said home staff were the main source of help and information. The level and nature of reported contact with Social Services care managers varied, both between and among publicly-funded and self-funded residents within and across closures. Support from care managers was described as indispensable, disappointing, or a source of additional problems. Only around two-fifths of those interviewed said a care manager had assessed resident's needs and some were unsure. For some self-funded residents an assessment had not appeared to be an option, despite relatives' stated desire for more expert advice on the needs' of residents. It appeared that the nature or non-provision of assessments sometimes meant that what should have been an opportunity to discuss resident's needs, preferences and interests was lost. A lack of vacancy lists was identified as unhelpful, as were some of the councils' lists of local homes.

The main process issues identified as important to relatives and residents were timescale, the opportunity to be involved to the desired degree in finding and deciding on where to move, the availability of timely information and help, and the maintenance of standards of care within the closing home. Choice of home was clearly important to the residents and relatives interviewed, but it was described as considerably limited, and by some as nonexistent. Looking for a new home during a closure alongside other residents appeared to make the competition for vacancies between service users more visible. Despite the limitations on choice many residents were said to have moved to a chosen home. The majority reported having visited prospective new homes to help in their decision but none appeared to have visited again to help them prepare for the change.

Some spoke of a need to ensure adequate supplies of care homes to enable choice and meet future demand. In addition to discussing how the closure process might be improved or managed, residents' and relatives' accounts emphasised that rather than focusing on the process, closures should be prevented from happening. That home closures were allowed to occur when older people were living in them, in some cases in areas of perceived under-provision, and when there is an ageing population was described as unbelievable.

Chapter 9

Care home staff perspectives

9.1 Introduction

This chapter describes care home staff experiences of five closures. Their views, experiences and beliefs are described in relation to the organisational characteristics of the closures, their reactions, feelings and concerns, and the nature of their role and involvement. Organisational characteristics examined included the way in which care staff were notified of the closure, ongoing information provision, leadership and support from management, and staffing levels and retention. Staff views of poor practices and external constraints and barriers are briefly described, and staff suggestions for good practice are identified throughout. Staff perspectives on the most important thing to get right during a closure varied in focus from what might be done to ensure the welfare of residents, to what might be done to secure their future employment.

9.2 Staff notification

Care staff provided information about how they, and residents and relatives were notified, highlighted advantages and disadvantages of different notice periods, and illustrated different approaches to the involvement of staff in resident notification across the homes, including one instance where there was confusion about when people were told. Across the closures, care staff were notified by letter or in a meeting. In two cases, staff were told before residents and family, although in one case the time difference was only a matter of hours.

Suggestions concerning length and form of notification included the recommendation that owners notify staff personally rather than delegate the task, and notice be between three and six months because time is needed to allow residents and families to look at places and for there to be a 'good chance that a vacancy might come up'.

At the home where six month's notice was extended, staff who completed questionnaires reported different notice periods, including five, six and seven months, which suggested confusion. Senior staff reported some secrecy between management and staff, as well as between staff and relatives and residents. Two staff said they were 'forced' to withhold knowledge of the closure from other staff; the assistant team manager said the manager told her, in confidence, about eight months beforehand, and suspected she was told before she was 'supposed' to because 'she (the manager) had to confide in somebody on a day-today basis'. The assistant manager herself spoke of keeping the news confidential as stressful; she described resident and staff notification as a 'huge relief... a great big weight off your shoulders, especially when we knew all over Christmas'. Staff were notified at a meeting, and relatives given a similar period of notice at a relatives' meeting. However, reports of the timing of these events differed. Some staff said that residents and relatives were given the same notice as staff. A care assistant, however, said she was told weeks before residents and relatives, and had to keep the information secret from them:

> 'We weren't allowed to tell anybody to start with... We had to be quiet and we couldn't speak to anybody outside obviously (presumably outside of the home)... We sort of had to whisper amongst ourselves out of earshot of anybody else.' (HC3CA3)

The reason given for not talking about the closure was that relatives and residents 'shouldn't hear it from anybody else'. It is possible that the time between being told at the staff meeting and the notification of relatives and residents became inflated for this person; she seemed to have found the inability to speak openly about the closure particularly burdensome.

Staff reported hearing rumours of closure before formal notification at two homes, including the one just described. The owners at the other home were said by staff to have first denied rumours of re-development after two articles appeared in the local press over a six month period, then to have written to them stating that closure was a possibility, giving a date for a 'final decision', and within days of this letter staff were given six weeks notice of closure. Relocation occurred quickly; some residents moved

before the initial date proposed for a decision. Staff spoke with bitterness about the deceit and injustice of being uninformed:

> 'From day one he has been lying' (HC7CA2)

> 'That was a load of rubbish that letter. I think it was just to shut us up for a while...They weren't honest with us and we found out from the newspaper or from a relative (who had read the newspaper)... the next thing we know we are getting letters telling us that it is closing, within a matter of 48 hours, which I don't think was fair on us...' (HC7CA1)

This care assistant went on to describe being caught up in the dishonesty:

> 'We were telling everybody: "No, we are not. We are not. It is rumours. We are not closing." Then, you are getting social workers phoning up and telling you it is'. (HC7CA1)

Care staff given six month's notice said it was plenty, and good for both staff and residents who needed this sort of time to find places. They speculated that six weeks would be too little time for staff and residents 'to get their head round things'. The assistant manager, however, noted that while six months was good 'in theory', it had disadvantages: residents found it distressing to remain in an emptying home, where the atmosphere was 'eerie'; it was difficult to maintain staff morale. Five weeks was considered short:

> 'From start to finish, bump, there done... It has all been a mad rush.'' (HC7CA1)

> 'People were being moved out right, left and centre and had just found out it was closing.' (HC7CA2)

The care assistant with experience of more than one closure described finding one month's notice 'very quick', and 'horrible', and too short to provide resident preparation- there was none.

Staff accounts highlighted that the timing of resident notification differed within homes. Notification of residents was said to depend on judgments by staff, or staff and relatives, about residents' capacity to understand and ability to cope with the news. In one home, management notified residents and/or their relatives in three separate meetings held on the same day. Some residents attended a meeting with their relatives, some relatives attended without residents, so that the relative might decide whether and how the resident would be told, and some residents went to a resident only meeting (presumably those who were considered able to understand but were without relatives). At another home, decisions about individual residents' ability to cope with the news were left to relatives. Relatives were sent a letter and it appeared that they were left to decide whether and when to notify residents. Staff spoke of telephoning more than one set of relatives and requesting they visit to tell residents because the news was 'spreading' among residents. A strategy of telling some residents 'as late as possible' appeared to be explained with reference to distress among residents who relatives notified when staff would have liked them to have been told later. Examples included residents who had stopped sleeping and eating properly.

9.3 Staff information needs

In contrast to the relatives, care staff said relatively little about ongoing communication and information. Experiences and views of communication and information provision between management and care staff differed across the closures. When asked in the questionnaire whether they would have liked more information about what was happening only four of the staff from three homes said they would out of the seven who responded.

One aspect of commonality across the closures was an apparent absence of guidelines or staff knowledge about principles of good practice during closure. In terms of procedures, one assistant manager said staff used an existing checklist for discharging residents to ensure the completion of particular tasks. She supposed guidelines were available, but had 'never had to use them'. A senior manager linked to one of the chain homes said the group had confidential closure guidelines but the intended audience was unclear.

Poor information provision was associated with a loss of management staff. One home was without a manager for months, and care staff here spoke about a paucity of in-house information about the closure process:

> 'We had to rely on their social workers, who turned out to be quite a good team, to run round and say to us "This is what's happening. What do you want from us?" And we are like "We don't know, because we don't know what to expect"'. (HC7CA1)

A care assistant described being unable to tell social workers what staff wanted from them, and 'had no idea what was happening'. In contrast, another care assistant said she was happy with the information provided and attributed the good communication and feeling of being skilled to the small size of the home, and the routine nature of some of the tasks, for example that staff knew what needed to be done when someone was leaving.

Some care assistants identified a desire for more information about their terms and conditions, such as more information about what would happen to working hours; one care assistant said she was confused about 'the next stage' and did not know how many hours she would be given. The value of information about redundancy rights and employment law was also highlighted. A care assistant at a home that was generally considered to be well-organised and supportive, noted that she would have liked independent information about entitlements because 'there was nothing to say "This is right", and she was aware that redundancy packages vary.

Some staff suggested that training on how to manage a closure would be useful to share good practice, and identify how staff might 'make it easier for residents'. A senior care assistant said would have valued advice about how to respond, for example, when a resident said 'I will never find anything as good as this.'

Staff spoke of appreciating being kept 'in the loop' and wanting to be informed about the new homes under consideration by residents, families and social workers. They also spoke of wanting to know how ex-residents were settling at their new homes. Some

said they would have liked an opportunity to visit ex-residents to see how they were and to help them adjust by providing continuity and a 'friendly face'.

9.4 Leadership and internal support

Staff described different experiences of support and leadership across the closures. Implications for staff of an absence of management included having 'no-one to give support', and being 'thrown in the deep end to deal with it all'. This experience was described as 'tough'. A senior care assistant at this home said staff needed more guidance, verbal support, and someone to talk to about their feelings. Management support and input during a closure were clearly identified as important, and discussions suggested that where this cannot be provided by an owner or manager, a designated person should be brought in to co-ordinate activities with social services and provide support to families as well as to residents and staff

Where available, the nature of the support given to staff appeared to be informal and dependent on the individual initiative of line managers. A team manager described the support she provided as unstructured; she talked with staff all the time. Care staff at this home reported appreciating discussions of possibilities of job opportunities within the company, help to find jobs, payment of NVQ training costs, and opportunities for further training such as practice with interviewing skills. Staff from Head Office provided personal mobile telephone numbers and said staff could contact them 'day or night'. One care assistant supposed that 'some people might feel as if they could talk to them' but that it was little more than a gesture to say 'you are not on your own'. However, another care assistant said staff had taken up this offer to help, and requested basic computer training to improve their employability. Another care assistant identified her line manager as the most important source of support, and said she would have expected more input from the personnel department. Two staff at this home said they were being supported to continue National Vocational Qualification (Level 2) training, even though the home was closing. Overall, the actions and information transparency at this home were described as extremely supportive.

9.5 Staffing levels and retention

Staffing levels and retention during closure are potentially important organisational features with consequences for standards of care. Staff levels were difficult to establish (for discussion of staff levels see Chapter 6), as was retention, because not all staff were in a position to know what was happening and interviews sometimes occurred as closures were happening. Staff at four homes provided insight into staffing issues including management strategies for maintaining adequate staff cover, and the problematic nature of reduced hours. The value of retaining existing staff, rather than using agency staff appeared to be assumed widely. One reference was made to the need to secure permission from the regulator for changing staffing levels.

A number of financial issues at the individual staff level were identified, including redundancy payments and retention incentives. At one home, staff who agreed to work until the end were given a retainer. The local shortage of care staff was said to be a factor that helped staff retention because staff knew they would find another job easily. At another home, staff not entitled to redundancy were offered a 'golden handshake' on the understanding that they worked until the end.

There were variations in the degree to which homes managed to retain existing staff and different starting points affected the maintenance of continuity, since some homes already relied heavily on agency staff while others did not. At one home, permanent staff were kept on and hours of agency staff reduced. The owner of another home said managing staffing levels was straightforward and 30 per cent of staff were kept on and there was no need to use agency staff. In contrast, a manager at a larger chain said staffing management was more difficult than anticipated, particularly towards the end when they 'ran out of people': 'we found that people (care staff) didn't leave as smoothly as expected, in line with our occupancy, so we had to bring in agency.' The staffing situation was given as the reason for bringing forward the closure date at this home (from three months to about seven weeks); the manager and her assistant were said to be exhausted from covering nights and days to ensure a member of existing staff worked alongside agency staff.

Staff identified the reduction of hours as problematic. One part-time care assistant described concern about managing with reduced hours, and wondered whether she would need to find a second job. Another care assistant said her hours were cut substantially during a previous closure because she was a recent employee:

> 'I'd only been there eighteen months. So, even though I was doing extra hours on a regular basis, all the time - it was a case of "Right your hours are cut right down to nothing at all now, and then you are off". Not "Thank you for the work you have done."' (HC3CA3)

Two chain organisations offered staff jobs in other homes. In one case, this did not develop as anticipated; only two care staff were re-deployed in this way, and this was attributed to the poaching of staff by other homes, sometimes when they came to assess residents.

A number of staffing related issues were unclear at one of the chain homes; there were inconsistencies and discrepancies within and across interviews. Such differences in accounts might have resulted from the different timing of interviews, but this did not seem to be the case. Rather, some accounts appeared less reliable than others, and this was the case for more than just details, which might have been forgotten. For example, an owner mentioned keeping on the cook during the closure, but a member of the care staff referred to cooking meals because there was no cook. The staffing position at this home was complicated by the employment of staff at other homes within the chain during the closure. Other comments made by the owner were strange and suggested his account should be treated with caution. For example, an assertion that redundancy payments would ensure staff remained working until the home closed, suggests a misplaced understanding of employment law and redundancy rights. This owner also gave an exaggerated report of the proportion of residents relocated to homes within the chain, citing thirty per cent when information provided by care managers suggested it was more like ten per cent.

9.6 Staff reactions, feelings and concerns

The emotional impact of home closures on care staff was identified as well as the strategies they used to deal with this and continue with their work. Staff feelings were described in relation to reactions to notification, motivation and morale, ways in which the work was distressing, and anxieties and concerns.

9.6.1 Reactions to notification

All of the staff described being upset and saddened by the news of closure. They experienced a mixture or range of emotional responses, which commonly included immediate concern for residents. One care assistant said this was because they 'take care of them (residents) and you know them.' Another care assistant, who said she coped by being stoic, reiterated the close nature of staff relationships with residents:

> 'You do build up quite a relationship and a rapport with the people that you have been looking after for six days a week, day in and day out, and you sort of miss them. You feel a bit half-gutted, but you got to sort of stick together haven't you? Hanging in there and all the rest of it.' (HC3CA3)

The nature of reactions appeared to be linked to understandings of the circumstances of notification and closure. Anger was identified by staff who said they were lied to, or thought owners should have kept a home going. A care assistant at the home that gave six month's notice said she was 'gutted' and shocked because she had the impression the home was going to remain open, via redevelopment or relocation. Staff at the home where there had been articles in the local press reported being unsurprised, with hindsight, and disgusted because of the reasons for closure: 'Money takes priority over people. It stinks.' At another home, an external senior manager noted that staff were 'quite angry' because they 'really wanted us to keep it going' and 'to invest in the place, ...they desperately wanted to hold it all together'. The emotional impact of the closures on some staff is discussed further in Chapter 10.

9.6.2 Staff motivation and morale

Some staff reflected on their motivation during the closure 4-7 months afterwards. Four staff from three homes agreed that they were de-motivated in their work during the closure, and three staff from three homes disagreed. The three who disagreed were relatively senior and included team managers and a nurse, so it is possible they considered themselves responsible for maintaining motivation, and associated this with professionalism. One team manager spoke about her responsibility for supporting the motivation of others. She said keeping staff moral high was the most difficult thing during the closure, although staff were generally 'absolutely superb'. When she spoke of finding it difficult to stay motivated personally, she referred to having less to keep her busy rather than any emotional reaction to the closure. Her accounts of how motivated staff were included references to how the team became stronger in adversity and managed to retain good humour: 'You have never heard so much laughter as in the last four months…'

Despite this general sense of pulling together, an experienced care assistant at this home spoke of feeling tearful, and hiding this from colleagues so as not to upset them:

> 'I get on a low about it, even now (the interview was conducted just before the home closed). Tears, and all the rest of it. But I try to keep it away from the others because you can't… It is going to bring them down and they don't need that. So, you tend to try and cope with it on your own.' (HC3CA3)

Another care assistant at this home also spoke of keeping her feelings to herself:

> 'You feel a bit disappointed or upset, but you keep that back. Just project the same happy-go-lucky person. I think the residents' appreciate that'. (HC3 CA1)

At another home, staff morale was said to be low, and exacerbated by the extra tasks required of remaining staff and the struggle to maintain standards:

> 'You have no cook, so you have got to cook meals for the ones you have got left. You have no laundry assistant, so you have got to wash their laundry for

them. And you are trying to do your own job at the same time as supporting people. It just gets too much.' (HC7CA1)

Tensions were described as 'running high', with increased stress, bickering and 'firing off'.

9.6.3 Distress

Staff identified general and specific aspects of work during a home closure as distressing. Resident distress was said to be difficult; staff said it was hard to see residents finding it hard to cope, who could not cope or who had no help from relatives. One care assistant highlighted as 'the hardest thing' confusion amongst residents who could not understand what was happening and why they could not stay. Waving goodbye to residents as they left or leaving them at new homes was identified as particularly upsetting by staff and some linked this to the way these departures seemed to make them answerable for what was happening to residents:

> 'It was heartbreaking. It felt like it was me leaving her. She thought that it was me. My fault. And it all sort of landed on me. It felt as though all the weight was on me, you know. Awful. Never, never do that again, never She turned round and said "Take me with you". And I said "I can't". "Why not?" So, I had to explain to her all over again why I couldn't. And it was awful... It was terrible.' (HC7CA2)

Staff described many encounters with distressed residents. At one home where flowers were sent to residents at their new homes, ex-residents were said to have phoned up and burst into tears.

9.6.4 Staff anxieties and concerns

All seven staff who provided follow-up information indicated they had anxieties about the future. Causes of anxiety included finding another job, worrying about the sort of job to apply for[1], and general uncertainty about would happen, or feelings of being 'in

[1] Decisions amongst the care staff to leave the care home sector are discussed in more detail in the chapter 10.

limbo'. One care assistant who was confident that she would find another job said she had no anxieties about the future. At one home, despite apparent job offers within the chain, staff spoke of being upset about losing their jobs; the loss of their particular job appeared to be important, irrespective of the availability of similar positions.

Staff identified concerns about the relocated residents when asked to identify their main concerns or worries when followed-up. Resident related worries included whether residents were settling, were distressed, happy, comfortable, or otherwise adversely affected by the closure. Two staff emphasised their close relationship with residents, saying they were 'like my family'. One interviewed care assistant became upset and was comforted by a colleague, who was sitting in on the interview, when she described how worried she was about whether residents would be looked after properly. For some, 'an ideal world' would enable staff to move to jobs where they could remain with the residents.

9.7 The role and nature of staff involvement

Care staff identified a range of closure related activities and roles, including administrative tasks, involvement in resident notification, provision of support, advice and information to residents and relatives, liaison with social services staff, and involvement in resident preparation and taking them to their new homes.

Two care assistants at one home said there was little, if anything, that could be improved as the home had 'done it in the best possible way' and this was associated with their level of involvement and sense of being 'part of it', particularly in terms of finding new placements and visiting homes to make sure places were 'right for them'. Staff recommended that other staff experiencing closure be as involved as possible, stay positive and focus on supporting residents:

> 'Try to stay positive and supportive for the residents.' (HC3CA2)

> 'Think of the residents. Do what you can for them.' (HC3CA5)

'Try to keep a level head about it. Be realistic and positive as this has a knock on effect on the other staff, residents and relatives.' (HC7CA3)

When contacted later, opinion was divided about whether care staff should be involved in helping residents to settle at new homes. However, when asked if there was anything else they would have liked be involvement in, one person reiterated wanting to have helped 'residents settle in and be with them'. Other advice to staff included expectation that a closure would be painful, stressful and difficult 'even with lots of support'.

9.7.1 Administration

Staff identified many administrative tasks during a closure as routine, although they were on a larger scale than when one resident moved. Administrative tasks identified by a manager related to resident relocation included checking residents had packed everything, including medication(s), incontinence products and valuables, notification of next of kin, General Practitioners, Care Managers and District Nurses, completion of discharge paperwork and an admissions register, cancellation of newspapers, and ensuring residents' needs were assessed and understood by care managers, and that care plans were transferred with residents to new homes.

9.7.2 Staff involvement in resident and relative notification

Staff involvement in resident notification and views about it differed across homes. Some spoke of telephoning relatives to request they tell a resident about the closure before they heard about it from elsewhere. In the home where residents and relatives were notified in groups, staff were given the task of asking residents who came out of meetings not to say anything in front those about to go in. One care assistant noted that this would have been less 'iffy', if more care had been taken about the ordering, to minimise the risk of someone shouting something out. When contacted later, opinion was divided about whether staff should be involved in telling residents about closure, and talking to relatives about the reasons for closure. Some agreed, but a few disagreed. Good practice suggestions for relative notification included the provision of information about how to find places, funding and support.

9.7.3 Provision of support, information and advice

Staff reports of providing support to residents and relatives post notification were widespread and included listening to and consoling them; discussions suggested that the provision of good support for relatives and residents was considered important by staff. Other supportive activities described by staff included offering advice about possible homes. At one home, staff attributed the lack of aggression from relatives to managers having made time to listen during the notification meeting. In contrast, at the home without a manager, relatives were said to have looked to staff for answers when they had none, and this was described as 'too much' and being 'in the direct firing line.' At another home, staff said relatives had not spoken to them about the closure.

Staff relationships with residents and families were sometimes described as heartfelt, but at the same time the situation was stressful and could cause conflict. There were reports of relatives being aggressive towards staff. An assistant manager highlighted how difficult it was to respond to queries from relatives about the purpose of the notification meeting when she was instructed not to tell them of the closure in advance of the meeting.

Staff at one home appeared to have adopted a relatively active role in helping residents and their relatives find new homes; various staff said the manager found places for the majority of residents and the role of social services was said to be 'negligible' because they found the new places. Staff at this home appeared to feel responsible for finding suitable alternative places for residents, and suggested that care staff should try to ensure residents go to 'the right places and that, hopefully, you don't find out in a month's time that they are not around. Because it happens.'

At another home, a senior care assistant spoke of relatives asking for advice, but appeared more prudent than staff at the latter home (according to relatives' accounts) about the type of information provided:

> 'It was like "I have heard of that home, this is the information I know". Or "I have heard of it, but nothing at all about whether it is good or bad. I couldn't tell you because I haven't heard".' (HC7CA1)

This staff member said that residents and relatives needed better information. Managers at another home said they telephoned homes to identify vacancies for self-funded residents, but the lead social worker told them this was not their responsibility, but that of the care managers and families.

One care assistant said staff tried to manage the atmosphere by making loads of noise to make the place seem 'busier'. A number of staff spoke of hiding their distress from residents, and keeping up a positive manner, to support residents.

Little was said about passing information to new homes. A few staff spoke of the importance of this, but when queried spoke only of ensuring care plans were forwarded, or of telling new staff of residents' 'ways'.

9.7.4 Liaison with social services

Relations with social workers was not identified on the interview topic guide but was touched on by several staff at two homes. One person said social workers asked care staff for information about residents, probably as part of their assessments of residents' needs. Another comment at this home suggested that it was qualified staff, such as nurses rather than care assistants, who were involved in this cooperation with social workers. The social workers working on this closure were described as 'inundated'. One description of dependence on care managers', implied a prior negative image of them amongst home staff:

> 'We had to rely on their [the residents] social workers, who turned out to be quite a good team, to run round and say to us "This is what's happening."' (HC7CA1)

For this care assistant, the social workers seemed to provide insight into the wider impact of the closure on older people living in the community, or in hospitals: 'It is affecting other people outside of here, although we don't know them, and all we were concerned about, was how it was going to affect these people.'

9.7.5 Resident preparation

The interviewed care staff spoke of resident preparation in terms of providing ongoing support, such as listening to residents, going with residents on or discussing visits to homes and talking about the need to move:

> 'If we could talk about it with the residents we did. Some of them had to research another place and they spent some days looking. When they came back, most of them were quite excited. Then we would talk about it. It's not like we're saying, "We don't want you. It's just that you have to move".' (CH6AC1)

Staff talked of being positive and providing reassurances about residents' futures:

> 'You have to reassure them that the place that they're going to next will be just as good. The care will be just the same.' (HC3CA1)

> 'About a couple got very upset about it and we felt we needed to spend time with them. You know, spend longer with them, and sort of explain that things are going to be all right.' (HC3CA3)

> 'We were able to encourage them - to say you're going to find new people. And try to make them think in a positive way... But we said,
> you can find very nice people, like you have found here. I think it is very important to encourage them - to tell them it is going to be a good change.' (HC6CA1)

A few staff spoke of reassuring residents that they had choice and control in terms of the power to refuse placements: 'if they don't like it, all they have got to do is just say'.

A number of staff spoke of attempting to be responsive to resident's individual needs, usually in terms of providing one-to-one support. Staff judgements about residents' needs for this appeared to draw on views about their anxiety levels or abilities to understand what was happening, and the length of time before residents moved, because some moved more quickly than others. Some staff reported being ill-equipped in terms

of knowing how best to respond to confused residents' distress: one care assistant described being at a loss as to what to say when a confused resident was upset about people disappearing and reportedly accused staff of killing residents: 'What answers, do you give them?'

Several staff expressed concern that the closure was particularly difficult for those with dementia, in terms of both the process and the consequence of being relocated somewhere new:

> 'It is hard for them. Especially the ones that don't really know what's going on.' (HC3CA3)

> 'I would say it is worse for somebody confused because they don't know what's happening... Like my lady, the one I was on about earlier that gets confused and agitated. Although she might not know who we are because she is confused, there will be something about us that she recognises. And she has gone into a complete new place where she doesn't know anyone, doesn't recognise anything. She is going to get confused, which is going to distress her even more because she doesn't know anything. She is just going to say to them: "Who are you? What are you doing? Get out!".' (HC7CA1)

Staff approaches to preparing residents with dementia for the move included giving 'gentle' weekly reminders about what was happening, and leaving the move as late as possible to give them time to adjust to the fact that they were leaving. When talking about residents with dementia, memory loss or confusion some staff seemed uncertain as to how to describe them:

> 'Some of them were very upset, which is to be expected. The ones that, how can I say this? I'm trying to find the right words. Certain residents, obviously depending on their ailments, probably will not realise until the very time that they go, what is actually happening.' (HC3 CA1)

Opinion differed about whether residents without relatives found the closure particularly difficult; some said not having relatives to help was hard for residents.

Helping residents visit potential new homes was generally discussed as an important part of resident preparation or support by care staff. At one home, however, staff noted the lack of support for residents to visit homes, although some were able to escort residents when they actually moved. At another home, staff visits to homes that were far away were said to be impractical. It was suggested that a key worker from new homes might visit a resident before the move so that they would have 'a face that they can relate to' afterwards. There was agreement that staff should be involved in taking residents to visit homes, and taking them to new homes.

9.7.6 Accompanying residents when they moved

Some staff accompanied residents on the day of the move, and the distress this sometimes caused was described earlier in the chapter. At one home, staff were said to have taken turns to go with residents and make sure they were settling. This home arranged for staff to have 'follow-on' visits, and telephoned to enquire about residents. Staff here spoke of trying to ease the transition for residents who were 'confused' by unpacking and arranging their possessions in comparable places in their new rooms to make them feel at home:

> 'We were going in the morning, taking their bits of furniture and all their bits and pieces and bedding, everything they had in their room and going to make that room almost the same. Like, the clock was there above their bed, or their calendar was over there. And just making it as similar as we could so that when they went in there they recognised things and it wasn't as different. Because some people were a little more confused than others.' (HC3CA3)

9.8 Poor practices and constraints

The staff identified a few examples of poor practice in their accounts, over and above some of their experiences of closure notification, and the majority of these related to management decisions. None related to internal day-to-day approaches to care practices. One concerned relationships with relatives. Staff were not invited directly to

identify problems or poor practices, as this was not the main aim and requests for 'whistle-blowing' considered unnecessary and inappropriate.

Poor practices identified by care staff included: room clearance while residents were still living in a home and a lack of support for residents to visit new homes to help make decisions. At one home, care staff reflected that physical environment standards had fallen:

> 'When we sit down and think about it now, everything pieces together. The home hasn't been renovated. I mean, it is a dump really, you know, and they have never bothered doing anything about it.' (CH7CA2)

Events described as minor problems included clashes with hospital appointments (the nature of these clashes was not identified but probably related to clashes with assessments or visits), and relatives not informing staff until the last minute about when residents were moving. This happened twice at one home closure and meant that care staff had little time to sort out medication. At one home staff identified several external factors which made finding homes for some residents difficult: delays caused by social services' funding decisions and reluctance on the part of homes to accept 'confused' or publicly-funded residents:

> "People are too quick to label clients as EMI (Elderly Mentally Infirm), or really confused, as disruptive because they don't always understand everything... They can be a little bit picky now, because there are so many places closing.' (HC3CA3)

9.9 Need for closure prevention

A couple of home staff raised the issue of measures or funding to help prevent homes from closing. One person suggested that the regulator should consider ways of helping homes to remain open when they 'run round and say "This isn't up to how we want it" and keep moving these little lines'.

9.10 Summary

This chapter has identified some of the ways in which care staff reported being affected emotionally by home closure, and how their reports linked these feelings to their relationships with residents and time spent with them; that working throughout a closure was described as distressing and stressful; stoicism and cheeriness were identified by staff as strategies to deal with their feelings while at work; that staff reported that their role during a home closure was to provide a source of normality and emotional and social support for residents.

In terms of other organisational and management issues, staff accounts highlighted the need for clear lines of responsibility for resident notification, the need for information to be given to staff about their employment and redundancy rights, the need for a consistent approach towards the consideration of residents' individual needs and towards the provision of help finding new homes and the need to ensure staff can maintain standards and care practices adequately.

Aspects of the process commonly identified by staff across the closures included: the absence of any closure guidelines (apart from one of the chain homes); staff experienced closure work as distressing; staff identified open communication and the provision of support to residents and relatives as important. Reported anxiety about the future varied across the closures and staff differed in their reports about the need for more information about what was happening and whether they felt de-motivated. Features which differed across the staff accounts of closures included: the nature and length of notice; the quality and amount of communication and information from the home; management support; strategies for managing decreasing staffing levels; approaches to providing information about homes, and the extent to which staff reported having to deal with angry relatives.

Chapter 10

Care managers' perspectives

10.1 Introduction

This chapter describes care managers' accounts of their aims and responsibilities during voluntary closures, approaches to team organisation, assessment of residents' needs, provision of help and support, arrangement of funding, search for new homes, follow-up, and their reactions, feelings and concerns [1].

The care managers helped to relocate 174 older people across eight closures, and just under two-thirds were publicly-funded (see Chapter 3 for details of the participating care managers and relocated residents). Relationships with half of the homes were said to be good or exceptional, and each was said to have gone well, in terms of 'nothing major' having gone wrong despite only one month's notice from two homes, and changes to the deadline at four. Other features that suggest room for improvement included the use of temporary placements, and the occurrence of subsequent moves.

10.2 Aims and responsibilities

The care managers expressed a shared understanding of their main aims as the identification of residents' needs and appropriate new homes. They also spoke of the importance of supporting residents and their families, of taking their concerns and wishes into account, of encouraging their participation in decision-making, and promoting their choice of home. It was acknowledged that accomplishing choice could be problematic, and for some this aim became more pragmatic, and about ensuring residents had somewhere to live.

[1] Findings presented in this chapter are published within a journal article: Williams, J., Netten, A., and Ware, P. (2007) Managing the care home closure process: Care managers' experiences and views, *British Journal of Social Work*. 37 (5) 909-924.

There was some difference in views about the scope of their responsibilities. Some seemed to assume that the council had overall responsibility for ensuring all relocations went as well as possible: a senior manager identified ensuring the safety of all residents as a central aim and a care manager said they had a 'duty to look at the protection and welfare of all residents'. However, another senior manager said the regulator should take the lead in ensuring good practice and that funding for closures should be provided by them, or via an insurance scheme:

> 'Is there not a pot of money at [the regulatory body] to pay for an emergency team to go in? Or like ABTA, should these homes not be insured like ABTA? You know, if you are stranded abroad someone sends a plane to get you. If you are stranded in a home shouldn't somebody put in an emergency team for the duration?' (Senior Manager, CS3)

Other matters identified as the responsibility of the regulator during closures included the monitoring of standards, such as staffing levels within homes. None of the care managers referred to the regulator as playing an active role during closures, and one team leader commented on the low level of communication from them with regard to closures; in seven years, she reported only once receiving confirmation that they had received information she had sent.

Views differed about some specific responsibilities, such as influencing the way in which residents are notified, or providing support to staff within closing homes. Some said attendance at notification meetings provides an opportunity to allay people's fears, but others emphasised that owners, or the regulator, are responsible for the nature of resident notification. Some said that they should be supportive to home staff, but one senior manager said that this was beyond their remit.

In terms of notice, the care managers typically recommended providers give two to three months, while acknowledging that this might be difficult for them. Longer periods were considered 'more painful' for residents.
Care managers at one of the councils highlighted the importance of building up a collaborative relationship with closing homes to support the achievement of positive outcomes for residents:

> 'We wanted to build up a relationship so that we could work well together to get what we all wanted for the service users - to move them to where they wanted to go.' (HC1 Care Manager)

Making time to talk to home staff also gave care managers the opportunity to explain their role during closures, which was said to be necessary because 'Sometimes the owners are not aware of what the social services processes are', and because otherwise home staff might inappropriately 'build up service users' hopes about going to homes that social services might not be prepared to fund'.

10.3 Organisation and resource use

There were variations in the way the closure work was organised in terms of how teams were made-up, the number of care managers involved and whether they continued other work. At one council, a team leader managed closures across the authority and put a large team together from volunteers from hospital and community teams. Each care manager worked with relatively few residents from a closure but sometimes worked on more than one closure simultaneously. They had to fit the closure work in alongside existing caseloads and carried out most of it as overtime at evenings and weekends. At the other councils, small groups or single care managers who worked in the same geographical area as the home were allocated the work. In one authority the work was given to an existing team that specialised in conducting reviews. The size of teams was said to depend on the notice period, with shorter periods requiring more care managers, the staffing capacity and the number of residents.

The majority of the care managers were experienced in working on care home closures: four of the care management staff, in the four area offices where individual care managers were allocated to closures, all of those in the authority where the team leader was the 'home closure' expert, and all five of the team managers. At least one had experience of an emergency closure, and one had worked on the closure of a local authority run care home (not everyone specified the nature of their prior experience). The latter said involvement in a closure of a council run home was so distressing that when she was asked to work on a closure again she initially declined. Another care

manager had experience of the closure process from the provider perspective, having worked as a manager of a home for another client group.

A couple of care managers said the number of older people involved and their unfamiliarity made assessments of need difficult:

> 'We just had to go through the procedures... It is difficult to do this with service users you have never met before and you had to get to know them in such a short space of time.' (HCl Care Manager)

> 'If you don't know them it's very hard.' (HC3 Care Manager)

Some care managers spent the equivalent of seven days, over a nine to fourteen week period, working on closure-related activities. The tasks that absorbed most time varied: four spent the highest proportion of their time (between two-fifths and one half) on office-based administration and paperwork – much of it consisting of forms that were used routinely when an older person moves to a care home; for three, face-to-face interaction constituted the highest proportion (between two-thirds and just over one half). Up to one-third of their closure related time could be spent on lengthy telephone calls, often over an hour. Calls were made to relatives to discuss progress, or listen to concerns, to the homes to gather assessment information, to other homes to find vacancies, to the Benefits Agency, and other authorities.

The average amount of time spent on each resident ranged from about four and a half hours, to almost five times that much. Assessments took about one to one and a half hours, although this ranged from thirty minutes to three hours. Reviews took between 30 minutes and two and a half hours.

None of the care managers reported having used council closure guidelines. Views about the value of guidelines differed. Potential benefits identified included a record to support good practice development and to promote consistency and accountability, and procedures and paperwork on which to draw instead of starting 'from scratch'. One senior manager said there was no need for another checklist. Two team managers, however, had developed their own checklists for closure work. The lack of any formal

council level planning might explain why one team manager described feeling that the closure work was unconnected to others in the council and outside agencies:

> 'So apart from this (the closure notification letter sent via another department) I do it on my own. There's nobody else… there is no other formal mechanism for me to report to. I'm never asked for any information.' (HC4 Team Manager)

Organisational recommendations included putting teams together promptly to ensure people are not left unsupported. Those in small teams recommended them and said they made communication easier, and visits to homes less disruptive to residents than visits by larger teams.

10.4 Needs assessment

Assessment practice differed across the councils in terms of who was assessed, the level of assessment conducted and specialist input. Assessments of publicly-funded residents were sometimes restricted to those who had been at the home for longer than a year, or those who had not had an assessment 'recently'. In some areas assessments were partial; certain modules were not covered, for example, social and community support, and the home environment – presumably because these were considered irrelevant when an older person was already living at a care home. In two councils, a nurse or other specialist was asked to contribute to an assessment if a resident was thought to have developed a need for nursing care.

The assessment of self-funded residents varied and could depend on the: timescale; whether residents had relatives; likelihood of eligibility for funding due to changes in financial circumstances; health; whether self-funders requested help. At two councils care managers said they offered to assess all self-funded residents. In one area this was linked to a feeling that the team was providing a 'home closure service' that was available to all.

The timing of assessments and their documentation could be improved upon. Assessments were not always conducted at a time when they could inform the identification of appropriate homes; one resident was assessed on the day he moved.

Some care managers adapted the layout and headings on generic assessment forms to make them more appropriate to the circumstances, for example, to record a resident's wish to move with another resident, or for a single room.

10.5 Provision of help and support

The reported levels of help and support given to both residents and relatives ranged widely. Some care mangers said the most important thing to get right during a closure was to ensure that relatives were aware of what was happening. One care manager recorded spending about 10 hours in meetings and one-to-one discussions with relatives and described trying to take account of and help them 'work through' emotions such as fear, anger and disappointment.

Help was provided mainly to publicly-funded residents and those in most need in terms of having poor health or no relatives, although in some cases it was seen as important by care managers to be available as an independent point of contact for residents as an alternative to relatives or home staff. One care manager noted that the transfer of residents from one team to another made this difficult. The challenge of providing support to older people who have difficulty communicating their needs was highlighted.

10.6 Funding

The care managers made requests to funding panels if they thought that a publicly-funded person should have a place funded above the standard council rate. At three of the four councils, care managers argued that relatives should not have to pay 'top-up' fees to homes that residents moved to as a result of a closure. Managers at two councils said the council would pay such additional payments if a case were made that circumstances were exceptional, such as the need to make sure a home was in visiting distance for relatives. However, in another area this reason was considered a low priority basis for requesting extra resources.

10.7 Finding new homes

Care managers said finding new placements was constrained by the availability of places. This was described as problematic or 'dire' at three of the four councils. In the fourth, short supply was implied by the competition for places: 'Everyone is fighting their corner.' In three authorities a lack of homes for older people with challenging behaviour was highlighted. One care manager pointed to a lack of homes for 'the pleasantly confused... the in-between homes'. In one area, care managers said the shortage of places was exacerbated by the use of care homes for 'step down beds' from hospital, and the move to providing temporary placements only in local authority run homes. In another, the inability to block-book temporary places was attributed to the closure of council-run homes.

The care managers described extensive negotiations when seeking new placements. This could involve balancing the perspectives of residents, relatives, the 'old' and 'new' homes, the finance department and their own priorities and concerns. Some prospective homes had caused problems by changing their minds about who would get a vacancy.

At times the aims of finding the most suitable home for residents' needs, of promoting service user choice and of refraining from giving advice appeared incompatible. Care managers spoke of encouraging people to look at homes that, given more vacancies, they might not have considered. Various strategies were used to help pursued residents and relatives to make decisions about homes within the deadlines. These included encouraging them to rethink preferred locations, to consider a temporary placement, and to focus on vacancies rather than homes:

> 'You say "We are really sorry, but this is all there is available unless you are prepared to move out of the area."' (HC3 Care Manager)

> 'They may have a home of choice but they'll need to pick a vacancy for their loved one to wait in until their home of choice is available. I can't ask someone to wait for a first choice for six months if I've got a four-week deadline.' (HC4 Care Manager)

Care managers said they sometimes urged relatives to change their plans to support what they considered to be a resident's best interests, such as choosing a better home, or moving residents quickly to avoid staying in a home that was nearly empty. They emphasised that their inability to recommend specific homes, or to comment on their quality, to avoid the possibility of being accused by providers of putting them out of business, and from families and residents that 'you said that this, this and this need would be met here'. This could lead to difficult situations when relatives and residents chose homes that the care managers would not have:

> 'If they pick a home that is not going to be completely suitable, even if we have raised our concerns – there is not a lot we can do.' (HC1 Care Manager)

> 'Sometimes people are going to go to a home that we are not allowed to say whether we like or not.' (HC3 Care Manager)

One care manager noted how unnecessary this situation was given their expertise and professional knowledge: 'You are a resource, you are a mine of information in a way that the relatives can't use, because you can't advise properly.'

> In some authorities, care managers managed the demand for care home places from older people in hospital, the community and closing homes simultaneously. One care manager described persuading other care managers to let the relocation of people at closing homes take priority. Arrangements for managing demand for vacancies were generally informal, 'sort of hit and miss', unplanned and 'first come first served.'

Suggestions to improve the process of finding appropriate places included better vacancy information, and the ability to offer genuine choice from a range of options. Recommendations regarding the actual move included the use of appropriate transport, and ensuring that someone familiar to residents travels with them.

10.8 Follow-up

Approaches to follow-up were similar across the councils and reviews were carried out much as they would for someone moving to a home for the first time, that is, after four to six weeks. Reviews were known as 'permanency' reviews because the aim was to establish whether a resident was going to stay, and if so, to sign a placement agreement with the home. Reviews could be extended by a couple of weeks, or repeated at three or six months, but by then residents would have to give notice to the home if they wanted to leave. Reviews could signify the end of involvement for individual care managers, as a resident might be transferred to another team.

A commonsense reason to review a placement after a move is to gauge the resident's well-being and this appeared to be generally assumed. One team manager, however, said that this was not a 'prescribed' policy, and happened because staff were 'great'. Reviews were seen as important and rewarding:

> 'That's where I really feel the benefit of our role, just by altering something or being able to discuss with the home owner or manager a misunderstanding and sort it out, that can make such a difference to someone's life.' (CS3 Care Manager)

However, review forms appeared to offer insufficient space for recording potentially important information, such as whether an older person's preference for a ground floor room had been met.

The timing of reviews was questioned by several care managers due to it being difficult to 'get everything settled', particularly finances, within four to six weeks. Recommendations included the flexibility for more frequent, as well as timely, reviews following moves because of home closure, ideally at six weeks to three months, and then again at six months before annual monitoring commenced. Self-funded residents were said to be 'on their own' in terms of monitoring.

10.9 Reactions and concerns

Many aspects of the work were described as upsetting or stressful, and some as potentially compromising values and ethics: ensuring that placements were found in time; not being able to give people their first choice; not being able to give people any choice; seeing residents upset or distraught, particularly when they actually moved; 'having to fight for everything'; trying to secure council payment of higher fees; the amount of work; working to a deadline; the pressure put on existing work:

> 'I found it really quite an anxious time because I knew that I wasn't doing what was the best for those residents, that they were actually taking second best.' (CS3 Care Manager group interview)

> 'It is difficult to remain constructive and positive and actually encouraging people to look at alternatives that perhaps you, as an individual, don't think is that person's best alternative.' (CS8 Team Manager)

> 'It's crazy. You know you are trying to advocate something that you are not always agreeing with, aren't you? So you are kind of contradicting, what's the word I'm looking for? Your own morals... I can't think what it is really. You may not personally or morally agree with something, but you have got to go with because of financial restraints.' (HC3 Care Manager group interview)

A colleague of a care manager who worked with a woman who died after attempting suicide soon after moving reflected that she felt guilty:

> 'I think she felt very guilty. Personally guilty about that, because – Could we have done something else? Could we have done something different to prevent that from happening?' (HC3 Care Manager group interview)

Another care manager reflected that she doubted she would have been able to cope if any of the residents with mental illnesses had 'gone out screaming' and was thankful

that the homeowner of the closed home had been so helpful and involved with ensuring each resident was moved as sensitively and appropriately as possible.

Many spoke of their concerns and fears for residents' health. Several said they thought home closures were traumatic, detrimental to health and increased residents' mortality rates. As well as feeling upset when residents' health deteriorated or they died, a couple of care managers spoke of being concerned that they were responsible, or might be held personally responsible by relatives; feelings of vulnerability, anxiety and guilt were mentioned. Some spoke of worrying that a new home would be unable to offer as good a level of care as the closed home. A team manager said that after working on a previous closure one of her team had been so upset when a resident subsequently died that they went on sick leave, ostensibly with a migraine, but she suspected it was due to the stress of what had happened.

Some expressed concern about the general lack of ongoing reviews. In two councils, annual reviews were not being carried out and it was likely that future care management involvement with these older people would be triggered only if a family, home or the regulator highlighted a problem. The implication seemed to be that any problems other that those that arose in the immediate to short-term might not be picked up.

Concern was raised about the lack of resources and strategies if a resident was 'giving up'. Care managers said the only options available were to contact a resident's doctor, family, Church, or an overstretched volunteer bureau. They also recommended that staff at homes be trained to be sensitive to the needs of residents arriving from closures who might be initially 'stressed, upset and difficult'.

The effect of closures on workload was identified as a source of stress, along with the nature of the work; 'having to fight for everything'; trying to secure council payment of higher fees; the amount of work; working to a deadline; and the pressure put on existing work were all stressful:

> 'It put pressure on you in respect of your rolling reviews and your other job, in that you can't be everywhere and do everything. So the reviews were dropped…' (HC3 Care Manager group interview)

'The impact on staff was just phenomenal. Because on top of their normal referrals, and those that are waiting for allocation on their caseloads, they actually had to move 160 people from home to another. So that was a tremendous amount of work.' (HC8 Team Manager)

10.10 Summary

The care manager interviews and activity logs identified the nature of care managers' involvement and work during independent care home closes, and highlighted key areas where approaches varied across councils, issues of concern to care managers, and their views of constraints, as well as suggestions for good practice.

While some responsibilities were similar to those when an older person first moves to residential care, care home closure work conducted by care managers was identified as distinct for various reasons, including the number of people requiring relocation in the same timeframe. The reported isolation of the work within departments was surprising, as was the lack of participation by the regulator. Some of the reported differences in care management arrangements could have implications for continuity of care, and for care managers' ability to respond in a timely and individual way.

Despite the lack of policy guidance the care managers showed a collective understanding of their aims. However, they simultaneously described the context as one where their aims could be incompatible, or seriously compromised.

The care managers reported that closures had gone well even when providers had failed to give the required three months notice. The care managers identified multiple constraints on their actions, some of which were within the control of councils (or the wider statutory sector) and others beyond it, given current policy and legislation. Internal constraints within their control, and which could cause unnecessary delays, included inflexible contracts with transport providers, authorisation procedures and postal systems, commissioning policies. The reported restriction on the advice care managers can offer about specific homes was described as frustrating and the policy

foundation for this appears unclear. Factors identified as beyond their control included closure timeframes, the actions of closing and new homes, the nature and level of local care home provision, and lack of internal resources (both in terms of fees and staffing) - although the extent to which resources are beyond councils' control is debatable. The time period was said to affect the number of vacancies or homes looked at, the types of homes that residents moved to, the degree of contact between care managers and residents and relatives, and the number of care managers involved.

Care managers reported concern about how residents might be affected and some said the work was stressful. While administration was identified as considerable, some reported spending considerable time negotiating new placements. This could involve balancing the perspectives of residents, relatives, 'old' and 'new' homes, the finance department, the needs of other older people wanting a care home placement and their own priorities and concerns. Sometimes the aim of promoting service users' choice, and finding the most suitable home were said to be difficult to achieve and/or incompatible.

For social services staff home closures were described as stressful. In their accounts anxiety and stress were associated with a variety of issues, including perceived internal and structural constraints on their ability to do their job to the best of their ability – commonly experienced in relation to attempts to secure the best and most appropriate new home for people; a sense of personal responsibility for, or at least of being caught up in the culpability for negative resident outcomes; the amount of work and impact on existing work; and concern about residents' health and well-being.

Chapter 11

The outcomes and consequences of closure

11.1 Introduction

Previous chapters have looked at the experiences and views of how homes were closed from the various perspectives of the different people involved. Exploration of long-term outcomes was beyond the scope of the research, however, it is impossible to ignore the question of what happened to people afterwards, and their perceptions of how they were affected. Consequently, an attempt was made to identify the types of consequences and costs experienced by the participating residents, relatives, providers, care home staff, care managers and social services departments.

This chapter describes findings related to resident outcomes, and highlights the domains of change experienced following relocation due to home closure, and whether they were experienced as positive or negative. Next, outcomes and consequences for care staff are identified in terms of their own perceptions of how they were affected and whether they continued to work in care homes for older people, within other types of social care provision, or had left the field of social care and why. Care managers' accounts of time spent on closure related activities and their identification of other financial and market related consequences for councils are also described. Outcomes and consequences can occur at the individual and collective level – here the focus is mainly on those experienced at the individual level except for where individuals made reference to wider impacts.

11.2 Outcomes and consequences for residents

First, the outcomes and consequences for residents are discussed in terms of the type of placement in the new homes, focusing in particular on whether and how the new placement differed to that in the closed home, in terms of type of care provided, home size, sector of ownership and geographical location. The occurrence of second or

multiple moves is highlighted, because they are a type of short-term outcome that, whether planned or unplanned in the short-term, resulted from the closure. Next, resident outcomes are described in terms of survival and perceived well-being and quality of care as reported by residents and relatives. Lastly, consequences for future residents as identified by care home staff and social services staff are outlined.

11.2.1 Changes associated with new care homes

Relocation due to home closure could result in changes to various aspects of housing and care; different types of placement in different types of care home; similar placements but in different types of care home; homes with different owners; homes in different sectors of ownership; and different home sizes. There were two instances of self-funded residents leaving residential care; one moved to a hotel, and said that this was largely due to the difficulty of finding somewhere that would take her dog (she planned to put her name on some waiting lists for when the dog died); another moved to a flat after deciding that she no longer needed care.

Care managers provided some follow up information for 69 per cent of the residents relocated from the closing homes (n=120), including the type of placement moved to. This information showed that for 22 per cent, the relocation involved a change in type of placement, for example from a residential home to a nursing home, or from a residential home to a nursing placement in a dual registered home. Such changes to placement type occurred across five of the closures; they were not clustered within particular homes or councils.

Amongst the smaller sample of residents known about via interviews with residents or relatives (n=43), the proportion of residents who moved to a different type of placement was smaller at 16 per cent. Such moves were typically characterised by moves to placements offering nursing care when residential care was provided at the closing home. There was one reported instance of a self-funded resident moving from a nursing home to a residential home. 28 per cent moved to the same type of placement but in a different type of home (i.e. residential placement in a dual registered home rather than a residential home), which could have the advantage of minimising the potential of any future move between homes for nursing care. Most of the residents who moved to a different type of care home were publicly-funded, including all those who moved to

nursing homes from residential homes; these residents also appeared to have lived at the closed homes for longer than the average length of stay.

In two of the closures, the majority of the residents moved together to the same new home. In home closure 4 all but one of the residents moved to the sister home. In the 'mini' closure, where the home merged with another existing home, the residents from the new home were relocated into the closing home during refurbishment and then all the residents moved into the refurbished home. Only five residents moved individually to new homes within the same ownership as the closing home.

Other changes identified via interviews included moves to homes in different sectors of ownership to that of the closed home; 32 per cent moved to private sector provision compared with voluntary, private for-profit sector compared with private not-for-profit, or voluntary sector provision compared with private provision. In terms of changes to home size, 35 per cent moved to larger homes than the closed home (35 per cent), just under one-third moved to similar sized homes and one- fifth moved to smaller homes.

11.2.2 Prevalence, perceptions and consequences of 'out of area' moves

Half of the interviewed relatives said the new home was further away than the closed home, and at one home care managers said all of the residents moved out of the area or ward. Descriptions of 'out of area' or 'local' differed. In relation to towns and cities for example, moves were sometimes described as 'local' if the home remained within the town, and sometimes described as 'out of area' if the home was in a different area or ward to that of the closed home. Relatives' descriptions of whether a care home was 'close by', or easy or convenient to visit drew on a variety of considerations: journey time; availability and frequency of direct or indirect buses, including those available for weekend journeys; whether a home was on a car or bus route to work; whether the journey required going through a town and high traffic levels; preferences to cycle rather than drive; and the rural nature of a home, and whether it involved driving on roads that might be hazardous in bad weather. Such considerations were said to influence relatives' ability to 'drop in'. One relative noted that there was no bus 'back' on a Sunday and since it took her 45 minutes to walk home, or the cost of taxi, she no longer visited on a Sunday. During the week the journey involved catching two buses, however, due to their infrequency, she usually walked the last stretch.

The resident and relative interviews identified various positive or negative consequences of moving to a care home in a different geographical location to that of a closed home. Relatives and residents from three of the closed homes identified a range of negative consequences associated with the location of the new home compared to that of the closed home: homes were less central within towns, or said to be 'generally inaccessible'; and amenities such as supermarkets, post offices, or village shops were further away or less accessible, for instance located down a steep hill. Knock-on negative consequences identified about being less central included residents' being unable to attend support groups, such as an Alzheimer's group, because a new home was too far away for the minibus driver to travel, and residents' finding it 'more difficult to ask' for a lift to church.

Comments suggested that satisfaction with home location was sometimes influenced by the way in which the location, or that of the closed home, linked to or had significance to a residents' geographical biography. The importance of place to sense of identity, and the resulting wrench when moves necessitated a dislocation from place, was identified explicitly:

> 'You are taking people away from an area that they know, that they have lived all their life.' (HC8 Relative3)

Attachments were described both in terms of particular locations and in terms of countryside versus town dwelling. One daughter said that her mother did not want to live where her new care home was because her mother was a woman of a particular county; her mother reportedly said 'I am a [name of shire county] woman, I don't want to live here.' Another relative noted that her mother was a 'town girl really'.

On the other hand, some new homes were said to provide residents with a sense of continuity of place or belonging, which for some represented an improvement on the location of the closed home. One man said he was 'very pleased' that he had returned to the town where he wanted to be and had lived for 90 years before he moved to live in the closed home. A daughter noted that her father had always lived in a certain place and was familiar with the location of the new home:

'He knows where this one is. So he knows the surroundings. He can associate, you know, 'that road and that road'. He remembers them all.' (HC1, Relative 1)

11.2.3 Patterns of relocation: multiple and temporary moves

Patterns of relocation included multiple transfers between homes, in the form of temporary moves, or subsequent unplanned moves from what were intended to be permanent placements. Moves between rooms within homes were also reported. Care managers indicated that nine per cent of residents for whom follow-up information was provided (n=120) moved a second time, and that second moves occurred across five closures. The length of temporary placements ranged from one and half weeks to over three months and these placements were typically within homes owned by the same chain as that of the closing home. Reasons given for accepting temporary placements included the ability to wait until a vacancy became available in a preferred home (which in one case was the same home as where the temporary place was), or the ability to move out of the closed home as quickly as possible. Relatives' concerns about the possible effect of temporary placements on residents were described in Chapter 7. One daughter described how a temporary move appeared to have increased her mother's confusion and perception that she was being punished: she said her mother asked 'What have I done wrong?' and that the home 'could have been ten miles away. She didn't know it was next door.'

Unplanned second moves discussed by relatives or care managers were attributed to new homes being considered unacceptable; one relative described moving her mother a second time, within a week, when she discovered that she had been put in a shared room without her knowledge or agreement.

11.2.4 Health and well-being

This section describes information collected about the short-term health status of residents following relocation. It includes reports of deterioration, improvement and deaths among the relocated older people. Following the move the health of around 60 per cent of the residents who were interviewed or discussed by relatives (n = 43) was said to be fine or OK; although this was the case for only one of the residents described by the sample of 'additional relatives'. Eight of the residents' health was said to have

deteriorated, and this included three of those described by 'additional' relatives. The care manager who relocated residents from the home registered to care for older people with mental illness said that during their stay at the closed home they had 'improved' to the extent that their needs were assessed as such that they could be relocated to general social services accommodation rather than specialist residential or nursing homes; some had moved to the closed home from a mental health hospital.

Amongst residents whose health was said to have deteriorated, relatives identified a range of illnesses, symptoms or worsening conditions: loss of mobility, deterioration in speech, increased confusion or memory problems; increased physical frailty; and weight loss or reduction in eating. Several relatives mentioned reduced mobility and falls by residents post relocation; one person's mother had fallen and broken her hip at her new home walking in from the garden. One resident said he lost the ability to walk independently within ten weeks of moving and needed to use a walking aid.

Six residents known about via interviews (n = 43), including three from the 'additional' relative sample, died between ten days and seven months after closure. Of these residents, four died within three months of relocating (9 per cent). Care manager follow-up data identified a further fifteen[1] deaths among residents for whom they provided information (n =120); they occurred across six of the closures studied. Overall, relative and care manager reported that eighteen residents from the main closures died (twelve women and six men), which increases the proportion known to have died to 15 per cent. Of these fifteen residents, most died within 3 months of the closure[2], and some died sooner; seven people died within five weeks, including one woman who died within days of moving and another after three weeks. Details were not provided for every case but several had recent prior experience of multiple hospital admissions.

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[1] Another resident who died after having been assessed but before the home closed has been excluded from this number because he was said to have been very ill and unaware of the closure and died before relocation

[2] Dates of death were provided for all but one of these residents

Three relatives of residents who died described relocations that involved multiple moves, which suggests that the weeks before their deaths were characterised by considerable upheaval and were very different from what they might have been. One son, from the sample of additional relatives, described how his mother was moved to a temporary placement against his wishes, where he considered the care to be inappropriate, and died within a fortnight. He said that the 'horrendous' experience 'must have had some effect'. Another 'additional sample' relative told of her father-in-law being moved three days before he died to a nursing home from hospital, where he had been admitted from the closing home for a heart condition, and of him having experienced a previous care home closure which occurred seven months after he moved in.

Care managers and residents also identified home closure as a risk to residents' mental health, particularly those with an existing diagnosed depressive illness. A care manager said one resident, who was 'desperately unhappy and depressed', attempted suicide within three months of relocating and died. Her death was said to have deeply distressed other residents, one of whom had 'witnessed' her suicide attempt. The care manager said she could not be certain that the woman would not have experienced a depressive episode in the absence of the home closure, but added that the timing of the closure and suicide suggested they were related. One of the interviewed residents said she had a pre-existing and long-term mental illness (bi-polar depression) and described how the closure constituted a major change and disturbance in her life, which she knew was a risk factor that was particularly challenging for her to cope with. She said that while it was difficult to isolate triggers, her periodic depression 'had probably been worse because of the upheaval and the move'.

In terms of perceived psychological well-being and adjustment following relocation, about half of the interviewed relatives said residents had settled in to their new homes. A few relatives said residents had improved in terms of being 'less confused'. A care manager said that some residents had even 'blossomed' at their new homes and three residents themselves said that they preferred or were happier at new homes compared with their closed homes. Such positive outcomes were linked to a range of factors including returning to a preferred locality, 'falling in love' with the home, and enjoying the new home more despite having enjoyed living at the closed home. However, some

residents were said by relatives to be unsettled or confused (nine residents), and some less happy than at the closed home (six residents). Some relatives' descriptions linked physical symptoms of illness such as breathing difficulties with general statements such as, 'the move has really taken it out of her', 'she is not her old self', and 'the move has completely thrown him.'

11.2.5 Quality of care

The relocations were said to result in gains and losses in terms of perceived quality of care. Better standards of care could be a positive outcome of home closure; relatives and care managers said they were not sorry to see some of the homes close because of the low standards in some cases, including quality of care, décor and accommodation:

> 'After the move I wasn't sorry she moved, because the home had gone down hill... after the initial move and the shock and the trauma, I was happy because she had better care.' (Additional relative 2)

Some residents and relatives said the new home was better than the closed home and improvements were noted in relation to various aspects; general level of care; staffing, including management, staff quality, retention and number; activities; facilities, including heating; food and the encouragement of eating; cleanliness and hygiene; and respect for personal possessions, including clothing practices. Relatives of older people who moved to homes providing higher levels of care commented on a sense of greater professionalism, increased numbers of trained staff, more one-to-one care, and more appropriate care and medical facilities. Relatives linked to three closures noted increased social activity and staff interaction with residents at new homes:

> 'At this one they sit with them, they talk to them and do things with them.' (HC8, Relative 1)

> 'They are encouraged to sit out, whereas at [closed home], I had to take her out to sit out and get some fresh air.' (HC8, Relative 4)

> 'There is plenty for them to do. They take them out for a walk. They take them round to the local pub at lunchtime...' (HC7, Relative 6)

'They have entertainment for them once a fortnight, which is an awful lot for a care home… it is stimulation. And I am very pleased.' (Additional Relative 2)

Some relatives suggested that residents' health and well-being was improving as a result of improvements in the quality of care provided at new homes, including greater hand movement due to better heating, and better verbal communication due to the provision of appetising food; one resident began to talk about how she 'loved' the food and to request scones when she normally appeared unable 'to say any sentences'. Relatives also reported appreciating improved personal care, care of clothing, and better cleaning compared with what had been experienced at the closed homes:

'When they had a meal, sometimes the food was still on the floor, if they had made a mess eating and throwing things. And it wasn't always vacuumed up, they may be didn't have time. I'm not saying it was like that every time, but couldn't they have just…and it's not that I'm as house-proud as you can be, but it just makes a difference. And at this home, where she is now, there is a couple of blokes come out with vacuums…It makes the place more sort of cared for.' (HC8, Relative 2)

'She is cleaner than she has ever been. Her clothes are clean. When they see she is throwing things in the bin, they take them out and wash them and put them back in her cupboard. … Always looks nice, and her hair is clean…I felt she was neglected. You would go in some days and there would be food down her clothes. And that is something that I can't bear, to go in and see my mum looking like that. I felt that was wrong. But they would say, "Well, if she doesn't want to change her clothes we can't make her."' (HC8, Relative 3)

'My mum is checked on every hour and turned [at night]. She wasn't at the other home… She wasn't incontinent at first and then she got incontinent. And the difference between [the homes], there is no comparison.' (HC8, Relative 1)

One daughter highlighted an improvement in the provision of privacy when visiting; staff at the new home offered to help take her father, who was a wheelchair user, to his bedroom so they could 'talk privately'. Clearly, the ability, or inability, to talk to a resident privately has potentially serious implications if there are any concerns or worries about their quality of care, or if the older person themselves has a complaint or something personal to discuss.

Some relatives, mainly from the sample of additional relatives, described improvements on poor clothing practices at closed homes. One daughter said her mother's clothes were treated by the closed home as if they were part of a collective resource:

> 'When I looked in my mother's wardrobe, she didn't have anything that was her own virtually... And I'd keep buying her something new. I remember, it was her birthday, so I got her this dress and it was very expensive, it was £89.99. I go in the next day, and there is another lady in it...[sometimes] she has not got her own glasses on.' (Additional Relative 6)

She suggested the sharing of clothes resulted from laundry management practices: 'they throw everything in the washer and then they distribute it all around the home'. Her comments indicated distress at the lack of respect for clothing both in monetary terms, and in terms of communicating autonomy, choice, individuality, sense of self, or dignity, and in turn an implied disrespect for residents' sense of self and self-worth. Another additional relative said a jacket that he had given to his uncle was ruined because it was washed rather than dry-cleaned.

Some relatives reported negative experiences of quality of care at new homes, including a lack of help to support residents' mobility. One daughter reported being troubled that her mother, who was blind and needed 'somebody on her arm' to walk, was left for 20 minutes in a dining room unable to get from her table to the door. Another relative suggested that loss of mobility was inevitable in a care home because staff have insufficient time to help residents' walk:

'They don't have a lot of time in homes to sort of keep their mobility going, so you find all their legs go. It is a terrible thing now, this care... It is easier for them to have them in a wheelchair because it is quicker.' (Additional Relative 6)

Another daughter said her mother missed the cooking, attention and favours from a cook at the closed home and noted that although she was putting on weight, her mother complained about the lack of choice, quality and quantity of the food at the new home. Two relatives reported dissatisfaction with the care provided by new homes because things they were assured would be in place were not: daily baths and a toileting regime.

11.2.6 Access to basic services

Problems with access to general practitioners were identified in relation to three new homes in different local authority areas:

> 'He said, "there is a doctor on the premises" but he only makes a monthly call. And, if you have any special reason he calls. But he hasn't called for any special reason for me. So, I am very lame today. It doesn't matter at 97 what you are." (HC7 Resident 14)

> 'The GP support here is of a much lower standard.' (HC3 Relative 5)

> 'I used to speak to her doctor and make sure that she was still taking her [medication].... And all this. And then I lost track of who her doctor was because each home had a different doctor. So, I don't know who her doctor is now.' (Additional Relative 6)

11.2.7 Quality of life

Both positive and negative changes were identified in relation to residents' quality of life, in terms of the nature of facilities available to them, interaction between residents, residents' ability to pursue hobbies and get around, and home ethos or homeliness. Some relatives of residents who moved to larger homes said they were more institutional and busy. The loss of some facilities was identified as having serious and ongoing consequences for residents' ability to do what they would like to do. For one

woman, for example, relocation meant the loss of her ability to garden, which she said was her 'great hobby'.

A resident with visual impairment identified a loss of freedom of movement within her home and of knowing where her things were in her room as a serious short-term consequence of relocation; such a 'big change' in her environment was identified as disabling and as bringing about feelings of 'total insecurity' and increased feelings of 'isolation'.

Relatives identified the loss of friends amongst residents and of relationships with staff as another negative consequence of relocation. A few residents and relatives said they were pleased when they found that care staff from a closed home worked at a new home.

11.2.8 Consequences for future residents

Social services staff speculated about the negative consequences of care home closure for future residents in terms of the supply and choice of homes. Some care managers identified a reduced choice of homes for future residents as the main consequence of home closures. The loss of smaller homes was highlighted; they were described as being under threat of 'extinction' and as associated with greater homeliness than larger homes, where people 'get lost'. A few care home staff also speculated that home closure reduced the choice of home for older people moving to residential care for the first time. Care managers in four council areas raised concerns that closures were causing gaps in service provision, in relation to nursing homes, residential homes, or homes registered to care for the elderly and mentally infirm (as termed at the time). The closure of the home that cared for older people with mental health conditions was said to signal the loss of any specialist homes for this group in the area. One senior social services manager suggested that the loss of residential care homes was particularly problematic for older people whose needs require high levels of personal care:

> 'What do you do with people who are bedridden, who don't require acute care? What do you do with somebody who needs 24 hour care that doesn't require hospitalisation?' (Senior Social Services Manager, Home Closure 3)

11.3 Outcomes and consequences for relatives and friends

The previous section on residents' outcomes identified that some relatives' reported new homes being further away for them than closed homes. Others said the opposite was the case; the new home was nearer or more convenient to get to. Changes in location and the resulting impact on journey time, was said to facilitate or hinder visiting. Other consequences experienced by relatives and friends included financial costs or gains and ongoing concerns about the welfare of the relocated residents.

11.3.1 Contact with residents

Following the relocation some relatives said they visited more often and some less often than before the move. Six said that they visited less often, for example only one or twice a week compared with everyday. Another loss identified by a relative was that he liked his mother to have a meal at home with him and his wife once a week, but this no longer happened. Others who said the new care home was closer and more convenient to visit than the closed home said they consequently visited more frequently than before, for example three times a week compared with once a month. As mentioned in relation to quality of care, the nature of contact too could change, in terms of the level of privacy supported by home staff.

11.3.2 Financial consequences

Relatives and residents identified a range of one-off or ongoing financial consequences of home closure. These could be negative or positive. One-off costs experienced in the short-term included transport costs, furniture/possessions removal expenses, the replacement of lost clothes, the re-equipping/furnishing of new rooms, and the owing of fees paid in advance to closed homes. The need to replace lost clothes was mentioned in relation to four closures, including homes from the main sample and the sample of additional relatives.

The total costs incurred varied across closures and individuals and this appeared to depend on resident's source of funding, council policies or care home policies. For example, the need to re-equip or furnish a new room depended on what was provided, requested or required by new homes. One relative reported spending about £300 on re-

equipping the new room, including the bedding and curtains. Another relative said the requirements of a new home were expensive and over-the-top because they included nearly £30 worth of itemised toiletries, and six of every item of clothing, including pyjamas. Relatives' reports indicated that some were held responsible for paying for removal costs for self-funded residents, while others were not. The variation appeared to depend on whether a closing home or the council paid removal costs or let if fall to them. One self-funded resident was said to have had to pay to be transported by ambulance.

One home paid compensation payments to residents, as well as removal expenses, with some caveats around length of stay and status of admission, that is that it was permanent rather than temporary.

Relatives identified incurring ongoing costs after home closure. These included increased care home fees or top-up payments, or the need to pay top-up payments when there were none before. Seven interviewed relatives referred to higher fee levels. However, of these, one said the additional amount was paid by social services and five relatives said the council paid top-up payments associated with the move. Relative reports of councils' policies towards picking up additional costs associated with moves necessitated by closure suggested that they varied across the councils. There was one case where it seemed that the council payment of a top-up payment that was higher than that paid at the closed home resulted in a saving.

11.3.3 Ongoing concerns

Friends and families identified ongoing concerns following the closures, which included fears that a resident might have to move again if, or when, their needs changed. Relatives reported being told by new homes of the limited nature of the care they could provide, with particular reference to mobility issues. For example, relatives said care homes providing personal care only were unwilling to care for residents who developed mobility difficulties, or were considered unable to 'help themselves'. For some, this was a new concern that followed on from the closure; the closed home had been 'willing to have them when they needed more care', whereas the new home was not. A second concern identified about the possibility of another move was a fear that a new home might close. Another worry identified by a relative concerned the larger size of

the new home and a concern that her mother might be overlooked she did not ask for help. Another concern about the loss of links with other medical professionals, such as GPs, was highlighted earlier in relation to changes in quality of care.

11.4 Consequences for care home staff and providers

Chapter 9 highlighted that some care home staff reported experiencing care home closure as a source of work related stress. Short-term outcomes associated with closures for home staff were identified in relation to feelings after experiencing home closure, job related changes and views about working in care homes, financial consequences and the loss of teams.

11.4.1 Feelings of loss and grief

Several care home staff indicated that they had liked or loved their jobs at the closed homes. Some spoke explicitly about experiencing feelings of grief and bereavement:

> 'I know you are not meant to, but you do get attached and in a closure it is the same as someone dying that you have looked after. And it is like bereavement, in a way. It is strange. ... I am not the only one that feels like it. ' (HC3CA3)

> 'The closure of a home after a lot of years is heartbreaking. I worked at (name of closed home) for 17 years. It was part of my life.' (HC3CA5)

An assistant manager said she felt the home closure process was 'like going through a slow torture' and was 'grief stricken'; the experience of having a large number of residents leave one after another in a concentrated period of time was said to amplify her sense of loss:

> 'When somebody dies it changes the dynamics of the building and you feel sad because you are used to that person being there. I mean, I know that grief is a selfish feeling, because it is your feelings of missing them. Every time somebody moves it is like somebody has died, because they are not

where they were and they are not there any more. So, therefore, you are sort of lost. In this small space of time, you have lost so many people and it is almost like a bereavement.' (HC3AM2)

A number of staff referred to missing the home and the residents. Some likened the closed homes to 'a family.' Care managers' reported seeing home care staff in tears and of worrying about how they were coping and being affected by the closure.

11.4.2 Job-related changes

For all employees a care home closure is likely to mean a change in job, if not employer. However, care staff reported that it was easy to find another job in a care home, and most said they had secured new jobs in other homes. For some this was working for the same employer, although others reported finding new jobs with new employers. For some, working for someone new was a deliberate change; they reported not wanting to work for the employer responsible for the closure because they no longer trusted or respected them. One care assistant noted that she changed her new job almost immediately due to the prohibitive travel time compared to getting her old job, so the transition to a new job was not always straightforward and could result in staff experiencing difficulties related to work.

One care assistant said she intentionally decided to work with a different client group, adults with mental health needs instead of older people, because she hoped that such specialist homes were less likely to close, and two staff reported changing their type of work to avoid the risk of experiencing another closure. However, this reaction of deliberately moving away from the care of older people in care homes to avoid future closure experiences did not appear to be a common one, although, for some the closure was followed by a career break, or a period of being out of paid work: a registered general nurse left nursing; another woman chose to work voluntarily at a school and attributed this to her age and reluctance to undertake training: 'I felt I was getting old and the NVQ training, I did not want to do.'

A few staff spoke of wanting less responsibility following the closure or of questioning whether they wanted to continue in their current role. An assistant manager said she did not want to work as a manager in a care home again because she wanted a less stressful

job. A senior care assistant also said she wanted less responsibility. Some care assistants said they were unsure or questioned the purpose of working as a care assistant:

> 'It has run through my mind loads and loads of times "Is there any point in carrying on with care work?"' (HC3CA3)

Another care assistant reported that she had changed her attitude towards work and tried to remain more detached emotionally:

> 'Although I have a job in another rest home I shall never feel the same as (name of closed home) was special. I don't let myself get involved anymore'. (HC3CA5)

When asked about factors that influenced their choice of new job four staff reported considering whether a new home would meet the new regulatory standards for the physical environment, which suggests that they were interested in whether it was likely to remain open and was financial viable. A couple also said they considered the occupancy level of homes, another potential indicator of financial viability.

11.4.3 Financial consequences

For one woman the timing of the closure and loss of job meant she lost maternity leave pay from an employer, and was unable to find another employer willing to employ her just before she was about to go on maternity leave. Another worker said she had to postpone buying a house as result of the financial consequences of redundancy due to home closure.

11.4.4 Loss of established teams

Several staff noted that care home closure resulted in the loss of experienced staff and teams of staff. A senior care assistant said this was one of the main negative consequences of closure. One manager noted that although the organisation offered care staff alternative employment in other homes within the chain, only three staff, including a housekeeper, accepted the offer and as a result he lost a valuable team:

'They were an excellent team of people. They were exemplary. They really humbled me as a workforce because they were so good and so dedicated to their jobs. Come the day they had to look after their family interests, I understood what they were doing, you know. I was just sad that we lost that talent and that ability.' (HC8, Project Manager)

11.5 Consequences for social services departments

Social services staff accounts suggested that closures were costly for councils. Financial consequences included costs related to the management of closures and ongoing costs. Staff also speculated that closures had negative consequences for social services in terms of the nature and quantity of local care homes and loss of valued providers.

11.5.1 Financial costs

Social services staff identified a variety of financial costs to councils including one-off costs linked to the costs of closure and ongoing costs linked to changes in placements. Some costs were common across the councils, but others appeared to vary depending on local policies.

Common closure costs included staff time spent on closure work, and for some the opportunity cost of doing the work in terms of the knock-on effect on the rest of their workload. As described in Chapter 10 staff reports suggested that the time spent on closure work could be considerable and included the time of care managers, their team managers and district managers. One senior manager estimated that an assessment takes about two hours of a care manager's time. Overall she estimated, 'crudely speaking', that the provision of an assessment, help to find a new placement and support to residents and their families required a minimum of ten hours of care manager's time per client. Analysis of the care managers' activity logs showed that care managers spent from thirty minutes to three hours on assessments, although they spent, on average about one to one-and-a-half hours. This could include joint meetings with relatives, staff and the resident, separate discussions with staff or a home manager and looking through existing paperwork. Care managers reported spending from 30 minutes to two

and half hours on reviews. Completing assessment or review documentation in the office could take a further hour.

Other costs of managing closure relocation incurred by participating councils included transport costs, which might be paid to internally provided social services transport or to external transport providers, (including taxis), and removal costs. Less visible costs to social services departments included staff mileage and the costs of assessments conducted by health professional such as mental health assessments.

Ongoing costs to councils resulting from the relocation of residents due to home closure included the payment of higher care home fees, and the payment of top-up payments where councils had previously not paid them. One district manager said local authorities were being 'priced out of the market' for places by fee levels. A care manager from the same council said some publicly-funded residents were moved to shared rooms because the council funding would 'only allow for a shared room... we are looking at who could share because it's cheaper.'

11.5.2 Impact on supply

Some people, mainly social services staff, identified more macro level consequences of home closure. They considered the 'bigger picture' in terms of the cumulative impact of closures on the future supply of care homes, and in turn the probable reduction in the choice available to those looking for a vacancy – due to the reduced number and type of care homes. In some areas, there was a perception that home closures were already making it difficult for older people to get the residential services they needed and wanted. A lack of care homes that provide personal care was highlighted as a particular problem for older people living in the community when their needs changed and they required 24 hour care. The risk of closures exacerbating delays in transfers of older people from hospital waiting for a care home placement was also identified.

A senior manager noted that care home closures meant councils lost valued providers in the independent and voluntary sector, and relationships with committed professionals.

11.6 Summary

This chapter has drawn together the experiences and views of residents, relatives, care staff and care managers to identify the short-term outcomes and consequences of the closure of independent care homes for the main actors involved.

In terms of residents, just over one-fifth moved to different types of care provision to that received in the closed home and these moves were usually to higher levels of care. Some older people moved to nursing placements for the first time as a result of needs assessments prompted by a care home closure. About one-third of the residents moved to homes in different sectors of ownership and one third to larger homes.

Reports of consequences and changes brought about by closure highlighted that they could result in older people moving to different geographical areas. Such 'out of area' moves were said to have a range of negative and positive consequences for residents. Negative consequences included reduced access to local amenities, and social clubs, and an increased or new sense of isolation and discontinuity. Positive consequences of geographical moves included a greater or continued sense of belonging and continuity with the past.

Multiple and temporary moves occurred. Sometimes as part of strategies to secure a permanent place in a preferred home at a later date, but also sometimes as a result of problems or dissatisfaction. Relatives who experienced temporary moves said they were disruptive, and some said moves were against their wishes. Other relatives worried about the possibility of a temporary move.

Short-term health outcomes following relocation amongst residents included deaths, health improvements and deterioration, or at least a coincidence in the occurrence of certain illnesses or health problems within the period following home closure. Lifestyle changes, such as house moves are known to be high-stress situations for everyone and are particularly stressful for people with existing serious psychiatric illnesses. The participants' accounts suggested that care home closure constitutes a high-stress situation, and one that might constitute a risk factor for suicide or depression amongst

some older people, particularly those with pre-existing mental health conditions. Some experiences within the sample suggest that residents who move between care homes might be more likely to experience losses to their mobility and/or falls than otherwise. This is probably due mainly to the change in environment per se, but might be exacerbated by the reason and nature of the process of relocation, that is, home closure.

Gains and losses were identified in relation to changes to the quality of care experienced at the new homes compared with the homes that closed: the general level of care, staffing, facilities and social participation and involvement in leisure activities, meals and mealtime support, cleanliness and respect for clothing/clothing regimes. For some relatives, the care provided at the new home marked a vast improvement or was said to be more appropriate to the older person's needs. Some reports suggested that certain deficiencies or poor practices were long-standing, others suggested they were linked to a time of financial difficulty before closure, or associated with the closure period itself, and in other cases the longevity was unclear. Clothing problems, for example were identified as long established at one home (even taken-for-granted as a characteristic of care homes by some relatives), but specific to the closure period at others. Poor care practices or difficulties were also identified at some of the new homes. The nature of some of these problems were unclear but tended to relate to staff behaviour and so probably indicated a need for better information about residents' needs, staff training or good practice development. Worryingly, some residents and relatives spoke of having difficulty accessing health care via a general practitioner. The problems related to the frequency of visits made by a GP to a home and poor communication between surgery and relative (and/or the home and relative).

The research found that for some residents the move could provide an opportunity to re-locate to a preferred location, and so improve sense of belonging. This, however, was unusual. More commonly, out of area moves were associated with discontinuity and reduced visits by relatives. The residents' reflections on what they lost or missed offered insight into what was important to them. Changes, which were interpreted as aspects of the residents' quality of life, were identified in relation to ethos, social interaction between residents, and with known staff, hobbies and a sense of security. Some of these losses were likely to have been transitory because they could have been

related to short-term adaptation and ameliorated with time. Others were likely to be more permanent.

As well as positive and negative experiences of changes to how often they visited residents post-relocation, the relatives identified a variety of other long and short-term financial consequences of care home closure. The incidence of such costs varied across the closures. The variation depended on the way in which care homes and/or councils shouldered or passed on the responsibility for costs, which resulted either directly or indirectly from the closures. Transport and relocation costs, for example, could be borne by the closing home, individual residents and/or their families, or councils. Similarly, some councils covered increased or new top-up payments when they were required by new homes, while others did not. Other consequences, identified by relatives included ongoing concerns about the welfare of residents, particularly about whether they might need to move again or might not be receiving the care they needed.

Although the number of participating staff at the closing care homes was small their experiences and views provide insight into the types of consequences of home closure for care staff. A care home closure was clearly described by care staff as a source of considerable stress. Some reported feelings of loss, and bereavement. Most found new jobs in other care homes easily. Some questioned their choice of working in care homes for older people. A minority looked for another type of job deliberately to avoid the possibility of going through another care home closure. A few staff wanted jobs with less responsibility than they had at the closed home. A couple of people relinquished paid employment for a time as a result of losing their jobs. Clearly this meant a loss of income. Other financial consequences were identified, including a loss of maternity leave cover.

Social services staff identified the extent of which closures can take up considerable council resources, particularly in terms of care management time, but also in terms of increased fee payments resulting from the relocation of residents to homes that charged higher fees. Their accounts also included speculation about the impact of care home closure on the quality and quantity of the local supply of care homes for older people.

This chapter has gone some way to identifying the potential range of effects of home closure on relocated residents and some of the effects on other actors, including those in the care workforce. Arguably understanding of the process of closure matters because the way in which people are affected is likely to be influenced by the way in which a home closes. The findings relating to outcomes and consequences, particularly those associated with home location, finances, and stress and concerns support this view, since they were usually linked to structural or process features of the closure processes. Some negative outcomes might have been avoided given, for example, more time, more homes to choose from in desired locations, and consistent policies across councils.

Part IV

Discussion

Chapter 12

Closures characteristics, influences and recommendations for managing practice

12.1 Introduction

This chapter discusses findings about the closure process identified from reviewing the findings from across the various perspectives and sources of evidence presented in previous chapters, and considers them in relation to previous research findings. First, the characteristics of closures are briefly reviewed in terms of the main actors involved, the general nature of their interaction, common characteristics of a closure process, and the principal phases identified based on the types of activity reported. The main influences on the process are then identified in relation to these phases. Two general types of influence are differentiated: structural and individual level factors. This is followed by consideration of the nature of the perceived and reported risks and opportunities posed by voluntary care home closure. The good practice recommendations made by the residents, relatives, front-line care managers, and care home staff are then brought together and discussed and the policy implications for approaches towards good practice identified and considered.

12.2 The nature of voluntary closures

Linked research preceding this study, described in Chapter 2, identified a combination of business related factors as typically underlying the voluntary closure of independent sector care homes. These included the low level of local authority fees (the major purchaser), staff recruitment and retention problems, and concerns about the cost implications of compliance with the new care standards, particularly those related to the physical environment. Another important factor underlying decisions to close a home is that providers who no longer want to run a care home are unable to secure a purchaser who might take the business on as a going concern.

12.2.1 The main actors

The closures studied included the usual mix of individuals and organisations involved in personal social services, with the exception that the regulator was noticeable by its absence from accounts and appeared to have little involvement. Care home closure involves older people, and their families, private or voluntary sector care home providers and their staff, and local authority social services staff, particularly front-line care managers and care manager assistants. The businesses being closed were small-scale private businesses, usually single operations and as such taken individually they affected small numbers of people. There was an unequal and inconsistent balance of powers, obligations and freedoms between and within the main actors.

Unsurprisingly, the population of care home residents experiencing closure was found to include a diverse range of people whose need for help from social services differed depending on various factors including their health, whether they had any relatives who could help, and whether the closing care homes and prospective care homes were helpful.

The care home closures were not described or discussed as joint enterprises by the various parties and organisations involved – with the exception of some care managers who saw it as important to work closely and sensitively with homes, and some council guideline recommendations that suggested that social services staff talk to owners and agree jointly resident notification. Residents' and relatives' reports showed little awareness of any overall management of the relocation process and closure by councils or the regulator, or awareness that the event was part of a larger phenomenon, although a few people spoke of the incongruity of care homes closures at a time when there was an ageing population. There was often a sense that everyone had had to do everything pretty much on their own. Preceding research found similarly that providers viewed themselves as doing 'everything' themselves during a closure to relocate 'their' residents (Williams et al., 2002).

This attitude may be linked to a feature of the care home closures process that appears both to reflect current policy approaches and to highlight limitations and complexities in the way in which they are conceptualised and dealt with in practice. That is, the way in which closures are regarded very much as an individual problem – at the home and

resident level. The apparent isolation of closure work within social services departments was on the one hand surprising, given the likely frequency and ongoing nature of closures, and the councils' wider remit of overseeing the commissioning of high quality services, but unsurprising given the wider policy and legal context. The apparent lack of established partnership working between the care managers involved, the residents and the closing homes has implications at the council level for the organisation of care management and the development of closure guidelines (which is discussed further below).

12.2.2 Common characteristics of closures

A recurrent finding identified across the perspectives of those involved in closures is that home closure may be characterised by variability, inconsistencies, difficulties, tension between goals and compromises. The closures studied were also typically experienced as a crisis. Considerable variability was found in residents', relatives', care managers' and care home staff reports of closures, both across homes and local authorities and within homes. Variability was identified in relation to numerous aspects of the process, and could be linked to the actions or inactions of homes and care managers, as well as differences in individuals' needs or circumstances.

Variability in and between residents' and relatives' experiences associated with the closing homes included the length, form, source or provision of notice, the degree of management leadership and support, and the quality of standards of care provided.

The review of councils' closure guidelines found variation in councils' approaches and policies, including understanding of their roles and responsibilities during closures, and advice about paying existing care staff or sending in social services staff until relocation is achieved. Some of the advice offered in the guidelines was contradictory: whether care managers should support all residents or only publicly-funded residents; whether temporary moves should be considered a useful option or avoided; whether residents should be moved gradually or simultaneously.

Unsurprisingly given this variation in guidance, a wide range of inconsistencies and variability was identified in relation to experiences and provision of care management and council practice. Criteria used in decisions by care managers about whether to offer

assessments to self-funded residents included whether they had any relatives to help them or were unable to select and secure a new care home place themselves, and whether residents' needs were considered to have changed. Reports of support received from social services sometimes appeared to vary in ways related to such inconsistent policies across councils, rather than service users' needs. For example, the level of assessment conducted and use of specialist input varied by council and reviews tended to be provided only to funded residents. Arguably, the level and timing of monitoring following relocation caused by home closure is inadequate both for funded and self-funded residents, particularly given that care managers voiced concerns that some older people were so distressed that they posed a suicide risk.

The research identified inequitable access to financial support from councils, as well as care management. The variation in councils' policies towards the payment of costs incurred or engendered by the relocation (such as new top up payments required by the new homes or transport costs) meant that the costs of home closure incurred by older people and their families differed in different parts of the country. Residents in areas where the care managers argued that the council should cover any additional costs incurred by such involuntary moves were more advantaged than those in areas where councils would not shoulder such costs. In turn, where councils would not pay higher fees or top up payments, funded and self-funded service users without relatives able and willing to pay top-up payments were more restricted in their choice of home than those with relatives who would.

As well as variability, the closures were characterised by tensions in people's aims and objectives. Some care managers spoke of conflict between meeting the needs and preferences of service users, and promoting choice in the context of limited or restricted resources in terms of supply and budgetary constraints. A few indicated that they were concerned that pressures led to compromises about placements which were not in the best interests of residents. Dilemmas were evident in relation to the central policy aims of promoting people's rights and freedoms while also protecting them from harm (Department of Health et al., 2004), of meeting people's needs *and* preferences within available resources, and of ensuring that services are person-centred and needs-led (Cm 4169, 1998; Department of Health, 2001). Care managers appeared to be forced to adopt the market broker approach as their dominant role, but noted that it was a

situation where someone should fulfill a risk assessor and protector role.

Residents and relatives also reported experiencing tensions around decisions about whether to act co-operatively or competitively. The research suggests that home closure is a situation where consumers' aims cannot be considered as purely rational in terms of being self-regarding and competitive; care home residents and their relatives described their own interests as linked to those of others. Some relatives spoke of wanting to move residents who had become friends together, but this degree of co-operation and planning was difficult given the problem of finding suitable vacancies for one, let alone two or more people. Some reported an awareness that one person's successful placement might mean less choice for those still looking.

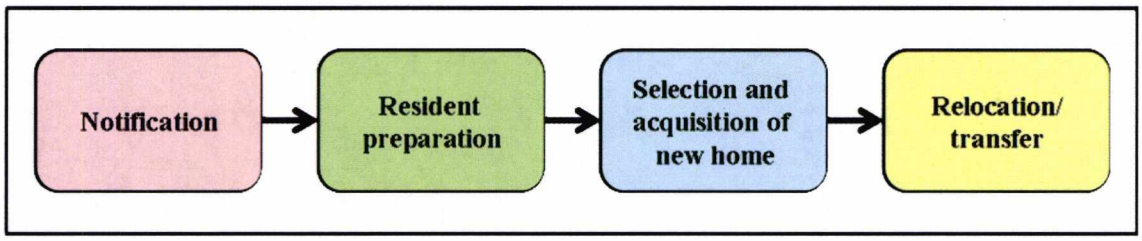
Another general characteristic of the closures was a lack of resources. The care homes investigated appeared to have no resources set aside to help maintain standards of care during closure periods, or to ensure homes remained open long enough for residents to find suitable alternative homes. The councils appeared to have no budget for dealing with closure situations and no services on which to draw on to help residents who were 'giving up' (care managers' concerns about the latter are identified in Chapter 10).

The process of care home closure presents a situation or context that highlights some of the tensions or disjunctions that can occur between the experiences of those involved and prevailing policy assumptions and expectations about how providers, staff and service users operate and about their concerns and motivations. The difficulties and compromises identified during the closures highlight tensions between broad structural issues such as market provision and rationing of funding resources, and individual level concerns and tensions around striving for the best possible outcomes for individuals in a competitive market, versus the achievement of appropriate and high quality outcomes for all.

12.2.3 Main phases of a closure

The study suggests that closures have four main phases or types of activity for residents, relatives, care staff and care managers: notification, preparation of the residents for the move, identification of vacancies in appropriate homes, selection and acquisition of appropriate alternative accommodation, and the relocation itself (see Figure 12.1).

Figure 12.1. Main phases of a home closure



Another two potential phases or elements of the relocation process include the preparation for resident's arrival by staff at new homes (these staff were not included in the fieldwork but could be the focus of future research) and formative evaluation of the process, which could be conducted by either or both the owner of the closing home, or the social services department or care management team involved. In addition, the research identifies the maintenance of standards of care during a closure as an important aspect of the process, which spans the four major phases of a closure.

12.3 Influences on the care home closure process

The policy review and fieldwork identified a range of factors that can influence a closure process, to complicate, support or constrain people's options. Figure 12.2 summarises the factors that influence each major phase of a care home closure process, and the way in which they may be managed, in terms of structural and individual level influences. Influences are presented as individual when they relate to people's aims and priorities, views, attitudes, beliefs and preferences, knowledge, understanding, and perceptions, as well as their resources and needs. Knowledge or awareness and practice level influences can be located within individuals, but sometimes are also linked to organisational approaches, policies and practices.

12.3.1 Structural level influences

Structural level influences include the legal framework, national and local policies and guidance about the arrangement of social care, the nature and level of market supply and level of competition locally, council policies (in relation to assessments, fees, temporary placements, the advice given by care managers about homes, and internal policies about the decision-making ability of care managers, and provision of transport and payment of higher fees or top-ups), care home admissions policies, the availability

of information about the process for service users, care home staffing levels and retention policies, and management support within closing homes.

The study found an ill-defined legal and policy framework around closures for local authorities. Local social services departments had little guidance from central government to help them to define, plan and execute their responsibilities during voluntary independent care home closures. The legal and policy framework chapter (Chapter 3) highlighted the general duties and powers of councils of relevance to home closure situations; councils' main duties during closures relate to their duties to assess, review and monitor the needs of older people. What little national guidance there is about councils' responsibilities tends to be 'confusing and fragmented'; much is 'contained in ministerial and departmental circulars and guidance, some of which is binding, some of which is not, and none of it is readily available except to those who are skilled in knowing where to look' (Bowen, 2006 p3).

There are few specific closure related process related legal requirements for councils or care home providers, and no outcome related requirements; overall the process is largely unregulated. Providers had some process related obligations to residents and to councils in terms of notification about closure, but neither councils nor the regulator had any obligation or powers to help when a provider was considering, consulting or giving notice of intention to close. Neither were there any obligations or powers conferred on councils or the regulator specific to a closure situation in relation to monitoring the service during a closure period, or towards how they might go about upholding or applying their general safeguarding or quality remit.

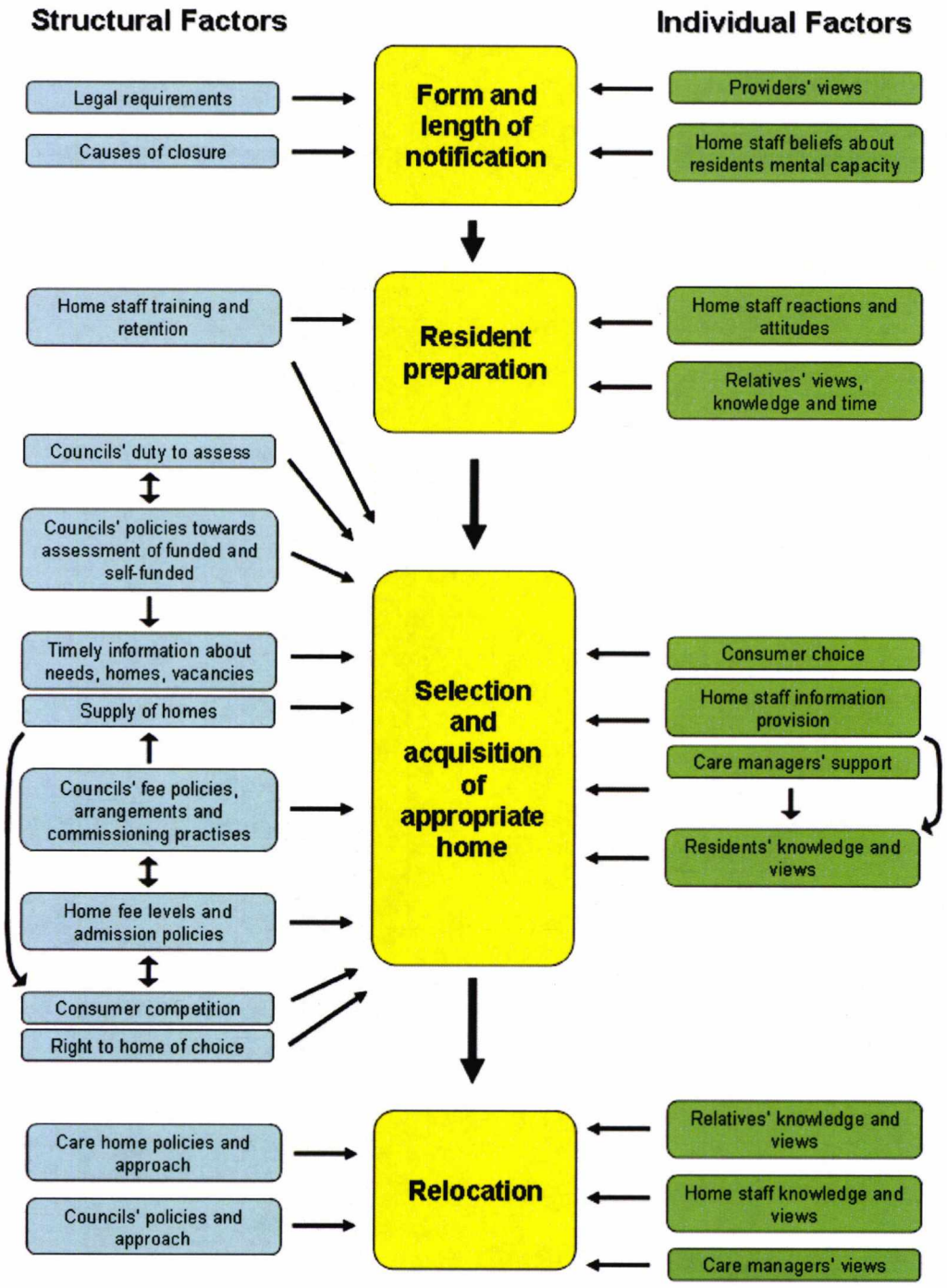
The review of local government guidance (Chapter 7) found a lack of discourse around the aims and objectives of local government during a home closure. Most of the local guidelines did not identify overarching aims and where aims were identified they tended to concern councils' general duties towards protecting service users' interests and ensuring relocation was managed safely. This focus suggests a concern with providing a safety net and guarding against worse case scenarios, namely preventing mortality. Some guidelines also referred to broader goals of promoting independence, choice, privacy, dignity and respect. However, these issues were typically identified as principles of good practice rather than addressed as important quality of life issues for

residents, with plans to ensure their delivery and implementation. Many of the existing council guidelines also failed to address areas of concern identified as important by relatives, such as how best to support residents with dementia during such relocation. In terms of how the main actors related, there were no requirements within the councils' guidelines for collaboration or control of the situation in terms of inter-agency consultation or agreement *before* a closure is decided upon.

Similar market related constraints upon the selection of a new home during a closure by older people and their family and friends were found as have been identified in relation to admissions to care homes in general: a lack of services from which to choose, a lack of homes providing particular services locally, a lack of information about vacancies, local authority fee policies, the slow speed of funding arrangements and the competing demand for care home places from other older people either living in the community or wanting to move from hospital places(See Ware et al 2003). Other constraints, in line with previous research, related to the admission decisions of prospective homes (Corden 1989). Some relatives reported difficulty finding care homes that would accept older people with complex behavioural needs. Care managers also identified an inability to block book temporary placements in local authority homes as problematic, and attributed it to the closure of council run homes, or their use as hospital step-down places.

Other structural constraints on choice of home identified include short timescales, and a lack of information about the process, as well as support and information about residents' needs and the options available. In general, policies emphasise that service users should be able to access timely and appropriate information. Service users and their relatives and care managers reported finding information seeking a time-consuming and sometimes difficult task. The present study highlighted that a care home closure situation can include conditions that Barnes and Prior (Barnes and Prior, 1995) identify as likely to make people experience choice as disempowering, difficult, stressful, confusing or as a risk: a lack of information on which to base decisions; little or no influence over the range of options available; a lack of confidence that what is available will meet their needs; and pressure to make a decision quickly.

Figure 12.2. Structural and individual level influences on the closure process



Many of the difficulties reported mirror problems that have long been identified in relation to the provision and receipt of care management and information, for example, the lack of timely and helpful information about what services are available (Department of Health, 1998; Department of Health and Social Services Inspectorate,

1998; Department of Health and Social Services Inspectorate, 2001; Bainbridge and Ricketts, 2003), a perceived lack of expert advice (Nolan and Dellasega, 2000), and uncertainty amongst some service users about whether or how their health and social care needs have been assessed (Myers and MacDonald, 1996; Abbott et al., 2001). The regulator recently highlighted that such problems are still widespread; it found problems in the adequacy of information provided to older people and their families when choosing residential care: inconsistent communication about the availability of assessments to self-funded older people across councils; a lack of awareness amongst older people and their relatives that a care home might not be a 'home for life' due to the need to move if their needs changed; inadequate information to prospective residents provided by 20 per cent of care homes; and variation in the information provision about entitlements and support during assessments across councils (Commission for Social Care Inspection, 2007).

The way in which the care management closure teams were organised meant that they rarely had prior involvement with residents or their families. This meant that they had to develop an understanding of complex needs and relationships in short timescales, which had implications for their ability to support and help prepare residents, and to help in the selection of homes appropriate to their needs. Other local authority policies and internal systems identified by care managers as having caused delays, or hampered organisation and communication, included authorisation procedures for the payment of higher fee levels or the restriction on the advice care managers were ostensibly allowed to give to service users about homes. The policy foundation for the view among care managers that they have to avoid commenting on the quality of specific homes is unclear. Most of these difficulties relate to a lack of autonomy and decision-making ability among front-line care managers and their immediate team leaders (See Le Grand, 2007a for a discussion of these problems in the provision of social work to looked after children).

Staffing levels within care homes and staff continuity during a closure were structural factors, at the care home level, that could influence resident preparation, selection of appropriate new homes and the relocation itself. The availability of other care jobs in the area may also affect the speed at which existing staff leave, which in turn may affect the quality of care offered and the speed of closure. A lack of management

involvement, support and availability as a point of contact for staff to go for support or for service users to direct their complaints or protest was another organisational level factor that could affect or compound both staff and relatives' sense of betrayal by providers.

12.3.2 Individual level factors

Individual level factors identified as influencing experiences of the process include beliefs about residents' mental capacity and how best to involve them, service users' aims and priorities (including the emotional aspect of choosing a home), a lack of information, the collective and competitive nature of securing new care home places, the emotional aspect of relocation (moving meant leaving somewhere that had become home), relatives' expectations about moves to homes within the same chain, the attitudes, commitment, experience and knowledge of care home staff, care managers' views about the scope of their responsibilities, constraints on their actions and good practice knowledge.

Individual factors that appeared to influence the variation within resident preparation across and within homes included decisions and views of providers, relatives, care home staff and care managers. The views of providers about the financial viability of the business and urgency of winding it up influenced closure timeframes and the timing of notification. Individual providers' openness and honesty, or lack of it, about the reasons for closure appeared to affect residents' and staff interpretations of their overall concern with their welfare. Beliefs about residents' ability to understand and cope with the news of home closure and about what would be in their best interests could influence whether, when and how residents were informed.

On the positive side, there was some evidence of individual residents' aims, views and preferences influencing the selection of appropriate new homes and of relatives' views affecting what happened. As mentioned in relation to structural factors, however, there were instances of gaps in knowledge, information and awareness about what was happening, the role of care managers and councils, and service users' rights.

The aims, and priorities of the main actors was an important influence on the process and outcomes and raised issues concerning various policy assumptions, such as older

people's willingness and ability to act as competent and rational consumers. Peoples' aims and priorities can be differentiated in terms of whether they were outcome or process related. The residents' and relatives' main outcome related aims and priorities during the care home closures were focused on finding an alternative home that could meet the residents' needs. The literature and policy reviews (Chapters 3 and 4) suggest that choice may be complicated in relation to initial admission to a care home (Barnes and Prior, 1995; Dellasega and Mastrian, 1995; Nolan et al., 1996b; Commission for Social Care Inspection, 2007), and the present study similarly found choice to be a complex issue in the context of home closure. The issue of choice for relatives and residents during a care home closure appeared to be very much about achieving the final outcome of a suitable new home. Choice may be a process related outcome that supports the more important final outcome

Thus, a focus on choice *per se* may be a red herring in a number of ways. First, choice could be interpreted as referring to being involved in making the decision about where a resident should move (i.e. they could say 'yes' or 'no' to a particular home, rather than choose between options). Secondly, in order to make a choice there would need to be a range of options, in terms of different types of home to choose between, offering appropriate care. Third, the opportunity for residents and relatives to exercise choice depended on the availability of information about vacancies and homes and information about their right to choose a home. For some choice of home was restricted by both the availability and characteristics of the homes in the area, and hampered by the information and time available. At the same time residents and relatives described having to compete against each other for available care home vacancies, which added to the feeling of pressure.

As mentioned in the section on common characteristics of closures, at the individual level the study highlights that home closure is a highly pressured situation which can be characterised by tensions. For example the competitive nature of finding and securing a care home vacancy could become apparent to service users due to the collective nature of the search and in turn increase the sense of pressure; all of the residents were looking at the same time and within the same timeframe. The possibility that choice may 'compound inequalities as take-up of choice varies across the social divide' appeared to

be in evidence, in part due to access to top up payments and local authority fee levels (Policy Commission on Public Services, 2004 p.9).

The review of policy highlighted various assumptions about the different actors and the way in which they are expected to operate in general in the care home market. The present study highlights that residents and relatives cannot be assumed to act as purely rational consumers due to the emotional aspect of their priorities and concerns. Their choices may have many emotional components, including the way in which the relocation can be experienced as moving home. Just as choosing a care home involves choosing a place to 'live in', not merely a question of choosing a health or social care provider (Reed et al., 1998), for some residents and their families home closure illustrated the degree to which a closing home can be a 'home', and relocation necessitate a 'loss of home' and need to choose and create another. The value and meaning of care homes as 'home' became apparent when the older people and their relatives spoke of their concerns about moving. The impending loss highlighted what was under threat and in turn what had become important about where they lived. This finding goes some way to counter the view that care homes by virtue of their institutional nature cannot become 'home'. Milligan (2003), for example, notes that in relation to Auge's (1995) notion of anthropological space , care homes constitute 'non space' due to the absence of connection, memory and identity. This may be the case when older people first move to a care home, but clearly is not always so for some residents once they have lived at a care home for some time. Older people may develop links to a place and construct a sense of home, even in institutional settings. Relocation for some can represent a form of dislocation from home. The retention, placing and continued use of familiar possessions may help residents build a sense of home within a care home and do so again following relocation due to home closure.

Moreover, the research suggests that residents may develop memories and ties to a care home due to its wider location and related continuity with a known community, or due to the relationships and events experienced there. As Rubinstein (1990) has argued ties to a place are 'lived' and personal identity is rooted in the present day as well as the past. Other ways in which a care home may be perceived as a home include residents' perceptions of a sense of belonging and/or territoriality (Cutchin, 2003), and that the home is a place of security and safety (Milligan, 2003).

The findings suggest that residents' and relatives' selection of a new home may be influenced by expectations or assumptions about the possibility of maintaining contact and continuity with care staff if they move to homes within the same chain, where care staff are being re-deployed. Some residents and relatives spoke of assuming that if they moved to another home in the same chain as that of the closing home they would continue to see care staff they knew and valued. This was not necessarily the case and could lead to disappointment.

Despite the lack of policy guidance the care managers showed a collective understanding of their aims and role in principle. Most were process related and linked to the primary outcome goal of helping residents move to appropriate new homes. Their views, however, differed about their responsibility for matters such as influencing the way in which residents were notified by homes and the provision of support to care home staff working at closing homes. A feature of the care managers' aims and objectives noticeable by its absence was a lack of measurable, and observable outcomes tied to service users' preferences over and above the most general aim of relocating them to care home that could broadly meet their social or health care needs before the deadline. The use of generic assessment and review documentation left little room for recording or reflecting on whether residents' preferences for particular homes, locations, or to move with friends, for example, had been met.

The study also highlights that the understanding and commitment of care home staff, particularly to their jobs, the residents and their employer, as well as their reactions to notification (which might affect the former), are factors that may influence the nature and quality of the support and help they are able to offer – particularly in relation to emotional support provided during notification, preparation, selection of new homes and relocation. This has implications for possible training and development around skills and good practice by care home staff during closures, as well as for the actions of providers when giving notice for example.

12.4 Risks and opportunities

An examination of care home closure should examine the significance of closures for those involved. Previous research on the consequences of care home closures (discussed in the literature review, Chapter 3) focused mainly on 'relocation effects' in terms of the potential negative consequences of such involuntary moves on the health of residents. Other types of impact for residents, such as social or economic outcomes were relatively unexplored, as were the nature or import of consequences for relatives, care home staff, social services care managers and social services departments.

In the media, and among providers, frontline staff and service users, care home closures have been portrayed in terms of risk of harm to residents. The participants in this research highlighted both negative and positive outcomes following relocation. The research highlights that the closure period, as well as the closure and relocation per se, has different impacts for different groups. Unsurprisingly, the most serious consequences identified relate to the individual residents who move. In some of the homes involved, older people were considered vulnerable and at risk of danger by virtue of their characteristics and actions or potential inactions of those responsible for ensuring their safety. The study supported the identification of a range of potential risks, which might occur during home closure, as well as afterwards. Residents without relatives and self-funded residents were identified as particularly vulnerable to being disadvantaged during the process and at risk of neglect or harm should standards fall during a closure period.

The literature review highlighted that there are a number of possible negative welfare consequences for future service users if closures are left to the market. Firstly, distributional problems may develop, such as the development of distinct areas with either under-performing or elite providers (6, 2003). Secondly, segregationist preferences of consumers or cream-skimming practices by home owners might reduce the choice of the most disadvantaged (Knapp et al., 1994; 6, 2003). Evidence suggests that, at least in the past, closures have affected capacity (Netten et al, 2002b). Yet, as highlighted earlier prevention of care home closures appears to be a topic that is actively avoided in policy documents.

A health and safety approach regards risk in terms of hazards, dangers and harm. Adopting this approach leads to examination of issues such as identification of the types of hazard and danger, who is harmed and how, the likelihood of harm, and what the precautions are, if any? This study does not provide evidence about the likelihood of harm but goes some way towards identifying who could be harmed and how. These are now discussed before some of the possible precautions are considered in terms of policy and practice development. The nature of some of the dangers associated with home closure can be regarded as having potentially high impacts for current residents and care home staff, but relatively little direct impact of significance for the wider population of service users and commissioners and care home staff.

12.4.1 Risks to current residents and relatives

Some of the potential hazards identified during closure periods mirrored the variety and types of hazards possible within residential care settings per se, and span the relatively moderate hazard of an older person receiving care that is not the most suitable to their needs, to the danger of financial or physical abuse, unsafe conditions or practices, or neglect, which may lead to deterioration in health and well-being, or even death. Other risks more peculiar to the situation of home closure concern the protection of prospective service users from the risk of unknowingly moving into a home when it will shortly close.

The proportion of deaths reported within the first three months of relocation (described in Chapter 10) represent a smaller proportion than the number of older people likely to die within the first three months following first admission to a nursing place (30 %), or a residential place (12%) (Bebbington et al., 2001). On the one hand, however, the number of reported deaths was surprising because all but one of the studied closures were residential homes and so the residents, although likely to be frail, were unlikely to have serious health conditions (or at least conditions that required nursing care). However, eleven of the relocated residents who died moved to nursing places and admission to a nursing place, along with admission from hospital, and diagnosis of particular illnesses, such as cancer or respiratory illness has been shown to increase death rates in care homes (Bebbington et al., 2001). Extreme caution is needed in interpretation of mortality rates based on a sample of this size and nature; the findings

should not be considered as evidence that can contribute to the wider debate on whether closures cause untimely deaths, as the study was not designed to measure relocation effect on mortality or health.

Risks for older people experiencing a home closure associated with the closure period itself include serious dangers related to the risk of harm or neglect. Moving to a temporary placement was associated with psychological trauma and relocation associated with untimely death, the possibility of homelessness, a new home unable to meet a residents' needs, negative changes in type of care home (level of care, sector, size, quality of care), negative impacts on health, personal well-being and quality of life, and higher fee levels or top-up payments.

The finding that some older people and their relatives perceived a loss in mobility and/or greater incidence of falls following the relocation concurs with findings from an American study investigating the clinical outcomes after involuntary nursing home transfer (again with a relatively small sample from only one home). A higher incidence of falls was found among newly admitted residents in the three months post-transfer, compared with the pre-transfer period. Extra fall precautions, such as frequent reorientation reminders and high levels of staff surveillance, were recommended (Capazuti et al., 2006) and this practice could be promoted in good practice closure and relocation guidelines.

The research found that relocation could lead to social exclusion; dimensions of social exclusion that were identified as negative consequences of relocation include less social contact with relatives, loss of access to community amenities, such as shops, and social clubs, and less access to basic services, such as General Practitioners (For discussion and findings about social exclusion among older people see Marmot et al., 2003).

A sense of security, continuity, belonging, purpose, fulfilment and significance have been identified as important to quality of life for older people (Owen and National Care Homes Research and Development Forum, 2006). Clearly, these are inter-linked and any move of residence is likely to have some degree of detrimental effect on an individual's sense of belonging and continuity, at least in the short-term. The nature,

and scale of any changes and discontinuities are likely to affect the extent to which they impact on people's sense of quality of life, and for how long.

Turning to who was at risk, the research suggests that care home residents are not all subject to the same risks. Risks to residents may be mediated by the presence of family, financial resources, personality traits of individual residents, and whether a home closure presents any opportunities for residents to improve upon their existing situation. Some dangers appeared to particularly concern those who were reliant on help from organisations, either by virtue of being without relatives, or their lack of mental capacity, or practices based on beliefs about their mental incapacity. Other dangers may be linked to the closure process and how it is managed by a home and social services. For example, identification of the provider as responsible for helping residents find suitable new accommodation may leave scope for unscrupulous providers to suggest residents move to another one of their homes within a chain, irrespective of its appropriateness due to their vested interest in their own occupancy levels.

The variability within care management approaches to self-funders suggests that self-funded residents may be a particularly vulnerable group during a care home closure: their needs may not be assessed by a care manager; they may find it difficult to find suitable alternative accommodation without advice about their needs and homes; once moved self-funding residents are likely to receive little or no monitoring from social services.

The risks identified for relatives were largely financial, emotional and social, although for some the move could hinder their ability to visit new homes. It remains unclear how important a sense of control is to residents during a home closure – both in terms of their ability to cope with the process and their adaptation to the change afterwards. Each of the four elements of control identified by Chenitz (1983) as important to adaptation to moving to residential care are unlikely to be present during a care home closure; relocation caused by home closure is unlikely to be perceived by residents as desirable, important, as for legitimate reasons or for a short-time.

12.4.2 Risks for care staff

Care home staff nearly invariably lost their job, unless they were offered another position within a chain. This could mean a loss of income. However, there was little indication that it was difficult to find another job and so closure did not necessarily lead to periods of unemployment. Only a few staff spoke of the experience of closure as so upsetting or disruptive that they would rather change occupations than risk experiencing a care home closure again. There were examples where staff reported wanting less responsibility or to not get so 'involved' with residents, which has negative implications for career development and a loss of expertise within the workforce. The sample was small, however, and limited in terms of being representative of care staff so further work would be needed to establish whether the experience or fear of closure affects people's length of time in the job.

In other fields the risk of redundancy and periods of unemployment is balanced by higher pay or other incentives such as bonuses, or other forms of performance related pay. This example of job insecurity, however, did not appear to lead to calls for compensation over and above the usual statutory redundancy payment, or for calls of greater financial rewards. This lack of dissatisfaction with such risks may be linked to the low status of social care work, acceptance of low pay within the sector and the nature of the workforce, namely women who are expected to value types of job satisfaction other than monetary reward. This state of affairs may change if the workforce is increasingly characterised by agency working, and this in turn leads to staff developing less close personal emotional ties to the people they look after. The feelings of betrayal and lack of trust in employers reported by some of the care staff may have implications for whether care staff choose to work for a care home provider or an agency.

12.4.3 Impact on councils

Participants were not asked about their views of the consequences of closure for social services. However, the care managers' discussions in interviews and time logs of closure related activities described in Chapter 10 show that a closure may be costly in terms of staff time, the opportunity cost or impact on their usual workload, and in terms of fee or top-up payment increases. However, it appears that most of these 'costs' are hidden or absorbed within departments and some varied by authority according to

council policies; such costs did not appear to be monitored, or counted and so could not easily be quantified and considered.

12.4.4 Opportunities

There were opportunities as well as risks. Moves caused by home closure may have positive as well as negative implications for the quality of care received by residents and so may present an opportunity for improvement. Closures were not always entirely negative events. Positive outcomes identified for residents included improvements in qualify of care, frequency of visits by relatives, and geographical locations.

Adopting a simple health and safety approach to considering the risks posed by closures helps to identify their nature more fully and locate their likely source. The issue of how proactive a role the state should take in protecting older people living in independent care homes that are closing voluntarily from the potential dangers remains and is discussed further in the next chapter.

12.5 Good practice recommendations

Figure 12.3 summarises the good practice recommendations identified by the residents, relatives, care managers and care home staff who participated in the present study. Principles for good practice are differentiated from practical recommendations and are presented under each major phase of the process: notification, resident preparation, selection of new placements, and relocation. In addition to these phases, recommendations were also made about the maintenance of standards within closing homes, the practice and organisation of care management, and for homes receiving older people who have just moved from a home that closed and these are also reported. The recommendations identified are mainly concerned with implementation and so are particularly relevant to practice development.

Most of the recommendations are specific and consist of procedural suggestions to improve the closure process. Some of the suggestions correspond to existing recommendations reported in the literature (reviewed in Chapter 4), especially some of the overarching principles. The recommendations highlighted here, however, usefully

augment or enhance understanding of what those involved in closures report as valuable or important about particular principles or objectives during a home closure. For example, involvement during a closure should involve opportunities to talk to the owner, to influence the nature of visits made to prospective homes and the rejection of prospective home. A common theme throughout the recommendations across the main phases of a closure is the importance of listening to residents and giving their views and preferences force. In relation to notification, unsurprisingly most suggestions concern people with influence over the form and length of notification (that is, providers and care managers). Some relate to the relationship between the main actors and the importance of timely and useful information.

Figure 12.3: Main recommendations from older people, their family and friends and front-line care home staff and social services care managers

A) Suggestions for notification

Principle

- Residents and relatives should be given the opportunity to talk to the owner(s) of a closing home

Practicalities

- Lack of consensus but most would probably have agreed with the recommendation of not less than two months' notice.
- Owners and councils should ensure that residents and relatives are not the last to know.
- Notice should be flexible where possible
- Councils should contact relatives of funded residents quickly to let them know their role
- Owners should consider the timing of closures in terms of closeness to summer holidays or Christmas
- Owners should notify councils quickly
- Relatives should be provided with information about what will happen, how they will be helped and by whom.
- Vacancy information should be provided when a closure is announced
- Ideally, relatives would like to be made aware that closure is being considered.
- They should be told the reasons for the closure.

- Communication should be open, honest and direct and acknowledge 1) the role of relatives in providing care for the resident 2) …

B) Suggestions for resident preparation

Principles

- Residents should be able to influence the nature and length of visits
- Residents should be listened to.

Practicalities

- Residents who visit potential new homes should be accompanied by someone known to them

C) Suggestions for selection of appropriate new placements

Principles

- Respect and take into account residents' desires to move to new homes with other friends

Practicalities

- Care managers should contact relatives and identify the support they need
- Care homes and social services departments should work collaboratively with residents and their relatives
- Provide a genuine choice of homes
- Provide access to advocates who are 'independent of relatives, the department, and other controlling people'

D) Suggestions related to the standards within closing homes

Principles

- Standards of care should be maintained
- Residents' daily lives should be kept as 'normal' as possible
- Staffing levels and management should be maintained

Practicalities

- Familiar routines should continue
- Obvious signs of packing up should be minimized in communal areas
- Levels of cleanliness should be upheld
- Ideally, existing staff should be employed throughout

E) Suggestions about relocation

Practicalities

- Practical help should be made available
- Appropriate transport should be used to ensure the safe transfer of residents
- Packing, transportation and unpacking should be planned
- Someone known to residents should travel with them to their new homes

F) Suggestions for social services departments

Practicalities

- Small closure teams support internal and external communication and avoid overwhelming homes with new faces and 'respect that people are living there.'
- Teams should be put in place promptly to ensure service users are not left unsupported.
- Consider using teams that offer continuity
- Structured follow-up and on-going support of residents should be provided (Reviews, ideally at six weeks to three months, and then at six months before moving to annual monitoring)

G) Suggestions for homes receiving people from home closure

Principles

- Closing homes should ensure that new homes have good information about residents and their likes and dislikes
- Staff should be told that residents have experienced a home closure and be sensitive to how their needs might differ from those admitted in other circumstances

Practicalities

- A dedicated staff member should look after residents and their families on arrival
- Residents should meet their key worker on the first day
- Residents should be shown around the new home
- Residents should be able to spend time with other residents or staff who have arrived from the closed home.

Very little was suggested about how residents may be prepared for relocation, apart from specific suggestions around the organisation of visits to new homes. Choice, independent help and advice and collaboration between providers and proactive councils were identified as important factors and characteristics that are likely to support selection of appropriate new placements. Suggestions related to the

maintenance of standards within closing homes focus on care practices within homes and actions to be avoided. No broad principles were voiced in relation to notification, relocation or the practice of homes receiving people from closed homes. Organisational issues and the provision of practical help were highlighted as important in relation to the actual move.

The suggestions for social services departments concern mainly organisational issues and the provision of meaningful monitoring and support. Few suggestions have implications for legislation or infrastructure change. A notice requirement is already specified in legislation, but it lacks force. The desire for a genuine choice of homes with vacancies, however, has implications for market management and commissioning, since genuine choice requires a range of homes with vacancies.

Providers interviewed about their reasons for closure in the antecedent study (described in Chapter 4) identified few recommendations for improving the process, although admittedly the focus of the interview was on reasons not process. The suggestions that were made related to social services and practical help, such as transport provision. None offered advice to other providers concerning their actions, other than taking 'control'. Some said nothing could be improved. Another interview was conducted with a 'good provider' with experience of closing a home, but there were not the resources to follow this up with additional interviews with providers who have experience of managing closures well.

Consideration of the recommendations from residents, relatives, care home staff and care managers on how a home closure may be managed provides a useful basis for further development work or tools to promote and strengthen good practice. Their recommendations include principles for good practice, as well as practicalities and include suggestions of relevance to each of the main actors. In some areas, implementation issues need further development, and in others the lack of suggestions probably reflects the lack of a current knowledge base rather than a lack of need for improvement, and these are discussed further below.

12.6 Approaches to good practice and need for improved guidelines

There is scope for voluntary care home closures to be better managed. The variation between councils' closure guidelines described in Chapter 7 suggests that care management during home closures varies across the country in ways that do not merely reflect local working arrangements or residents' needs. Some differences represent alternative ways of achieving similar objectives, but others may lead to variation in the level or quality of support received by service users. Whether there is sufficient value in, or need for guidelines is a matter of opinion. Arguably, the nature of the risks involved and their involuntary nature for older people raises the question of whether the risks are 'reasonable' and perhaps more importantly, the safeguards and precautions adequate.

Should a care home closure be a crisis? A crisis is usually a turning point that is distressing, probably sudden, unplanned and in some way critical. For many of those directly involved and who participated in this research it was experienced as a crisis, at least in terms of being distressing and sudden. Those involved described a range of extreme emotions similar to the reactions associated with a crisis. Relatives spoke of a range of feelings: panic about being given a date by which to move residents' out, apparently whether they were ready or not; fear and apprehension about the likely upset and possible negative impact on residents' health; trepidation and anxiety about telling residents. For care home staff and social services staff closures also appeared to constitute a crisis. This raises the question of whether it is acceptable to allow what, at the market level, might be considered an 'inconvenience' when it is experienced, particularly by older people forced to move, as a crisis?

The research suggests that people experiencing a care home closure are likely to have low expectations of the process. For example, care managers' described closures as having gone well even when providers had failed to give the required three months notice. The preceding research into regulators' views of the reasons for closures described in the Literature Review (Chapter 5) found that inspectors working under the previous regime of regulation described 'well planned' closures in various ways, some of which related to factors that made the task easier or harder to manage, rather than

well-accomplished (for example, the number of residents to relocate, the local capacity of care homes in the area, and whether the timescale was short). It appears that closures can be judged as having gone well or badly very much in terms of worst case scenarios and practicalities. The ease of finding placements may be an important process related factor, but is qualified by the question of whether this helps people find appropriate placements. Clearly, finding an unsuitable placement easily should not be considered a good outcome. It may be that the magnitude of the most serious risks posed to residents, that is a hastened death or homelessness, are such that despite the lack of evidence based knowledge about their likelihood, fear of their occurrence dwarfs other concerns about the lesser risks and dangers to such an extent that they are not given the attention they deserve. That is, the main thing may become finding somewhere else to live before the deadline. Expectations need to be raised and supported.

Consideration of possible solutions or approaches to the better management of care home closures raises a number of questions: How should closures be judged to have gone well? What should the aims of any good practice be? What approaches might address the constraints identified? Quality can be understood in numerous ways and service users may value aspects of quality differently; in relation to public services quality has often been considered in terms of 'inputs', 'process' of service delivery, 'outputs' or activities carried out during the delivery, or in terms of 'outcomes'. It is generally recognised that the 'two most important [aspects of quality] for the actual users of public services are probably those concerned with process, ... and those concerned with outcome' (Le Grand, 2007b p8).

Managing the process of a care home closure requires that a balance be struck between what is desirable and what is achievable. The literature on relocating older people tends to describe broad objectives and types of activity related to minimising residents' distress (Lane, 1987; Woolham, 2001). Where specific approaches or issues are discussed many recommendations are 'ideal' and relate to aspects of relocation likely to be outside councils' control, such as the retention of existing care home staff throughout a closure period. Similar tensions between objectives and their practicability were evident in the reviewed council guidelines.

The absence of local guidance at some councils may reflect a number things, which may require examination if consistent and widespread guidance is to be developed: a lack of leadership and guidance from central government; a belief that closures are merely part of the market mechanism; a view that additional guidance and paperwork is unnecessary; and a belief that closures are the concern of individual providers and their care home residents.

The range of roles, responsibilities and procedures described in the guidelines reviewed, as well as the practices described across the local authorities suggest that there is a need for local government plans to ensure that systems are in place. Guidelines may also ensure that care managers have access to the information and support they need to support service users, and promote joint working between social services, health and independent providers. Social services departments do identify residents that are publicly-funded when notified of a home closure, irrespective of whether local guidance is in place, which suggests acceptance of responsibility to some degree. The nature of their responsibility needs clarification. Good practice development would clearly benefit from central guidance on the implementation of care management policy during home closures, particularly about legal issues, such as whether existing care staff can be paid by councils, or council care staff sent to closing homes to prolong a closure period.

More generally the responsibilities of the state, councils, the regulator, and providers need clarification. The brief review of legal requirements around home closures in other countries in Chapter 3 highlights that tighter controls and greater state involvement is possible. The current situation in England appears to reflect the narrow 'safety net' approach to the role of government when a broader approach would seem more in line with current policy developments, notwithstanding the tensions highlighted within approaches to risk.

In terms of regulation, closures could be treated as situations of risk where the regulator is required to have specific duties to check that standards are adhered to. Greater monitoring and communication could happen even earlier with a view to triggering new means by which to raise standards and financial viability amongst otherwise good quality homes.

The value of good practice guidelines or toolkits depends partly on how broadly they are conceived, implemented and used. The care managers' views suggest that any future development of closure guidelines should guard against promoting the completion of checklists over and above direct work with individuals or developing guidelines runs the risk of merely adding to proceduralisation and bureaucracy (Watson, 2002). An advantage of guidelines includes their potential use to record, evaluate and develop councils' involvement in managing the closure process, but care should to be taken to ensure that service users' and providers' views of what works and what helps are included in the process.

If there is a shift towards person centered planning (Dowling et al, 2006) among frontline staff working with older people during a closure there may be the potential to develop tools and approaches to involving care home residents during closures in more sophisticated ways than merely asking them what they think and their preferences for where they would like to move. Potential checklists and documentation that could be provided in a toolkit for managing independent care home closures include:

- Lists of information, and sources of advice for resources for residents, families and guardians (to include voluntary sector guidelines on how to choose a care home, rights and regulations, who to make a complaint to…)
- Guidance on the role and responsibilities of the regulator
- Concordat or code of practice between care home sector (private and third sector providers), residents' representatives/relatives and carers groups, and local government
- Notification requirements
- Overview of the phases of a closure: aims and tasks, and service users' recommendations
- Residents' rights and responsibilities

There is a need for improved workforce knowledge and expertise in the area of home closure. Little was said in the closure guidelines reviewed about some aspects of the closure process likely to be important to resident welfare and which professionals may be expected to be able to do something about, given the appropriate knowledge and resources. For example, how residents may be helped to adjust after a home closure

was a neglected area in the council guidelines and one that is under-researched. At the very least it seems sensible that general recommendations for the support of newly arrived residents should be followed, for example, that care plans should indicate how staff might help and how relationships with other residents might be supported (Reed and Payton, 1997). Similarly, few recommendations were offered about how residents might best be prepared, supported, or involved, particularly those with dementia, beyond discussing forms of notification, offering assessments and help to find a new home. These inadequacies clearly point to a lack of knowledge and need for better understanding.

Chapter 13

General policy implications and suggestions for further research

13.1 Introduction

Little was known about the experience of older people and their families when a care home in the independent sector closes voluntarily. This is the first in-depth study to review local closure guidelines and to explore what happens when an independent sector care home closes and to do so from the perspective of the people directly involved. The previous chapter discussed the findings from the study in relation to previous research and focused on implications for the management of closure at the practice and local council level. The extent and nature of local and national guidance and involvement in care home closures raises wider questions about national policies and the statutory powers and obligations of central government, and the allocation of responsibilities between individuals, the state, local councils, independent providers and the regulatory body.

This chapter considers the nature of voluntary care home closures as a policy issue and then goes on to highlight and discuss some of the wider policy implications raised by care home closures for national policies of relevance to closures. These include policies of wider relevance to social care provision for older people with complex health and social care needs since; as highlighted in Chapter 3, closures are framed more by general policies and legislation than guidance and regulations specific to them. Many of the difficulties and tensions found to be associated with the way in which care homes are closed voluntarily would benefit from greater clarification or development within broader policies and approaches, as well as greater attention to how these may influence closures. The next section discusses policy developments that may have a positive or negative impact on closures. The strengths and limitations of the research are then outlined before suggestions for further research.

13.2 The nature of voluntary closures as a policy issue

The background (Chapter 2) and policy and legal review (Chapter 3) identified a wide range of contextual issues and factors that appear to have resulted in a lack of consensus about the nature of the issue of voluntary independent sector care home closures. These include the 'quasi-market' nature of provision, complex state funding arrangements for placements including boundary splits between health and social services, a funding gap between care home fees and state funding, a general policy preoccupation with supporting people to live in their own homes, and confusing council obligations around the arrangement but not provision of care and around their responsibilities towards people assessed as able to pay for residential care. The lack of clear national policies specific to voluntary care home closures, and the unclear legal framework exacerbates as well as reflects an ambiguity about the extent to which voluntary care home closures are considered a 'problem'.

This section highlights some of the ways in which it appears that aspects of contemporary social policy have resulted in voluntary care home closures being neglected as a policy issue. Closures have been portrayed or discussed in various ways by the media and policymakers, as a non-story, a 'bad news story', or a 'good thing'. This state of affairs seems blinkered and short-sighted for a number of reasons, including the likelihood that closures will continue, and care homes remain a major form of provision of social care for older people with long-term or complex needs, given that demand for care homes is expected to increase (highlighted in Chapter 2). Whilst new forms of housing and care provision are being developed, there is little evidence to date that they are replacing care homes in large numbers, and some evidence suggests that extra care housing is catering for different people to those who move to care homes, or at least people at an earlier stage in the life-course (Darton et al., 2007).

13.2.1 A non-story

Voluntary care home closures are a neglected issue, almost a 'non story' within social policy. Only the organisation *Counsel and Care* has called for something to be done to help residents experiencing relocation due to a voluntary closure (Bright, 2000; Bright,

2001; Brindle, 2001). The issue of care home closure has rarely been discussed explicitly in policy documents or press releases - neither in terms of what they mean for individuals, the bigger picture (in terms of the impact on the character of the market/greater concentration of larger firms, larger homes etc or loss of supply), or as a trend or feature of the market. The welfare of current residents affected by relocation due to care home closure appears to be below the national policy radar. This is despite the fact that large numbers of people have been affected (see Chapter 4 for evidence on the scale of closures) and that the issue is an emotive one due to the potential impact in resident's health and mortality.

Postcode lottery concerns, frequently highlighted in relation to other sorts of health and social care services, have not been picked up by the press in relation to home closures. Neither have the implications for more collective control or tighter management of market mechanism been pursued. Central and local government documents seem devoid of any moral discourse about the possible welfare consequences of the market mechanism, of the acceptability or otherwise of the risks of home closure and forced relocation due to business failure, or of the related issue of older people's lack of tenancy rights in care homes. This situation may reflect the general political emphasis within social policy on supporting economic growth. The pre-eminence of market principles within social care provision is discussed further below in relation to how care homes closures could be regarded as a 'good thing'.

Within social policy for older people in general care homes are a low priority. The main task of the New Public Management trend of promoting market systems within service provision has been accomplished and policies are now principally focused on ensuring that existing policies continue to function effectively and efficiently. Much of the desired infrastructure change that could take place has taken place. Chapter 3 highlighted that, in terms of the quality improvement arm of the drive to modernise social services, various mechanisms are assumed to ensure continuous improvement within the care home industry, including the market mechanism, registration and inspection by the regulator (which is undergoing considerable institutional level change), and the performance framework within local authorities.

Policy makers may regard care homes for older people as an "unsexy" subject for other reasons too. Arguably, care homes are associated with 'old style' social risk welfare policy, which was concerned with managing dependence and economic 'burden'. This contrasts with 'new risks' areas that require policy development and 'new policy solutions', such as mobilising the paid workforce, particularly women with children, which have emerged and are currently more in-line with the focus on supporting independence and the modernising focus. Consequently, the area of long-term care for older people does not have the scope or provide an opportunity for Ministers to achieve progress in the types of change they are interested in bringing about (Taylor-Gooby et al., 2004). It is probably difficult to 'sell' developments within the care home sector as achievements in terms of bringing about a wider range of innovative providers as outlined in policy visions for the future (Commissioning framework for health and well-being, 2007). Care home provision also seems at odds with the central policy agenda of promoting independence and supporting people to live in their own homes, and are seen to represent poor 'economic sense' (Commissioning framework for health and well-being, 2007, p13)

The rare occasions when care home closures are discussed in policy support the view that they are mainly considered important because they are seen to influence the more economically significant issue of use of expensive NHS places. Chapter 2 highlighted that when the present study began care home closures were recognised as an issue within public policy debates in relation to economic concerns about the part they played in causing delayed transfers amongst older people ready to leave expensive NHS beds.

There may be an element of ageism in this area of social policy. In terms of social care provision for older people, care homes concern the oldest old and policies which focus on promoting independence and living at home have directed attention to other forms of social and housing service provision such as domiciliary care, extra care housing and other forms of specialist housing arguably more suited to 'younger' older people (Department of Health et al., 2007). In addition, the 'oldest old' living in care homes, who are likely to be women, are not a particularly well-organised or vocal group on the political stage.

Within this wider policy framework and economic rationale care home closures may be regarded at the policy level as a 'non-story' because they may be seen merely as an inconvenience, or even positive side-effect of the market. This view, that voluntary closures are a 'good' thing is discussed after the way in which closures can be regarded as a 'bad news' story.

13.2.2 A 'bad news' story

It seemed to be generally accepted within the media that closures are a 'bad news' story – in the sense that they are assumed to pose a risk to current residents' health. Media reports of closures suggest that there is a public perception that care home closures and relocation harm residents' health, well-being and even cause untimely deaths. This assumption also appeared to be held by participants in the present study. Similarly, it can be supposed that policymakers are aware of the risks assumed to be associated with care home closure. The regulatory body considers the forced closure of a care home as a sanction of last resort, presumably because it is concerned about the impact of such forced relocations on residents' health.

It is worth reiterating that the literature reviewed in Chapter 4 identified a considerable degree of uncertainty around whether relocation following home closure causes or is associated with negative health outcomes for residents. Notwithstanding the problematic nature of the evidence base, it may be expected that any concern that closures are associated with increased rates of mortality and morbidity would lead to the government adopting a 'safety net' role during care home closures, at the very least, and possibly stimulate a more proactive role in their monitoring, prevention or regulation. However, it may be that the 'bad news' story element of the issue and the problematic nature of closures in the independent sector has resulted in the issue being shied away from and in turn, contributed to the status of closures as a 'non story'.

13.2.3 A 'good thing'

Some policymakers appear to consider care home closures a 'good thing'. This viewpoint can be linked to a number of factors and assumptions, including the view that care homes are an option of last resort for older people, that it is poorly performing homes that closed, and that the needs of the care home population may be better supported by other means. The policy assumption that residential care is the option of

last resort for most people, because older people rarely choose to move to a care home as a positive improvement to their situation, has been built on within policy to such a degree that there is a policy recommendation that people be supported in a 'right to request' *not* to live in a care home setting (Department of Health, 2005 p32). That this right would also serve the function of forcing those who recommend residential care to explain why they have done so is noted.

Closures can sometimes result from the re-provisioning of services for older people, via the development of new forms of housing and care considered more suitable to promoting independence and well-being. Some local authorities have closed local authority run care homes with the intention of promoting new extra care housing developments or re-modelled sheltered housing in their place and of investing in intermediate care services to support people in their own homes. The Health Minister Stephen Ladyman explicitly linked the development of extra care housing to a desire to reduce or replace the use of care homes (Ladyman, 2004b; Ladyman, 2004a).

As highlighted in chapter 3, the economic rationale underlying the promotion of a 'quasi market' within residential care is that the market system will exert competitive pressures, which drive up standards, foster cost efficiency and promote quality. According to this rationale closures are part of the quality improvement process; care homes that provide poor quality care and fail to be responsive to consumer demand will fail to attract new business, become uncompetitive, and exit the market, leaving the overall supply of homes improved. Poor quality providers should exit the market as part of the market mechanism: closures should be the result of supply-side responsiveness to consumer power and the quality improvement process.

There is an important caveat here, the market mechanism brings about exit by a provider not necessarily service closure. Closures result from providers' inability to sell care homes as going concerns. However, as recently as December 2007 local authority commissioners were being encouraged by the social care minister, Ivan Lewis, to 'use their buying power to drive [poor quality care homes] out of business' (Topping, 2007). Commissioning was thus explicitly portrayed as a tool that should be wielded by local authorities to rid themselves of poor performing providers in the name of improving the

market, ignoring the implications of such exit for current residents. Such an approach to poor practice in other situations may be regarded as unconstructive and bullying.

Another reason why care home closures may be regarded as a good thing is that care homes as providers of institutional care are considered objectionable per se. As mentioned earlier care homes appear to be at odds with the policy focus on promoting independence and when care homes are discussed by politicians and highlighted in the media it is often in negative ways, and in relation to scandals about abuse and poor practice. The negative perception of the sector may lead to an assumption that closures are a good thing in terms of reducing the number of what must be a 'bad thing'. A UK report on people's perceptions of the age discrimination faced by older people found that 76 per cent of people think that care home residents tend to be forgotten by society and that 59 per cent of people with someone close to them who lives in residential care believe that care homes often neglect their individual wishes (Bytheway et al., 2007). The negative image of care homes is thought to be related to a belief that poor standards of care are provided (Nolan et al., 1996).

13.3 Policy implications

This chapter has highlighted the hidden nature of the issue of care home closures and the lack of any sustained national public or policy debate about policies to improve the process or outcomes for older people who experience care home closure. Instead, accounts and comments on closures suggest that if they are considered at all, it is as a 'bad news' story or a 'good thing'. The closures studied occurred in a context of regulatory change at the national level and the reasons for closure, typical of closures at the time, were business related. The nature of provision means that a care home closure does not constitute a major public crisis with far reaching social, economic or political consequences. Roles and responsibilities of relevance both to care home closures and broader national policy goals within the provision of social care for older people are now discussed, focusing on the objectives of providing high quality services, care and protection, fair access to community care, adequate complaints and redress mechanisms, and enforcement powers.

13.3.1 Quality services

Broadly speaking service providers, local authority commissioners and regulators each have a role to play in improving the quality of individual care homes and the market in general. Councils are expected to manage the market and conduct performance monitoring via clear contract specification, and review mechanisms (which might include user satisfaction surveys). If the state accepts a role as guarantor of quality of social care, as well as a funder, then it follows that it has a responsibility to ensure that the quality of care provided by care homes while they are closing is monitored and maintained.

During the closures studied, however, the role adopted by the local authorities appeared to focus very much on the relocation aspect of the event, and thus their duty to help people find appropriate services, and not on quality performance (via monitoring to ensure that the conditions of their contracts for publicly funded residents were being met) by the closing providers during the closure period. Can and do local authorities monitor the performance of care homes through their contracting effectively? Prolonging the timescale of a closure or preventing closure is likely to require policy development across departments in councils and work with providers. *Building Capacity and Partnership in Care* (Department of Health, 2001a) may have encouraged councils to work more closely with providers to prevent the closure of good quality homes but there is little evidence of this having happened.

Could there be an insurance to cover the need for homes to stay open for reasonable periods during closures and to ensure the provision of quality care? The issue of resources to help keep a home open long enough to relocate all residents to suitable places raises the issue of who would or should pay for resources to help manage care closures: home providers, or a mixture of public and private purse?

As mentioned above, some policymakers appear to regard local authority commissioners as potential architects of closures, via their ability to drive poor performing homes out of business, rather than as potential players in preventing the closure of good quality homes. Yet, management of the market supply of care homes across the country might imply and involve concern that good quality homes do not close. Interestingly, proposals for the future regulation of health and adult social care

state that, should the new Care Quality Commission take action that results in a service closing, either temporarily or permanently, ' then commissioners (PCT or local authority as appropriate) would retain responsibility for ensuring continuity of service' (Department of Health, 2007a p24). This appears to underscore councils' general responsibility towards social care users and to imply that measures should be available for improving or turning around failing services if temporary closure is a possibility.

The regulator could adopt a more proactive and explicit monitoring role in relation to market quality by identifying care homes that are in danger of closing and in need of support. An 'early warning' system would be needed, along with a desire and means for someone to do something to help financially struggling but good quality providers. An early warning signal ought to be possible, although currently the onus is on individual providers to identify financial problems, and the legal requirement that they inform the regulator if they have ceased to be financially viable or 'will cease to be viable within six months' (Commission for Social Care Inspection, 2006a p3) lacks sanctions and therefore force.

The financial monitoring of care homes is weak in general: the Annual Quality Assurance Assessment (AQAA), developed since the present study began, do not require providers to comment on financial viability explicitly (Commission for Social Care Inspection, 2007a); financial aspects of homes are not normally commented on in public inspection reports, unless the regulator consider residents' well-being to be at risk. More positively, the AQAA reports may signal serious problems which may augur closure or trigger support to improve a home, because they require care home owners to provide information to the regulator about occupancy, the number of complaints received, the number of safeguarding adult referrals, referrals to POVA, admissions to Accident and Emergency, the number of deaths and the number of people who have developed pressure ulcers. Some interest in the monitoring of the extent of business failure amongst voluntary closures is also evident in the data collected by the CSCI (Commission for Social Care Inspection, 2006a; Commission for Social Care Inspection, no date).

The retention of care home staff during closures and the provision of monitoring have resource implications. However, these relate to the use of short-term and existing inputs

rather than new interventions that would require new or long-term cost increases. With effort and little additional expenditure councils may be able to address some of the problems identified internally. For example, senior managers could ensure that individual care managers are appropriately prepared and supported when working on a care home closure.

The state might be expected to play a role in supporting the quality of the social care workforce, including those working in independent sector care homes. The study highlighted the value placed by service users on the continuity of care provided by care staff working in care homes and how they associated this with care staff employed by homes as opposed to agencies. Any increase in agency working among care assistants working in residential care settings may have implications for the quality of care provided during care home closures as well as more generally - if quality of support and care is linked to continuity and familiarity for the service user and, as appears to be assumed, those working directly for a provider have greater loyalty and commitment than those employed by an agency.

13.3.2 Care and protection

To the extent that publicly-funded service users' needs are usually assessed and monitored via care management procedures during and after closures, local authorities are executing their duty of care for those whose services they fund. The inconsistencies across councils in the provision of help and support offered to self-funded residents who are entitled to assessment, however, brings into question whether councils are promoting the well-being of those in need of social care.

The concept of councils' duty of care is acknowledged within policy debate to be 'underdeveloped in theory, and in practice, in the social care labour market and among provider organisations' (Manthorpe, 2007 p239), and this certainly appeared to be the case for councils, as well as providers and care staff, in relation to residents of independent care homes experiencing a care home closure. Issues raised by the closures include whether independent sector care homes act on the behalf of local authorities, local authorities retain ultimate responsibility for the contracted functions provided by independent care homes and if so, whether they hold care homes to account for their actions adequately? It was worrying that two of the councils' closure guidelines

emphasised that it was the proprietor of the closing home who has responsibility for making alternative accommodation arrangements.

Another aspect of protection linked to closures is awareness amongst the public and prospective service users' of care homes' lack of financial viability or risk of closure. The study found that some older people had moved to homes that closed during the period that owners were probably aware that they might close, or had even taken the decision. Should care homes experiencing difficulties be identified akin to schools that are placed under 'special measures' by OFSTED? Arguably, it is within the public interest for the regulator to comment on the financial standing of an establishment in public inspection reports so prospective residents and their families can make an informed choice about the risk of moving to such a home. The regulator has the power to share financial viability information with councils for the purpose of commissioning and service improvement, but does not seem to do the same for individual consumers (Commission for Social Care Inspection, 2005; Commission for Social Care Inspection, 2006b) .

Arguably, councils' duty of care should be applied widely to all older people living in care homes, not just those categorised as unable to act for themselves: it is inappropriate to expect individual care home residents, however much they may be able to act for themselves in their daily routines and decisions to take responsibility for safeguarding their own interests if threatened with abuse or neglect; the characteristics of care home residents and the nature of the risks to their health and well-being posed by any deficiencies in the care provided by care homes during closures periods make market led or individual based solutions, such as personal litigation using civil law, politically and socially unacceptable; protection is a government responsibility.

Burgner highlighted the need to protect all social care service users because of their vulnerability and relative isolation from family and friends (Burgner, 1996). One might expect the regulator to have a role during closures in monitoring care standards, including the safe and effective daily operation of the establishment, and the safe transfer of residents to their new homes. The lack of any requirement for the regulator to conduct routine monitoring during the closure process, suggests a potentially serious gap in the current regulatory framework. The short length of closure periods combined

with the relatively infrequent cycle of routine inspections of care homes means such monitoring is likely to be difficult to achieve under current regulatory arrangements.

13.3.3 Fair access to help and support

It was always anticipated within central policy guidance that councils may face difficult decisions when trying to fulfil their obligation to meet people's social care needs within available resources (Department of Health, 1990 p27). The nature of their obligations to provide fair access to social care are qualified to take account of resources: councils have a power, but not a duty to provide social care services to those assessed as needing them; councils can refuse them on the grounds of scarce resources so are not obliged to ensure that needs are met; councils can take account of their resources when assessing an individual's need and the form of assessment, which in turn considers people's need in relation to the needs of others, as well as available resources (Department of Health, 2002). Policy guidance suggests that where there are difficulties, points of difference should be recorded (Department of Health, 1990). However, there was little evidence of reflection, evaluation or recording of unmet need by care managers in the context of the care home closures in the present study, despite the finding that such situations may be characterised by compromises and shortfalls.

The research raised issues about the adequacy of the availability, timing and level of help and support made available by councils to publicly-funded and self-funded residents and their relatives and to providers during closures. The inconsistency of support and help from councils to self-funded residents during closures was highlighted as a particular problem. The variation in arrangements for allocating care management staff to residents also has implications for the continuity of residents' contact with care managers, since some arrangements mean residents have had no prior contact with care managers. More generally, contact between care managers and self-funded people making arrangements to enter residential care has been identified as 'the exception rather than the rule', and home closures have been identified as one exceptional context, along with an investigation, individual eviction or depletion of a resident's savings, within which councils do become involved with self-funders (Henwood and Hudson, 2008 p86 and 118).

The evidence from this study suggests that in the context of such a major event as a home closure, councils should have an obligation to offer to assess all residents to ensure that any change in need or eligibility for help is identified. The potential vulnerability of self-funding residents during a care home closure raises the question of whether care management, at least in terms of assessments and reviews, ought to be universal and made available to all during care home closures, or continue in some areas to be rationed to those in most need depending on the attitude of the team leader allocated to a closure? It would seem sensible for care managers to have the power to review self-funded residents and their placements after such a move.

The need for independent help and advice, over and above that which the care managers reported being able to provide has implications for who is best placed to provide independent advice and how it could be resourced. Proposals to reform social care services for adults emphasise that the role of supporting people through the social care system may be fulfilled by professionals other than care managers, and that the provision of skilled social work should be confined to people with complex problems, or in need of long-term support (Department of Health, 2005). This research suggests, however, that developing care managers' skills, and knowledge and clarification of their role may be an appropriate way of providing support and continuity to such a potentially vulnerable group of service users as older people. Separating out the role of advocate may fragment the care management process, and prevent the development of trust between service user and care manager, which can enhance the assessment, expression and review of need. If care managers are unable or prevented from providing an advocacy role there is a need for alternative forms of advocacy. Currently, advocacy services for older people in England are underdeveloped which suggests there may be serious gaps in meeting need in this area at least in the short-term (Cantley et al, 2003; Margiotta et al, 2003).

However, the current role of care management and the pressure of restricted resources may prevent care managers from helping residents to prepare for relocation. In general, care managers' work is thought to be increasingly focused on the completion of complex paperwork, based on 'ever increasing procedural instructions', which leaves little time for direct work with service users (Postle, 2002: 343). Care managers accounts suggested, however, that they drew on 'tacit knowledge', such as consideration

of the wider family and social context from talking to people, as well as experiential knowledge, not just technical or procedural knowledge and some reported spending considerable time supporting relatives. That some care managers felt their ability to promote outcomes in the best interests of residents indicated a clear need for either changes to the role of care managers so that they can fulfil the role of providing advice and support in residents best interests, or the need for the role to be fulfilled by someone else, such as an independent advocate.

It could be argued that there is a need for a supportive response to providers both during closures and earlier, when they are facing difficulties. The review of guidance and performance in practice highlighted that there is no support available from local authorities, the main purchaser, or from the regulator either during closures – in terms of help to stay open to ensure closure periods were of a reasonable length or met with requirements, or earlier when they were experiencing financial difficulties. Should councils or the regulator help to ensure that homes remain open for reasonable periods while closing? The lack of a supportive response may be attributable to the need to support market principles and allow the market mechanism to operate in a manner that is responsive to forces of demand and supply. The CSCI is clear about their position: it is not their role to manage or deliver care, and so they cannot act as consultants or take part in the management of a care service (Commission for Social Care Inspection, 2006b). However, Chapter 4 highlighted evidence that suggests that good quality homes sometimes exit the market, which in turn suggests that closures cannot necessarily be attributed to market responsiveness to falling consumer demand linked to poor quality.

State health care providers and councils who are poorly performing are offered support to improve in ways that independent care home providers are not: Primary Care Trusts are helped to improve via turnaround teams; 'failing' local authorities have been helped via Office of the Deputy Prime Minister Lead Officials, Monitoring Boards, and Improvement Partnerships between groups of councils. However, if help were to be provided by councils or the regulator to poorly performing of financially unviable independent sector care home providers where would the line be drawn? Questions are raised about whether such help would be in contravention of fair competition, who

would pay and whether any state support and engagement would imply, or result in a nationalised industry?

13.3.4 Complaints and redress

The possibility of neglect during a care home closure process raises the issue of the effectiveness of complaints and redress mechanisms. The study suggests that service users should not be relied upon to ensure that standards are met during a closure process via their 'consumer power' to complain, or to raise the standards of care provided prior to closure via an assumed ability to take their business elsewhere.

Complaints routes are complex and confusing and reflect wider ambiguities and uncertainties about responsibilities and accountability between the different organisations and agencies. Procedures differ depending on circumstances and multiple complaints may be made at the same time to different organisations (such as a care home and a local authority): individual providers are responsible for dealing with complaints about their service (unless they concern abusive or criminal practices, the regulator considers a concern relates to a regulation that it is required to monitor or that it considers 'inappropriate' for the provider to take the lead on); local authorities and or the police are responsible for responding to allegations of abuse or criminal behaviour; and the regulator focuses on whether providers are complying with regulations and improving their services.

A closure situation may be regarded as one that raises particular problems with the policy of holding service providers responsible for investigating complaints about their service. If a provider is about to cease operating altogether, that is, it has no other care homes and does not intend to continue in the industry, what motivation would there be to rectify any neglect of provision of care while the business was winding up? The lack of independent complaints investigation in relation to care homes has been the subject to high profile media coverage (Panorama, 2007), and the national charity, *Counsel and Care* have called for an independent care complaints commission (Counsel and Care, 2007).

Market assumptions about care home residents' consumer power and ability to complain appeared to persist alongside research that showed that few older people made

complaints and find it difficult (Office of Fair Trading, 1998; House of Commons Select Committee on Health, 2004b). *Help the Aged* argued explicitly that it was unrealistic to expect older people to act as whistle-blowers(House of Commons Select Committee on Health, 2004d).

Individual care home residents' ability and willingness to make complaints have implications for the role of central and local government, as well as for the mechanisms and structures in place for adult protection. The research highlighted numerous problems with applying market assumptions about competent consumers to service users in the care home market. Complications and caveats around the assumption that care home residents are competent and rational were highlighted in Chapter 3 and Chapter 12 in relation to influences on the closure process. The study also raised or confirmed concerns about two other elements of care home residents' ability to act as consumers. There was a suggestion that care home residents do not find it easy to take their business elsewhere even when they have concerns that residents' needs are being met inadequately, because of a fear of the anticipated negative impact of any relocation. Moreover, in the context of a home closure the prospect of residents taking their business elsewhere is likely to have little power or influence over a provider who is already in the process of closing due to business failure. This suggests that consumer power at the individual level is unlikely to raise standards, even if it were appropriate to leave it to do so.

Redress can mean compensation. It is likely that in other fields or in relation to other populations of 'consumers' there would be an expectation of compensation if negligence were established or a service discontinued or disrupted. Given the perception that there is a growing compensation culture in general and pressure on businesses rooted in fear of litigation it is perhaps surprising that care home providers do not appear to be doing more to protect themselves. This may reflect the lack of or under-developed nature of 'consumerism' or 'compensation culture' within the population of care home residents and their relatives. It may also reflect the practicality that some providers closing homes are by definition (if they are not owners of multiple homes) exiting the market and potentially bankrupt, and so have little to lose. In other fields of business, such as the travel industry, consumers who purchase services from a

private-for-profit provider can claim compensation for inconveniences or broken contracts.

13.3.5 Enforcement powers

Turning to the form and length of notification, the legal framework lacks enforceability. Neither local councils nor the regulator are in a position to ensure that homes comply with the notice requirement of three months. This lack of enforceability also applies more widely to care standards that do not have equivalent regulations. The length of a closure period is linked to the reasons for closure, invariably business failure, and the review of local policies highlighted confused and conflicting messages about whether councils have the power to step in and help homes remain open until all residents had been relocated satisfactorily.

Similarly, the regulator cannot prevent a home from closing if it is bankrupt. The requirement that providers apply to the regulator to cancel their registration suggests that permission is being sought and that there is a possibility of refusal. However, the regulator does not seem to be in a position to refuse, disallow or prevent a voluntary home closure in the independent sector and it is unclear on what grounds they could refuse to grant such an application. The ability of independent care home providers to flout notification requirements and close at short notice may allow disreputable providers under investigation to 'jump before they are pushed', that is to close voluntarily at short notice to pre-empt an enforced closure. The prevalence of such closures would be hard to establish because they would be recorded as voluntary closures.

13.4 Policy and legislative developments

Numerous policy developments have occurred that may have positive or negative impacts on care home closures and the way in which they are or may be managed. Significant developments include proposals to improve the enforcement powers of the regulator (Commission for Social Care Inspection, 2007b), the promotion of well-being and focus on outcomes within social care, and the emphasis on principles of dignity, personalisation and age equality (Department of Health, 2005; Department of Health,

2006) and the increased recognition of elder abuse (House of Commons Select Committee on Health, 2004a; House of Commons Select Committee on Health, 2004c). Relevant infrastructure developments include proposed changes to integrate the regulation of health and social care. Legislative changes likely to have an impact on practice during care home closures include the Mental Capacity Act and suggestions that the Human Rights Act will be made to cover residents of independent care homes.

Policy developments proposed by the regulator that may have a positive impact on the 'policing' of closures include the CSCI's proposals to strengthen their enforcement powers, and in particular broaden their range of enforcement options (Commission for Social Care Inspection, 2007b). A need to deal with continuing and chronic poor standards in situations which do not require urgent cancellation has been identified and the example given of such situations is akin to that of voluntary closure: unacceptable standards during periods when providers appeal against non urgent actions, which can effectively turn into 'slow' closures.

The Single Assessment Process should have a positive impact. Poor assessments and unsatisfactory care plans have long been recognised as a problem (Department of Health and Social Services Inspectorate, 2000; Social Services Inspectorate, 2001; Bainbridge and Ricketts, 2003; Tanner, 2003). Progress in implementation, however, has been slow and performance monitoring does not pick up on the experience of those already in the system (Department for Communities and Local Government, 2005).

It is increasingly apparent within policies that there is an emphasis on the state doing more than providing a welfare safety net and working with individuals and the private and voluntary sectors to actively improve people's lives is increasingly evident within policies. The White Paper, *Our Health, Our Care, Our Say,* identified seven outcome areas for adult social care (Department of Health, 2006). If this approach to outcomes were to be applied to closure situations, it would follow that the state should ensure more than a minimum standard of welfare during a home closure and aim to ensure that the best possible outcomes are supported. If it became routine for professionals to consider the principles of dignity and personalisation and well-being outcomes in relation to moves between residential settings then the need to promote them during relocation and to consider the risks posed by such relocation, to social exclusion for

example, could be taken more seriously and solutions more readily addressed. These are big 'Ifs'.

A new political consensus in the centre ground was recently identified by Bochel and Defty (2007) and even if the government's role were viewed as minimal, that is the provision of a safety net to those in most need, then at the very least it should ensure that older people living in care homes are looked after and moved safely. Tensions with the latter perspective arise due to the observations about rational actor approaches discussed earlier. State approaches to risk particularly exemplify the difficulties of applying standard approaches to service users across social care settings.

On the one hand the new approach to risk within policy (Department of Health, 2007b) may have a positive influence because it underlines the need for action where individuals are or *may be* at risk, and that actions should be pre-emptive and proactive rather than merely responsive. On the other hand, this may have a negative impact due to the concern to minimise bureaucratic and burdensome regulation and the argument that consumers should take some responsibility for managing risk and ensuring the standards they expect are delivered (Better Regulation Commission, 2006). An important feature of the risks identified in relation to care home closure, however, is that they are 'involuntary'; closure is imposed by private sector businesses; the risk is not one that residents had chosen to take.

The integration of health and adult social care regulation may be detrimental to attempts to address better the issue of how care home closures are managed and regulated. The government's response to the consultation on the future regulation of health and adult social care had a health focus (Department of Health, 2007a), and the regulator raised concerns that the proposed outcomes framework fails to reflect adequately that most social care is delivered via the independent sector and that the majority of the 'first order metrics' relate to the NHS and public health agenda and therefore under-represent adult social services (Commission for Social Care Improvement, 2007). There is also a danger that such outcome based indicators may provide councils with neither the information they need to pinpoint improvements in service delivery (by enabling them to link problems to individual providers or to choose actionable solutions) or adequately

reflect the complexity and reality of social care provision for older people living in residential care settings.

The Mental Capacity Act 2005 may have positive implications for care home residents who lack capacity to make decisions and have to move due to home closure. First, the Act should ensure that professionals, such as care home staff and care managers, make clear and consistent decisions about whether residents lack capacity to make decisions about such issues as where they live. However, this would require that an assessment of capacity be triggered and carried out, if it had not already. There is some evidence that staff who participated in this study made assumptions about people's conditions and in turn, about their capacity for understanding and taking part in discussions about where they would move. Second, the Act allows for the possibility of people putting their wishes and preferences in writing in advance of any loss in mental capacity. This can include their wishes, feelings, beliefs and values. This may be a valuable source of information for those deciding what would be in their best interests when selecting a new home during a closure.

Third, the Act makes provisions for the appointment of an Independent Mental Capacity Advocate (IMCA) to represent the best interests, and wishes of a person who lacks capacity and has no family or friends to speak on their behalf. Within the Act and related guidance, however, there appears to be an assumption that there will always be a decision-maker or person with Lasting Power of Attorney. Presumably social care staff and family or social workers may act as decision-makers. Those without family and who are self-funded are likely to remain in a potentially vulnerable position, however unless a social worker steps in and acts as their decision-maker – unless they have made an advance written statement about their preferences or appointed an LPA for their personal welfare. Clearly this presupposes a great deal of forward planning, and it is unclear who someone without friends or relatives could identify as their welfare attorney. The example given in the guidance refers to someone with Alzheimer's appointing his or her daughter as a welfare attorney, but does not suggest who an advocate would advise in the absence of an LPA. It is likely that for residents to benefit from the IMCA service during care home closures it would need to be available at short notice and appointable as soon as residents are notified of the need to move. Care home

providers and councils would also need to be clear about who was acting as the decision-maker for those who lack capacity.

Chapter 3 outlined the way in which residents of independent care homes are excluded from the Human Rights Act and summarised the rights identified in the HRA of most relevance to the care home sector, and to care home closures in particular. A key aspect of the HRA of importance to local authorities is that it confers a proactive and pre-emptive obligation to take preventative measures to protect individuals. The implications of any application of the HRA to residents of care homes *per se* and to residents of homes that are about to close in particular remain unclear. However, it is possible to speculate about some of the potential consequences if 'public authority' were interpreted widely or care homes were brought within the remit of the HRA in some other way (so that other private bodies remain excluded).

Article 8 could be invoked by relatives in relation to their right to visit residents, and so might be used in relation to resistance to resident transfers or home closures by relatives wanting to ensure that they can continue to visit residents (identified by minority in H/L Appeal – Baroness Hale of Richmond). Article 8 might confer upon residents a procedural right to consultation before any withdrawal of service provision/home closure. Any denial of choice of accommodation might also be construed as a breach of an older person's human rights. However, it is doubtful that the HRA could be used to prevent private providers from closing care homes per se. The minority Law Lords (House of Lords, 2007) who were in favour of regarding independent care homes as performing services of a public nature highlighted the inadequacy of redress mechanisms for infringements of human rights of both publicly-funded and self-funded residents of care homes, was highlighted by. Age Concern England, the Joint Committee on the Human Rights of Older People in Healthcare and the British Institute of Human Rights, Liberty, Justice, the Disability Rights Commission and Help the Aged declared disappointment with the House of Lords judgement (British Institute of Human Rights et al., 2007; House of Lords, 2007; Joint Committee on Human Rights, 2007; Age Concern, No date). Moral standpoints put forward by the losing minority relevant to the issue of home closure include the question of what older people should be able to expect, and what is appropriate: older people should be able to expect councils to take an active role in protecting their human rights. It has long been argued that the

performance of private care homes should be recognised as a matter of public concern, which is why they are regulated (Age Concern and The National Council on Ageing, 2002).

13.6 Strengths and limitations of the study

The study was qualitative and aimed to describe and explore what happened during home closures by collecting and analysing the accounts of people with experience of the process. It did not investigate all possible types of care home closure; it excluded the closure of local authority run care homes and the emergency involuntary closure of care homes due to regulatory action.

There is a lack of criteria for assessing sampling procedures and sample sizes in qualitative research (Coyne, 1997). However the multiple case studies had a number of sampling related advantages; the sample of homes included a range of homes (in terms of type of care home, type of local authority, geographical location); the sample of residents had characteristics typical of the wider population (in terms of age, gender, source o funding and length of stay); the homes were not untypical of the type of homes that were closing at the time; the closure processes included a diverse range of circumstances (in terms of length of notice, the way in which people were notified and the degree to which the home staff, councils and social services staff were involved and related to each other); the fieldwork focused on people's experience of a recent and for some, ongoing, event; the data was; analysis identified attributes, patterns and processes in participants' accounts and perceptions of their experience of care home closure.

The credibility and value of the data and analysis is supported by the following considerations: the interviews were tape recorded and transcribed, the presentation of quotations allows the reader to assess the plausibility and credibility of the analysis (Hammersley, 1990); the interviewees discussions seemed frank; attempts were made to clearly distinguish discussion, interpretation and analysis and data (Dingwall, 1992); the analysis and discussion sought to draw on relevant theoretical ideas and information about closures and the participants (Gomm et al., 2000a p.105); analysis sought to be well-grounded conceptually and empirically (Dey, 1993); the study produced rich

information about the topic and believable accounts (Curtis et al., 2000); the inclusion of multiple closures sought to allow exploration of the diversity and complexity of circumstances and conditions (although there was little prior knowledge of either the theoretical or literal conditions of the closures likely to be of relevance) (Yin, 2003). Of course, the qualitative nature of the investigation means that the findings do not provide a basis for statistical generalisation. The study was cross-sectional and the closures occurred in particular places, at a particular time, and in particular circumstances. Whether case studies can or should produce general conclusions is the subject of much debate (Hamel et al., 1993; Gomm et al., 2000b; Stake, 2000) . While the sampled participants were broadly representative of the wider populations at the time, information about future populations would be needed to assess the validity of generalisation over time (Gomm et al., 2000a p.105), such as the populations of future closures, and their residents, relatives and staff. Arguably, logical inference is possible because the validity of the analysis rather than the representativeness of a case is the basis for such generalisation (Mitchell, 1983 p.207). Tentative generalisation from those interviewed to the wider populations is also supported by the degree to which some of the findings related to issues that have long been established in previous research, such as the problems experienced among residents and relatives when seeking to select a care home place. Clearly the context is important and any generalisation is necessarily a tentative working hypothesis, and any transfer would require information about both the existing and new context (Lincoln and Guba, 2000). Alternatively, generalisation by the reader might focus on generalising to broader theories rather than to a wider population (Yin, 2003). It was intended from the outset that the study support the development of theories about what is important to the management of care home closures, given the conditions and context of the settings and individuals sampled.

Other limitations include the reliance on self-selection and volunteers, and the lack of participation in the research by residents with cognitive impairment, and residents and staff from black and minority ethnic communities. The former was slightly mitigated by the inclusion of interviews with relatives of residents with cognitive impairment and any study that wanted to particularly understand their experiences would benefit from a more focused piece of work involving researchers skilled and experienced with working with older people with such impairments. The self-selection amongst the relatives was

likely to have resulted in a bias in the sample towards those relatives who were actively involved in the closure process, and who had a story to tell.

Similarly, the participating staff were likely to be those who had something to say about the subject. The number of participating care staff was relatively small and less than other participating groups, and none volunteered from the nursing home. Involving care staff in research is a common problem: both quantitative and qualitative research studies have reported achieving relatively small sample sizes (Goodman et al., 2005; Zimmerman et al., 2005). The location and timing of the care home staff interviews, during work hours at the homes, might have had a negative impact on participation levels, because it meant their input was visible to colleagues. The setting might also have affected the nature of participation; a more neutral setting might have distanced staff more from their work role and relationships and encouraged them to reflect more on the closure's consequences for them. Group interviews with existing friendship groups, if they could be identified, might be a useful alternative approach to involving care home staff since such groups can provide a supportive setting for discussion (Morgan, 1988; Fielding, 1993; Kitzinger, 1994). There would, however, be difficulties in finding a setting other than the workplace and a time convenient to all.

Older people with 'mental health problems' were represented in the sample of closures, albeit via the perspective of the care manager involved. Views about the ability of these residents to give consent varied. Initially the care manager said that one resident and several of the relatives might like to take part and invitations were sent to the care manager to pass on. Unfortunately, none of the relatives responded to the invitation to be interviewed although the care manager indicated that a number had given permission for us to see copies of assessments and reviews. The care manager later said that none of the residents could have given consent because of their mental illness, adding that they had all previously lived in a psychiatric hospital. The issue of who could be expected to give informed consent was not treated uncritically but responses from the 'gatekeepers' were at times confusing and conflicting. The sensitive nature of the situation and the desire not to exert any pressure or persuasion in such circumstances meant that these issues were not pursued with the gatekeepers as they perhaps might have been.

The research design did not set out to ensure that particular groups were represented and so we did not attempt to recruit particular types of care home resident. It was an exploratory study, which nonetheless attempted to ensure that potential participants had the opportunity to take part. Invitations to residents and relatives were sent in large print, for example, and the travelling expenses of the few people who travelled to the research unit reimbursed.

13.7 Suggestions for further research

This study is the first to investigate processes and short-term impacts of home closures. As with many such studies, alongside the findings it highlights areas where our knowledge base is still far too small, such as the nature and degree of other forms of relocation between care homes more generally.

In terms of understanding the issue of voluntary closure of independent care homes and the involuntary relocation of older people it would be useful to explore providers' views, experiences and good practice recommendations for managing the care home closure process. In an ideal world a quantitative study would track process related characteristics of closures and link these to resident outcomes in the long term. This would help identify what process and structural factors are associated with better outcomes (adjustment, well-being, health) and could build on what has been found out about aspects of the process (for example, timeframes, form of notification, reason for closure, degree of involvement in search and selection of new home, amount and nature of support, perceived acceptability of new home, decisional autonomy). National longitudinal monitoring of reasons for care home closures and quality of homes that close would also be useful, as would data on the prevalence of enforcement activity.

The study did not focus on the experiences of care home staff, rather it attempted to include rather than exclude them. Further work could explore their experiences in more depth and seek to involve staff that better represent the full range and diversity of the social care workforce working in residential care settings.

More specifically, it would be useful to find out whether complaints are made during closures periods, or the preceding 12 months, whether the notice period requirements implemented by national minimum standards are complied with (3 months notice of closure required), and whether homes report business problems to the regulator.

Further development work could look at the experience of older people with dementia and how they might best be helped through the experience of a closure. It would be useful to try to establish which actions or measures are essential to successfully supporting residents and their families and /or carers, and to safeguarding residents' health and safety and to promoting collaboration between councils, residents, relatives, home owners and staff. A focused study could aim to confirm particular predictors of stress for those involved and practices that support coping and adjustment.

A better understanding of how older people could be helped to adjust to relocation between homes by staff at new homes and by their families and friends would also be useful. Impact could be explored further in terms of the impact of care home closure and relocation on residents' social networks (size and level and nature of contact), including family, former informal caregivers and friends, and in turn social life and social well-being, access to amenities, and public transport. Another unknown is whether there is a loss of good providers/expertise. How many care home owners who have closed homes leave the field to work in other areas unconnected to housing, health and social care? Research and development might identify what works, develop content for guidelines, consider how staff might be trained on implementing good practice and possibly include resources for relatives and residents themselves.

The research might explore other types of closure within adult social care services. Little is known about what happens when a domiciliary care agency goes out of business. Is there a drop in quality in service provision when they are struggling financially?

In terms of care home research in general, the research highlighted a number of neglected areas. There is a lack of recent research that specifically focuses on older people's perceptions of care homes. Much of the literature on people's experience of moving to a care home notes the likely impact of the negative image of residential care

on people's lack of anticipation of the possibility of having to move to a home, and the consequent lack of planning and reluctance to choose such long-term care (Espejo et al., 1999; Oldman and Quilgars, 1999; Nolan and Dellasega, 2000).

Similarly, there is a lack of recent research evidence about the media profile of care homes for older people. A preliminary review of social care press coverage in recent years suggests that it is in some ways contradictory. The dangers associated with care homes appear to be of high media salience, in so far as scandals frequently receive coverage (2002; Iyer, 2004), and sometimes coverage includes a campaigning element (MacIntyre, 2003; Wynne-Jones and Webster, 2004).

A number of questions and areas of uncertainty were identified, which would benefit from greater knowledge and understanding: the prevalence of different types of moves between care homes; the incidence, prevalence, pattern and significance and consequences of out of area moves; the experiences and needs of older people living in care home without relatives; the prevalence, and amount paid in top-up payments to care homes; the role of the regulator during voluntary home closures (are they currently responsible for checking standards are maintained during closures?); the nature and level of communication between prospective residents and relatives and prospective new homes.

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List of Appendices

Appendix 1: Summary of findings 1 - rates and reasons for closure

PSSRU

at the University of Kent at Canterbury, the London School of Economics and the University of Manchester

Closures of Care Homes for Older People

Summary of Findings, No. 1

February 2002

BACKGROUND

The rise in the incidence of care home closures over recent years has been the subject of considerable public concern. This summary describes the results of a Department of Health funded research project investigating the causes, process and consequences of closures of care homes for older people. The research aims of this first stage of the study were to identify the:

- rates of closures nationally
- types and characteristics of homes that are closing
- circumstances that lead to home closure.

PARTICIPANTS AND METHOD

A national survey of registration and inspection (R&I) unit managers was carried out to identify rates of closure, consequences for local supply, characteristics of closed homes, and the range of possible reasons. Telephone interviews were also conducted with a sample of R&I managers to ask about two recent closures, and to request contact details for independent providers of recently closed care homes. These providers were then interviewed to identify the combination of factors and circumstances that led to the closure.

Box 1. Research data

- National survey of R&I units
- Telephone survey of sample of R&I units about recent closures
- Interviews with providers of recently closed homes

177 (82%) of the 215 R&I managers contacted completed the survey. Telephone interviews were conducted with 39 R&I managers (89% of units contacted), who provided information about 69 recent closures (see table 1).

Table 1. Number of recent closures described by R&I managers

Home type	No.	%
Residential	34	49
Nursing	28	40
Dual registered	7	10
Total	69	100

Preliminary interviews were carried out with five providers and structured interviews were carried out with a further 20. They offered a range of experience and views in terms of geographical location, home type, home size, sector of ownership, and size of organisation (see table 2). The majority had previous experience of working in the care sector and seven had worked in the field for more than 20 years.

Table 2. Size and registration status of providers' homes

Home type	No. homes	Average places
Residential	11	19
Nursing	6	34
Dual registered	3	52
Total	20	28

RATES OF HOME CLOSURE

During the year ending March 2001, the overall rate of closure for independent care homes for older people was 5%. The highest rate of closure, 11%, was amongst small homes (homes with fewer than four places) (see table 3).

Rates of closure varied regionally (see figure 1). The highest rates of closure of residential and nursing homes were in the South East and South West (7%) and the lowest in the Eastern region (3%). The rates of residential home closure were slightly higher than the rates for nursing homes in the Northern and Yorkshire, North West, West Midlands and London regions, while the reverse was the case in Trent.

EFFECTS ON CAPACITY

Overall, the number of closures exceeded the number of new registrations for each type of home (see table 3). The net effect of closures, openings and changes in registration on capacity can be seen in terms of the number of homes and the number of places (see table 4).

Table 3. Rates of homes closing and opening, 2000–2001

Home type	% closing	% opening
Residential	5	3
Nursing	5	1
LA	4	<1
Small (<4 places)	11	7

Table 4. Percentage reduction in number of homes and places, 2000–2001

Home type	Homes	Places
Residential	–4.0	–1.1
Nursing	–4.8	–4.2
LA	–5.8	–8.5
Small (<4 places)	–4.9	–7.6

The number of nursing homes fell in all regions. The number of residential homes also fell, except in Trent and London where there was a slight increase (by 1.3 and 0.7%). Similarly, the number of small homes fell in all but one region, the North West, where the number increased slightly (by 0.6%). The greatest reduction was in the South West, in both residential (9.9%) and nursing homes (6.4%).

THE RESEARCH TEAM

The PSSRU staff conducting this study are Ann Netten, Robin Darton and Jacquetta Williams at PSSRU, University of Kent. The project secretary is Lesley Cox (01227 823963; e-mail L.A.Cox@ukc.ac.uk).

Nationally, the number of places reduced for each type of care home, but rates varied by region (see figure 2). With the exception of London, nursing home places reduced in every region. However, there were some slight regional increases in the number of residential places in four of the eight regions: London, Trent, the North West and West Midlands. In the North West and Trent, the increase in independent residential places exceeded the fall in LA places. The greatest reductions in the number of residential places were in the southern part of the country, whereas among nursing homes the reductions were distributed more evenly.

THE CHARACTERISTICS OF CLOSED HOMES

The majority of the recent closures described by the R&I managers were privately-owned homes. Over half had been singly-owned homes and just under a third were one of a pair. The nursing and dual registered homes were less likely to have been in a chain than nationally. For each type of home, the average size was smaller than the national average (see table 5).

Table 5. Average size of closed homes

Home type	In sample	Nationally
Residential homes	15	22
Nursing homes	24	35

R&I managers rated the quality of care as excellent, good or OK in 61% of the recently closed homes (see table 6), and as poor in less than a quarter (19%). In two cases registration had been cancelled, and a further 12 had compliance notices outstanding.

Table 6. R&I assessment of quality of care in recently closed homes

Assessment	Residential	Nursing	Dual
Excellent	3	3	0
Good	8	9	1
OK	10	4	4
Fair	5	8	0
Poor	7	4	2
Total	33	28	7

THE TIMING OF CLOSURES

The provider interviews highlighted the variability in the time that can elapse between when closure is first considered and closure itself. Closures can occur as quickly as four weeks after the decision to close or after a considerable period (sometimes years).

The timing was influenced by judgements about when losses were no longer sustainable or when the home was no longer financially viable. Changes in circumstances, such as a sudden drop in occupancy, the loss of a key member of staff, or an increase in the value of the property, also influenced timing.

REASONS FOR CLOSURE

Inspectors were asked to classify homes that closed during the year ending March 2001, in terms of business failure, enforcement action or other reasons.

Business failure was cited by R&I managers as the main reason for 46% of residential home closures, 58% of the nursing home closures and 37% of the small home closures during this period.

Three perspectives were gained on reasons for closures:

- R&I managers' perspective on factors relevant in their area
- R&I managers' perspective on the causes of individual closures
- the providers' perspective.

We draw on each of these perspectives to discuss the main factors and circumstances identified.

Box 2. Factors leading to closure identified by providers

- Local authority pricing policies
- Care standards
- Type and level of demand
- Staffing issues
- Property market
- Commissioning and regulatory environment

Local authority pricing policies

Local authority pricing policies were seen as a factor associated with closures in their area by two-thirds of the R&I managers. The use of residential places for 'high dependency' residents was also highlighted as a factor in nursing home closures by 40% of the health authority R&I managers.

Nearly three-quarters of the providers said that LA fees not covering costs influenced their decision to close. For ten it was decisive. At the time of closure fees were lower than the average regional weekly fees paid at March 2000 (*Laing's Healthcare Market Review 2001-2001*, Laing & Buisson, 2000) in all but one case. Weekly LA fees paid at the time of closure ranged from £304 to £343 for nursing homes (with one London home receiving £488), and from £218 to £269 for residential homes.

Figure 1. Rates of closure by region, 2000–2001

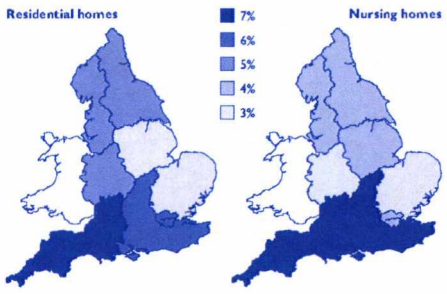
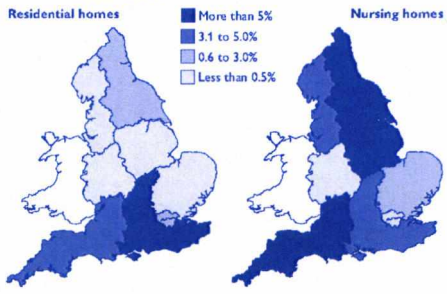


Figure 2. Reduction in number of places by region, 2000–2001



The providers emphasised:
- fee increases below inflation
- long term payment of low fees
- low fees being at odds with providing a service of increasingly high quality.

Combined with relatively small sized businesses, low fees could lead to insufficient profit levels to support intensive re-investment or to service a loan for alterations to comply with the new standards.

Care standards and the National Minimum Standards

About half of the R&I managers identified care standards as a factor leading to closures in their area. An inability or unwillingness amongst providers to meet standards was also the third most common reason given by R&I managers for the two most recent closures. When combined with similar issues, such as the maintenance of premises, management and quality of care, the relevance of current and future care standards increased to being a factor in 60% of the recent closures.

The cost implications of the National Minimum Standards, along with LA prices not covering costs, was the factor most often decisive or relevant to providers' decisions to close. Cost implications included:
- level of initial investment needed (especially to meet the physical environment standards)
- projected reduction in the value of the business if the number of places were reduced to meet room size standards (identified by a quarter of the providers)
- anticipated increases in running costs.

Four providers said the home could not be adapted to meet the new environment standards.

Demand and supply

Lower demand for publicly-funded places was identified by R&I managers as a factor affecting closures in their area. It was highlighted less often than the use of places for 'high dependency' residents (discussed above) but more often than lower demand for self-funded places.

Eight of the 20 providers cited reduced demand for publicly-funded places as decisive. Occupancy in the 12 months prior to closure ranged from 5–40%. For smaller homes a relatively small drop in demand could reduce the business to the break-even point or below.

Just under a third of the R&I managers identified over-supply of residential homes as a reason for local closures and a fifth over-supply of nursing homes. Views varied regionally. However, none of the R&I managers cited over-supply as a reason for individual closures.

Staffing issues

Nursing recruitment was the factor most frequently identified by health authority R&I managers as associated with closures in their area (by 81% of managers). Just under half of the R&I managers identified care staff recruitment as a factor affecting nursing and residential closures. Recruitment was not identified by any R&I managers as a factor affecting either of the two most recent closures, although retention problems were, and providers identified recruitment as a background issue.

Recruiting care staff was a factor for over a third of the providers, and recruiting nursing staff was a factor for a third of the nursing home providers. Recruiting or retaining managerial staff was also a factor for four providers. Recruitment difficulties were linked by providers to:
- high levels of competition in local labour markets
- limited budgets for salaries and advertising
- the demanding nature of the job
- the national nursing shortage.

Wage rates were identified by over a third of the R&I managers as a factor influencing closures in their area, although staff costs were only highlighted by managers as a cause of 6% of the recent closures. Increases in staff costs or the impact of the National Minimum Wage were also identified by seven providers.

Property market

About a third of the R&I managers identified high property values as a factor in their area. It was most frequently identified as a factor by R&I managers in the south of the country, although in London less than half saw it as an issue. In the telephone survey, 18% of the R&I managers also said the lack of affordable premises affected the local supply of homes.

The high value of premises or land was identified by a quarter of the providers as a factor in their decision to close. For three it was decisive. For some, high property values meant that the property was worth more than the business. This could provide an opportunity to exit, when there was little prospect of selling as a going concern. It also made future capital investment uneconomic.

The commissioning and regulatory environment

LA contracting arrangements were identified as an issue affecting local closures (by 19% of the health authority R&I managers and 11% of the LA R&I managers), although this issue was only noted by one R&I manager as having caused a recent closure. Four providers identified contracting arrangements as a factor in their decision to close, and for one it was decisive. Almost three-quarters of the providers reported a lack of negotiation over the price of placements. Purchasing intentions were also said to be unclear.

In terms of their general relationship with the LA, eight providers reported good relationships, describing co-operation, communication and strategic planning. However, seven reported poor relationships. Problems experienced included delays in payment (reported by a quarter of the providers), delays from assessment to admission, and delays in the time taken to assess clients. Such practices increased levels of uncertainty and could reduce levels of income.

Just over half of the providers described their local care market as organised unfairly, in terms of the use of LA provision and of the referral of new admissions with high dependency levels having been assessed as having low dependency needs. Just over a quarter said LA homes received preferential treatment.

Relationships with care managers also varied. Examples of poor relationships included a sense that refusing a referral would run the risk of being 'punished' by having future referrals withheld. Two providers said that their homes had been deliberately boycotted.

Most of the providers did not identify their relationship with the R&I unit as a factor in the closure. Several described their relationship as good or excellent. Nearly a third, however, said it was a decisive factor. Poor

relationships were characterised by:

- 'endless nitpicking'
- poor communication
- inconsistency between officers in their interpretations of regulations
- inconsistency in the implementation of regulations across homes
- inconsistency between the requirements of the R&I unit and other regulatory bodies.

Loss of motivation

Loss of motivation was a factor in the decision to close for about a third of the providers. While many had entered the business hoping for professional and creative achievement, in practice they had felt swamped by bureaucracy and regulation that appeared to be inconsistent, irrelevant and ever-increasing. Representatives of a charitable organisation also identified moral and social justice issues as decisive factors, since continuing to invest in a service to meet the gap created by insufficient government funding was considered to be wrong and unachievable.

Personal reasons

R&I managers identified a change in personal circumstances (including retirement and bereavement) as a main reason for a quarter, and a factor in almost a third, of the 69 recent closures. Of the 20 providers, a quarter had wanted to retire, and for three this was decisive.

Combination of factors

Most providers identified more than one reason for closure. Although none had closed due to bankruptcy, all but two homes had been closed to avoid further losses or because of insufficient financial return. This was linked to the combined influence of LA prices not covering costs and the cost implications of the new National Minimum Standards for about a third of the providers. Low occupancy tended to be a factor in closures when combined with either or both of these factors and/or increases in running costs, a concern that LA prices were unlikely to cover costs in the future, and/or wanting to retire. A desire to retire tended to combine with other factors such as being unable to meet the new standards, a poor relationship with the R&I unit, or a fall in occupancy.

STEPS TAKEN TO AVOID CLOSURE

Strategies introduced or investigated by providers in response to fees not covering costs included:

- increasing existing sources of income
- diversifying into other service areas
- and/or minimising further losses by cutting expenditure.

Strategies to increase income included:

- changing the home size
- trying to improve occupancy rates
- trying to increase the proportion of self-funded residents.

Some providers were deterred from diversifying, either by the process, the requirements, or the belief that it would not solve the problem.

Strategies to reduce costs included changing staffing levels, freezing wages (although some providers increased salaries to retain staff), and reducing additional services.

CHANGES THAT MIGHT HAVE PREVENTED CLOSURE

Providers were asked what, if anything, might have prevented the closure. A quarter regarded closure as unavoidable. Several others said it might have been delayed but they would still have tried to exit. Providers most often (two-thirds) identified an increase in LA fees as something that might have prevented closure. On average, an increase of 22% was indicated, although this varied.

Four providers indicated that higher levels of occupancy might have prevented closure. Six identified a relaxation of the regulatory environment and three highlighted an improved relationship with the R&I unit as factors that might have prevented closure.

Other changes that might have prevented one or two of the closures include: greater partnership with the LA; availability of funding for new service development; improved local labour supply; and availability of suitable managerial staff.

FUTURE RESEARCH

Future work aims to develop a better understanding of the process of closures and the consequences for residents, relatives and carers, providers and staff and local authority social services and commissioning departments.

This summary and the full reports are on the PSSRU website: http://www.ukc.ac.uk/pssru/

- The Rate, Causes and Consequences of Home Closures (DP 1741/2)
- Care Home Closures: The Provider Perspective (DP 1753/2)

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The **PERSONAL SOCIAL SERVICES RESEARCH UNIT** undertakes social and health care research, supported mainly by the Department of Health, and focusing particularly on policy research and analysis of equity and efficiency in community care, long-term care and related areas — including services for elderly people, people with mental health problems and children in care. The PSSRU was established at the University of Kent at Canterbury in 1974, and from 1996 it has operated from three branches:

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Appendix 2: Care homes in England

Introduction

This Appendix provides further detail about the general background and context of care home closures in England summarised in Chapter 2. It reviews the evidence the size and characteristics of the care home industry, the complexities of the funding system, the characteristics of care home residents and their relatives, what is known about moves between care homes, and the characteristics of the social care workforce, focusing on care home staff and care managers working for social services departments, as well as some of the wider workforce issues.

Size and characteristics of the care home industry

At the end of March 2003, 21,825 care homes for adults (for all client groups) were registered in England (National Care Standards Commission, 2003). Of these, 12,994 were care homes for older people (Dalley et al., 2004). Information on the number of all types of care home was not available in a straightforward form, nor reported consistently prior to the national regulator. The number of residential homes was available from the Department of Health from 1998 until 2001, but not for 2002 (the year fieldwork was conducted), nor thereafter. In 2001, there were an estimated 24,100 homes providing residential care for adults and older people, of which about 11,500 were registered to care for older people (Department of Health, 2001b)[1]. In March 2001, there were an estimated 4,170 general nursing homes for adults, as well as older people (Department of Health, 2002a). An additional 2,280 homes were dual registered (Department of Health, 2002a). Laing & Buisson estimated that there were 14, 125 care homes in late 2001, which provided around 430,000 places: 5,468 nursing homes for older people and chronically ill and physically disabled people and 8,657 residential care homes (Laing & Buisson, 2006). By 2006 the number of homes had fallen to 12,208, which provided around 408,000 places: 4,660 care homes with nursing and 7,548 care homes without nursing (Laing & Buisson, 2007).

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[1] Department of Health data on nursing homes for adults was published alongside information about hospitals and clinics for three years up to 2001.

The industry is also sizeable in terms of the amount of public expenditure on funding care home places and the overall estimated value of the market. A substantial proportion of public expenditure is spent on residential care. Councils spent 45% of their total gross expenditure on personal social services for older people in 2002-03. Of this, £4,250 millions was spent on residential provision for older people (Department of Health, 2004d). This represented around 59 per cent of the gross expenditure on residential provision for *all* client groups (£7,190 millions) and around 27 per cent of total gross expenditure on personal social services (£15,200 millions). The proportion spent on residential care for older people has remained roughly similar: by 2006-07 services for older people accounted for 43 per cent of total councils' expenditure on personal social services, which represented 56 per cent of total expenditure on all residential care, and around 23 per cent of total expenditure on personal social services (The Information Centre, 2008). In 2002-03 most of the gross expenditure on care home placements for older people, just under two thirds, was spent on residential placements, and just over one-third on nursing placements, and these proportions remained about the same in 2006-07.

The market value of all forms of residential care (including long-stay hospitals as well as residential care for the chronically ill, physically disabled and older people) was estimated to be £10.2 billion in 2001-2002 (Laing & Buisson, 2002), increasing to £11.8 billion by 2006 (Laing & Buisson, 2007). In 2001-2002, £6.9 billion of this was spent on the private (for profit) sector, and this rose to £8 billion by 2006. £1.9 billion was spent on the voluntary sector in 2001-2002, which fell to £1.6 billion in 2006 (Laing & Buisson, 2002; Laing & Buisson, 2007).

Sector of provision

Care homes for older people vary in terms of the status of the provider organisation, which might be in the independent (private or voluntary) sector or a local authority run organisations, and the type of care provided. The vast majority of homes are in the independent sector. During the period of fieldwork (2002) care homes were classified as residential, nursing or dual registered to provide both residential and nursing care. Homes were subsequently re-classified as care homes with or without nursing care (Care Standards Act 2000).

By 2000, almost 75 per cent of all residential homes were in the independent sector, only 10 per cent were owned by local authorities and 9 per cent by the voluntary sector (Bajekal, 2002). The new national regulator reported that in 2003, over 80 per cent of all care homes for adults were provided by the private sector, about 13 per cent by voluntary organisations and around six per cent by local authorities (Dalley et al., 2004). The picture remained much the same in 2006 (Commission for Social Care Inspection, 2006).

Type of care

The majority of care homes, over two thirds provide residential care. In 2000, 71 per cent of all care homes for older people were residential homes, 12 per cent were nursing homes and 17 per cent dual registered (Bajekal, 2002). Nursing care is defined as care that is provided, planned, supervised or delegated by a registered nurse (Health and Social Care Act 2001). Unfortunately, up-to-date information on the number of homes for older people with and without nursing care was not found in recent reports from the regulator (Commission for Social Care Inspection, 2005; Commission for Social Care Inspection, 2006).

Size of home

Care homes in England are typically small. In 2001, the average size of residential homes for older people was 18 places (Department of Health, 2001b). Nursing homes tend to be larger. Laing and Buisson estimates for all care homes for elderly and physically disabled people suggested that average home size rose between 2001 and 2006 from 38 to 46 amongst nursing homes, and from 23 to 26 amongst residential homes in the same period (Laing & Buisson, 2006).

Small firms

A distinctive feature of the care home industry in England is that it is a 'cottage industry', largely composed of small providers. Corporate provision is expanding, although not at a rate that means control of the market. In 2004, Laing and Buisson estimated that only one-third of providers of homes for older people were organisations that included three, or more homes (Laing & Buisson, 2004). Nonetheless, in 2005, the regulator emphasised that the structure of the market is changing, and that their information suggests it is smaller homes that are closing, and larger homes which are

opening (presumably larger homes are associated with more corporate providers). They warn that increasing corporate provision may have a negative impact on councils' ability to negotiate fees and influence service development (Commission for Social Care Inspection, 2005).

The funding system

In 2004, people with assets of less than £20,000 were eligible for some level of financial support from local authorities, subject to an assessment of their needs and weekly income (National Health Service and Community Care Act 1990, ; Department of Health, 2004a). Free nursing care for self-funded residents was introduced in England from October 2001, and for publicly-funded residents from April 2003. From October 2001, the NHS funded the cost of nursing care provided by registered nurses in nursing homes (Department of Health, 2001d; Department of Health, 2001c) and from April 2003 (after the period of fieldwork) the funding of residents of care homes providing nursing care previously funded by local authorities in England was transferred to the NHS (Department of Health, 2003b). The amount the NHS pay for nursing care depends on the amount of care required, which is assessed by an NHS nurse.

As at March 2004 there were 214,100 supported residents aged 65 or over (Department of Health, 2004b). Older people represented 78 per cent of all supported residents aged over 18 in 2004 and 2003, one per cent less than in 2002. 56 per cent of them were living in independent residential care homes and 31 per cent were living in independent nursing care. The number of supported older people in care homes was around 200,000 from 1998 (Department of Health, 2002b) increasing to 218,500 in 2003 (Department of Health, 2003a), before falling again in 2004 (Department of Health, 2004b).

An estimated six per cent of residents in independent sector homes are funded by the NHS (Laing & Buisson, 2004). 112,000 older people were said to have received funded nursing home places in 2002, compared to 106,000 clients in the previous period. Department of Health figures estimate that 128,375 residents were NHS funded in 2004/05 and 128,855 in 2005/06 (Department of Health, 2004c).

There is very little information about the extent to which third parties pay 'top-up fees', or the amounts paid. Data collected about local authority supported admissions to care homes in 1995 indicated that about 14 per cent of supported residents had their fees supplemented in this way (Bebbington, 1998). This survey of publicly-funded admissions was repeated by the PSSRU in 2005, to feed into the updating of the Department of Health's *Personal Social Services Formula Spending Share* grant allocation for older people, and included a question about the level of any top-up payment. In 1997-98, it was estimated that 14 per cent of local authority funded residents had their fees added to by a third party, with values ranging from £15 to over £65, at a total cost of £80 million per annum (Laing, 1998).

Various modifications were introduced to funding arrangements throughout the period of study, including changes to the level of capital disregarded from the means test (Cm 4818-1, 2000; Department of Health, 2004a), and the introduction of deferred payment grants from councils, which had the stated intention of allowing 'the possibility of a return home' (Cm 4818-1, 2000 p12; Department of Health, 2001a).

Care home residents' characteristics

There is a lack of routine data available about the characteristics of older people living in, or being admitted to care homes. A number of surveys have been conducted, but each use different questions and measures, making comparison difficult. The 2000 *Health Survey for England* found that four per cent of people aged 65 years and over were living in a care home (Bajekal, 2002). Census data suggests that 4 per cent of people aged 65 and over, lived in communal establishments in 2001. Applying this proportion to the population estimate for 2002 suggests that around 436,000 older people were resident in a care home. The proportion increased to 18 per cent for people aged 85 and over (Office for National Statistics, 2004c). 3.7 million people were aged 75 and over in 2002 (7.6 per cent of the population) and this was predicted to rise to 4.1 million in 2011, and to 6.4 million in 2031 (11.7 per cent) (Government Actuary's Department and Office for National Statistics, 2003).

The *Health Survey for England* found 75 per cent of residents were women (Bajekal, 2002). A survey conducted in 1996 found a slightly higher proportion at 80 per cent

(Netten et al., 2001a). In terms of age, a 2005 survey found 54 per cent of older people admitted to care homes were aged 85 or older, and 77 per cent were aged 80 or older (Darton et al., 2006). The average age of residents is higher for women, at roughly 85 years compared with 83 for men (Bajekal, 2002). Women are more likely to be widowed than men; 75 per cent of women were widowed, compared to 50 per cent of men in 2000 and men were more likely than women to be married, single or divorced (Bajekal, 2002).

In terms of ethnicity, 1.2 per cent of a sample of publicly-funded admissions in 1995/6 were of African, Caribbean or Asian origin (Bebbington et al., 2001). This study concluded that, when the age distribution difference between ethnic groups was controlled, the admission rate among ethnic minorities was nearly twice that for the white group.

Care home residents usually have multiple personal care needs: 57 per cent of women and 48 per cent of men living in care homes were found to need help with one or more self-care tasks in 2000 and women tended to be severely disabled more than men (Bajekal, 2002); an earlier study of admissions in 1995, which used different measures of dependency, found that around 65 per cent of residents in nursing homes had higher than moderate dependency levels, about 45 per cent had a severe impairment, and a slightly smaller proportion a mild impairment (Netten et al., 2001a); a 2005 study found 96 per cent of people admitted to care homes needed help with more than one self-care task and 94 per cent had a limiting long-standing illness (Darton et al., 2006). Older people living in care homes have been found to receive less social contact than those living in private households (Tait and Fuller, 2002).

The type of evidence and degree of detail available for length of stay differs. The *Health Survey for England* provided the median length of stay by gender: one to two years for men and two to three years for women (Bajekal, 2002). Another survey found length of stay for permanent residents differed according to funding: on average, self-funded residents were found to have been living in homes for shorter periods of time (four months less) than publicly-funded residents who on average had been in homes for 37 months (Netten et al., 2001a). Cross-sectional estimates only reflect the stay of current residents and under-represent those with very short stays and over-represent

those who stay in homes for a long time. A longitudinal study, that spanned 1995 to 1999, found the median length of stay for people admitted to nursing homes was one year, and just over two years for those admitted to residential homes. A median survival period for publicly-funded residents was estimated to be 20 months, and the average length of survival to be 30 months (Bebbington et al., 2001).

Self-funded residents

The government does not routinely collect information about self-funded residents of care homes and there is a lack of national data. In 1996, a cross-sectional survey of private homes in 21 local authorities found that about one-third of residents in residential care, and about a quarter of residents in nursing care, were self-funders (Netten et al., 2001a). Of the publicly-funded residents, 14 per cent had initially been self-funding on admission and had later become eligible for public funding. More recent estimates suggest that 32.5 per cent of elderly or physically disabled residents of independent care homes (123,000) were self-funded in November 2001, and 31 per cent (118,000) in April 2003 (Laing & Buisson, 2002; Laing & Buisson, 2003). These later estimates include physically disabled residents because they are based on estimates of total residents minus publicly-funded residents.

A survey of self-funded admissions to care homes found that in 1999-2000 self-funded residents differed from publicly-funded residents in a number of ways: self-funders tended to be older than publicly-funded residents and were less likely to be married (Netten et al., 2002). Self-funded residents have also been shown to be less likely to be admitted from hospital, and less dependent than publicly-funded residents, with lower levels of impairment, particularly those who move to residential home (Netten et al., 2001a). However, although self-funded residents were found to be less dependent on admission, other risk factors suggest that their expected length of stay is very similar to that of publicly-funded residents (Netten et al., 2001b).

Relatives

Little is known about the number or characteristics of relatives who continue to care for or visit older people living in care homes. In the general population, approximately one

in six adults aged 16 or over (about 6.8 million people) care for a sick, disabled or elderly person in 2000 and just over half of these looked after a parent or parent-in-law (Maher and Green, 2002). Of residents with relatives, a survey found that nearly two-thirds were visited at least once a week, which suggests the presence of a relative or friend (Bejekal, 2002).

Qualitative evidence shows that relatives and informal carers who help older people move into care homes may themselves, as the adult children or spouse, be over 60 (Nolan and Dellasega, 2000; Ryan and Scullion, 2000). Quantitative analysis of the 1985 Office of Population, Censuses and Surveys (OPCS) *Informal Carers Survey* also found that over one-third of informal care to people over 65 living in the community was provided by older people (Arber and Ginn, 1990). Spouse carers may also have poor health (Parker, 1993 cited in Pickard; 2004).

Nationally, the number of care home residents without relatives or close friends is unknown. The survey of self-funded admissions conducted in 1999-2000 found that the name of a friend or relative could be identified for only 65 per cent of recently admitted older people (n=921) (Netten et al., 2001b). The Office of the Public Guardian provides financial protection services to people who are unable to manage their financial affairs because of mental incapacity or who are without people to act on their behalf. However, the number of older people living in care homes who draw on their services is unknown.

Prevalence and nature of moves between care homes

There is no routine published information that permits easy identification of the prevalence and nature of moves between care homes. A longitudinal follow-up of admissions in 1995, found that at 42 months, ten per cent of the sample had moved to a different home. Older people admitted to a residential places were more likely to move to a different type of place than those admitted to a nursing place (10 per cent compared with 5 per cent) and to a different type of home (12 per cent compared with 8 per cent) (Bebbington et al., 2001). When the source of admission was taken into account, 19 per cent of admissions to a residential home were found to have moved to a different type of place.

A smaller study conducted in 1988-1989 found that 16 per cent of the private residents interviewed (n=51) had moved to a residential home from another home. The authors concluded that this demonstrated 'the ease with which some private residents can exercise a choice and vote with their feet'; they described this as rarely an option for residents of local authority run homes (Allen et al., 1992 p168). A study of private nursing homes, also conducted in the 1980s, found that eight per cent of new admissions had moved from another home (Challis and Bartlett, 1988). A later study (1999-2000) of relocation between homes in two councils found that 33 per cent of residents (n=255) had experienced one relocation, and four per cent had experienced two or more relocations (Reed et al., 2003). This study analysed the pattern of moves between homes and identified five relocation trajectories: progressive, lateral, fluctuating, de-escalatory and anticipatory moves (Cook et al., 2001). Progressive trajectories were characterised by moves precipitated by higher levels of dependency and moves to more specialised types of care. Lateral moves were moves to the same level of care but to similar or different types of provision and usually prompted by residents/relatives' dissatisfaction with the care or geography of a home. Fluctuating moves related to moves associated with short-term/temporary placements and anticipatory moves were moves to higher levels of care provision before it was immediately required. De-escalatory moves were also identified, showing that it was possible at the time for some older people to move to lower levels of care.

Care home staff

Little is known about the size, composition, or employment patterns of the social care workforce working in independent sector care homes[2]. Historically, the social and health care workforce in the UK was not the subject of routine government funding for research or data collection, and little was conducted other than the National Institute for Social Work studies (Social Care Workforce Research Unit, 2003) (McFarlane and McLean, 2003), which did not cover the independent workforce.

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[2] Better data should become available about the social care workforce, for example via the *Skills for Care* National Minimum Data Set for Social Care (NMDS-SC), the Social Care Register, and the Social Care Workforce Research Unit at King's College London.

Size and demographics

A large number of people work in social care (McFarlane and McLean, 2003), and care assistants constitute the largest single occupational group within the sector (Commission for Social Care Inspection, 2005); in 2001, 2.5 million people worked in the health and social care field and of these 450,000 worked as care assistants in residential homes, or as home care workers (Office for National Statistics, 2004a) and the regulator estimated that around 50 per cent of the paid social care workforce worked in residential care homes for older people, adults or children in 2004-05 (Commission for Social Care Inspection, 2005).

Some information is available about the demographic characteristics of care assistants. Unfortunately, Labour Force Survey data does not separate care assistants in care homes from those providing domiciliary care, but showed that 89 per cent care workers were women, and that 57 per cent worked part-time (Office for National Statistics, 2004a). It is also estimated that the social care workforce involved in direct care, including that of children, are typically (three fifths) aged between 25 and 49 years old, with the proportion aged 50 plus increasing (Eborall, 2003). Estimates for 2003-4 show that the workforce continues to be predominantly female (95% in residential care), and that settings for older people tend to employ older workers (Eborall, 2005). In terms of ethnicity, data for 2002 suggest that 7.5 per cent of direct care workers are from non-white minority ethnic groups (Eborall, 2003).

The most up-to-date information about the independent sector social care workforce at the time of the fieldwork was a 2001 survey of independent care homes (Social and Health Care Workforce Group, 2002; Eborall, 2003). It estimated that there were 377,000 staff working in the independent care home sector, including nursing staff, care workers, working proprietors and night staff (Social and Health Care Workforce Group, 2002). Of these about 76 per cent (285,300) were care workers, 11 per cent registered nurses (43,200), and 13 per cent (49,200) managers and supervisors. Subsequently, around 150 care workers who worked in private nursing and residential care homes responded to a survey of social care workers, but reports of the findings do not differentiate their demographics, duties, work history and reasons for leaving jobs, from those who worked in people's homes and other settings (Skills for Care, 2007).

Qualifications and training

Little is known about staff qualifications and training in independent care homes, although it was generally accepted that direct care workers in care homes traditionally had few, or no qualifications. A survey in 1995-6 (n= 901) of residential care workers (38%) and home care workers (62%) found care assistants working in care homes for older people were less qualified than those who worked with children, and the highest qualification for a substantial proportion of these workers, almost one-third, was the school leaving certificate (McFarlane and McLean, 2003). This could only partly be explained by the age profile of the workforce since at that time only 51 per cent were aged 40 or over. The care workers expressed an interest in receiving training in quite basic skills, such as first aid and National Vocational Qualifications (NVQs). At that time, about 29 per cent of residential care workers (in homes caring for children as well as older people) reported having, or working towards, a vocational qualification, usually Level 2 in Care. A national survey of care homes found that in 1996 some care assistants had an NVQ or BTEC award in two-thirds of the participating private, voluntary and local authority homes (Netten et al., 2001a). In 2005 the regulator reported that 62 per cent of residential care homes for older people met the requirement that 50 per cent of care staff be qualified to NVQ level 2 or equivalent (Commission for Social Care Inspection, 2005).

Pay and conditions

A study of the introduction of the national minimum wage in April 1999 (set at that time at £3.60 per hour for workers aged 22 and over and £3 for 18-21 year olds), found it had a considerable impact on the care home sector (Machin and Wilson, 2004). Before its introduction, about 32 per cent of all workers in the care homes surveyed were paid less than the minimum wage. A 2001 survey found that hourly rates of pay for care workers varied considerably by region, ranging from an average (median) of £6 in London to £4.55 in Yorkshire and Humberside (Social and Health Care Workforce Group, 2002). In contrast, nurses' pay was relatively consistent. Topss England's (Training Organisation for Personal Social Services in England) second review concluded that care workers' pay ranged widely across the social care workforce depending on geographical location, experience, qualifications, settings and employer types: those in the public and voluntary sector earned on average more than those in the private sector; pay was highest in London; pay for a female care worker in April 2004

ranged from £4.80 to £8.30 per hour (Eborall, 2005). NVQ qualified workers did not appear to be paid more. Rates of pay also varied depending on duties and local labour markets. LearnDirect suggested that care assistant salaries start at around £10,000 to £13,000 a year, with people working in residential settings with unsocial hours earning up to £16,000 a year (LearnDirect, 2007). The regulator reported that care assistants were paid on average around £180 per week in 2003 and that pay by the private sector was generally lower than the public sector (Commission for Social Care Inspection, 2005).

In 2001, an estimated five per cent of the independent care home sector workforce were long-term agency staff (employed for longer than a month), and 88 per cent of these were care workers (Social and Health Care Workforce Group, 2002). In relation to the NHS, the increased use of agency nurses has raised concerns about the risk of such staff being inappropriately qualified or trained (Meikle, 2001).

Shift work is common, although shift patterns vary. Unison represented social care workers as well as social workers, but, details of its care assistant membership are not publicly available, although it claims to represent 40,000 qualified social workers, and 300,000 members working in social care services (UNISON, 2007).

Recruitment and retention issues

The shortage of nurses in the National Health Service was described as acute and rates of nurse recruitment from overseas as increasing (Carvel, 2001). Overseas nurses are employed by the independent care home sector too, and here, as well as in the NHS, there were reports of exploitation (Gow, 2001; Carvel, 2002; Hinsliff and Connolly, 2002).

In 2001, the overall vacancy rates for direct care worker posts and nursing posts in independent care homes were broadly similar, with 7 per cent of care worker and 8.5 per cent for registered nursing posts vacant (Social and Health Care Workforce Group, 2002). In terms of length of time in job, about half of the social care workforce as a whole were found to have worked in the field of social care for ten years or more (Eborall, 2003).

However, the average gross turnover rate was particularly high amongst care workers, with 24.9 per cent of staff leaving in the previous 12-month period, compared to 15.3 per cent of registered nurses and 9.5 per cent of managers and supervisors. Residential care workers were estimated to change jobs at twice the rate as local authority care workers, who had a turnover rate of 10 per cent or above in 2001, and of 16 per cent in local authority care homes for older people (Eborall, 2003). Vacancy and turnover rates varied by region (Social and Health Care Workforce Group, 2002). A US study found that 30% of participating nursing assistants planned to quit their job (Parsons et al., 2003).

The social worker workforce

Size of the workforce

Focusing on field social workers, the Social Care and Health Workforce Group highlighted Department of Health staffing data showing that 41,555 field social workers were employed by social services departments in England in September 2002 (Social Care and Health Workforce Group, 2003). The Office for National Statistics (ONS) identified slightly fewer, 35,800 (Office for National Statistics, 2004b). No break-down of the number of social workers or care managers employed by local authorities to work in older people's services was found, although the Topss 2002 *Social Services Workforce Survey* separates field social workers who work with children from those who work with other client groups; just over half (21,200) worked in children's services (Social Care and Health Workforce Group, 2003).

Pay and conditions

About 75 per cent of social workers are female and 73 per cent of these work full-time (Office for National Statistics, 2004a). Social workers have a set salary range, but authorities have some discretion to pay over and above this. The 2002 social services workforce survey explored the numbers of social worker staff undertaking qualifying training, but not the qualifications held by social workers (Social Care and Health Workforce Group, 2003).

Recruitment and retention issues

At the end of September 2002, the average vacancy rate for field social workers employed by social services departments to work with client groups other than children was 9.2 per cent (up from 8.9 per cent in 2001) (Social Care and Health Workforce Group, 2003). The 2001 Census identified 48,460 social workers in health and social care in England and Wales (Office for National Statistics, 2004a)[3]. Drawing on various sources for the same period, the Topss identified 52,700 qualified social workers employed by local authorities in England. This represented 69 per cent of the estimated total of 76,300 social workers employed by the NHS and other employers, as well as local authorities (Eborall, 2003).

The average turnover rate for these social workers over the previous 12-months was 10.5 per cent (slightly down from 10.9 per cent in 2001). Vacancy and turnover rates varied widely by region. Overall, the recruitment and retention of social workers for client groups other than children was easier than for those that worked with children. During 2002, 27 per cent of responding authorities reported difficulties recruiting field social workers for client groups other than children, compared with 47 per cent in relation to social workers for children's services. Retention problems were less severe than in relation to those working with children: only 12 per cent of authorities reported retention difficulties for this group, compared with 32 per cent in relation to field social workers for children. This difference might reflect the greater demand for social workers to work in children's services. Social services departments identified a lack of suitably qualified applicants as the main reason for these difficulties (Social Care and Health Workforce Group, 2003).

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[3] The General Social Care Council (GSCC) required social workers to register with them by December 2004, but the deadline was extended despite the two years in which they had to register by this date Brody, S. (2005) Nearly 30,000 social workers to miss registration deadline, *Community Care*, March 29.. This register should provide a useful future source of information about the size of the workforce.

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Appendix 3: Feedback Summary 2 - Local authority guidelines

PSSRU
at the University of Kent,
the London School of Economics
and the University of Manchester

PSSRU Research Summary 26

Closures of Care Homes for Older People

Summary of Findings, No. 2
Local government guidelines
October 2003

INTRODUCTION

This summary reports the prevalence and content of council guidelines for managing the closure of independent care homes for older people. The research was part of a wider project investigating the causes, process and consequences of home closures, funded by the Department of Health.

How the closure and relocation process is managed is likely to affect the level of any risk to residents' health, safety and emotional well-being, so it is important to identify what is already known about managing a home closure and what approaches, policies and procedures are recommended.

The process is likely to involve social services departments, the home owner and their staff, the residents, their relatives and/or informal carers and possibly other councils and agencies working together to help residents move to suitable alternative homes.

RESEARCH AIMS AND METHOD

We wanted to identify:

- The extent to which councils had guidelines for managing the closure of care homes;
- The aims and objectives of any guidelines;
- How roles and responsibilities were allocated;
- Recommended approaches, policies and procedures.

In 2002 all councils in England were asked if they had a protocol, and if so to send a copy. Councils with 100 or more independent residential or dual registered care homes were contacted twice since they were most likely to have experienced closures and to have put plans in place.

LEGAL AND POLICY CONTEXT

Registration regulations, introduced under the Care Standards Act 2000, legally require providers to:

- Apply to the National Care Standards Commission (NCSC) to close, three months before the proposed closure date (Regulation 15 [2]);
- Notify service users no more than seven days later (Regulation 15 [3]).

The National Minimum Care Standards also state that providers should:

- Give residents a statement of terms and conditions or a written contract, which includes the notice period (Standard 2);
- Offer prospective residents the opportunity to visit new homes and to move in on a trial basis (Standard 5).

There is no law or statutory guidance aimed specifically at the closure of independent care homes. However, in 1993 the Department of Health advised authorities to draw up plans so that home closures or resident eviction can be handled effectively (LAC (93)6). Since the guidance was issued under section 7 of the 1970 Local Authority Social Services Act it carries the force of law.

THE RESEARCH TEAM

The PSSRU staff conducting this study are Jacquetta Williams, Ann Netten and Robin Darton at the PSSRU, University of Kent. The project secretary is Lesley Cox (01227 823963; e-mail L.A.Cox@kent.ac.uk).

More recently a Health Service Circular provided detailed guidance about how to move older patients after hospital or long stay ward closure (1998/048). *Building Capacity and Partnership in Care* also stated that, if services have to be withdrawn, councils should work with independent providers to manage closures in a planned way (2001).

Councils' responsibility to assess vulnerable people and, if certain criteria are met, to arrange admission to their preferred accommodation applies during a home closure just as it does in general. The extent to which councils are obliged to re-assess or review the needs of self-funded residents who arranged their own care home place, or indeed publicly funded residents, however, is unclear, as is the extent of their power to help self-funded residents.

The Human Rights Act has been used in a number of legal challenges to decisions to close local authority run care homes. However, the Act applies to public authorities and to date independent care homes have been judged as outside the definition of public authority.

PREVALENCE OF GUIDELINES

Sixty-eight per cent of the 70 councils with over 100 care homes in their area responded to our enquiry. 62% of these 48 responding councils said that they had a protocol/guideline and 37% said that they did not. A further seven authorities with less than 100 homes in their area responded. All seven said they had closure guidelines. In total a third of councils in England (55) indicated whether they had a protocol and of these responding councils just under two thirds said that they had written guidelines.

Thirty-three guidelines were received and reviewed: 26 guidelines from councils with over 100 care homes and a further seven guidelines from councils with fewer homes. The analysis focused mainly on 27 guidelines. These covered voluntary closures (13) or voluntary and emergency closures (14) and included 22 guidelines from councils with over 100 care homes and five from councils with fewer homes. Six covered either emergency closures or council run home closures only.

NATURE AND SCOPE OF GUIDELINES

The guidelines varied in scope, date, audience and length. About half covered both voluntary and emergency closures. Ten had been agreed jointly between health and social services. Dates ranged from 1994 to 2002. Some were drafts. Some were for a single audience, others for multiple audiences. Length varied from one to 71 pages. A third were two to six pages. Five were checklists and a further 14 included checklists.

Less than a third of the guidelines outlined aims and objectives. About half highlighted principles of good practice such as protecting service users' welfare, maximizing choice and minimising distress. Few considered measures to prevent closures; most focused on actions to be taken after notification.

LEGAL ISSUES

Just under half of the guidelines highlighted legal issues. These included:

- Councils could not expect registration and inspection unit staff to alert them about concerns they might have about the financial viability of a home;
- Councils do not have the power to move residents against their will;
- The registered person must give permission for records about residents to be moved;
- Council staff must not 'meddle' with the running of an independent home.

Advice differed about whether councils could pay existing care home staff or provide new staff to keep a home running for as long as possible. One guideline said it was not possible because it would make the council responsible for the care provided at the home and require registering a temporary manager, which could not be done. In contrast two protocols said it was possible to pay or to provide staff.

ALLOCATION OF RESPONSIBILITY

The allocation of overall responsibility varied and included a co-ordinating task group, the registration and inspection unit and a district manager in social services. Responsibility for

particular tasks also varied. For example, helping residents find new places was generally the responsibility of care managers but four guidelines said the person in charge of the home was responsible. Approaches to assigning care managers to closures included allocating: care managers who had assessed the residents before admission; an existing specialist team, such as a review team; a temporary team.

NOTICE

A quarter of the guidelines referred to the length of notice proprietors should give councils. A month or as much notice as possible was most commonly recommended. Recommendations about how residents and relatives should be notified varied and included:

- The form of notification should be discussed by social services staff with the proprietors;
- Staff from social services and registration and inspection should be present;
- Residents and/or relatives should be told as a group;
- The form of resident notification should be decided on an individual basis;
- Proprietors are responsible for resident notification;
- Care managers might have to tell residents if they have not been told;
- Residents should be notified in writing, not just told verbally.

ASSESSMENT OF RESIDENTS' NEEDS AND HELP WITH ARRANGEMENTS

Councils approaches to assessing residents' needs varied in terms of whether:

- Assessments were to be offered to all service users, or only to those whose needs had changed;
- Assessments were to be offered to all residents, or only to publicly funded residents.

Approaches to providing help to self-funding service users also varied. Some guidelines recommended offering assistance to all residents and/or relatives. Others said that help would only be offered to self-funded residents without relatives or to those who were unable to find accommodation unaided.

INFORMATION ABOUT VACANCIES

The guidelines referred to providing residents and/or relatives with lists of care homes, home brochures and/or inspection reports. Little was said about ensuring the quality or usefulness of this information.

About a third of the guidelines suggested how care managers might find vacancies. Some councils had a vacancy list. Others suggested care managers ask the contract department or phone homes.

Four protocols recommended that residents be given the opportunity to visit potential new homes.

TEMPORARY MOVES

Few guidelines commented on temporary moves. Those that did offered different advice. One suggested that temporary moves be arranged to allow residents to move out and wait until there is a vacancy at their preferred home. Another protocol described temporary moves as an option during emergency closures when time is likely to be short. Another advised that placements be permanent.

RESIDENT PREPARATION

Few guidelines discussed how residents might be prepared for the move other than making sure residents had been told. Only one protocol referred to the value of having residents visit a chosen home to become familiar with the new people and surroundings.

INVOLVING CARE HOME STAFF

Care managers were recommended to involve care home staff in about a third of the guidelines: to ask them to help, perhaps to record 'pen pictures' of residents for the new home, to keep them informed of arrangements, to respect their relationships and to allow staff to say goodbye to residents.

MOVING ARRANGEMENTS

Opinion differed about whether residents should ideally be moved in a short space of time or gradually over more than a week. Practical recommendations included: relatives should be asked to be present; evening and weekend moves and the use of taxis should be avoided.

PLACEMENT REVIEW AND PROCESS EVALUATION

Plans for reviewing residents in their new home rarely said whether all residents would be reviewed or only publicly funded residents. A minority planned to debrief care managers or to evaluate the process.

IMPLICATIONS OF FINDINGS

The range of responsibilities and procedures described in the guidelines suggests that guidelines are clearly needed if councils are to respond efficiently and effectively to home closures. Systems and plans need to be flexible so that staff can respond to different causes of closure, local circumstances and individual need. At the same time it would be sensible for certain procedures and responsibilities to be standardised across the country to ensure fair access to help and services. The variation in procedures was considerable, and some recommendations were contradictory.

It would be useful to establish which actions or measures are essential to successfully supporting residents and their families and/or carers, to safeguarding residents' health and safety, and to promoting collaboration between councils, residents and their relatives and home owners and their staff.

The extent to which a council can influence how an independent care home provider closes a home is unclear. It is also unclear whether the new requirements for notice of closure are practicable or enforceable by the National Care Standards Commission. There is a need to clarify councils' responsibilities and duties during a care home closure and the legal constraints on their actions.

Further Information

This summary and the full report are on the PSSRU website: www.PSSRU.ac.uk

- Jacquetta Williams and Ann Netten (2003) Guidelines for the closure of care homes for older people: prevalence and content of local government protocols (DP 1861/2)

Acknowledgements

We should like to thank all the local authority staff who kindly responded to our inquiry and who sent copies of guidelines and the Department of Health who funded the research. Responsibility for the report and this summary is the authors alone and the views expressed do not necessarily reflect those of the Department of Health.

The **PERSONAL SOCIAL SERVICES RESEARCH UNIT** undertakes social and health care research, supported mainly by the Department of Health, and focusing particularly on policy research and analysis of equity and efficiency in community care, long-term care and related areas — including services for elderly people, people with mental health problems and children in care. The PSSRU was established at the University of Kent in 1974, and from 1996 it has operated from three branches:

Cornwallis Building, University of Kent, Canterbury, Kent, CT2 7NF
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Appendix 4: Feedback summary 3 – Residents and relatives' perspectives

PSSRU

at the University of Kent,
the London School of Economics
and the University of Manchester

PSSRU Research Summary 27

Closures of Care Homes for Older People

Summary of Findings, No. 3
Relatives' and residents' views
October 2003

INTRODUCTION

This summary describes the process of care home closures from the viewpoint of residents and relatives. It focuses on their suggestions for improvement. The way in which a home is closed can influence how residents are affected so it is important to find out what happens, and which courses of action are in residents' best interests. Understanding residents' and relatives' experiences is clearly an important part of understanding what happens during home closures, their impact and how the process might be improved in the future.

The research summarised here is part of a wider project, funded by the Department of Health, which is investigating the closure of care homes. It presents an opportunity for policy makers, regulators, councils and providers to draw on the views of older people and their relatives.

RESEARCH AIMS AND METHOD

We wanted to explore:

- The process of care home closure from the viewpoint of residents and relatives.
- Their recommendations for improving the management of care home closures.

Thirty-five relatives and/or carers and 10 residents were interviewed about their experiences. Information was collected about 43 residents linked to fifteen closures. Eight closures were identified as case studies and investigated by interviewing those involved. 28 relatives and carers and 10 residents were interviewed 4–6 weeks after these closures. A further seven relatives were interviewed about other closures to widen the range of experiences included.

THE CLOSURES

The eight case study homes closed in 2002. They were in five local authorities: two shire county councils, two metropolitan district councils and one shire unitary authority. Two of the other closures experienced by relatives were in other areas, both metropolitan district councils. The homes were all in the independent sector and were closed for financial/business related reasons. They included different types of care home and varied in size.

The way in which the homes closed varied considerably in terms of length of notice, how residents and relatives found out about the closure and the amount of help residents and relatives received from proprietor(s) and care managers.

THE INTERVIEWEES

The average age of the residents was slightly older than the national average, at 87 years compared with 85 and about three quarters were women. On average the residents had lived in the closing homes for 27 months. Slightly more of them, 72%, were publicly funded compared with 66% among the national population of care home residents.

The majority of the relatives were the children of the residents although a variety of relationships were represented including friends as well as other family members. Some were retired. Some lived near to the closing home and others lived some distance away.

TYPE AND PATTERN OF MOVE

The pattern and nature of the residents' moves varied. Six publicly funded residents moved to placements offering higher levels of care than that in the closed home. In five

THE RESEARCH TEAM

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cases this was a result of assessments undertaken upon notification of the closure. Eight residents experienced multiple moves: four residents moved to temporary placements until there was a vacancy in their preferred home; two moved again as the new home was unsatisfactory or unacceptable; two residents moved rooms in the new home.

Some relatives felt forced into accepting temporary placements. Two said the placements provided inappropriate care. Others worried that they might have to accept a temporary placement and associated them with further stress and confusion for residents:

> 'I didn't want my mum to go somewhere just as a slot ... It is too much upheaval.'

> 'I got panicky about not finding anywhere and she might end up in a temporary bed somewhere.'

NOTIFICATION

Notice periods varied considerably. Notice at the case study closures included a month, eight weeks, five months and over a year. Notice at the other closures ranged from two months to three weeks.

People found out about the closures in a variety of ways, including letters, group meeting, rumours at the home and the local press. Some relatives would have liked some prior warning of the possibility of closure.

Relatives' and residents' main concerns on hearing that a home was closing were to find vacancies and to find an appropriate new home.

Relatives were not always told whether residents had been notified. About a quarter said it was left to them to tell residents. Deciding how to do so was difficult. They worried about how and what to tell residents so as to minimise their distress. Some chose not to tell residents with cognitive impairment. Others decided to tell them that they were moving, but not that the home was closing.

A few delayed telling residents until a new place had been found.

> 'I was mortified as to how we could tell her.'

> 'We didn't know how to do it.'

> 'We just said she was going somewhere to make her feel better.'

Relatives' and residents' recommendations

- Notice should be no less than two months.
- Notice should be flexible where possible.
- Relatives should have the opportunity to talk to the home owner(s).
- Owners should notify councils quickly so they can respond promptly.
- Notice should include the reasons for closure; reassurances that places are available; indicate what is expected of relatives.
- Ideally providers should talk to relatives before the closure decision and involve them in attempts to find an alternative.

INFORMATION, HELP AND ADVICE

Information, help and advice from staff at the home and from social services departments was valued, as was co-operation between the provider and care managers. Residents spoke of wanting to be involved and relatives wanted to make sure they found the most suitable new home. Experiences of help from the owner or staff at the home varied:

> 'They were there to talk to and to question if you wanted to... I think it was all handled well.'

> 'I never really saw the matron much. Nobody seemed to say much at all, it was funny.'

The level and nature of information, help and advice offered by care managers varied across and within closures and local authorities and among both public and self-funded residents. Experience of support from care managers ranged from very helpful to extremely limited:

> 'I don't think I could have had any more help from the social worker.'

> 'If it hadn't been for this care manager I wouldn't have known where to start.'

> 'I think somebody in the early days got in touch with me... but then that's the last I heard.'

> 'You were left to your own devices.'

The provision of assessments of residents' needs varied among publicly and self-funded residents. About two fifths of the interviewees said a care manager had conducted an assessment. Just under a quarter, including publicly funded residents, said there had not been an assessment.

To find vacancies and choose a new home relatives and residents needed timely and useful information. A range of sources were used: council produced lists of homes; advice from care managers or home staff; personal recommendations; the Yellow Pages. A lack of information about vacancies was unhelpful and some found information about homes insufficient:

> 'It is no good sending people willy nilly to different places... Because you are wasting our time... They should have places ready.'

Relatives' and residents' recommendations

- Providers should be open and tell people about any changes, such as changes to the timescale
- Care managers should contact relatives and identify the support they need.
- Vacancy information should be available, and provided when the closure is announced.
- Councils should provide more information about care homes and what they offer.

VISITS TO NEW HOMES

Thirty-one of the 35 relatives and four of the interviewed residents had visited homes before making a decision. A variety of people arranged visits. After having visited and made a decision about a new home none of the residents visited as preparation for the move, to familiarise themselves with the new people and surroundings.

Relatives' and residents' recommendations

- Someone they know should accompany residents.
- Residents should be able to influence the nature and length of visits.
- Residents' views should be listened to.

CHOICE OF HOME

If a publicly funded person in need of residential care has indicated that they want to receive care in a preferred home councils in England are required by law to arrange for care in the place of their choice, given certain conditions. Of the 28 publicly funded residents or relatives asked nearly two thirds said the new home reflected their choice. Over a third said the home had been suggested to them rather than selected by them. Some said there was no choice.

Choice of home was restricted by a number of factors: insufficient information about vacancies and homes; insufficient number and range of homes; time pressure; delays in assessments; lack of information about the process for arranging accommodation and about publicly funded residents' right to choose a home.

MAINTENANCE OF STANDARDS

The care provided at the closing homes was described as good at five homes and as unpleasant, upsetting or unacceptable at three homes:

> 'The two nurses stayed on right until the end... they couldn't have been better.'

> 'I felt if she had an accident, how would they know?'

Falling standards and fear for residents' health and safety were associated with staff reductions and the loss of management. Preserving the physical environment was also important:

> 'Furniture was being emptied and piled up, sort of around those still living there... It didn't seem to be a home anymore.'

> 'Furniture was being sold and carried out and there was a sense of closure and turmoil.'

Relatives' and residents' recommendations

- Standards of care should be maintained: familiar routines should continue; levels of cleanliness should be upheld; residents' daily lives should be kept as 'normal' as possible.
- Staffing levels and management should be maintained and ideally existing staff employed throughout the closure period.
- Obvious signs of packing should be minimized.

MOVING

The move was a source of anxiety and distress for some families and carers, concerned about the potential affect on residents' health. Some described the move as well organised, others as disorganised or carried out without any help. Relatives were unsure about how to prepare residents while also protecting them from

distress, particularly those with a cognitive impairment:

> 'She was going into the unknown. So how can you help them through that? I really don't know.'

Relatives' and residents' recommendations

- Practical help should be made available.
- Packing, transportation and unpacking should be planned.
- Someone known to them should travel with residents.

SETTLING IN

No health problems were reported for 61% of the residents and about half were said to have settled. The health of about 19% of the residents was said to have deteriorated and 21% were unsettled or confused. Six of the residents died between ten days and seven months after relocation. Four of these residents died within three months of leaving the closed home. This represents a smaller proportion than the number of older people likely to die in the first three months following admission to a care home. However, the study was not designed to investigate links between closures and residents' health.

Three residents were said to be happier or to prefer the new home.

Relatives' and residents' recommendations

- Staff at the new home should be told that residents have experienced a home closure and be sensitive to how their needs might differ from those admitted from elsewhere.
- Ideally there should be a staff member dedicated to looking after the resident and their families/friends on arrival.
- Residents should meet their key worker on the first day.
- Residents should be shown around.
- Residents should be able to spend time with other residents or staff from the closing home.

KEY MESSAGES

This research suggests that councils need to have plans or systems to manage all types of home closure. The relatives and residents received different levels of help across and within the closures studied. Councils need to offer efficient, timely and consistent help, which responds to individual's needs and protects residents' best interests and health and safety. The fall in standards of care sometimes experienced raises the issue of whether regulation is sufficient or enforceable.

Councils need to address limitations on residents' and relatives' involvement and their ability to make decisions. Key restrictions were a lack of information and appropriate places.

Further Information

This summary and the full report are on the PSSRU website: www.PSSRU.ac.uk.

- Jacquetta Williams, Ann Netten and Patricia Ware (2003) The closure of care homes for older people: relatives' and residents' experiences and views of the closure process (PSSRU Discussion Paper 2012).

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The **PERSONAL SOCIAL SERVICES RESEARCH UNIT** undertakes social and health care research, supported mainly by the Department of Health, and focusing particularly on policy research and analysis of equity and efficiency in community care, long-term care and related areas — including services for elderly people, people with mental health problems and children in care. The PSSRU was established at the University of Kent in 1974, and from 1996 it has operated from three branches:

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Appendix 5: Feedback Summary – Care managers' perspectives

PSSRU
at the University of Kent,
the London School of Economics
and the University of Manchester

PSSRU Research Summary 32

Closures of Care Homes for Older People

Summary of Findings, No. 4
Care managers' experiences and views
July 2005

INTRODUCTION

This summary reports care managers' activities and their views of helping older people relocate when their care homes closed. Little is known about how independent sector homes are closed by owners, or people's views about what happens. The nature of the process is important as it may influence how residents are affected by these moves.

Before older people move to a care home for the first time councils have a duty to conduct a full needs assessment; older people have a right to this irrespective of their financial circumstances. During a care home closure, councils' care management responsibilities are less clear. There is little national policy guidance specific to the situation.

Councils have a responsibility to help arrange alternative care for publicly-funded residents, and to offer information and support to those funding their own care (self-funders). However, local guidelines are patchy and policies and plans differ.

The research was part of a wider project, funded by the Department of Health, which investigated the process of care home closure from the viewpoint of residents and relatives, care managers and care home staff. Earlier work looked at the causes and consequences of closures.

RESEARCH AIMS AND METHOD

We wanted to identify:

- What care managers do during a care home closure.
- Care managers' recommendations for improving practice.

A case study approach was used to explore in detail people's experiences of eight home closures. These findings focus on interviews with 24 social services staff, in four local authorities: 16 care managers/assistants, five team managers and three senior managers. Seven of the care managers also kept a diary/log of their activities to identify the broad nature and scale of their closure related work.

THE CLOSURES

The eight homes closed in 2002 for a variety of financial-related reasons. They included six residential homes, one nursing home and one dual registered home. One was registered for care for older people with dementia and another for older people with mental health problems. Seven were in the private sector and one in the voluntary sector. The number of places ranged from 17 to 38.

The care managers said the closures went relatively well, although the way in which they closed varied considerably and some residents moved again soon afterwards.

CARE MANAGERS' AIMS

During a care home closure the care managers aimed to:

- Identify residents' needs.
- Help residents and relatives understand their options and make informed choices.
- Help relocate residents to appropriate alternative placements.

Views differed about their responsibility for some matters, such as influencing the way in which residents were notified and providing support to care staff at closing homes.

THE RESEARCH TEAM

Jacquetta Williams and Ann Netten at the PSSRU, University of Kent, and Patricia Ware at the Nuffield Institute for Health. The project secretary is Lesley Cox (01227 823963; e-mail L.A.Cox@kent.ac.uk).

THE TEAMS

Organisational arrangements varied. Staff in social services offices based in the same geographical area as the closing home usually took responsibility for overseeing the relocation of publicly-funded residents. Staff were sometimes drawn from across and sometimes from within existing teams. Some care managers were allocated residents they had not met or worked with before.

The number of care managers involved in each closure ranged from one or two, to over 11. This depended on the length of notice, staffing capacity and the number of residents. Sometimes care managers from other authorities were involved. Each care manager was allocated between one and eight residents.

At one authority, care managers helped to relocate individual residents from multiple closures, more or less simultaneously. This team worked on closures only at evenings and weekends, on top of their usual duties.

The activity logs showed that care managers could spend the equivalent of seven days, over a nine to 14 week period, working on one home closure. Generally, the majority of this time was spent before residents moved. The average time spent on each resident ranged from 4.5 hours to almost five times that much.

THE WORK

The work was conducted without local policy guidance; only one person knew of any and that was a draft. The tasks that absorbed the most time varied: some spent up to half their time on administration, others spent this amount of time communicating with residents, their relatives and home staff.

The work could be stressful. Care managers saw closures as possibly endangering residents' health. Some spoke of feeling responsible for and concerned about how residents' might be affected, and some were worried about being held responsible if anything went wrong or someone died.

Aspects of the work described as stressful included not being able to give people their first choice of home, the general lack of choice, having to 'fight for everything', such as council payment of a higher fee levels, the pressure put on existing work; and encouraging people to look at homes that, given more vacancies, they might not otherwise have had to consider. Tensions between the aims of finding the most suitable home for residents while promoting their choice of home were highlighted.

Situations that were identified as particularly frustrating included being unable to recommend specific homes or comment on their quality, unable to object if a resident or relative chose a home they did not think was the most appropriate, or to do very much if a resident appeared to be 'giving up' on life afterwards.

Administration was considerable, but much of it consisted of routine forms and procedures. Needs assessment work was said to differ from usual due to the number of people who needed be to assessed in a short time, which was particularly difficult when care managers had not met residents before.

The provision of assessments varied across areas in terms of who was assessed, the level of assessment and use of specialist input. In some places assessments were not carried out if a resident had been living in a home for less than a year, or assessed recently.

Policy and practice towards assessing self-funded residents varied; in some areas self-funding residents were not offered an assessment and in others they were if they had no relatives, had high level needs, or their financial circumstances would mean they would soon be eligible for public funding.

The timing of assessments were not always ideal. One resident was assessed on the day he moved.

The care managers sometimes asked the council to fund a new placement at a higher rate than paid to the closing home, at a higher rate than the standard, or to pay an additional third party top-up payment. Decisions were usually made on an individual basis, but reasoning varied across the councils.

Other procedures that varied and were often managed in an informal way included the identification of vacancy information, and arrangements for managing the demand for vacancies in care homes from people wanting to move from hospital and people in their own homes, as well as those at closing homes.

The care managers described offering support and advice to residents and families, particularly about finding an appropriate new home. Extensive negotiations could involve balancing the perspectives of residents, relatives, the

'old' and 'new' homes, the finance department and the care managers' own priorities and concerns. This could involve emotional counseling and inter-personal skills, as well as practitioner and local knowledge. Those who had poor health, or no relatives and who were publicly-funded tended to receive the most support.

Choice of home was limited in each council. To help people make timely decisions about a new placement care managers encouraged them to focus on vacancies rather than homes, and to review the locations they were prepared to move to.

Approaches to follow-up were similar across the councils; care managers conducted reviews four to six weeks after a resident moved. This was sometimes too soon to tell if a resident had settled, or a placement was suitable. Reviews were seen as important and rewarding, but under-resourced.

CONSTRAINTS

Multiple constraints were identified, some within a councils' control and some external to it. External constraints included:

- Short closure notice periods.
- A lack of local care homes and vacancies.
- A lack of homes that provide for older people with dementia, challenging behaviour, or mental health problems.
- Owners of new homes who changed their minds about to whom to give a vacancy.

Constraints linked to council policies included:

- Internal systems, such as contracts with transport providers, authorisation procedures and postal systems.
- Restrictions on care managers' advice about specific homes.
- The inability to block book temporary placements in local authority homes, due either to their closure, or use as hospital step-down places.

VIEWS OF GOOD PRACTICE

Care managers' recommendations for good practice by home owners, care managers and councils are summarised in the box.

Views differed about the value of guidelines; some said they would support practice development and accountability, and others that they were unnecessary.

Advocacy was identified as important. The care managers clearly tried to represent and advocate for residents' best interests, and highlighted the need for an independent point of contact for residents as an alternative source of support to home staff or relatives.

The need for ring-fenced resources to manage closures was highlighted by a senior manager. She suggested that resources should be made available to ensure that an emergency council team could go into a home and ensure that it stayed open for a reasonable period to allow residents to be relocated appropriately. Suggested sources included the regulator, or a form of insurance taken out by homes 'like ABTA'.

Care managers' recommendations

Care homes

- Owners of closing homes should give two to three months notice.
- Closing homes should ensure new homes have information about residents' likes and dislikes.
- Staff at new homes should be sensitive to the needs of older people who have experienced a home closure.

Care managers

- Relatives should be kept informed.
- Working collaboratively with homes is important.
- Moving residents quickly is best if home staff start to leave.
- Appropriate transport should be used to ensure a safe transfer.
- Residents should be accompanied on the journey by someone known to them.

Council policies

- Small teams support communication and should be put in place quickly.
- There should be greater flexibility in the timing and frequency of reviews.
- Better vacancy information should be available.

KEY MESSAGES

The research found that managing the relocation of publicly-funded residents during care home closures could involve considerable amounts of care managers' time. Some care management arrangements varied and sometimes this had implications for service users' continuity of care and access to support. Local guidelines could ensure greater consistency in the provision and development of good practice.

Policy guidance on how councils and care managers can resolve potential tensions between their aims during care home closures would be helpful.

The research suggests that the care managers' professional knowledge, experience and skills meant they were well-placed to provide help and support to older people, and their families, during care home closures. Improved practitioner discourse would be useful in some areas, such as how best to support older people with communication difficulties.

Further Information

Other summaries of research investigating care home closures, and associated reports are available on the PSSRU website, www.PSSRU.ac.uk, and include:

- Closures of Care Homes for Older People, Summary No. 1 (2002)
- Local Government guidelines, Summary No. 2 (2003)
- Relatives' and residents' views, Summary No. 3 (2003)

Published articles (also accessible via the PSSRU website) include:

- Williams, J. and Netten, A. (2005) English local authority powers, responsibilities and guidelines for managing the care home closure process, *British Journal of Social Work*.
- Netten, A., Williams, J. and Darton, R. (2005) Care-home closures in England: causes and implications, *Ageing and Society*, 25, 3, 319–338.
- Netten, A., Darton, R. and Williams, J. (2003) Nursing home closures: effects on capacity and reasons for closure, *Age and Ageing*, 32, 3, 332–337.

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The **PERSONAL SOCIAL SERVICES RESEARCH UNIT** undertakes social and health care research, supported mainly by the Department of Health, and focusing particularly on policy research and analysis of equity and efficiency in community care, long-term care and related areas — including services for elderly people, people with mental health problems and children in care. The PSSRU was established at the University of Kent in 1974, and from 1996 it has operated from three branches:

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E-mail: PSSRU@kent.ac.uk Website: http://www.PSSRU.ac.uk

Appendix 6: Resident interview guide

The aims of the interview are to:

- **Find out about your experience of a care home closure**
- **Identify any additional questions we should be asking residents - so that the research reflects what matters to residents**

Information will be treated in confidence and will be anonymous.

Date of interview: _____ Check date of closure: _____

Name of closed home:

_____

Name of interviewee:

_____

Gender _____ Date of Birth/Age _____

Summary of main questions

1. How do you feel about the closure of [name of closed home]?

2. How did you find out that the home was closing? When was that?

3. What were your main concerns? What were you most worried about?

4. Was there someone you could talk to about any worries or concerns?

5. What was it like trying to find another home?

6. Did you have a say in what happened? [i.e. Did you feel you had any choices, options or decisions? Did you feel that you could influence what happened and/or when? E.g. consider options such as the home, or the date of the move date?]

7. When you were looking for a new home, what was important to you? What were your preferences? Why is that?

8. Was the location important to you? How does the location of [new] compare with [closed home]?

9. When did you move? [*Compare to closure date and when told of closure.]*

10. What, if any, were your main worries or concerns about moving to [name of new home]?

11. Before the closure, did you feel at home in [name of closed home]? Why is that?

12. Do you feel at home now in this home? Why is that?

13. What have been the main effects of the home closure for you?

14. Looking back at the way in which [name of closed home] was closed, what was managed well? E.g. were you kept sufficiently informed about what was happening?

15. What, if anything, could have been improved, or managed better?

16. What is the most important thing to residents when a home closes?

Detailed Guide:

1.1 How long had you lived in [Name of closed home]? _____

1.2 Was it the first care home you had lived in? – Yes No

a) **If no**, how many other homes have you lived in? _____
b) How long have you lived in care homes? (Does that include/exclude time spent in closed home?)

2. How do you feel about the closure of [name of closed home]?

3. How did you find out that the home was closing?

3.1 How (and by whom) were you told?
3.2 How did you feel when you heard?
3.3 What did you think about the way in which you were told?
3.4 Were you given all the information you wanted?

3.5 **When** did you find out that the home was closing/what was the length of notice?

_____

3.6 How did you feel about the length of notice you were given?
3.7 How much notice would you have preferred? Why?

3.8 What if anything, could have been changed or improved about the way in which you were told about the closure?

4. What were your main concerns? What were you most worried about?

4.1 What might have helped?

4.2 Was there someone you could talk to about your concerns? Who?

5. What was it like trying to find another home?

5.1 **Did you have a say in what happened?** Did you feel that you had any options, choices or decisions to consider? **Did you feel that you could influence what happened** and/or when? [e.g. choice of home, date of move?]

5.2 How did you go about identifying possible homes?

5.3 **Who** helped?
5.4 What sort of help and advice did they give?
5.5 What involvement have your family had?

5.6 **What did you want to get out of the move? What were your preferences?**

5.7 How much **choice** was there? How many homes did you/your relative(s) consider?

5.8 [If appropriate] What was the **most important influence** on the decision /choice of new home?
What helped you to decide? What was most important?

5.9 What **sources of information** did you use? [e.g. Did you look at home brochures?]

5.10 Did a nurse or social worker talk to you about moving to another home?
5.11 What was that like?

5.12 Did people from other homes come to meet you?
5.13 What was that like?

5.14 Was there an opportunity to **visit** any homes?
5.15 IF YES: Can you tell me what happened when you visited?
[How much time did you spend there? Did you talk to residents? Did you talk to staff?]
5.16 Was the visit helpful?

5.17 When did you know/have it confirmed that you would be moving here?

_____

5.18 How was the decision made? (i.e. on what basis? and, who made the decision?)
5.19 Was there sufficient time to make a decision?
5.20 Was there sufficient information to make a decision?

5.21 Did the decision (this home) reflect your preferences, views?

5.22 Is there anything that could have been done to make the time between finding out about the closure and moving easier for you?

5.23 Is there anything you would have liked to have happened, that didn't?

6. When did you move out? [*Compare to closure date.]* _____

You moved out [before the home closed OR just as the home was closing]…

6.1 Why was that? (Why did you move early OR move as the home was closing?)
6.2 What happened?
6.3 How did you feel about it?

[If not already clear]
6.4 Did most people move out around the same time?
6.5 How did you feel about that?

6.6 Who helped you to move?

6.7 Did you have any preferences about how you wanted to move?
6.8 Did the move go as you would have liked?

6.9 Was there anyone you wanted to say goodbye to? (e.g. other residents, staff)
6.10 Was there an opportunity to say goodbye to them?

6.11 Is there anything that could have been done to make the actual move easier for you?

7. What were your main worries or concerns about moving to [name of new home]?

7.1 What happened when you arrived?
Did staff welcome you?
Was your room ready?
Did your things arrive safely?

7.2 What would have made moving in easier for you? [In an ideal world...]

7.3 It can take time to settle into a new environment - Was there someone you could talk to about your feelings and worries during this period?

7.4 **Looking back** at the way in which the home was closed **were you kept informed about what was happening?**

7.5 Again, thinking about the way in which the home was closed, what was most important to residents?

7.6 What is most important in terms of how residents are told about a home closure?
7.7 What is most important in terms of finding and selecting a new home?
7.8 What is most important in terms of the move itself?
7.9 What is most important in terms of how residents are received in new homes after a closure?

I now want to ask you some questions about the closed home

8. Was the location of the [name of closed home] important to you?
8.1 Was the home close to where your relatives live?
8.2 Was the home close to where you had lived?
8.3 Explore definition of 'close to' and whether (and how) location was important

9. Did you feel at home when you lived at [name of closed home]? Why was that?

9.1 What did you like the most about the closed home?
9.2 Why is that important to you?

9.3 What did you dislike the most about the closed home?
9.4 Why is that important to you?

9.5 What was good about the care provided at the closed home?
9.6 Why is that important to you?

9.7 What, if anything, was bad about the care provided at the closed home?
9.8 Why is that important to you?

10. What have been the main effects of the home closure for you?

10.1 How many friends did you have in the closed home?

10.2 How would you describe your relationship with staff at the closed home?
E.g. Did staff treat you with respect?
Could you confide in staff?...

Turning to this home...

11. Do you feel at home in this home? Why is that?

11.1 Would you describe yourself as having settled in? Why is that?

11.2 Did you already know of this home? How/what did you know?

11.3 Did you know anyone here when you moved in?

11.4 Did any of the staff from [name of closed home] come to work here? How do you feel about that?

11.5 Did any of the other residents from [name of closed home] move here? How do you feel about that?

12. Is the location of this home important?

12.1 Is this home near to the closed home? How important is this?

12.2 Is it near to where your relatives live? How near? How important is this?

12.3 Is it near to where you had lived? How near? How important is this?

[Explore definition of 'close to' and how location was important]

12.4 What do you <u>like the most</u> about this home?

12.5 What do you <u>dislike the most</u>, if anything, about this home?

12.6 What is good about the care provided in this home?

We want to make sure that the project includes issues important to residents

13. Is there anything about your experience of a closure that has been missed out in this interview? Anything else you would like to say?

14. Is there anything we should make sure we include in interviews with other people who experience a home closure? E.g.
    - Any areas of concern?
    - Are there any additional issues we should be asking about?

Would you like a summary of the research findings? Yes No

Confirm contact details [e.g. address of this home]:

IF THE INTERVIEWEE HAS NOT ALREADY BEEN ASKED FOR PERMISSION TO SEE A COPY OF THEIR ASSESSMENT AND REVIEW – PLEASE ASK NOW AND REQUEST SIGNATURE ON FORM.

As part of this study we would like permission to see a copy of the assessment and review of your care needs, made by the social worker before and after you moved. Records will be treated as confidential and your name will not appear in any reports…

Thank you for taking the time to talk to me today.
We will send you a summary of the findings when they are available.

Appendix 7: Relative interview guide

The aims of the interview are to

- **Find out about your experience of a care home closure**
- **Identify any additional questions we should be asking relatives - so that the research reflects what matters to relatives and carers**

Information will be treated in confidence and will be anonymous.

Date of interview: _____

Name of closed home/ case study:

_____

1.1 The relative who had to move was your (mother, father…)? _____

1.2 How are they?

1.3 How old are they? _____

CHARACTERISTICS OF CLOSED HOME (In case study interviews – skip to Q. **2.6**)

I'd like to spend the first 5 minutes asking some factual information about the closed home.

What sort of home was it? 2.1 Residential, nursing, dual registered, EMI
2.2 Private, voluntary, local authority

2.3 When did the home close/the home closed on…? _____

2.4 How many places did the home have? <3 4-9 10-19 20-30 30-50 50-70 70-90 >90

2.5 Was the home part of a group of more than one home?

YOUR RELATIVE

2.6 People go into a care home for various reasons – because they need personal care or are suffering from an injury or Alzheimer's. Can you tell my why (name) went into the home?

2.7 Did they receive any help from the local authority in paying their fees?
a) Did they/you pay a top-up?

2.8 How long had (name) been living in the home before it closed / when did they move in /how old were they when they moved in? _____

2.9 Was the closed home their (or your) 'first choice' when you were looking for a home? Yes No
a) Were you involved in choosing the home? Yes No
b) How easy was it to find a home? What were your main criteria?

2.10 Was it the first care home they had lived in? – Yes No
b) **If no**, how many other homes had they lived in?
c) How long have they lived in care homes? (Does that include/exclude time spent in closed home?)

2.11 Where was the home? a) Was the home close to where your relative had

lived?

(Case Study Relatives Go to a) b) Was the home close to where you live?

c) Explore definition of 'close to'

2.12 Did they have their own room/ or share?

2.13 What did your (name) <u>like the most</u> about the closed home?

a) Was there anything <u>they disliked</u> about the closed home?

I'd like to move on to talk about the home closure and the move

- **starting with how you were told about the closure**
- **finding another home**
- **and then the move itself and settling in**

CLOSURE ANNOUNCEMENT AND LENGTH OF NOTICE

3.1 When were you told the home was closing (Length of notice)? _____

3.2 How (and by whom) were you told about the closure?

a)	Was a meeting organised? Who by?	Yes	No
b)	Did you receive notification in writing?	Yes	No
d)	Were you offered an individual private discussion? Who with? Helpful?	Yes	No
e)	Had you previously been told that closure was a possibility?	Yes	No

3.3 What were you told?

a) Were you told why the home was closing? Yes No

b) Were you told the closure date? Yes No

3.4 What was the reason for the closure? (Probe for as many details as possible)

3.5 Were you told before your relative was told? a) When were they told?

3.6 How were they told?

a) How did they react to the news?

b) Could the way they were told have been done better, and if so how?

PREPARATION

4.1 Was you offered any support or reassurance?

a) Who by?

b) What were your worries, anxieties?

4.2 Was your relative prepared for the move?

a) Was support offered? What kind?

b) e.g. Emotional support? Counselling?

4.3 Who was the main person in charge of organising the closure? (Home manager, SSD, R&I Unit?)

4.4 Who else did you have contact with?

a) SSD?

b) GP?

c) Advocacy service?

d) Registration and Inspection unit?

e) Other agencies or charitable organisations?

4.5 Was your relative's health re-assessed by a social worker or nurse? Yes No

4.6 Did your relative have a care manager allocated to them? Yes No

4.7 What might have helped to better prepare <u>your relative</u> for the closure and move?

4.8 What might have helped to better prepare <u>you</u> for the closure and move?

FINDING ANOTHER HOME

5.1 In what ways did you get involved in finding another home?
   a) How much time did you spend helping?

5.2 What was it like trying to find another home?
   a) What sources of information did you use?
   b) Who provided it?
   c) What sort of help and advice were you given?
   d) Who from?

5.3 Did you or your relative visit potential homes? Yes No
   a) Did anyone help arrange visits? Who? Yes No

5.4 What was the most important influence on the decision /choice of new home?

5.5 Was the new home your relatives (or your) 'first/preferred choice'? Yes No
   a) **If No** – What happened?

5.6 How did looking for a new home compare to when you selected the home (that closed)?

THE CLOSURE AND MOVE

6.1 To recap - How long did the closure take from the announcement? (weeks/ months?)

6.2 How was the closure itself handled?
   a) Did residents leave on the same day or was it more gradual?
      i. How did your relative feel about this?
   b) Did residents move
      i. all together to one new home?
      ii. in groups to a couple of homes?
      iii. individually?
   c) Did **staff** start leaving?
   d) Did new staff have to come in?
   e) When did your (name) move out? - i.e.
      i. before the home actually closed?
      ii. or on the day?
   f) Did your (name) have a chance to say farewells to friends and staff in the home?
   g) Was this important to them?

6.3 What help did you get with the actual move and who from?
   a) Who packed belongings?
   b) Who made sure there was sufficient medication, if needed?
   c) Who organised the transport – what was it?
   d) Did belongings arrive in one piece? Was anything lost or broken?

SETTLING IN & LONGER TERM ADJUSTMENT

7.1 How did your relative settle in, in the short term (first month or 6 weeks)?

a) Were they offered any support to help them settle in? Yes No
b) **If yes**, what sort of support and who from?
c) **If no**, what would have been helpful?

7.2 Were you invited to an evaluation meeting – to explore the impact of the closure on residents and relatives like yourself? Yes No
a) Did you make any suggestions or complaints? Yes No

[SKIP 7.3 with Case Study relatives]

7.3 In the longer term, did your relative settle in? (Move again? What problems, if any were there?)

7.4 Was information about your relatives care passed on from the closed home to the new home?

7.5 Did your relative have to change

a) Social worker/care manager	Yes	No	d) **If Yes**, Who arranged these changes?
b) GP	Yes	No	
c) Consultant	Yes	No	

7.6 Were there implications for financial arrangements or any financial difficulties?
a) E.g. Were charges more costly? Top-ups?
b) E.g. Did you have to pay the first month's fees in advance?
c) E.g. Did you have to buy new things?

7.7 Were there any other consequences following the closure and move?

GENERAL VIEW

8.1 How did you feel about the home closure - at the time?
a) and now?

8.2 What was most difficult about the closure <u>for you</u>?

8.3 What was most difficult <u>for your relative</u>?

8.4 What were the main positive aspects, if any, of the experience? E.g. was anything handled well?

8.5 What could have been changed or done better?

8.6 Was there anything that could have been done, that wasn't?

I'd now like to ask some factual information about the new home

What sort of home is/was the new home?

9.1 Residential, nursing, dual registered, EMI
9.2 Private, voluntary, local authority

9.3 What were the main differences between the old and new homes?

9.4 How many places does the new home have? <3 4-9 10-19 20-30 30-50 50-70 70-90 >90

9.5 Is the new home part of a group of more than one home?

9.6 Do they have their own room/ or share?

9.7 What do they like the most about the new home?

9.8 What do they dislike the most about the new home?

9.9 How satisfied are you with the new home?

9.10 How does the new home compare to the closed home in terms of:

a) accommodation?
b) quality of care?

9.11 Where is the new home?

- Close to where your relative had lived?
- Close to the old home?
- Close to where you live?
- Explore definition of 'close to'

9.12 Looking back at how the home was closed and

a) How you were told … What is it most important to get right?
b) The process of finding another home … What is it most important to get right?
c) The move itself … What is it most important to get right?
d) Settling in … What is it most important to get right?
e) And the consequences … What is it most important to get right?

REVIEW OF INTERVIEW QUESTIONS

We want to make sure that issues important to carers and relatives are included in future interviews and possibly a larger study - and I'd like you to help by telling me what you think about the questions I've asked.

10.1 Is there anything about your experience of a closure that has been missed out in this interview?

a) Is there anything we should include in interviews with others? E.g.
- Any areas of concern?
- Are there any additional issues we should be asking about?

10.2 Have you any other advice or suggestions about how interviews should be carried out?

WAYS TO INVOLVE RELATIVES IN A LARGER STUDY?

Now I'd like to ask you about some of the possible ways of involving carers and about when and how we might contact them. Home closure can be very emotional …

11.1 When would be the best **time** to try to talk to relatives/carers?

a) How long after home closed? 3 weeks, 6 weeks

11.2 Would you have been prepared to complete a **questionnaire**?

a) How much time should we leave after a closure before sending questionnaires to relatives?
b) What are the main things we should bare in mind if we design a questionnaire?

11.3 If a letter was passed to you, possibly via the owner or care manager, would you have minded being **telephoned** by a researcher?

11.4 If we interviewed **residents** of homes that were closing/closed – what do you think we should take into account?

a) Would there have been an acceptable time to talk to your relative before the closure (Are we right in thinking that it is too upsetting a time to try to talk to residents)?

b) When would be the most sensible time to talk to residents after a closure?

c) What would be the best way to invite residents to take part in the research? (via owner, care manager, or relatives?)

d) In your view, what would be the best way to involve residents when researching home closures?

11.5 What should we make sure we ask residents about?

11.6 Is there anything else you would like to say about your experience or views about the home closure?

11.7 **If appropriate**/not already discussed – Do you think your relative would like to talk to us?

Thank you for taking the time to talk to me today.

Would you like a summary of the research findings? Yes No

Confirm contact details:

Appendix 8: Care manager interview guide

To understand the process and consequences of home closures the aims of the interview are:

- **to discuss your experience of independent home closures, both voluntary and enforced, and**
- **to identify issues relating to good practice**

Information will be treated in confidence and will be anonymous.

Date of interview: _____

Position of interviewee: [ ]

Contact details
[for summary]: [ ]

1.1 Can you briefly outline your overall role/ job description/ activities?

1.2 In general, on what basis are assessments and reviews of residents of care homes carried out?

1.3 How is the assessment workload currently managed?
a) Min-max caseloads? – ongoing cases separate to assessments?
b) How prioritised?

1.4 How are records stored? – Are records manual or computerised?

YOUR EXPERIENCE OF HOME CLOSURES

2.1 How many closures have you been involved in?

MANAGEMENT OF CLOSURES: ROLES, RESOURCES AND RESPONSIBILITIES

3.1 Which agencies get involved in the process of home closures?

3.2 Who / which agency takes the overall lead (e.g. SSD, R&I unit, home owner)?

3.3 Can you please outline your responsibilities in a home closure?

3.5 Is there usually a main contact at the home in charge of organising the closure?

3.6 Does your involvement with residents vary depending on whether they are **self-funders**?

3.7 Are you aware of any **legal issues**, which have to be taken into account when deciding how the SSD should get involved in independent home closures?
Yes No
a) **If yes** - What sort of legal issues are there?

PROTOCOLS

4.1 Are there any written protocols or guidelines for home closures? Yes No

4.2 **If yes**, how does the protocol or guideline work in practice? How do you use it in practice?

4.3 In what ways, if any, could it be improved?

4.3 **If no protocol** – what sort of guidelines or documentation would be useful?

First I'd like to review the case study closure in terms of what went well, possibly drawing on your record of activities for examples, if you have it with you.

CASE STUDY CLOSURE: REFLECTION

5.1 Looking back, what went particularly well? E.g. procedures, approaches?

5.2 Is there anything you would highlight as an example of good practice? Anything else?

5.3 What lessons or advice would you give to other social workers involved in a home closure?

Probe: Any advice about what to look out for, what to try to avoid, or what to ensure is done?

I'd now like to talk through the process of the closure in more detail, drawing on your record of activities where this is helpful.

NOTIFICATION OF CLOSURE

6.1 How did you find out that the home was closing?
a) **If experienced more than one closure**: Can the way you find out vary? Please give examples?

LENGTH OF NOTICE

7.1 What was the length of notice? (Clarify who was notified, when and confirm closure date)
a) Did the timescale change or remain the same? (home close later or earlier?)
b) **In your experience**, how can length of notice vary? Please give examples of short and long notice?

7.2 Does the length of notice affect residents?

a) **If yes** In what ways can a <u>short period</u> of notice affect residents?
Advantages and drawbacks? How much time is a short period of notice?

b) In what ways can a <u>long period</u> of notice affect residents?
Advantages and drawbacks? How much time is a long period of notice?

THE CAUSE OF CLOSURE

8.1 Does the reason for the closure influence how you get involved? If so, how?

PREPARATION OF RESIDENTS

9.1 Were you involved in how residents or relatives were told of the closure? *Please give examples?* 9.2 How do you think residents <u>should</u> be told?

9.3 Were you involved in preparing residents for a closure and relocation? If Yes-
In what way?
9.4 How do you think residents should or can be prepared for a closure and relocation?

9.5 How much contact did you have with relatives and carers during the relocation process?
   a) What sort of things did you do?
   b) What advice would you give to other social workers about contact with relatives during a home closure?

9.6 Did all residents have a care manager allocated to them (anyway? During the closure process?)

   a) On what basis are care managers allocated to residents/homes during a home closure?

9.7 On what basis are residents' care plans/needs assessed before relocation?
   a) Are self-funders' needs assessed or reviewed?

FINDING VACANCIES

10.1 Did you get involved in finding new placements for residents?
   a) **If yes**– in what ways?
   b) Did anything go particularly well?
   c) What advice would you give to other social workers about finding vacancies during a closure?

10.2 a) What sources of information are available about vacancies?
   b) Are there readily available lists of homes with vacant places? Yes No
   c) **If yes**, who produces it?
   d) Can relatives get copies of lists? Yes No

10.3 How much time can it take to find a new placement? Min and max. time?
   a) What factors affect the time taken (e.g. no. of residents, length of notice, preferences?)

10.4 How is the placement of clients from care homes that are closing, from hospital and from the community managed? (Are there waiting lists? How are clients prioritised, if at all?)

10.5 Did the majority of residents get to move to a home that reflects their (or their relatives) choice?
   a) When a new home does <u>not</u> reflect their choice, how is this dealt with?

10.6 In your experience, have residents moved again because the new home was not their first choice, or did not meet their needs?
   a) How often does this happen? (probe - common or unusual?)
   b) How long after the initial move do second moves usually happen?
   b) What do you think about temporary placements and multiple transfers? Why? (e.g. way of supporting choice or something to be avoided? – why?)

10.7 How, if at all, could the process of finding new placements be improved?

THE CLOSURE AND RELOCATION

11.1 Were you involved in the actual moving of residents (in terms of their last day)?
   a) **If yes**, in what way(s)? What is important?
11.2 What are the advantages of moving residents individually or in small groups over time?
11.3 And the disadvantages?
11.4 What are the advantages of moving residents together or over a short period of time?
11.5 And the disadvantages?

FOLLOW-UP AND EFFECTS ON RESIDENTS

12.1 Were residents assessed/reviewed after a move?

a)On what basis? e.g. is everyone?

b) When? – how long after moving in?

c)Could this information be used to track residents after a closure to see how they are?

d) Have you ever been involved in tracking residents? If yes, what did you do?

12.2 What sort of positive outcomes for residents, if any, can result from a home closure? *Examples?*

12.3 What sort of negative outcomes for residents can result from a home closure? *Examples?*

12.4 I'd like you to highlight what is most important to resident welfare at each stage of the closure process…[ask the following questions for each]

• The closure announcement	What about the announcement is most important to residents?
• Length of notice	What is most important about the length of notice?
• Preparation	Which elements of preparation are the most important to resident welfare? E.g. visits to new home? Information sharing?
• The new home?	What about the new home is the most important to resident welfare? E.g. Quality? Resident preferences?
• The way the actual move is managed?	What is most important to resident welfare? E.g. practicalities? Who meets them at the new home? Farewells?
• The settling in process	What is most important to resident welfare?
• The role of social services	What is most important to resident welfare? E.g. working relationships & procedures with providers, other SSDs, HAs?

12.6 Do resident characteristics influence how they are affected by a closure?

a) **If yes**, which characteristics?

b) And what sort of outcomes are linked to which particular characteristics?

12.7 What sort of issues should be taken into account when moving residents with dementia?

12.8 What other factors influence how residents are affected? E.g.

a) Characteristics of closed home?

b) Causes of closure?

c) Characteristics of the new home? E.g. its location (nearness to relatives, where lived…)

d) Other characteristics of residents? E.g. past experience of moving house or care home

EFFECTS ON OTHERS

13.1 How are you affected by home closures?

a) In terms of your workload? Your other work?

13.2 What is the most difficult aspect of a home closure for you?

13.3 What types of financial costs can be incurred by the department?

13.4 Are there any other effects on the department and local authority?

GENERAL VIEW

14.1 Are there any other consequences of closures we've not already discussed?

14.2 Do nursing home closures differ from residential home closures? If yes, in what ways?

14.3 Is there anything else that could be changed or improved upon?
a) Is there anything that should be done, that isn't always?

14.4 What would a well-managed closure be like? Criteria?

15.1 Is there anything important about home closures we haven't talked about? -
a) Anything that we should include in future interviews?
b) Any areas of concern?

[The remaining questions can be omitted if time is limited]

A NATIONAL STUDY

16.1 How might we identify homes that are closing?

16.2 Who would be the best person to ask to complete a follow-up form/survey to assess residents' health after a closure?

16.4 How might we track residents? – we would need to find out where they'd moved to and contact the new owner ....

a) Do you have lists of residents by home?

b) If someone has moved can they be identified by the old home?

c) Do you have lists of relatives of residents?

16.5 We would have to think of how to gain informed consent...do you have any suggestions about how we should go about this?

16.6 **Timing**: – home closure can be very emotional – when would be the best time to try to talk to residents, relatives/carers, and staff ...

a) e.g. Is it feasible to try to speak to residents and relatives <u>during</u> a closure?

b) And to follow-up residents, when would be a sensible time <u>after a closure</u>, 3, 6 weeks?

INVOLVING RESIDENTS AND HOME STAFF

17.1 If we interviewed residents of homes that were closing – what issues should we take into account and how?

17.2 In what ways could we follow-up <u>staff</u> to see if they are still working in the care sector?

17.3 In what ways might the impact on social services departments be measured?

17.4 Are there any other issues you would like to talk about? **THANK YOU**

Appendix 9: Team manager interview guide

To understand the process and the consequences of home closures the interview aims are to:

- **get an overview of current demand and supply of care homes for older people**
- **discuss your experience of independent home closures, both voluntary and enforced**
- **identify any practical, organizational or policy issues relating to good practice**

At the end I'd like to ask about

- **issues we could include in address in the research that would be of particular interest to you**
- **practical issues around identifying homes and tracking residents as they move**
- **how we might best involve care managers, residents, relatives and staff**

Information will be treated in confidence and will be anonymous.

Date of interview: _____

Position of interviewee: | |

Contact details: | |

1.2 Can you briefly outline your overall role/ job description?

1.2 On what basis are assessments carried out? (When would residents normally receive an assessment?)

1.3 How is the current assessment workload currently managed?

a) Number in team?
c) Min-max caseloads?
d) How prioritised?

1.4 How are records stored? – Are records manual or computerised?

CURRENT AVAILABILITY

2.1 What is the current supply of care home places like?

- ❑ In equilibrium
- ❑ under-supply
- ❑ over-supply
- ❑ Other

YOUR EXPERIENCE OF HOME CLOSURES

3.1 In the last two years – how many closures have there been in this offices' area/local authority?

3.2 How many have you been involved in?

MANAGEMENT OF CLOSURES: ROLES, RESOURCES AND RESPONSIBILITIES

4.1 Which agencies get involved in the process of home closures?

4.2 Who / which agency takes the overall lead (e.g. SSD, R&I unit, home owner)? How well does the allocation of responsibilities work?

4.3 Is there always one manager from social services department who is responsible for SSD overall involvement?

4.4 Is there usually a main contact at a care home in charge of organising the closure?

4.5 Can you outline the team's responsibilities during a home closure.

4.6 Does your involvement with residents vary depending on whether they are **self-funders**?

4.7 Are you aware of any **legal issues**, which have to be taken into account when deciding how the SSD should get involved in independent home closures?
Yes No

a) What sort of legal issues are there?

PROTOCOLS

5.1 Are there any written protocols, procedures or guidelines? Yes No

5.2 Who produced them?

I'd like to talk through the process of a closure and as we go along ask you to highlight

- **any record keeping or routine paperwork**
- **any policy or practice issues that are particularly important to residents welfare**
- **the ways in which closures can vary, and on what basis**

NOTIFICATION OF CLOSURE

6.1 How did you find out about the closure of this home?

6.2 How do you usually find out that a home is closing?
a) How can this vary? *Please give examples?*
b) Is there usually 'official' notification? Who from?

6.3 Sometimes contracts with providers specify a period of notice for closure, do you know if this is the case? It might be useful to talk to the contracts department –
Could you suggest a contact name and telephone number of someone in the Contracts Dept?

LENGTH OF NOTICE

7.1 When did you find out about this closure? (When were you officially notified, if different?)

7.2 What is the typical length of notice you are given?
a) What is the range of notice like? *Please give examples of short and long periods of notice?*

7.3 Does the length of notice affect residents? If yes

c) In what ways can a short period of notice affect residents? (Advantages and drawbacks?)

b) In what ways can a long period of notice affect residents? (Advantages and drawbacks?)

7.4 How long can closures take from notification to closure itself? *Examples, short, long?*

7.5 Does the length of notice affect the way in which social services are involved? In what ways?

THE CAUSE OF CLOSURE

8.1 Does the cause of closure affect the way a home is closed?

a) **If yes** – how?

b) Does the reason for the closure affect how care managers are involved?

PREPARATION OF RESIDENTS

9.1 Does SSD get involved in how residents or relatives are told of the closure? *Examples?*

9.2 Does SSD get involved in preparing residents for a closure and relocation? In what ways?

9.3 What, if anything could be changed to better prepare residents for closures and relocation?

9.4 Does SSD have much contact with relatives and carers during the relocation process?

a) **If yes** – in what way?

9.5 Do all residents have a care manager allocated to them (anyway? During the closure process?)

a) On what basis are care managers allocated to residents/homes that are closing?

9.6 On what basis are residents' care plans/needs assessed before relocation?

b) What is the main purpose of the needs assessment?

c) Are self-funders' needs assessed?

9.7 How many Social Work Assessors are allocated to a closure? Please give examples, e.g. one Social Work Assessor to how many residents _____

If we were to research the consequences of closures for resident welfare we would need to establish their health and social care status before a closure –

9.7 In your view, how might we best go about this to take advantage of existing procedures?

9.7a) Can I have copies of any documentation completed during a home closure?

9.8 Would it be feasible to assess every resident before a move?

a) Could this be achieved at a time early enough before the closure itself to reasonably assume that residents had not yet been affected by it? Ideally when would this be?

FINDING VACANCIES

10.1 In what ways, if any, do SSD get involved in finding new placements?

10.2 What is it like - trying to find new places? (easy or difficult?)

a) What sources of information are available?

b) Is there a vacancy list? Yes No

c) **If yes**, who produces it?

d) Can relatives get copies of lists? Yes No
e) **If not**, how are vacancies identified?
f) How, if at all, could the process be improved?

10.3 What factors affect how easy or difficult it is to find new placements? (e.g. no. of residents, notice)

10.4 How is the placement of clients from care homes that are closing, from hospital and from the community managed? (Are there waiting lists? How are clients prioritised, if at all?)

10.5 What sort of help or advice is offered to residents and relatives looking for a new place?

10.6 Do the majority of residents get to move to a home that reflects their (or their relatives) choice?
a) When a new home does <u>not</u> reflect their choice, how is this dealt with?

10.7 Do many residents move again because the new home was not their first choice, or did not meet their needs?
a) How long after the initial move do second moves usually happen?

10.8 In what ways could the process of finding new placements be improved?

THE CLOSURE AND RELOCATION

11.1 Do SSD ever get involved in the actual moving of residents (in terms of their last day)?
b) **If yes**, in what way(s)? What is important/what are the main issues/concerns/aims?

11.2 Is it preferable to move residents out of a home on a gradual basis over time, OR all at once in a short period (day or 2)? What are the advantages/disadvantages?
a) Why?
b) What usually determines the way in which residents are moved out?

11.3 Is there any kind of review of the process of closure at a later date?
a) Who by?
c) When?
c) Have procedures been changed as a result of a review?

FOLLOW-UP AND EFFECTS ON RESIDENTS

12.1 Are residents reviewed/assessed after a move?
a) On what basis? [everyone?] [If not said] Are self-funders reviewed?
b) When are reviews carried out?
c) How frequently? [more than once?]
d) What is the main purpose of these reviews?
e) Could this information be used to track residents after a closure to see how they are?
f) Have you ever been involved in tracking residents? If yes, what did you do?

12.3 What sort of positive outcomes for residents can result from a home closure? *Examples?*

12.3 What sort of negative outcomes for residents can result from a home closure? *Examples?*

12.4 Do you think the way in which a home is closed influences how residents are affected?

12.5 I'd like you to highlight what is most important to resident welfare at each stage of the closure process…[ask the following questions for each]

- The closure announcement - What about the announcement is most important to residents?
- Length of notice - What is most important about the length of notice?
- Preparation - Which elements of preparation are the most important to resident welfare? E.g. visits to new home? Information sharing?
- The new home? - What about the new home is the most important to resident welfare? E.g. Quality? Resident preferences?
- The way the actual move is managed? - What is most important to resident welfare? E.g. practicalities? Who meets them at the new home? Farewells?
- The settling in process - What is most important to resident welfare?
- The role of social services - What is most important to resident welfare? E.g. working relationships & procedures with providers, other SSDs, HAs?

12.6 Do characteristics of individual residents influence how they are affected by a closure?
c) **If yes**, which characteristics?
d) And what sort of outcomes are linked to particular characteristics?

12.7 What sort of issues should be taken into account when moving residents with dementia?

12.8 What other factors influence how residents are affected?
e) Characteristics of closed home?
f) Causes of closure?
g) Characteristics of the new home? E.g. its location (nearness to relatives, where lived...)
h) Other characteristics of residents? E.g. past experience of moving house or care home

EFFECTS ON OTHERS

13.1 What sort of consequences, if any, can home closures have for carers and relatives?

13.2 Are you aware of home closures having an impact on the social care and nursing workforce?
a) If yes, what sort of impact?

13.3 What sort of consequences, if any, can home closures have for <u>you</u>?
b) In terms of your workload? Your other work?

13.4 What types of financial costs can be incurred by the department?
13.5 What is the most difficult aspect of a home closure for you?
13.6 Are there any other effects on the department and local authority?

GENERAL VIEW

14.1 Are there any other consequences of closures we've not already discussed?
14.2 What could be changed or done better?
a) Is there anything that should be done, that isn't always?

14.3 **If written protocol** - How does the protocol/guidelines work in practice?

14.4 What would a well-managed closure be like? Criteria?

14.5 How, if at all, do nursing home closures differ to residential home closures? (Our case studies are mainly residential homes…)

INTERVIEW QUESTIONS - REVIEW

15.1 Is there anything important about home closures we haven't talked about? -
a) Anything that we should include in future interviews?
b) Any areas of concern?
c) Are there any additional issues we should be asking about?

A NATIONAL STUDY

16.1 How might we identify homes that are closing?

16.2 Who would be best placed to assess residents' health before a closure?

16.3 Who would be the best person to ask to complete a follow-up form/survey to assess residents' health after a closure?

16.4 How might we track residents? – we would need to find out where they'd moved to and contact the new owner ….
a) Do you have lists of residents by home?
b) If someone has moved can they be identified by the old home?
c) Do you have lists of relatives of residents?

16.5 We would have to think of how to gain informed consent…do you have any suggestions about how we should go about this?

16.6 **Timing**: – home closure can be very emotional – when would be the best time to try to talk to residents, relatives/carers, and staff …
a) e.g. Is it feasible to try to speak to residents and relatives during a closure?
b) And to follow-up residents, when would be a sensible time after a closure, 3 weeks, 6 weeks?

INVOLVING RESIDENTS AND HOME STAFF

17.1 If we interviewed residents of homes that were closing – what issues should we take into account and how?

17.2 In what ways could we follow-up staff to see if they are still working in the care sector?

17.3 In what ways might the impact on social services departments be measured?

17.4 Are there any other issues you would like to talk about? **THANK YOU**

Appendix 10: Senior manager interview guide

Thank you for agreeing to be interviewed. The aims of the interview are to identify:

- **current commissioning context and service availability**
- **any closure procedures – for both voluntary and enforced closures**
- **views of best practice**
- **consequences of closures for residents, relatives, care home staff and social services departments**

At the end I'd like to ask you about:

- **issues we could address in the research that would be of particular interest to you**
- **practical issues around identifying homes and tracking residents as they move**
- **how we might best involve care managers, residents, relatives and staff**

Information will be treated in confidence and will be anonymous.

Date of interview: _____

Position of interviewee: [ ]

Contact details: [ ]

1a. Can you briefly outline your overall role/job description.

THE COMMISSIONING CONTEXT

1. Current availability of services

1.1 What is the current supply of care home places like in general in your authority?

- ❑ In equilibrium
- ❑ Under-supply
- ❑ Over-supply
- ❑ Other

1.2 What is the current capacity in terms of

a) places? _____

b) homes? _____

1.3 How many providers do you have for

a) Residential care for older people? _____

b) Care for older people with dementia _____

c) Nursing home care? _____

d) Day or respite facilities? _____

1.4 In terms of the style and type of provision – what proportion of the homes are

- Purpose built? _____
- Large? (50 or more places) _____
- Medium (30-49 places) _____
- Smaller? (20-29 places) _____
- (4-19 places)

1.5 Approx how many independent residential home **closures** were there in the authority/district in the year ending 2001?
1.6 And how many nursing home closures were there in the year ending 2001?

1.7 What proportion of purchasing is cross-boundary or regional?
a) Is this related to the supply of homes? Or
b) The choice of users/relatives? Other?

2. Managing the market

2.1 Have any plans or strategies been implemented (or planned) in response to recent home closures?

2.2 What are the *short-term* plans, or strategies, for managing the market? Time-scale?

2.3 What are the *longer-term* plans, or strategies, for managing the market? Time-scale?

2.4 What are the main constraints on long term residential/nursing care services for older people?
a) Is that at the local or national level?

2.5 What changes, if any, have been made to commissioning arrangements as a result of the introduction of NHS funded nursing care in nursing homes?

2.6 How would you describe relations with providers? E.g. collaborative, competitive...?
b) What sort of consultative processes are there?

2.7 How much scope is there for providers to negotiate fees?
b) What are the arrangements for negotiation?

2.8 How would you describe relations with independent provider associations?

2.9 In the context of a home closure, do commissioners ever negotiate with providers to preserve a good quality service or establish a new one? Can you give examples?

3. Pricing arrangements: *(includes questions from Survey of LA Commissioning Arrangements)*

3.1 Thinking about how prices are determined for the purchase of (publicly funded, long term) care from independent (private and voluntary) providers, which of the following arrangements are most commonly used by the local authority to purchase residential home care? [SHOW CARD]

OPTION A
a single price that is invariant across different (publicly-funded) providers in the authority (and is also invariant with respect to clients/residents)

OPTION B
a price that can vary by provider, but does NOT vary by (publicly funded) clients/residents served by the provider

a) Does the price typically reflect residents' dependency levels?
b) Does the price typically reflect some aspect(s) of the provider's quality?

OPTION C

a price that can vary by (publicly-funded) client/resident (and so can vary by provider)

a) Are prices determined at the time of placement, being specific to the particular resident (i.e. not set in advance)?

b) Can prices change after initial placement to reflect changes in resident dependency?

3.2 Are the pricing arrangements for the purchase of care from independent nursing home providers the same? If not, how do they differ?

4. Price levels

4.1 What is the average price of a typical placement in (do you have a list of prices I could take with me?)
- a) independent residential care?
- b) Independent nursing care?

5. Contract types

5.1 What type of contract does the authority typically use with residential home care providers?

5.2 And which contract does the authority typically use with nursing home care providers?

5.3 What is the typical duration of contracts with independent sector providers?
b) Reason for length of contracts?

❑ <1 year ❑ >1 but <3 ❑ >3 but >5 ❑ >5 but <10 ❑ 10 or more ❑ N/A

5.4 What is the duration of the shortest contract used?
- a) What is the duration of the longest contract used?
- b) When/why would they be used?

5.5 Do contracts specify a period of notice for closure? Yes No
- a) Are there any clauses that relate to termination due to enforcement action or voluntary closure?
- b) What specifications are made?

6. Purchasing decision-making

6.1 Who makes purchasing decisions? Centralised, panel, area level purchasing, team leader, devolved to care manager level?

CLOSURE PROCEDURES

7. Roles and responsibilities

7.1 What is the role and responsibility of the social services department during a home closure?

7.2 Which social services staff are involved?
a) How are teams organised?
b) What are their responsibilities?

7.3 What other agencies are involved in the process of a home closure?
a) In what ways, if any, could working relationships and procedures be improved?

7.4 How do the local authority and the National Care Standards Commission liaise over closures?
a) How does this differ, at all, from liaison with the Registration and Inspection Unit?

7.5 What sort of changes, if any, do you expect to take place with the implementation of the National Care Standards Commission?

7.6 Does the nature and level of social services involvement in closures vary? Yes No
If so, how? e.g. according to whether

a) a closure is voluntary or enforced? How?
b) a resident is a local authority client or self-funded? How?
c) the home is a single business or part of a chain? How?
d) Anything else?

7.7 Are there any written protocols, procedures or guidelines for closures?
Would you find guidelines useful? In what ways?

7.8 When were they introduced?
b) Who produced them and for whom?

7.9 Are there any **legal issues**, which have to be taken into account when deciding how social services should get involved in closing independent care homes? Yes No
a) **If yes**, what are they?

8. Characteristics of closures

8.1 How does the social services department usually find out a home is closing?

8.2 In what ways can closures vary?

8.3 Why is this?

8.4 What, in your view, constitutes a well-managed closure?

9. Best practice

9.1 What aspects of the closure process are the most important to get right?

9.2 What circumstances, or conditions promote good practice?

9.3 Are there any obstacles that routinely impede good practice?

9.4 What aspects of closures pose the most difficulties for
a) social services staff/care management teams
b) the local authority – in terms of supply, managing the market?

9.5 What aspects of closures pose the most difficulties for resident welfare?
9.6 In what way(s), if any, could current practice be improved?

9.7 Are closures reported on, reviewed or evaluated in any way?
a) Who by?
b) When?
c) Have procedures been changed?

9.8 Are residents who are involved in a closure ever tracked?
a) In what way?
b) Is the data reviewed?

CONSEQUENCES OF HOME CLOSURES

10. For residents

10.1 What sort of positive consequences can result from a home closure?

10.2 What sort of negative outcomes can result form a home closure?

10.3 Do you have any evidence (e.g. reports or data) relating to the consequences of home closures for residents?

10.3 What factors influence how residents are affected by closures? [Then ask about the following:]
a) Characteristics of closed home?
b) Causes of closure?
c) The way in which the home was closed/process?
d) Characteristics of the new home?
e) Characteristics of residents (their dependency level, length of time spent in home)

10.4 What sort of consequences can result for carers and relatives?

11. For staff and workforce

11.1 What sort of consequences can result for the staff of homes?
b) For the social care and nursing workforce?

12. For providers

21.1 What sort of consequences can result for providers?

13. For commissioning

13.1 What are the consequences of closures for commissioning – in the short term (*ask for their definition of short term)?*

13.2 In the long term? (*ask for their definition of longer term*)

13.3 Any consequences for the future balance of services?

14. For social services departments

14.1 What are the consequences for social services departments in general?

14.2 What sort of financial costs are incurred during home closures? What kinds of costs might there be?

OVERVIEW

15.1 Is there anything else about home closures that we should follow up in our research? Any areas of concern? Issues we should be asking about?

15.2 Is there anything else you would like say about home closures before we move on to talk about the feasibility of a large quantitative study?

[PLEASE TURN OVER]

FEASIBILITY OF A NATIONAL STUDY

16.1 How might we identify homes that are closing?

16.2 Who would be best placed to assess residents' health before a closure? And afterwards?

16.3 What level of participation would it be reasonable to ask of care managers [on a larger scale]?

For example:

a) complete a checklist indicating whether particular events and activities took place during the closure
b) make a note of difficulties experienced
c) assess residents before relocation
d) provide whereabouts information so that residents can be tracked

16.4 Is there any information, which is routinely collected, that may provide useful data on home closures?

b) Any procedures currently in place for tracking residents who have moved?

c) Any information about the impact of closures on social services departments?

16.7 How might we track social care and nursing staff?

Are there any other issues you would like to talk about?

Thank you

Appendix 11: Care home staff interview guide

Thank you for agreeing to take part in our research. The aim of this interview is to discuss

- **Notification of closure**
- **Your role and the closure process**
- **Your feelings, views and plans**

Information will be treated in confidence and will be anonymous.

What is your job title?

Notification of the closure

1. When were you told the home was going to close? What length of notice period were you given?
    a. Has the timetable remained the same or have things changed?

2. How were you told about the closure?

3. What was your reaction/how did you feel?

4. In an ideal world - what length of notice of closure would you like? Why is that?

5. What are the benefits and drawbacks of a longer or shorter period of notice?

Your role and the closure process

6. How would you describe your role during the closure?

7. When were the residents notified of the closure?

8. How did the residents react?

9. How did relatives and carers react?

10. How were people's concerns managed or addressed? [Residents? Relatives? Staff concerns?]

11. Were residents prepared for the move to another home?

    a) If so, in what ways? What sort of support was offered? b) Any residents without relatives?

12. Did any of the residents have dementia?

    a) How were they told about the closure?
    b) How were they prepared for the move to another home?

13. Have you been involved in helping residents to move out?

    a) What sorts of things did you do? What were your main concerns?

14. Looking back, what, if anything, should have been done differently/ could have been improved for the residents?

Your feelings and views and plans

15. Have you felt ...

a.	... that you were provided with a sufficient level of support?	Who was most important in providing support? Who could have been more supportive?
b.	... that you would have liked to have more information?	What about? What would have helped?
c.	... de-motivated in your work?	What might have helped?
d.	... anxious about the future?	What might have helped?

16. What have been your main concerns throughout the closure process?

17. What are your plans for the future?

Overview

18. Looking back, what, if anything, should have been done differently/could have been improved from the **staff** point of view?

19. Thinking about how a closure is managed - What is **most important** in terms of what happens to staff and how they are affected by a home closure?

20. What would the criteria for a well-managed closure be?

ADVICE: Future research

1. In terms of the possible consequences and effects of home closures for staff –

   a) Are there any other issues we should try to research in any future work?

   b) Should we be asking about financial consequences for staff?

   c) If so, what sort of things should we be asking about?

2. The questionnaire -

I'd now like to show you a short questionnaire. We think it would be interesting to see what happens to staff after a home has closed, to find out if closures have any effect on where people work. The questionnaire asks for brief details about your employment history and for your permission to contact you again to see whether you are working in the care sector.

Appendix 12: Care home owner or manager interview guide

INTRODUCTION

Thank you for agreeing to take part in our case study work. The aim of this interview is to

- **Identify the characteristics of the home**
- **The reasons for closure**
- **Discuss your plans for the closure/ the process of closure**

[IF NOT ALREADY DONE SO]

1. Request access to staff contact details so that they can be invited to take part/ask if will forward invitation (3 interviews and short questionnaire to the rest of the staff re: employment history and contacting them at a later date)

HOME CHARACTERISTICS

What were your motivations for becoming a home owner?

You are the owner or the owner/manager? Job title? _____

What was the registration of the home? Nursing Residential Dual registered

What sector was the home? Private, voluntary, or not for profit trust?

Is the business a: Partnership, Limited company, family business, sole trader?

Did the organisation run any other homes or care facilities, and if so, how many?

Number of places? _____

Proportion of self-funders? _____

Number of places currently occupied? _____

Average level of occupancy over the previous year _____

What type(s) of care does the home provide? (short stay, respite…)

How many staff are (ordinarily) employed at the home? e.g.

	Full-time	Part-time
Supervisory staff		
(If applicable) Nursing staff		
Care staff		
Night staff		
Agency staff		
Total		

What happened to staffing levels during the closure?
a) How were they managed?

What type of contract did you have with the local authority?

What is the current level of fees being paid by the LA per person per week? _____
Turning to the physical environment of the home - was the building purpose built? When?

What sort of changes if any, would need to be made to meet the new Care Standards?

- Number of double rooms/ percentage of places in shared rooms?
- Floor area

REASONS FOR CLOSURE

Why did you decide to close the home? Reasons/ factors?

- Fee levels
- Care standards
- Type of demand (e.g. increased level of dependency)

  _____
- Level of demand
- Staffing issues (training, recruitment, retention)

  _____
- Property market
- Type of contract with LA
- Regulatory environment
- Retirement or ill health
- Disillusionment, 'burn-out'
- Changing registration/use
- Other _____

What was the decisive factor?

_____

When did you/the owner decide to close the home (how long before the date set for closure?)?

Why did you decide to close at that time?

Was there anything that could have happened that would have changed the decision to close?

Have you approached anyone for advice about the process of closure? Draw on any guidelines?

Has anyone offered any advice or guidelines? What was it?

When is the closure date? [ ]

[IF NOT ALREADY CLEAR] – Do you know what is going to happen to the building?

CLOSURE PLANS - I'd like you to tell me about the closure plans:

21. What is the current situation?
    a. Who has been notified? Residents? Relatives? Staff? R&I Unit, SSD, Other (Bank ....?)
    b. When did you give notification/length of notice given?
    c. How did residents and relatives or carers react?
    d. How did you manage people's concerns?
    e. Did you have any residents with dementia? – did preparation differ....

2. What are your main aims and objectives for the way in which the closure is managed?

2. Are there any reasons for the way that you are planning to do things?

3. What are your main concerns? Are you expecting any particular obstacles, problems, difficulties?
4. How do you see the role of
   - Social services – social workers?
   - Registration and Inspection Unit?

6. Can you tell me about the financial costs incurred during the closure – the sorts of costs there've been?

7. What would the criteria for a well-managed closure be?

ADVICE: If we were to conduct a national study –

1. How might we identify homes that are closing?

2. How could we contact providers to ask them about the causes of closure and the closure process?

3. When would be the most appropriate time to contact providers?

[IF RESIDENTS HAVE NOT BEEN RELOCATED YET]

1. Would it be feasible for a researcher to meet with senior staff to gather information about residents before they moved? (Show example of form)

THANK YOU

Appendix 13: Project outline

CLOSURES OF HOMES FOR OLDER PEOPLE: PROCESS AND CONSEQUENCES
Outline of a research project funded by the Department of Health

Ann Netten, Robin Darton and Jacquetta Williams

P45c/ March 2002

BACKGROUND

Considerable public concern has been expressed about the rise in the incidence of home closures. Concerns centre on the reasons for closures, the consequences for supply, and the welfare of residents. The first stage of this study focused on variations in the rates of closures nationally, the types and characteristics of homes that were closing, the effect on the supply of places and the circumstances that led to closure. This second stage focuses on the process and consequences of closures from the perspective of residents, relatives and carers, providers and staff, and local authorities.

AIMS AND OBJECTIVES

The aims of this second stage of the research are to:

- Review existing closure protocols to identify good practice
- Investigate the process of home closure from the perspective of relatives and carers, residents, providers and staff, and social services departments
- Identify the consequences and effects of closures experienced by residents, relatives, and carers, providers and staff, and social services departments
- Explore the feasibility of conducting a large-scale study to investigate whether the way in which homes are closed influences the nature of any consequences or effects

PARTICIPANTS AND METHOD

A sample of closure protocols from local authorities in England will be used to identify best practice and approaches currently in use. Carers and relatives will be interviewed about their experience and views of home closures. (Providers experiences and views were also gathered in the first stage of the study.) Local authority staff will be interviewed in two local authorities, one county and one metropolitan district. Interviewees will be consulted about the focus of the research to ensure that it reflects issues that matter to them. A number of closures will also be studied as case studies to find out what happens during the process of a closure, and the consequences for those involved.

TIMETABLE AND CURRENT STATUS

Copies of protocols for home closures were requested from social services departments in March 2002. Carers and relatives of residents who have recently experienced a closure have been invited to take part via carers support groups, and interviews will be carried out between February and May 2002. Interviews with social services staff will be carried out in Spring 2002. The case study research will be conducted in the summer. A report on the process of closure will be available in the autumn.

Appendix 14: Invitation to residents

Direct Line: 01227 827587
Email: J.M.Williams@ukc.ac.uk

Dear Resident

There is a lot of public concern about the effect of home closures on residents and their relatives or carers. We are doing research to find out what happens to people and how they feel about it. Please find enclosed an outline of our research aims and objectives. I am writing to ask if you would talk to me about your experience of a home closure. We hope our research will help those involved in future closures when they do happen.

About four weeks after you have moved we would like to contact you to ask if we can interview you about your views. If you would like to discuss your experience and views please complete and return the reply-slip in the pre-paid envelope provided. All information provided will be confidential and anonymous. Your name and the name of the care home will NOT be divulged in any publications.

We would be most grateful for your participation in this important research. We will be happy to send you a summary of the findings and if you would like to discuss any aspect of the research please do not hesitate to contact me.

Yours faithfully

Ketta Williams
Research Officer

Closures of Care Homes for Older People Project:

Interviews with Residents

Reply slip

If you would like to take part in our research please complete and return this reply slip using the pre-paid envelope provided. I will contact you to arrange a date, time and place convenient to you.

I would like to be interviewed about my experience of the closure of a care home [Please ✓ box] ☐

Name: _____

[PLEASE PRINT IN CAPITAL LETTERS]

Telephone number(s): _____

Current Address: _____

[PLEASE PRINT IN CAPITAL LETTERS] _____

_____

Name of closed home: _____

I would like to be sent a summary of findings from the research [Please tick ✓] ☐

Many thanks

Ketta Williams

Appendix 15: Invitation to relatives

Direct Line: 01227 827587
Email: J.M.Williams@ukc.ac.uk

Dear Relative or Carer,

I am writing to you because a relative of yours was a resident of a care home that has recently closed. The social worker kindly agreed to forward this letter on my behalf. I am working on a research project to find out what happens to people when a home closes and how they feel about it. Letters are also being forwarded to residents. The project is funded by the Department of Health and being carried out by the Personal Social Services Research Unit at the University of Kent at Canterbury. Please find enclosed a summary of the aims of the project. I am writing to ask if you would talk to me about your experience, views and feelings about the home closure. We hope our research will help those involved in future closures when they do happen and want to make sure we highlight the perspective of relatives and carers.

If you would like to take part please complete and return the reply-slip in the pre-paid envelope. Please indicate if you would prefer to complete a short questionnaire or would like to be interviewed. The interview would last about an hour and, with your permission, be tape-recorded. All information provided will be confidential and anonymous. Your name, the name of your relative and the name of the care homes will not be used in any reports.

We would be grateful for your participation in this research and thank you for taking the time to consider doing so. I will be happy to send you a summary of the findings, once these are available. If you would like to know more about the project please contact me (01227 827587), or Dr Ann Netten (01227 823644). We would be happy to discuss any questions that you might have.

Yours faithfully,

Ketta Williams
Research Officer

Appendix 16: Invitation to additional relatives

Direct Line: 01227 827587
Email: J.M.Williams@ukc.ac.uk
Website: http://www.ukc.ac.uk/pssru/

February 2002

Dear Carer

We are researching the causes, process and consequences of closures of care homes for older people for the Department of Health. We would like to interview people with experience of a care home closure in order to understand the experience and consequences for residents, relatives and carers. We hope to ensure the research reflects issues that matter to relatives, carers and residents.

If you have experience of a closure and would like to discuss your experience and views please complete and return the reply-slip. Interviews will be entirely confidential. Information and views will be summarised and possibly quoted in publications but no names will be used. The interviews would last about an hour and, with your permission, be tape-recorded. If you know of anybody else (residents, relatives or carers) who has recent experience of a home closure and might also like to be interviewed please tell them about our research and let us know.

We would be most grateful for your participation in this important research and thank you for taking the time to consider doing so. If you would like to discuss any aspect of the research project or the interviews further please do not hesitate to contact me, Ketta Williams (01227 827587) or Ann Netten (01227 823644). We would be happy to discuss any questions that you might have.

We look forward to hearing from you.

Yours faithfully,

Ketta Williams
Research Officer

Enc

Closures of Care Homes for Older People Project: Carers interviews

Reply slip

Please return this reply slip to me by March 11th 2002:

Ketta Williams,
PSSRU,
Cornwallis Building,
University of Kent,
Canterbury,
Kent, CT2 7NF.

I will contact you to ask about convenient dates. Many thanks.

I would like to be interviewed about my experience of the closure of a care home for older people [Please ✓] ☐

Name: _____
[PLEASE PRINT IN CAPITAL LETTERS]

Telephone number(s): _____

Address: _____
[PLEASE PRINT IN CAPITAL LETTERS] _____
_____
_____

Approximate date of home closure: _____

Type of care home for older people: [Please ✓ one box]: Residential home ☐ Nursing home ☐ Dual home ☐

I would like to be sent a summary of findings from the research [Please tick ✓] ☐

Appendix 17: Interview invitation to care home staff

Direct Line: 01227 827587
Email: J.M.Williams@ukc.ac.uk

26 April 2002

Dear Member of Staff,

We are researching the causes, process and consequences of closures of nursing and residential homes for older people. The project is funded by the Department of Health and being carried out by the Personal Social Services Research Unit at the University of Kent at Canterbury. This letter has been given to you because you are working in a home that is closing.

I am writing to ask if you would agree to be interviewed. We want to find out about your role in the process of closing the home, about the issues you think are important and about how you feel about the closure. We hope that our research will help those involved in future closures when they do happen, and want to make sure we highlight the perspective of everyone involved, including home providers and staff, residents, and relatives and carers. Please find enclosed a project outline summarising the aims of the project.

I will be visiting the home on ..... April from 1:30 pm onwards and can see you then if you would like to discuss your experience and views. I have asked (name of manager) to pass this letter to staff. All information provided will be treated as confidential and anonymous. Your name, and the name of the home will not be used in any reports.

We would be grateful for your participation in this important research and thank you for taking the time to consider doing so. I will be happy to send you a summary of the findings once these are available. If you would like to know more about the project please do not hesitate to contact me, Ketta Williams (01227 827578) or Dr Ann Netten (01227 823644). We would be happy to discuss any questions you might have.

Yours faithfully,

Ketta Williams
Research Officer

Appendix 18: Care home staff questionnaire before home closure

April- June 2002

Case Study Serial No. ☐

Individual Serial No. ☐

Closures of Homes for Older People:

Process and Consequences

Care Staff Questionnaire

Thank you for taking the time to complete this questionnaire. All information will be treated in the strictest confidence. No-one will ever be able to identify you or the care home in any reports.

Name ☐

Name of care home ☐

1. Job title ☐

2. Date questionnaire completed ☐

3. Date of home closure ☐

Qualifications, training and development

	Yes	No	
4. Are you a trained nurse? [Please ✓ box]	☐	☐	If No – Please go to Q.6

If Yes -

	Yes	No
5. Are you currently registered with the UKCC?	☐	☐
6. Do you have any NVQs?	☐	☐

7. Please indicate which of the following qualifications you have, or are working towards [Please tick as many as applicable]

	Have	Working Towards
a) NVQ in Care (levels 2, 3, 4)	☐	☐
b) NVQ in Promoting Independence (level 3)	☐	☐
c) NVQ in Diagnostic and Therapeutic Support (level 3)	☐	☐
d) Registered Managers (Adult Services) NVQ [level 4]	☐	☐
e) Social Work Qualification e.g. Diploma in Social Work, Higher National Certificate (HNC) or Higher National Diploma (HND) in Social Care	☐	☐
f) Other relevant qualifications (Please specify)	☐	☐

Experience

8. Before working in this care home have you <u>been employed</u> as a carer:
[Please tick as many as applicable]

	Yes	No
a) in other care homes for older people?	☐	☐
b) in care homes for other client groups?	☐	☐
c) caring for people in their own homes?	☐	☐
d) in other types of care work? Please specify?	☐	☐

9. How many different jobs have you had in the last five years?

10. Please indicate the total length of time you have been employed in care work:

11. How long have you worked in the care home that is closing/has closed?

Your job in the care home that is closing

12. At the time of the closure what type of contract did you have?

[Please ✓ one]

a) a permanent contract with the home ☐

b) a temporary/fixed term contract with the home ☐

c) working for an agency ☐

d) Other (Please specify) ☐

13. Before the closure was announced, what number of hours did you work per week?

Hours per week.

14. How much notice were you given? [i.e. between when you were told the home was closing and the date of closure]?

Weeks.

15. Were residents told about the closure: [Please ✓ one]

a) At the same time as staff ☐

b) Before staff ☐

c) After staff ☐

Finding other work

16. Have you already found another job? [Please ✓ one]

Yes	No
☐ Go to 17.	☐ Go to 18.

17. If yes, what is the job title and type of work?

Job Title:

Type of work:

Please go to Q. 21

18. Have you started looking for other work? [Please ✓ one]

Yes	No
☐	☐ Go to 18 a.

18 a. If No – please say why?

19. Are you looking for a similar position in another care home? [Please ✓]

Yes	No	Undecided
☐	☐	☐

20. Where are you looking for work? [Please ✓ one]

a) mostly within care homes for older people ☐

b) mostly within care homes for other client groups ☐

c) as a home care worker for people living in their own homes ☐

d) mostly outside the care sector ☐

e) undecided ☐

21. If you are looking for work (or have found work) outside the care sector – why is this? [Please ✓ as many as apply]:

a) It is difficult to find a job in another care home ☐

b) I don't want to go through a care home closure again ☐

c) I want to try something different ☐

d) I don't enjoy this type of work ☐

d) Other (Please specify] ☐

22. How old are you? ☐

23. Are you Male? ☐ Or Female? ☐

24. Are you White? ☐ Black? ☐ Asian? ☐ Other? ☐

We would like to contact you 3 months after the home closure to see where you are working. If you are willing for us to do this please give us a contact address and telephone number where we will be able to reach you: (your name and details will not be divulged to anyone but it will help us to contact you and to send you a summary of the research findings.)

Contact address: _____

_____

_____

_____

_____

Telephone Number _____

Please use the space below to note any other consequences of the care home closure you would like to tell us about.

Please return the questionnaire in the pre-paid envelope provided.

Thank you for your help.

Appendix 19: Letter about questionnaire to home staff

Direct Line: 01227 827587
Email: J.M.Williams@ukc.ac.uk

30 April 2002

Dear Member of Staff,

We are researching the causes, process and consequences of closures of nursing and residential homes for older people. The project is funded by the Department of Health and being carried out by the Personal Social Services Research Unit at the University of Kent at Canterbury. This letter has been given to you because you are working in a home that is closing.

I am writing to ask if you would complete a short questionnaire. We want to find out some brief details about the employment history and qualifications of care staff. We hope that our research will help those involved in future closures when they do happen, and want to make sure we highlight the consequences for everyone involved, including home staff and providers, residents, and relatives and carers. We will also be carrying out some interviews with a small number of staff to identify the role, consequences and concerns of staff in more detail. Please find enclosed a project outline summarising the aims of the project.

We would be grateful if you would complete the enclosed questionnaire and return it in the pre-paid envelope provided. All information will be treated as confidential and anonymous. Your name, and the name of the home will not be used in any reports.

I will be happy to send you a summary of the findings once these are available. Thank you for your participation in this important research. If you would like to know more about the project please do not hesitate to contact me, Ketta Williams (01227 827578) or Dr Ann Netten (01227 823644). We would be happy to discuss any questions you might have.

Yours faithfully,

Ketta Williams
Research Officer

Appendix 20: Care home staff follow-up questionnaire

CONFIDENTIAL

Care Staff Follow–Up

Closures of Care Homes for Older People

Research Project

Thank you for helping us with our research. We want to understand how home closures affect care staff. We want to find out your views about the home closure, and what you are doing now. Your views are very important to us. There are no right or wrong answers. The research is being carried out by the Personal Social Services Research Unit and is funded by the Department of Health. All information will be treated in the strictest confidence. No-one will be able to identify you, or the care home in any reports.

If you would prefer a researcher to telephone you to go through these questions please call 01227 827587 and we will arrange to call you back at a convenient time. We want to include your views.

A. Your details:

1. What is your name?

2. What was the name of the home that closed?

3. What was your job at the closed home?

4. When did you stop working at the closed home (date)?

B. What are you currently doing?

1. Are you [Please ✓ Yes or No for each]	Yes	No
a) Working in a residential or nursing home?	☐	☐
b) Working as a home care worker?	☐	☐
c) Working in a day centre?	☐	☐
d) Working in the health sector, e.g., hospital, health centre, GP practice?	☐	☐
e) Working in retail or wholesale?	☐	☐
f) Working in another type of job?	☐	☐
g) NOT working in a paid job?	☐	☐

If you answered YES to f) or g) please give details: e.g. full-time parent, in full-time education or training, or working in a hotel or restaurant. Etc.

IF you are <u>not</u> working please go to Section E, page 5

2. What is your job title? (If you have more than one job give the name of your main job)

C. If you <u>are</u> working in a residential or nursing home

[If not please go to Section D, p 4]

1. Are you: [Please ✓ Yes or No for each]	Yes	No
a) Working for the same employer as before (i.e. in another home owned by the same owner/company as the closed home)	☐	☐
b) Working with older people?	☐	☐
c) Working with adults (aged 16-65)?	☐	☐
d) Working with children?	☐	☐
e) Working part time?	☐	☐

2. Is your employer: [Please ✓ one]

a) A private company or firm? ☐

b) A local authority? ☐

c) A voluntary organisation? ☐

d) Other (Please specify)

3. What factors did you take into account when you decided to work in the care home where you are working now? [Please ✓ Yes or No for each]

	Yes	No
a) The pay and conditions of work?	☐	☐
b) The location of the home?	☐	☐
c) The quality of care provided within the home?	☐	☐
d) The level of support from management?	☐	☐
e) The occupancy level/how full it was?	☐	☐
f) The training opportunities	☐	☐
g) Whether the home would meet the new physical and environment standards?	☐	☐

h) Other (Please specify)

Now please go to Section E. page 5.

D. If you are <u>not</u> working in a residential/nursing home

1. People change the type of work they do for many reasons. What influenced your decision to work where you are working now? [Please ✓ Yes or No for each]

	Yes	No
a) I was offered the possibility of different work	☐	☐
b) I wanted to try something different	☐	☐
c) I didn't want to risk going through a home closure again	☐	☐
d) It was difficult to find a job in another residential or nursing home for older people	☐	☐
e) I am working in this job on a temporary basis while I continue looking for another job	☐	☐
f) I am looking for another job in a residential or nursing home	☐	☐

g) Other (Please specify)

2. What is the main reason you are no longer working with older people in a care home?

The next section asks

- how you felt about the closure
- how well it was organised and
- the support you were given

E. Looking back at the home closure

1. During the closure did you feel:

	Yes	No
a) You would have liked more information about what was happening?	☐	☐
b) You were given a sufficient level of support?	☐	☐
c) You were de-motivated in your work?	☐	☐
d) You were anxious about the future?	☐	☐

2. What were your main concerns or worries during the closure?

3. Do you think care staff should be involved in:

	Yes	No
a) Telling residents about the closure?	☐	☐
b) Taking residents to visit potential new homes?	☐	☐
c) Talking to relatives about the reasons for closure?	☐	☐
d) Taking residents to their new home?	☐	☐
e) Helping residents to settle into their new home?	☐	☐

f) What else would you have liked to be involved in during the closure process, if anything?

[Please turn over]

5. What were the main positive consequences of the home closure for you, if any?

6. What were the main negative consequences of the home closure for you, if any?

7. What advice would you give to other care staff experiencing a home closure?

Please ✓the box if you would like to be sent a summary of the research findings: ☐

Please use the space on the other side to note anything else you would like to tell us about your experience and views of the home closure.

THANK YOU FOR YOUR HELP
Please return the questionnaire in the pre-paid Envelope provided

Appendix 21: Care manager activity logs

Closures of Homes for Older People
CLOSURE ACTIVITIES (BEFORE THE HOME CLOSES)

Thank you for taking part in this case study. We would be very grateful if you could fill in this form, there is a WHITE COPY for work carried out before the home closes, and a YELLOW copy for activities after the closure (e.g. reviews, second relocations). The form is intended to be a record of your work on one home closure. The information you provide will help us establish the consequences and effects of care home closures. Please note activities, tasks and time taken (and the code of the resident where possible) for face-to-face meetings/interaction, administration and telephone calls. Another page has been provided for noting any issues arising.

Name of Authority	
Name	
1. Job Title	
2. Grade (including point)	
3. Number of residents allocated to you (from the home that is closing)	
4. Date work on home closure commenced	/ /
5. Date of home closure	/ /
6. Total amount of time spent (to the nearest half day):	Please EXCLUDE time spent on other, non-closure related tasks.

Please feel free to photocopy pages for additional space if needed, and to note any comments about the consequences and effects of the closure.

Many thanks

Please return to: Ketta Williams, PSSRU, Cornwallis Building, University of Kent, Canterbury, CT2 7NF

Record of pre-closure activities and tasks:
FACE-TO-FACE INTERACTION

e.g. assessment of residents, meetings with relatives or carers or the home manager …
Please note the date when a new day starts.

Date	Activities	Time taken

Record of pre-closure activities and tasks:
TELEPHONE CALLS

Date	Activities	Time taken

Record of pre-closure activities and tasks: ADMINISTRATION

Date	Activities	Time taken

Record of issues and concerns:

Closures of Homes for Older People

CLOSURE ACTIVITIES (AFTER THE HOME CLOSES)

Thank you for taking part in this case study. We would be very grateful if you could fill in this form, there is a WHITE COPY for work carried out before the home closes, and a YELLOW copy for activities after the closure. It is intended to be a record of your work on one home closure. The information you provide will help us establish the consequences and effects of care home closures. Please note activities, tasks and time taken (and the code of the resident where possible) for face-to-face meetings/interaction, administration and telephone calls. Another page has been provided for noting issues arising.

Name of Authority	
Name	
1. Job Title	
2. Grade (including point)	
3. Number of residents allocated to you (from the home that is closing)	
4. Date work on home closure commenced (after the actual closure)	/ /
5. Date closure related activities 'end'	/ /
6. Total amount of time spent (to the nearest half day):	Please EXCLUDE time spent on other, non-closure related tasks.

Please feel free to photocopy pages for additional space if needed, and to note any comments about the consequences and effects of the closure.

Many thanks

Please return to: Ketta Williams, PSSRU, Cornwallis Building, University of Kent, Canterbury, CT2 7NF

Record of post-closure activities and tasks: FACE-TO-FACE INTERACTION

e.g. assessment of residents, meetings with relatives or carers or the home manager …
Please note the date when a new day starts.

Date	Activities	Time taken

Record of post-closure activities and tasks:
TELEPHONE CALLS

Please note the date when a new day starts.

Date	Activities	Time taken

Record of post-closure activities and tasks: ADMINISTRATION

Please note the date when a new day starts.

Date	Activities	Time taken

Record of issues and concerns:

Appendix 22: Resident details form for care managers

Resident Details

Individual Serial No. ☐

Please complete a form for each resident. Information will be treated in confidence and personal details only used to contact residents who have agreed for us to do so and to send a summary of the results.

1. Local Authority: ☐

2. Code of resident (If you allocated a code to the assessment): ☐

3. Age of resident: ☐ 4. Gender: ☐

5. Name of closed home: ☐

6. Length of time lived in closed home: ☐

7. Length of time lived in nursing/residential care: ☐

8. Has the resident experienced a home closure before?

No ☐ b) Yes, one closure ☐ c) Yes, more than one ☐ d) Don't Know ☐

9. Date moved from the closed home: ☐

10. Where moved to: [Please ✓ one]

a) a residential home/place ☐

b) a nursing home/place ☐

c) hospital ☐

d) Other: _____

11. Do they have a cognitive impairment? Yes ☐ No ☐

12. Are they unlikely to be able to consent to an interview? Yes ☐ No ☐

13. Has the resident/relative agreed that researchers can look at assessments and reviews? Yes ☐ No ☐

14. Has the resident agreed to be interviewed after they have moved? [If yes please provide contact information below:] Yes ☐ No ☐

15. Has the relative agreed that we can contact them? Yes ☐ No ☐

Appendix 23: Resident follow-up form for care managers

Individual Serial No.

Resident Details

Please complete a form for each resident. Information will be treated in confidence and personal details only used to contact residents who have agreed for us to do so and to send a summary of the results.

1. Local Authority:

2. Code/ID of resident (If allocated):

3. Age of resident:

4. Gender:

5. Name of closed home:

6. Length of time lived in closed

7. Length of time lived in nursing/residential care:

8. Has the resident experienced a home closure before?

a) No ☐ b) Yes, one closure ☐ c) Yes, more than one ☐ d) Don't Know ☐

9. Date of needs assessment:

10. Date moved from the closed home:

11. Where moved [Please ✓ one]

a) a residential home/place ☐
b) a nursing home/place ☐
c) hospital ☐
d) Other: _____

12. Do they have a cognitive impairment? Yes ☐ No ☐

13. Do they have any relatives? Yes ☐ No ☐

14. Have they moved again/a second time following the closure? Yes ☐ No ☐

Please give details:

15. Have they settled in (based on the placement review]? Yes ☐ No ☐

16. If they have died – please give the date of death:

Appendix 24: Response to survey of council guidelines from local authorities with more than 100 homes by type

Council type	*Number of Councils > 100 homes*	*No. of responding Councils*	*No. that reported having a protocol*	*No. that sent an example protocol*
Shire County	31	25	17	16
Shire Unitary Authority	18	10	5	3
Metropolitan District	15	10	7	6
London	5	3	1	1
Total	69	48	30	26

Appendix 25: The nature and scope of Inspection Reports

Nine inspection reports were found and reviewed. Elapsed time between the last inspection and home closure ranged from as little as six months to as long as twelve. Two homes were inspected six months before closure, another two seven months, one eight months, a further two nine months, and one twelve months before closure. One home was inspected while the closure was pending, that is, the inspection report referred to the closure and the good standards of care and pleasant environment that were being maintained. The annual report for two of the homes covered more than one inspection: one report covered three inspections within the previous nine months, two of which were unannounced; another covered an announced and unannounced inspection. In two cases, the last inspection prior to closure was unannounced, and another two homes had unannounced inspections described in their most recent inspection reports. Unannounced inspections were conducted with a view to monitoring compliance with regulations and requirements identified as needing action in previous announced inspections. At this time, inspection and regulation units carried out at least one announced and one unannounced inspection in a twelve-month period.

Two of the reports, from different inspection units, were written in a 'short report format'. In one case, this was attributed to the need to simplify the reporting process as part of the preparation to transfer to the National Care Standards Commission in April 2002. One consequence of this was that the reports, along with some of the unannounced reports, contained little descriptive information about the homes. With hindsight, this data should have been reviewed more carefully at the time of receipt and the fuller reports from previous years, or the previous announced inspections, requested. One report explained that announced and unannounced inspections focused on different issues, with the former focusing on quality of care, staffing and management arrangements, and unannounced inspections focusing on the environment, records, policies and procedures and health and safety. Lay Assessors were involved in two of the announced inspections.

Appendix 26: Characteristics of interviewed residents

	Resident Interviewees (n=10)	*Residents of case study relatives (n = 28)*	*Residents of non-case study relatives (n=7)*	*All residents known about via interviews (n=43)*
Men	3	7	2	12
Women	7	21	5	31
Mean age	81	89	87	87
Minimum	70	75	82	70
Maximum	96	101	92	101
Resident had some degree of cognitive impairment	1	14	6	20
Publicly funded	5	23	5	31
Self-funded (including deferred payment agreements)	5	5	2	12
Closed home 1st care home	9	23 (n=27)	3	33 (n=42)
Mean length of stay in closed home (excluding one resident's stay of 17 years)	2 yrs 1 mnth (n= 9)	2 yrs 5 mnths (n=27)	1 year 5 mnths (n=6)	2 yrs 3 mnths (n=41)
Minimum	4 mnths	4 mnths	10 mnths	4 mnths
Maximum	4.5 yrs	8 yrs	5 yrs	8 yrs

Notes:

1. Gender of non-case study residents: 7 interviewees talked about 8 relatives as one relative discussed a married couple. Only the husband's characteristics were included in the dataset since the couple were admitted into care because of his needs.
2. One of the relatives interviewed had mild learning disabilities.
3. In two instances a relative of a resident who was interviewed, was also interviewed. The information about the resident has only been included once in the final column about all residents and consequently the sample size of residents known about is 43 rather than 45.

Appendix 27: Nature of relationship of interviewed relatives to residents

	Case study relatives (n = 28)	*Additional relatives (n=7)*	*All relatives (n = 35)*
Son	8	2	10
Daughter (incl step)	14	4	18
Other relative	5	0	5
Friend or carer	1	1	2

Appendix 28: Number of care staff by case study and method of participation

Case study	*Interviews*		*1st questionnaire*			*2nd questionnaire*		Total	
	Care staff	*Manager/Assistant Manager*	*Care staff*	*Manager Assistant Manager*	*Of which interviewed*	*Care staff*	*ManagersAssistant Manager*	*Staff inc managers*	*Care staff*
3	2	2	4	2	3	1	2	7	5
4	0	0	3	0	0	0	0	3	3
6	1	1	0	0	0	0	1	2	1
7	4	0	0	0	0	2	0	4	4
99	1	1	1	0	1	1	0	2	1
Total	8	4	8	2	4	4	3	18	14

Appendix 29: Number of interviewed social services staff by local authority, case study and position

Local authority	*Case study*	*Care managers or assistants*	*Team Leaders*	*District Managers or higher*	*Total*
1	*1*	2	1	0	3
	2	1	1	0	2
2	*3*	3	1	2	6
3	*4, 5, 6, 7*	10	1	1	12
4	*8*	0	1	0	1
Total	8	16	5	3	24

Appendix 30: Resident outcome information received from care managers by closure

Home Closure	*Number of residents relocated*	*Number for whom summary information provided*
1	23	10
2	19	7
3	28	12
4	14	13
5	18	16
6	11	9
7	30	22
8	31	31
Total	174	120