How to close a care service

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Introduction

Health and social care services close for many reasons. Perhaps the Covid-19 pandemic cuts off the supply of funds to a niche charity, austerity policies bankrupt the local authority, profit margins disappear in the commercial care home sector, or the old cottage hospital is decommissioned[1] to fund a shiny new unit in the next town. While a companion paper[2] considers the relocation of care delivery and how people transfer from the old service to the new one, this paper focuses on the death of the old service and simply asks how to end well. It stands as a modern managerial interpretation of the Medieval guides on the art of dying. Other resources are available[3], but one wonders if the ending of a service may be something of a taboo subject which is hard to acknowledge and difficult to explore[4].

Because many real world situations are hybrids in which closure and relocation occur together, materials in this pair of companion papers are not duplicated and the two documents should be considered as a single resource. The papers are lengthy and contain so many endnotes that they

should be considered as resource files from which shorter and more digestible materials may be generated. For more information about the writing strategy, see the final section of this paper.

There are three headline issues that emerge from this literature review, as follows:

- Closing services are subject to a raft of psychological and emotional forces that are neglected in the literature on decommissioning, which tends to prefer an anodyne version.
- Despite the rhetoric of coproduction, practical approaches to involving people who use services in decommissioning social care services are under-developed.
- Service closure provides a vibrant litmus test of the way in which social care is commissioned and delivered and which will affect everyone receiving these services, whether or not they are affected by a closure programme.

Scope and purpose

We take a broad scope, including health and social care, charitable and commercial activities, statutory and voluntary services. It includes circumstances when closure leaves a gaping hole and points to a companion paper addressing those occasions when undertakings are transferred to another provider[5]. Emergency closures[6] are considered as well as endings which are painstakingly planned; where stakeholders reach the finishing tape with profound satisfaction and those who rage against the dying of the light.

This paper is intended to support stakeholders who are closing a service to do so well[7]. It is not intended to be a convenient anaesthetic permitting callous managers and politicians to reduce expenditure and withdraw services with the least possible fuss and bad publicity.

Strategic values

A general Decommissioning Strategy[8] and arrangements for provider failure[9] should underpin an individual closure plan. This Strategy should be coproduced with all stakeholders, including people using the service, as illustrated by the following:

> *"We separated the service user consultation from the decommissioning decision, and then focused on what support they wanted….there was service user representation on the joint commissioning group who were well briefed about commissioning issues, and fed into the consultation process."*[10]

The Decommissioning Strategy will include the following items that specifically relate to closure in addition to other issues that have broad application:

- Social care services should undertake business continuity planning to establish resilience against threats and so avoid provider failure whenever possible. Alongside this, they should prepare for all contingencies, including planned departure from the market and emergency closure[11]. The plans should pay particular attention to high risk, high impact and hard to replace services[12].

- Primary responsibility for the welfare, safe and effective care of residents lies with the care home provider, so all staff must contribute to the smooth running of the service as well as the closure or relocation process[13], while the local authority also has statutory duties.

- Changes should comply with the law and statutory duties, so services that must be provided may be reconfigured but not withdrawn. Local authorities have responsibilities under the Care Act 2014 in respect of the care market, provider failure and service interruptions[14], particularly in relation to the closure of registered care provision where they have a temporary duty to ensure that people's care and support needs are met[15]. While it is not the responsibility of the local authority to keep failing providers afloat, they may support an individual provider to repair its problems[16] or delay closure so that people using the service have a smoother transition[17]. Services may need to change in response to new legislation, caselaw, needs or evidence. The formal agreements set out in the commissioning contract must be adhered to, including any funding clawback agreements in the event of a closure.

Challenge #1

What actions have commissioners taken to protect the market and to find alternatives to closure in this instance?

- The closure needs to be managed in collaboration with the local authority, Clinical Commissioning Group and the Care Quality Commission as well as neighbouring authorities who may be affected, third sector bodies who may be able to provide support. Agencies need to work together to ensure that the people receiving the service are supported as effectively as possible. Where the closure is unplanned, the Police, Health and Safety Executive, professional bodies or local Safeguarding Board may need to be notified too[18], especially in the event that the service is subject to immediate suspension, closure and deregistration by the Care Quality Commission

- Strategy for decommissioning, operational planning (including the business case set out in a Decommissioning Brief) and delivery (including sufficient notice of the final decision to close the service whenever possible) should be coproduced with all stakeholders including people using the service[19] and founded on clear evidence of the local population[20] and market, demand, best practice, the efficacy of local services and available funding from all possible sources. Official guidance is available on managing care home closure[21].

Challenge #2

Are people who use services present and participating in all levels – (i) developing the commissioning strategy; (ii) writing the decommissioning strategy; (iii) negotiating the section on closure in an individual contract; and (iv) membership of the Project Board that manages the closure of an individual service?

Does your team have a closure plan ready for action if the time comes?

- Contract duration will balance the need for continuity and to enable people using the service to maintain stability with the need to refresh the market from time to time. The optimal duration will vary according to the service being commissioned and will also be scheduled to manage commissioning capacity and maintain market stability. Three to five years is a commonly used 'sweet spot' for smaller services.

- Commissioning relationships should begin with the end in mind, so that decommissioning arrangements are built in from the start and contain a duty for providers to give reasonable notice of their intent to cease the service where closure is planned[22]. This may need to include a discussion about the wider implications of taking on and then losing a contract for the whole provider organisation, as starting one service can refocus all the activities of a

provider organisation, while closing it can make a whole organisation nonviable. Such consequences should not lead to the commissioners being held to ransom.

There are a number of challenges to success in delivering this approach, many of which are described elsewhere in this paper and in its companion piece on relocating a care service. One in particular is relevant here. Whilst the intention and expectation is that people using the service and carers will be fully involved in every part of the process, it is already clear that this can subject the people involved to substantial stress, especially where residents are fragile and and the service is heavily depended upon. In this situation, it is helpful to separate out the various steps listed here, of agreeing a commissioning strategy, then a decommissioning strategy, then a decommissioning process to be built into individual contracts, then an individual plan of action for the service in question.

Challenge #3

How do decision makers meet with and genuinely connect with the experience of people using the service?

There is a case that might easily be made for separating out each of these functions and allocating places on each project group to different people, including different persons representing people using services and their family members. The result of dividing up the task in this way would be that each participant would be allocated a limited span of accountability and be obliged to trust that others had their stage of the process in hand. In this way, the burden of responsibility is reduced to a tolerable level, the number of variables is limited, and so to a certain extent, each group has to simply accept the outputs and activities of other teams who are working at different stages of the journey. This approach has great appeal and seems common sense, yet some may have taken it too far, as recent advice suggests that service change by '*removing the distances between commissioners, providers and those of us with care and support needs.*' [23]

Distress and its effect on people using the service

The focus on practical arrangements and shared decision-making mentioned above is well and good but may obscure the intensely emotional aspect of closure or transfer. Indeed, one guidance document advised that the news about closure should be communicated in a manner which is as 'simple, explicit and as unemotional as possible"[24]. It is hard to know whether this would be perceived as callous or comforting, when the news is an eviction, a compulsory purchase, a forced migration. It is possible for the closure or relocation process to be brutal.

People who have relied on the service will grieve its loss[25], and this may repeat a pattern of withdrawal and abandonment that they have suffered throughout their life. Even where proposals are communicated well in advance by the right people[26], some of those using the service and some relatives either fail to hear or understand it, while others dismiss it as fanciful. This means that when the changes begin in earnest, some people react with shock and dismay, perhaps cynically attributing corrupt motives to the change leaders, such as believing that the change is being imposed impulsively to withdraw services and save money rather than due to any coherent and measured plan to safeguard people and improve care. Even if these negative reactions do not occur, people are very likely to feel stressed and disempowered by the change, as all change is stressful and the decision may well have been made by strangers in a distant place. Maximising opportunities for choice and control will help people to feel a little less powerless.

One project[27] helped new arrivals in a nursing home create life story books as a means of learning about the new resident and supporting them to integrate this most recent move into their

autobiography. While it was done after moving into residential care and so took a retrospective approach, there is no reason to doubt that similar techniques would not be helpful in anticipation of a service closure.

Coproduction

Some commentators[28] have argued that it is expedient to keep closure plans secret until all the important decisions have been made and time to complain is as short as possible, in a bid to avoid commercial damage and unpleasant, costly and distressing disputes, despite a clear expectation from Government and the courts that such decisions are made in consultation with people who use the service[29]. As one guidance document instructs; service users, their families and care workers themselves must never be left out of the loop and should be engaged in planning for potential service interruption.[30] Reality may be lagging behind the rhetoric. As recently as 2014, international experts on decommissioning were neglecting the voice of people using services in their definition of best practice[31]. Others lock people out until it is too late: '*stakeholders should be informed once a decision to decommission a service is made. Commissioners should seek legal advice regarding information that can be shared with stakeholders at different stages of a decommissioning process*.[32]

Challenge #4

How do people exercise their opportunity to influence the closure decision before it is taken?

An alternative is genuine coproduction, where the organisation is jointly managed, and people using the service, relatives and other stakeholders have the opportunity to be fully involved in both the pleasant decisions (administering new funds, conducting research[33], designing novel services, recruiting staff, marketing and so on) and the difficult ones, like developing and activating a closure plan. Despite the fact that the United Kingdom is leading the world in coproduction[34], these challenging areas remain little more than an aspiration in many places.

Challenge #5

To what extent are people using services involved in day to day decision making?

Some care home residents and their relatives will want to be involved and sit on the Project Board[35] from the beginning, prior to decisions being made about closure - and those who don't will still want to be kept fully informed[36] and have the opportunity to contribute. In general, increasing choice, control and involvement in decision-making reduces the amount of harm done by involuntary moves[37], and choice has been established as the first principle to be applied wherever possible during home closures[38]. Tasks for the Project Board are set out in the box below:

Receive and consider the feedback from consultations and dialogue with interested parties. Support the decision makers to reach a final decision about closure or its alternatives. Set out the closure timetable. Agree the communications plan. Undertake organisational risk assessments (in the case of the local authority also in respect of the wider market for social care). Consider local risk assessments. Receive progress reports. Monitor progress against agreed milestones. Monitor performance of the project team against agreed quality standards. Ensure rights of residents and staff are protected. Coordinate the work of key partners.[39]

This advice to coproduce the closure process with representatives of people using the service is frustratingly vague on detail and neatly ignores some of the complexity of doing this well. Guidance[40] recommends that any conflicts of interest should be 'carefully managed', such as where

the people who make the decision about decommissioning are also receiving the service, but no suggestions are made on how to mitigate for these risks without excluding people who use the service and their relatives, as some have recommended[41].

Commissioners are directed to meet with the provider at the first point that decommissioning is being considered, so that they are aware of the commissioner's thoughts and have the chance to suggest alternative courses of action[42]. We might imagine that many provider owners and managers would be extremely reluctant to involve their residents in such a meeting, as they fear that it might trigger distress, lead to the loss of frontline staff, switch off referrals and generally destabilise the service.

Perhaps the 'representatives' of people using the service are not intended to actually be people who are using the service, but people who are at arms-length – people using other social care services, past users, relatives of users or champions, perhaps the staff of an organisation set up to campaign in the interests of a group, such as Age UK. If this is the case, are such individuals expected to keep the deliberations of the Project Board secret from the people who are to be affected by its decisions? This could harm the relationship between committee members and other stakeholders in the change, whilst turning the principle of coproduction into a charade.

Another crucial moment in the decommissioning process is when the commissioner issues a Formal Notice of Contract Termination, which occurs after the findings from consultation have been considered and a decision has been made to decommission. Coproducing the process means that people using the service and carers are part of the group that evaluates consultation feedback alongside the other evidence, considers alternatives to decommissioning, comes to a decision and drafts the Formal Notice. Coproduction could mean that people using the service and carers are voting members of the decision-making group rather than merely advisers or consumers of the outcome.

This vision of coproduction must jostle with other worldviews, such as the democratic process by which elected members of the local Council and their officers shoulder the burden of deciding these matters and cannot surrender these responsibilities or cede them to others, even people using the service. A second concern addresses the assumed competence of people using the service, suggesting that either they lack cognitive skills to understand the process of decommissioning, respond to reputation and anecdote rather than more objective evidence[43], or lack the psychological resilience to bear the weight of the decision itself. More broadly, Daniels and his colleagues[44] found some respondents who feared that involving the general public in decision-making would shift funds away from worthwhile but unpopular services as people discriminated unfairly against people judged to be undeserving, so services aimed at people who misuse substances, sexual health clinics and rehabilitation of offenders or smoking cessation could well lose their funding.

Challenge #6

How does your approach to coproduction respond to conflict?

Feelings run high in closure processes, and some people want the resident view to be presented as adversarial, demanding and uncooperative rather than amenable. Committee members who take a pragmatic approach, who at some point select appeasement rather than continuing an endless fight and then negotiate terms of surrender while remaining involved may be viewed as collaborators or traitors[45]. While these are unpalatably confrontational words for some, the images of a life and death struggle against an oppressive force accurately capture the reality for others, who do not want to be told that 'we are all on the same side'. Daniels' team[46] have provided evidence

from the English NHS to suggest that much guidance material on consultation is written with the assumption that, with sensitive handling, unanimity across all stakeholders may be found and so conflict is to be avoided. A more robust approach would suggest that creative solutions may arise at the point where swords clash and dispute is at its fiercest, but in these mechanisms participants on both sides must prepare to lose from time to time.

One might imagine that some closures are conducted as a compromise in which the process is codesigned in principle, including notice periods and the quality of information that is given, whilst staff, owners, commissioners or local politicians retain the power to make final decisions and set dates. Again, guidance is muted on the real issues by using the beguiling phrase, 'If, after a meeting with the service provider the decision to decommission is confirmed, the provider should be notified in writing'[47], without exploring whether people using the service are occupying any more than an advisory role or actually coproducing the decision to close. Perhaps commissioners, owners and local politicians are unwilling to share their power and prefer to retain the idea that advice can be coproduced, but in the last analysis, they have a duty to make the vital decisions.

A regularly updated 'You said, we did' poster will serve to remind people about the changes that have been made as a result of listening to stakeholder views and the reasons why other proposals were not implemented. Feedback should also be gathered from people who have used the service and their relatives after a service interruption, closure or relocation[48] and a review of the decommissioning process should involve people who were using the service[49].

It may be that closure planning reveals whether coproduction is a guiding value for the organisation or not. For example, shareholders in the commercial sector may adopt the language of coproduction in a tokenistic way, but continue to acquire or divest themselves of individual parts of their portfolio in response to profitability rather than the interests of the people receiving their service[50]. While local politicians, researchers and other groups may not be driven by the profit motive, they may have other reasons for failing to pay attention to everyone who has an interest in the proposed changes[51]. Fifty years ago, Arnstein[52] created a 'ladder of citizen participation' to distinguish the different types of participation including those where decision making is genuinely shared and others which are settled far from the place where their impact will be felt. Sometimes the language used can partially obscure the extent of coproduction, as in the following advice, which provides no opportunity to influence the actual decision to close:

> "*Communication should be both proactive (sharing information and keeping people informed) and responsive (dealing with queries and allaying people's anxieties*)."[53]

Challenge #7

How will you mark the ending of the service?

Other guidance[54] provides assurances that residents and their families will be involved in the individual decision about where to move to, and promises that, wherever possible, residents will be consulted before a decision is made to close a care home. Where the closure plan for one service involves a relocation of some or all of the people, the transfer arrangements can overshadow everything else and introductions to the new routines prevent people being given the time to say goodbye to the old, familiar associations with the closing service. The goodbye at the old place and the welcome at the new one are equally valuable[55].

Where the service is being closed because its quality of care has been poor, it is important for people using the service to have been aware of the quality standards that should have been met and

be involved in quality monitoring and assurance activities. If this is not a routine part of the service, then the revelation that they have been receiving a poor quality of care will be disturbing.

The closure-relocation matrix

Closure and relocation can be placed as axes on a scatter graph and then individual plans plotted on to it, as illustrated by the examples below. Individuals can be plotted on the graph too, as one person may be focused on what they are losing through the closure, while another is captured by the possibilities of relocation. Some of the numerous options are considered in the following examples:

- The English hospital closure programme of the 1980s and beyond moved large numbers of inpatients from Victorian long-stay asylums into community-based residences resulting in dramatic changes in environment and lifestyle, requiring residents to negotiate traffic, manage money and interact with neighbours in new ways after perhaps decades of institutional, campus-based living. Whilst evidence from these moves[56] is illuminating, this group had a level of institutionalisation that made them quite different from people who transfer from one care home to a similar place down the road.

- The team who are faced with closure work with allies to find a new way to keep going. They may engage a fundraiser, apply for previously unexplored grants or partnership funding, reframe their offer to meet new contracting requirements or negotiate a buyout and continue in an amended form as a new member-run or community enterprise. This option enables the closure to be done in a way that maintains relationships between staff and people using the service – a significant goal in many situations. Secondly, these opportunities are commonly identified by the provider of the previous service[57], who is recognised as resourceful and creative rather than traditional and obstructive. However, the Public Contract Regulations 2015 indicate that major departures from the original contract would be considered a 'material change' and require a new procurement process, thus giving other providers an opportunity to enter the market[58]. Furthermore, efforts to recover from the brink of closure may not regain the confidence of commissioners once it has been questioned.

- The service is closed and the people who used it are offered an individual assessment triggered by the closure, which might result in the offer of alternative support from services that are continuing. Sometimes expert and impartial advice is offered to help people choose an appropriate alternative to the service that is closing. This should start at the earliest possible moment, so that people are supported to move on rather than being processed all in a rush at the last minute, or being obliged to endure a gap in service before being picked up again. See the section below on person-centred planning. Sometimes the assessment and support planning which is needed here is compromised because the local service lacks expertise and capacity. Some people will need a phasing out period[59].

Challenge #8

Are people able to enjoy individualised and person-centred options for care or is there a limited array of 'off-the-peg solutions?

Challenge #9

How do you prepare people for independence and mutual support in the community beyond services?

- The service is simply closed and people who used it are cut adrift without the service it provided or are left to make their own application for alternative provision. In this case, the 'new' service may be nothing at all, informal interdependence and mutual support in the community rather than state-funded, one-way help. Staff may choose to alert commissioners or other agencies to those who have significant needs for ongoing support, while others depend more on longterm supports, such as friends and universal community networks rather than paid staff and projects which, by definition, are almost always short-term.
- The service was commissioned on a fixed term contract which has simply come to an end, perhaps because funders at the time had windfall monies that they were willing to use on an entirely experimental initiative and had never any intention of continuing. In these circumstances, some seconded staff will be happy to return to their substantive post, relieved that the pilot project is over, especially where it was demanding and success was hard to find, and others will relish a change triggered by the clear notice period regarding this endpoint in funding. In contrast, others who have provided or utilised this service will focus on the positive value it has delivered and find it hard to believe that continuation funding will not be provided, feeling as if the closure passes judgement and invalidates their personal efforts. In an example of classical intermittent reinforcement[60], this optimism is underscored when other time-limited projects are granted an extension. Where it is reasonable that providers may expect continuation, commissioners should provide at least six months' notice of impending termination[61].

Listen to the opposition

Frontline staff can feel especially disempowered by the closure process, compounded by financial difficulties and fear of long-term unemployment as well as the challenge of finding a new job that fits in with their domestic arrangements. As well as needing support, frontline staff may recruit other groups to present their case, such as engaging people using the service or relatives to campaign on their behalf.

The UK government uses publication in three ways: a Green paper invites discussion prior to any specific proposals, a White paper presents a firm proposal and asks if there are any flaws in it, and an Act publicises the decision that has been taken. In general, all stakeholders can recognise and accept these different stages, and only lose faith if they are misrepresented, such as when a plan is shared as if it is no more than one idea amongst many but in fact the decision has already been taken. Similarly, it is vital to be clear about who has the final say, so that, for example, the Residents and Relatives Council know whether their unanimous decision to oppose closure will change the outcome or whether it is a foregone conclusion. Local politicians may engage in listening exercises and provide helpful input and challenge to the process if they are suitably briefed about the intentions, rationale and evidence for the closure as well as the viewpoints of all stakeholders. In the worst scenarios, advocates are drafted in to 'listen' in the hope that this will be cathartic and enable people to be reconciled to the change, but to intentionally do so is to manipulate rather than to empower.

If the closure takes time, some of the most highly motivated and resourceful workers will find alternative employment, leaving a rendered down group which may become dominated by passive or unimaginative staff, thus increasing risk for people using the service. Amongst the group who remain to the very end others choose to do so because of their high level of commitment the people they support and their determination to ensure that care is delivered to the highest possible service standards. As the number of people remaining in the closing service reduces, staff who remain are able to spend more time with each person and this can be highly valued.

Challenge #10

Who is committed to stay on and deliver excellent care right to the end?

Some people using the service may have particular reasons for their reaction to the closure announcement. Some entered the service a long time ago under more liberal conditions and the tightening eligibility criteria have not been applied to them until this moment. The closure announcement finally triggers a long-delayed review which inevitably finds that they are no longer considered eligible even though they have not changed in themselves. In this case, the closure is then used as a convenient excuse to apply the modern approach and reassign scare resources. To the dispassionate observer, the person has been treated generously since the shift in eligibility, perhaps many years ago, but to the person themselves, the new assessment seems capricious and unfair. On occasions, this point is reversed, as where closure planning triggers an independent assessment which finds that the current residents have more complex support needs than the old service was commissioned to provide. This may mean that the residents have been receiving a good service, richer than is being paid for, or that the current difficulties are a consequence of poorly skilled and resourced staffing. The assessment team then have the challenge of working out what support each resident will need in the long term.

Challenge #11

How are changes to eligibility criteria being applied routinely across all reviews of care and support?

There are many forces in the system to create and sustain too much support and it is only zero-budget reviews or crisis events like the review triggered by closure that bring these arrangements to light[62]. If these matters had been dealt with at the time and without delay, then the problem would be less severe at the moment of closure. They become a magnet for feelings of unfairness, as people compare their support package with that received by other people, or they contrast their entitlement at various points in their history and cannot see why there are differences in entitlement. Providing education on eligibility criteria might help, although support ought to also factor in environmental conditions and ambition as well as individual factors. For example, different levels of staffing are needed for a blind versus sighted person, for walking on a footpath through the fields or on a pavement by the roadside, and for the person who always expects to be accompanied and the person who is learning to travel independently.

Challenge #12

Is anyone getting too much support?

Perhaps a small amount of support acts in a preventative way, reducing the need for a much larger support package. The closure of one service that has been highly valued can increase fears of deterioration and sometimes trigger a crisis through which the person needs a great deal more help, with the nett result being more cost to the overall care system rather than a reduction in demand. Some people will be grieving because the service has been a lifeline and its closure will result in tragedy.

On the other hand, people in the service may have become dependent and the closure will kick-start a new level of self-reliance, press people to find real friends rather than depending on friendly staff, get just enough support rather than too much. Such persons will outperform all previous predictions carved into their assessment reports.

Person-centred planning

Closing the service means that potential new referrals need to be diverted to alternative sources of support and if the ban on referrals is started well in advance of the closure, then this creates an 'empty nest' feeling for those who continue using it or working there. Staff may choose to leave rather than feel underemployed and unwanted, while in congregate services, people who in normal times attended to meet up with their friends can feel abandoned, as if others have left the party before the end. In services where people can choose whether to attend or not, some people who are still on the books may reduce their participation or give up their place entirely, leaving the declining service as a ghost town. Some of these services, such as day centres, can be repurposed as community facilities by welcoming new, mainstream community groups into the building to add new connections and vibrancy to the closing weeks.

Planners should assign the task of assessment, planning and signposting to an identified specialist team or else by default it will end up being handled by the service that is closing. In the case of care home closures, commentators[63] have recommended that at least one member of the assessment team should be based full time in the care home, so that residents, relatives and staff have easy access to them.

The closure will also destabilise similar services that are technically unaffected but fear that they will be next in line for closure.

Although it is a mantra that the support needs of the people receiving the service should drive the change, this is often not the case, since the closure is triggered by external factors such as the owner's retirement or building dilapidation. In these circumstances, a resolution must be reached between these external factors and the needs of the individuals which means that the change is carried out in as person-centred manner as possible. This principle is braced when the assessment team take a firm line that no resident should be transferred to an unsuitable environment (such as moving into an environment where there are unwarranted restrictions), even if a bed is available and nothing more suitable has yet been found.

Where the person moves 'sideways' to an alternative provider of the same level of care, this can have the effect of reducing the person's quality of life, especially where so-called privileges that the person has been gradually awarded in their old setting are withheld by the new team and used as bargaining counters to elicit appropriate behaviour from the new and unknown resident. In contrast, the step down to a new service provider may provide such a lot of additional freedom and a quality of life that is so improved, that these minor inconveniences at the beginning of the new residence are perceived as trivial. Overarching this whole discussion is the question that must be asked about a care regime that relies on such bargaining.

When considering reprovision from a closing service it can be helpful to find out exactly what people are getting out of the service and then think about how that should be replaced. So one day service attendee wants to meet his friends and another family needs a break. So the relocation can include amending the service to achieve a better match with people's needs. Secondly, it can be helpful to consider what the person thinks is an equivalent place rather than just asking staff. A place six miles

away may seem near to the manager but is practically the next country for people who have enjoyed little mobility in life.

A contracts manager may be able to hold vacancies open in services that are imminently closing and retain vacancies in continuing services until they are needed by the people making a transfer from the closing service.

Some current participants will not like the current service very much and will be glad to receive an offer of additional support to make their plans for moving on.

Careful planning and preparation must not be used to over-extend the duration of uncertainty beyond the person's capacity to endure it[64] and some residents will need careful preparation in an environment that is not marred with the visible signs of packing and flight or insensitive visits by the new owners, followed by almost surgical speed in effecting the change. Others will need time to get used to the idea. Effective planning will require a 'plan B' to be ready for the eventuality that something unexpected thwarts the first set of arrangements for each person.

Yet others may need very little help in order to move forward once the closure plan has opened up new opportunities and created ideas that were previously unimagined. Years ago, it is said, a day centre was closed and two of its longstanding members responded by finding themselves paid employment. Such easy, early wins will encourage everyone. These individuals may move away from publicly funded support or take up a personal budget[65] and these experiences may shed light on risk-averse cultures and gloomy predictions about the vulnerability of individuals rather than their resilience. Whilst some staff and relatives will find these events heart-warming and a welcome challenge to their expectations, others will be threatened and defensive, determinedly treating the account as an 'exception that proves the rule' or predicting that the uplift will be short-lived and a precursor to deterioration.

Challenge #13

Are staff permitted to continue to provide contact and support to ex-clients?

The policies of many social care organisations insist that staff should end their contact with people who have been discharged or transferred to another part of the system. While this makes sense when the person is receiving intensive therapy which could be inadvertently spoilt by the random interventions of a previous worker, such circumstances are extremely rare. When ordinary citizens move house or move to a new job, they often stay in touch for a time, so that the old life and the new one overlap, but this is rarely the case in the relationships between people using a social care service and the staff who support them. One person compared the experience to an alien abduction, so the departing person simply vanishes and staff refuse to speak of them, get in touch with them or permit other residents to make any contact[66]. Whilst this may be an extreme example, if similar practices are allowed to shape the approach to wind-down and closure, then people who have been using these services will be cut off from sources of both formal and informal support.

Some people may fall through the net, withdraw from services and languish, rather than doing well[67]. Others may withdraw from services and do better than is expected, but this is not well understood.

The bucket list

When Justin Zackham wrote a list of things to do before he 'kicked the bucket', it changed his life and bequeathed us all a useful phrase as well as an entertaining film. Imminent death, whether in confronting one's own mortality or preparing to close a service, sharpens the mind and establishes new priorities. For example, a Foodbank may stop taking new referrals and start to teach current customers how to forage and cook instead of just giving out tins. Perhaps these deathbed reforms are what the service should have been doing from the start.

Challenge #14

What do the people facing closure tell us we should be doing to support people who use social care?

Some people will respond to the closure news with an initial period of shock and dismay but at some point decide to make the most of the inevitable and begin to demonstrate acceptance and resilience by looking forward to the next phase in their life rather than just looking back at what they have lost. Others give up on their commitment and begin to be merely present in body, while applying for alternative employment. Pleasure abandons the workplace and the singing and laughter fade away, perhaps replaced by resentment or anger. Staff use their personal influence to compose a lament or orchestrate a resistance campaign.

Planning blight

The term 'planning blight' was coined in the 1960s to refer to the neglect that occurred as a direct consequence of the announcement of plans to demolish poor quality housing. Since the house was to be pulled down, owners could not sell and saw no reason to continue with repairs and maintenance so the area declined much more rapidly than it would have done without the announcement. In social care, planning blight can be manifested as a lack of investment in buildings and décor, reduced budgets, decline in official visitors and referrals, silence in marketing communications, assumptions that staff who remain are incompetent, all of which in turn can lead to a rise in unwanted and challenging behaviour by people using the service. In some cases, the decline is so rapid that observers change the metaphor and speak of the service haemorrhaging, losing investment, staff, referrals and participants so rapidly that closure becomes disorderly and the service may become non-viable well before the planned end date.

Challenge #15

How will you know if the service becomes nonviable during the winding down period and what will you do about it?

Planning blight occurs when people beyond the closing service believe the closure announcement, while a range of practices which might be grouped under the headings of 'denial' or 'challenge' arise when people either inside or outside the service do not believe the news. In one case, the property had been sold, so it was easy to convince everyone that the closure date was not a matter for negotiation. As far as possible, relationships and routines should continue unchanged throughout the closing down period to minimise disruption to people using the service[68]. The provider, local NHS and local authority should work together to secure a managed closure at a reasonable pace so that people using the service are well cared for.

This process can happen in health and social care settings, especially where longstanding services have been subject to repeated cuts in investment. So-called 'efficiency savings' combine with vacancy freezes and refusal of maintenance and development requests to erode the visual appeal, resources and range of supports available to people. In passing, it is worth noting that these cuts can

have a disproportionate impact on managers who measure success by growth, and on non-statutory, experimental and outreach services where closure can be accomplished without building closure. As a result, staff may feel abandoned and withdraw their labour. Some find alternative employment, leaving vacancies that no one wants to fill[69], while others withdraw from all the voluntary activities and emotional investment that does not appear on their job description but nevertheless adds real value. It should not be assumed that planning blight will affect all teams – indeed, it would be interesting to know why some keep going, like the dance band who continued to play as *The Titanic* slipped beneath the waves.

While closure is usually imposed on the team by external forces, whether market pressures or commissioning processes, some staff will deal with it by choosing to leave their job. They are then likely to exhibit 'pre-quitting behaviours', almost all of which will impair team performance and care for the people using the service. This is manifested as:

- **Productivity**: Reduced attendance, focus, effort, motivation and output
- **Teamwork**: Less like a team player, less interested in pleasing their manager
- **Withdrawn**: Less interest in customers, less enthusiasm for the mission and unwilling to commit to long-term timelines
- **Attitude**: negative and dissatisfied[70]

Challenge #16

Have you stopped to really listen to people's grief?

Stakeholders also need to grieve the ending of a lifeline, a team, a service, an identity, a friendship. Sadness needs to be acknowledged and processed by the people who feel it. Clumsy attempts to steer the process for others can do more harm than good, communicating tokenism and false empathy. When individuals face death, doctors are sometimes naively optimistic, and this may affect social care staff too, while the Stockdale Paradox guides us to face the harshest truth of our situation whilst holding on to hope in a positive ultimate outcome. Courageous change managers face the harsh realities with compassion, bring genuine comfort and communicate hope in the bleakest times.

Some resident's move into a care home will have been triggered by the death of a spouse, and many will have lost friends, so admission can make people feel that they are a step closer to their own death. Experiencing another loss, such as the ending of a service or the closure of a care home, can reinforce this perception. Where the closure process is poorly handled residents experience repeated disappointments and changes of plans which may be manifested in challenging behaviour. Where staff lack empathy, the person may be blamed for the distress they experience which has been caused by these conditions, and they may even be moved to an unsuitable and restrictive service as punishment for the distress that the change managers have created themselves.

The particular grief of entrepreneurs

Entrepreneurs working in the creative sector will be familiar with closure, as individual shows or exhibitions are expected to be time-limited and the triumphant party to celebrate the final curtain call is a staple feature. Other sectors too enjoy successful closure, as manufacturers maximise their profit and then abandon a niche market at just the right time and property owners sell up and retire at the perfect moment when the market will give them the best return.

Ucbarasan and colleagues[71] studied the impact of business failure on entrepreneurs and found financial, social and psychological consequences, including the potential for trauma. Its components include:

- **Financial** – insolvency and bankruptcy, adverse credit rating and debt, diminished career prospects and homelessness
- **Social** – marital breakdown, loss of work colleagues, stigma and blame
- **Psychological** – disappointment, shame, pain, remorse, humiliation, anger, guilt, fear of the future, grief, anxiety and depression, helplessness and loss of motivation.

Entrepreneurs in the care sector have an added challenge, as it is rare to find an example of an intentionally time-limited service where closure is associated with success. Rather, the manager and other senior staff who have been deeply involved in designing and shaping the service are likely to be distressed, ashamed or furious to see it close. These strong feelings will be compounded where the closure is in response to a safeguarding issue and staff fear disciplinary or legal action or damage to their reputation and future employment prospects. This may require more than simple commands such as those found in the guide that directs staff to "*separate your own personal anxieties about moving homes from the support you are providing to residents. At all times use open, friendly body language such as leaning forward when listening, smiling, nodding and understanding. Crossed legs and arms do not suggest openness*."[72]

Challenge #17

Who is supporting owners and managers to get through the closure process?

The intensity of the emotional response to business failure will depend on a number of factors, including the consequences for other people. In the care sector, and in particular, in residential care homes, failing to provide a safe home for life is likely to carry considerable opprobrium, and this will be heightened yet further if the closure is triggered by abuse. People in the midst of these intense negative emotional responses will likely be preoccupied with them and so unable to learn from or make sense of the failure unless they are either capable of regulating their own emotions or have had time to process the experience. People who are able to regulate their emotions influence three things: (i) which emotions to have; (ii) when to have them, and (iii) how to experience and express them.

Studies of project failure within the commercial sector[73] have focused on learning from failure, but this is not always the goal. Some owners and employees will simply leave, either giving up work entirely or moving into a different employment sector. Bankers will be reluctant to give failed entrepreneurs a second chance in social care, regulators and professional bodies may refuse further registration and the media and general public may continue to vilify the people they see as responsible for the failure.

If the failure occurs in a family business, it is the whole family's ability to deal with the failure that will determine the outcome. In the early stages of processing the grief, some entrepreneurs manage these circumstances by blaming others, such as their employees rather than their own competence, and so block the necessary learning processes of gathering information, searching for root causes and reflecting on experiences[74].

Some lessons may be drawn from the neighbouring field of moral disengagement theory (MDT), which is normally applied to the situation where people adopt unethical practice[75]. In most cases, provider closure is driven by external forces or well-meaning incompetence rather than the wilful and inhumane behaviour that is the focus of MDT, but the responses identified in MDT may also be

found in the emotional world of people who have overseen a failing care service[76]. Rather than be crushed by a feeling of guilt that the promised care has not been provided, owners and managers may exhibit one or more of the following MDT behaviours, using each process to mitigate an overwhelming sense of failure rather than to nullify every regret:

Moral disengagement strategy	Example in care homes	People say	Mitigations
Moral justification	Neglect is justified as giving people choice and independence	Cruel to be kind. The end justifies the means.	Recognise conflicting demands. Admit guilt. Remorse.
Euphemistic labelling	Nagging and issuing commands is called 'encouraging'.	Jargon. Waffle.	Name it.
Advantageous comparison	CQC special measures rather than staff sent to prison.	I didn't fail as badly as them.	Select a range of comparators
Displacement of responsibility	The Commissioners held down wages, so we couldn't recruit.	It was their fault we had to close.	Forcefield analysis
Diffusion of responsibility	Nobody suggests things could be better or challenges the status quo.	I was just a cog in the machine	Brave review of personal choices made
Disregarding or misrepresenting injurious consequences	Focus on procedures rather than people and avoid really listening to residents and relatives.	I had to do the paperwork in the office	Follow the whole journey, rather than obsess on a particular moment in time
Dehumanisation	Closing a care home by supporting all the residents to move elsewhere is described as 'decanting'.[77]	They have dementia, so won't feel it	Empathise and so resist the tendency to treat people as commodities.

The fourth strategy listed above is called 'displacement of responsibility' and it deserves a further comment. Sometimes responsibility is too great to bear and so it is split, so that someone removed from the situation, such as a commissioner or regulator, bears the weight of the ultimate decision, freeing the people in the frontline from the task of shouldering it so that they can focus on supporting the individuals who will be affected. This is a kind of displacement but may be a reasonable one. A less comfortable version of displacement of responsibility occurs when the person feels two contradictory emotions and resolves the cognitive dissonance by denying the uncomfortable pole, splitting it off and imputing it to the person who draws on care. For example, when people self-harm, the nurses in the emergency room feel both compassion for the person's distress and anger that the person has 'chosen' to absorb resources which could otherwise have helped another patient who is there through 'no fault of their own'. By splitting these contradictory emotions, the nurse can feel virtuous about their own role, whilst punishing the patient for their perceived transgression[78].

Another reasonable adoption of 'moral disengagement' may be linked to the sixth item on the list above. While it is harmful to disregard or misrepresent injurious consequences, an excessive focus on the harm caused by the failure can crush the person who feels responsible. Those who survive

failure may do so by stepping away from the hurt they have caused and focusing instead on the positive opportunities that arise from the failure and this enables them to regulate their grief response and move towards recovery. The business may have failed, but the entrepreneur gets to spend more time with his family. One career may have ended, but new opportunities beckon.

A further framework that sheds light on the experience of closure is moral injury. This is defined as 'the psychological, social and spiritual impact of events involving betrayal or transgression of one's own deeply held moral beliefs and values occurring in high stakes situations.' It is deeply personal, so the same events may trigger injury for one person and not for another. It can occur when the pressures of a challenging situation result in the person themselves doing or failing to do 'the right thing' or when they are affected by someone else's actions. Responses can include:

- feelings of guilt, shame, anger, sadness, anxiety and disgust
- intrapersonal outcomes including lowered self-esteem, high self-criticism, beliefs about being bad, damaged, unworthy or weak, and self-handicapping behaviours
- interpersonal outcomes including loss of faith in people, avoidance of intimacy and lack of trust in authority figures
- existential and spiritual outcomes including loss of faith in previous religious beliefs and no longer believing in a just world[79].

On occasions, action needs to be taken by the local authority and others to ensure that people using the service are safe despite the low level of cooperation being given by the staff working in the closing service[80]. Indeed, the respondents interviewed by Glasby's team considered it almost inevitable that managers would be unable to communicate the reasons for closure in the right manner[81]. These observations are reminiscent of the behaviour of small children who react to criticism by tearing up the work that they have laboured over and were proud of before the negative judgement changed everything.

Challenge #18

Closure changes everything. Are people safe?

Frontline staff will have also made a considerable emotional investment in providing care and will be subject to relocation stress themselves[82], and so it will be important to support them throughout the closure process, both for their own sake and because otherwise their loss of morale, sickness absence, burnout and turnover[83] will harm the people using the service.

Grief begins with shock, immobilisation, denial and anger before moving into a period in which the person repeatedly revisits key moments in the loss accompanied by intense emotions interspersed with periods of distraction. The hard work of sense-making then begins with rationalisation and gradual acceptance as the person forms a coherent, personal explanation of why the failure occurred. In positive grief, this explanation includes learning based on a realistic appraisal of the limits of control and responsibility for the events. The person oscillates between these different responses for some time, gradually restoring equilibrium, normalising the experience, finding meaning and recovering a future orientation rather than a preoccupation with past events. The person begins to take part in the world again, choosing life and exercising their potency, able to recall the failure with tranquillity.

Leadership

Leaders need to be strong and compassionate rather than callous. They need to be visible and available so people can get to know them, trust them to be responsive and available to answer their

questions. It needs to be clear that they are focused on supporting people to get better lives. Leadership is not just the wielding of hard power over others but a matter of winning people over, helping them to recognise the merits of the proposed change. It can help to separate internal managers leading and acting as the human face of the closure decision from external managers exercising their regulatory or commissioning powers.

Service closure illustrates the Biblical proverb 'As you sow, so shall you reap'[84].

- If management has a track record of indecision, capricious changes of direction, vendettas against individuals, cave-ins when media or political pressure is applied, baling out anyone who shouts loudly enough or a host of other poor practices, then these poor practices will cast a long shadow and affect the way that the current change is handled.
- If people using the service are routinely kept out of political and managerial decision-making processes, they will not have much knowledge of how the process will work for this current situation. If personal choices are routinely frustrated and personal preferences ignored concerning small decisions like when to get dressed, what to eat or who to talk to, then people will have real difficulty in choosing where to live.
- if a high percentage of people using the service are self-funders or have an individual budget, then they control the design of services and manage the decisions to continue, upgrade or close the project. Many spot-purchased individualised packages continue to be contracted by the commissioner rather than held by the person as an individualised budget, so the power remains with the system rather than being in people's own hands. On the downside, individualised supports can be subject to more budget sniping than large capital investments.

Challenge #19

Are enough people designing and managing their own support packages through direct funding or individual budgets?

- If people using the service and families have been encouraged to get and then hold on to as much official help as they can, ignoring growth, independence, personal resources and natural supports in the community, then they will approach every review as a contest where the prize is the biggest possible support package. These and other processes result in the person receiving too much support rather than just enough and make both closure and relocation more difficult. Moreover, 'service-centred' cultures ignore the significance of unpaid and unregulated relationships with members of the general public and so insist that everyone is DBS checked, subjected to a formal written risk assessment or co-opted into the care system, rather than supported to establish and maintain informal friendships in an unregulated world. Closure brings these things to a head, shedding light on a weakness in the everyday practice of the care system.

Challenge #20

How are people being supported to have a life beyond the service?

In contrast, it is Important to be clear where decision making authority lies as it may be with the Council rather than a democratic meeting of people using the service. Then there is the 'soft' decision-making, so although the campaigning period runs right up to the budget meeting of Councillors, history tells us that most reports get nodded through. People using services may be naïve in their expectations about their potential for influencing the outcome and need to be better educated about how local political systems should work and actually work. At the level of the individual, a closure decision may be a triumph of important for over important to.

Members of Parliament or local politicians, including portfolio holders and members of scrutiny committees may visit the threatened service but unless they are briefed, they may not understand what best practice looks like and so be persuaded to block legitimate service improvement or respond defensively to an unpopular change.

One response to receiving the bad news of closure is withdrawal and both residents, staff and managers can feel isolated and alone in their negative emotions. Providing peer support from others who have been through similar experiences can help with recovery.

Mourning and funeral

Arrange support and career guidance for staff and terminate staff contracts. Terminate contracts for offices, mobile phones, computer maintenance etc. Dispose of computers, desks and other office equipment. Develop a closure rite for each person and a closing day for the team and a farewell celebration of achievements. Will dismantling the service in front of people's eyes help everyone to adjust to the new reality or simply cause distress?

Grief is a difficult emotion to experience and to observe, so others sometimes try to jolly the person out of it rather than sitting alongside and listening well, which can be especially hard for staff who have a strong desire to fix things for people. In palliative care, some people have months or years to prepare for their physical death, and gradually come to terms with the reality of it and make preparations, rather than assuming that all the details will spontaneously emerge when the time comes. Perhaps a social care service could take the same approach and take a long time to think through how they want their project to end.

People need time to say goodbye to one another and to staff, as well as saying goodbye to a building or garden. They may need to tell others on the team how much they have loved their company, put wrongs right, finish something that is incomplete or let something go. Sometimes a 'funeral ceremony' is helpful, although people need the opportunity to balance grief, lament and thanksgiving in a meaningful way that reflects their own response. Some people who leave a service want a wake where they can celebrate the good things that they have enjoyed there. The event draws a line under their connection with it and marks its ending. A few may need to 'visit the grave' afterwards by creating a physical place where the project is remembered, a place they can visit when recalling that part of their life, a memorial of some kind where others can read the inscription and learn that something was alive here once.

Legacy

Challenge #21

How have you captured your legacy wisdom and who will inherit it?

As well as thinking about the transfer of support arrangements to alternative providers, it is important to think about how to hand on the legacy of learning accumulated by the service. This may be particular innovations or simply those occasions when everything ran smoothly and it was a joy to be involved[85]. This is all valuable intellectual capital that will be lost if the service is fully occupied in delivery when things are fine, and then entirely preoccupied with managing the closure. Furthermore, writing up the wisdom accrued by the service is changed once termination is on the horizon and emotions start to take a more prominent role. When closure is the subject of media campaigns[86] or legal challenges it is

especially difficult to admit mistakes or failures and reflect on the learning. For all these reasons, gathering and sharing this wisdom for the benefit of those who follow should be an essential part of the ongoing life of the organisation, rather than hurriedly composed during its final days.

Alongside the journal of reflections about the development and operation of the service is the specific story that can be told about its ending. The recent tradition of sharing personal accounts of terminal illness online reveals a number of benefits of this sort of narrative, many of which may apply to those who write about the death of a project or service. These include mourning and memorialisation, educating others, peer support, and to simply share one's personal story as well as the importance of meaning-making and hope[87]. In palliative care, dignity therapy offers a framework for this sort of life review which involves generating a legacy document that is eventually given to others[88].

Post closure

The care manager who supports each person's review prior to the move should continue afterwards, thus providing consistent monitoring and evidence of changes in wellbeing, physical and mental health and social connections and contribution. Some commentators[89] have found that the move has resulted in improvement rather than the expected deterioration.

Status of this document

This is one of a suite of more than 30 *How To* guides that explore practical ways to coproduce delivery of health and social care, teaching, research and evaluation. Most can all be downloaded from here. Each has been co-authored[90] in public, is available online from the very first draft and each version is amended as soon as anyone suggests an improvement to the text[91]. They are therefore never finished and always open to capturing tacit knowledge and proven expertise from new sources.

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[1] The NHS and Community Care Act 1990 introduced commissioning as part of the adoption of market arrangements in health and social care. Fear of market failure is believed by some to drive up quality.

[2] See Bates P (2020) *How to relocate a care service*. Available at https://peterbates.org.uk/wp-content/uploads/2020/07/How-to-relocate-a-care-service.pdf.

[3] See https://commissioning.libraryservices.nhs.uk/commissioning-cycle/disinvestment.

[4] Airoldi indicated that decommissioning is a neglected topic for researchers, while one of Robert et al's respondents described it as a taboo subject. See Airoldi M (2013) Disinvestments in practice: overcoming resistance to change through a socio-technical approach with local stakeholders. *Journal of Health Politics Policy and Law*. 38 (6), 1151-1173. Also Robert G, Harlock J & Williams I (2014) Disentangling rhetoric and reality: an international Delphi study of factors and processes that facilitate the successful implementation of decisions to decommission healthcare services. *Implementation Science* 9:123. A research study launched in April 2021 to examine care home closures, led by Professor Jon Glasby – see https://fundingawards.nihr.ac.uk/award/NIHR201585.

[5] In the UK, many employees are protected under the Transfer of Undertakings (Protection of Employment) Regulations – see https://www.gov.uk/transfers-takeovers.

[6] SCIE define unplanned closures as those where there is less than three months warning of the service being shut down. See SCIE (2011) *Short-notice care home closures: a guide for local authority commissioners* London: Social Care Institute of Excellence.

[7] See Glasby J, Robinson S, Allen K (2011) *Achieving closure: Good practice in supporting older people during residential care closures*. Health Services Management Centre, University of Birmingham and the Association of Directors of Adult Social Services, London. Also https://onlinelibrary.wiley.com/doi/pdf/10.1111/spol.12412

[8] See, for example, Shropshire's Decommissioning Guidance at https://shropshire.gov.uk/media/5847/decommissioning-guidance.pdf.

[9] NCVO have produced guidance on closing charities and voluntary organisations – see https://knowhow.ncvo.org.uk/organisation/closing-your-charity-or-voluntary-organisation?_cldee=cGV0ZXIuYmF0ZXNAbmR0aS5vcmcudWs%3d&recipientid=contact-6c7a02b87501e711810f3863bb345bd0-6fa9cca3e73a49be85a8903a07876149&utm_source=ClickDimensions&utm_medium=email&utm_campaign=NCVO%3A%20Coronavirus&esid=df3c0e84-8fb4-eb11-8236-000d3ab2797b

[10] Yorkshire and the Humber Joint Improvement Partnership (2010) Decommissioning and reconfiguring services: a good practice guide for commissioners of adult social care. Paragraph 7.2. Downloaded from https://ipc.brookes.ac.uk/publications/pdf/Decommissioning_and_reconfiguring_services.pdf on 24 July 2020.

[11] LGiU (2015) *Care and Continuity: Contingency planning for provider failure - A guide for local authorities.* This paper is jointly badged by the Department of Health, ADASS, the Local Government Association and LGiU. The local authority's duties in respect of emergency planning are set out in the Civil Contingencies Act, 2004.

[12] LGiU (2015) op cit. Page 15.

[13] NHS England (2015) *Managing care home closures: A good practice guide for local authorities, Clinical Commissioning Groups, NHS England, CQC, providers and partners.* This paper is jointly badged by the Department of Health, ADASS, the Local Government Association, The Care Provider Alliance, Care Quality Commission and NHS England.

[14] NHS England (2015) op cit. Also Department of Health and Social Care (updated 24 June 2020) *Care and Support Statutory Guidance* section 4 on market shaping and section 5 on provider failure and service interruptions - https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance.

[15] This temporary duty applies to both publicly funded and self-funding recipients of registered care provision and is set out under Section 48 of the Care Act 2014. See http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/Duties-and-powers-Care-Act-2014.docx. This duty only extends to stepping in to prevent closure if there is no alternative suitable provision in the area.

[16] Local authorities may revise the terms of the contract, offer a grant or loan or second staff to help out a struggling provider. 'Stepping-in rights' can be built in to the contract with providers to set out circumstances when the local authority can move in and manage the staff employed by the provider. See SCIE (2011) op cit. Pages 2, 71.

[17] LGiU (2015) op cit. Page 12.

[18] NHS England (2015) op cit. Page 6.

[19] LGiU (2015) op cit. Page 12. In contrast to this, SCIE advice (page 3) on unplanned care home closures expects residents to be involved in the decisions relating to their new home, but they are not included in the list of stakeholders who are active at an earlier stage – developing a local strategy for managing closures, triggering preventative action, or taking any of the decisions related to the closure itself. Such matters are left to regulators, commissioners, receivers, NHS, and residents' representatives rather than residents themselves. Later on, the guidance recommends that the closure is managed by a Project Board that may (not must) include representatives from the residents, families and staff (page 13). See SCIE (2011) op cit.

[20] Much of this will be in the local Joint Strategic Needs Assessment.

[21] See http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/Checklist-managing-care-home-closures.docx and associated documents.

[22] NHS England (2015) op cit. Page 5.

[23] ADASS (July 2020) *Adult social care – shaping a better future. Nine Statements to Help Shape Adult Social Care Reform.* Page 7. Downloaded from https://www.adass.org.uk/media/8036/adult-social-care-shaping-a-better-future-nine-statements-220720.pdf on 25 July 2020.

[24] SCIE (2011) op cit. Page 41.

[25] Jolley D, Jefferys P, Katona C & Lennon S (2011) Enforced relocation of older people when Care Homes close: a question of life and death? *Age and Ageing* 40; 5; 534-537.

[26] Le Mesurier & Littlechild found some care homes where residents first heard of the closure plans by rumour or from the press, or the job of telling residents was left to relatives. Le Mesurier N & Littlechild R (2007) *A Review of Published Literature on the Experience of Closure of Residential Care Homes in the UK.* Institute of Applied Social Studies, The University of Birmingham

[27] Tan CM & Tan M (2020). 回艺 (huí yì): Exploring art-based life review to support the relocation process for older adults with dementia in nursing homes. *Journal of Applied Arts & Health* 1-17. 10.1386/jaah_00011_1.

[28] See for example, the advice on a webpage dated 2016 at https://www.qcs.co.uk/ask-sheila/notice-required-close-care-business/?utm_source=Googlep&utm_medium=cpc&utm_adgroup=All%20web%20pages%20-%20Google%20Index&utm_campaign=01_England_DSA&matchtype=b&keyword=&network=g&device=c&gclid=EAIaIQobChMItJ-H3PHf6QIVmNxRCh3McQd0EAMYASAAEgJ3vfD_BwE. Accessed 25 July 2020.

[29] See Bates P (2015) *How to meet legal obligations in your public consultation.* Nottingham: East Midlands Academic Health Science Network. Available at https://peterbates.org.uk/wp-content/uploads/2017/04/how_to_meet_legal_obligations_in_your_public_consultation_process.pdf.

[30] LGiU (2015) op cit. Pages 4 and 18.

[31] Robert et al (2014) op cit.

[32] Croydon Council (undated) op cit. Page 8.

[33] Backhouse T, Kenkmann A, Lane K, Penhale B, Poland F, Killett A (2016) Older care-home residents as collaborators or advisors in research: a systematic review, *Age and Ageing*, Volume 45, Issue 3, May 2016, Pages 337–345, https://doi.org/10.1093/ageing/afv201Older care-home residents as collaborators or advisors in research: a systematic review | Age and Ageing | Oxford Academic (oup.com)

[34] Fusco F, Marsilio M & Guglielmetti C (2020) Co-production in health policy and management: a comprehensive bibliometric review *BMC Health Services Research* 20:504. https://doi.org/10.1186/s12913-020-05241-2.

[35] Williams J and Netten A (2003) *Closures of care homes for older people: summary of findings, no. 3 – relatives' and residents' views*. Canterbury, Personal Social Services Research Unit. For advice about involving people who use services as Board members see Bates P (2014) *How To involve the public as Board members.* Nottingham: East Midlands Academic Health Science Network. Available at https://peterbates.org.uk/wp-content/uploads/2017/04/how_to_involve_the_public_as_board_members.pdf.

[36] NHS England (2015) op cit.

[37] Leyland AF, Scott J, Dawson P (2014) Involuntary relocation and safe transfer of care home residents: a model of risks and opportunities in residents' experiences. *Ageing & Society*. Feb;36(2):376-99.

[38] NHS England (2015) op cit.

[39] SCIE (2011) op cit. Page 13.

[40] Croydon Council (undated) op cit, page 22.

[41] Bruni RA, Laupacis A, Martin DK and The University of Toronto Priority Setting in Health Care Research Group (2008) Public engagement in setting priorities in health care. *Canadian Medical Association Journal*, 179 (1): pp. 15–18.

[42] Yorkshire and the Humber Joint Improvement Partnership (2010) op cit, para 7.3.

[43] Daniels T, Williams I, Bryan S, Mitton C & Robinson S (2018) Involving citizens in disinvestment decisions: What do health professionals think? Findings from a multi-method study in the English NHS. *Health Economics, Policy and Law*, 13(2), 162-188. doi:10.1017/S1744133117000330.

[44] Daniels et al (2018) op cit. This research generated 42 statements about public involvement, listed in the paper, and invited respondents to indicate whether they agreed or disagreed with each. Results were analysed using Q Methodology to derive three clusters. Respondents in this study were working in and commenting on the English NHS rather than social care, so there may be some differences arising from the more hierarchical culture in the NHS.

[45] Marshal Philippe Petain led the Vichy government in France during World War Two. He chose to collaborate with the Nazi invasion force and was convicted of treason after the war was over. Collaboration in a situation where power is unevenly distributed is not always popular or ethical.

[46] Daniels et al (2018) op cit.

[47] Yorkshire and the Humber Joint Improvement Partnership (2010) op cit, para 8.3.

[48] LGiU (2015) op cit. Page 14.

[49] Yorkshire and the Humber Joint Improvement Partnership (2010) op cit para 9.1.

[50] Is there any evidence to indicate that boardrooms are guided solely by the profit motive and remain untroubled by social responsibility?

[51] For an historic example, see the work by Halliwell et al that collected information about a proposed care home closure from care staff and family doctors but neglected to ask residents, relatives or social workers. See Hallewell C, Morris J & Jolley D (1994) The closure of residential homes: what happens to residents. *Age and ageing*. March 1;23(2):158-61.

[52] Arnstein, SR (1969) A Ladder of Citizen Participation *JAIP*, Vol. 35, No. 4, July, pp. 216-224.

[53] Health and Social Care Board (2013) *Good Practice Guide – Reconfiguration of Statutory Residential Homes* Northern Ireland. Paragraph 2.1. Similarly, Hampshire's policy in 2011 was that the right time to communicate with residents about a care home closure is immediately after the decision to close has been taken. This is notifying people of the outcome, not coproducing the decision. See SCIE (2011) op cit. page 46.

[54] City of York Council, op cit.

[55] LGiU (2015) op cit. Page 24.

[56] Smith A & Crome P (2000) Relocation mosaic - a review of 40 years of resettlement literature. *Reviews in Clinical Gerontology*, 10(1), 81-95. doi:10.1017/S095925980000109X. For an example from the USA, see Rothman DJ & Rothman SM (1984) *The Willowbrook Wars: Bringing the Mentally Disabled Into the Community* New York, NY: Harper & Row.

[57] Yorkshire and the Humber Joint Improvement Partnership (2010) op cit. Paragraph 7.3.

[58] See https://www.gov.uk/guidance/public-sector-procurement-policy,

[59] Croydon Council (undated) op cit, page 8.

[60] Variable interval intermittent reinforcement slows extinction of gambling and other behaviours.

[61] Croydon Council (undated) op cit, page 12.

[62] https://peterbates.org.uk/wp-content/uploads/2017/04/6t.pdf

[63] Glasby et al 2011 (op cit), p10.

[64] For some residents, anticipation and worry about the move does more harm than the move itself - see Hodgson N, Freedman VA, Granger DA & Erno A (2004) Biobehavioral correlates of relocation in the frail elderly: salivary cortisol, affect, and cognitive function. *Journal of the American Geriatrics Society* 52 (11): 1856-62.

[65] SCIE advise that some residents from a closing care home may take up an individual budget, receive a home care package or utilise a family placement scheme rather than transfer to a new residential care home. See SCIE (2011) op cit. Page 4.

[66] See https://peterbates.org.uk/wp-content/uploads/2019/12/Challenging-the-hive-mind.pdf.

[67] Ken Simons revisited a register of adults with learning disabilities after some years and found that 30% had disappeared from view – see Simons K (2000) *Life on the Edge* Brighton: Pavilion Publishing in association with Joseph Rowntree Foundation.

[68] Health and Social Care Board (2013) op cit. Paragraph 2.4.

[69] Increased workload after relocation led to an increase in sick leave and staff turnover in the site studied by Canham's team, which in turn disrupted the 'team around the person' as skilled staff were moved to the place where the management saw them as being most needed and away from the residents they knew best and most enjoyed supporting. See Canham SL, Wada M, Battersby L, Lan Fang M & Sixsmith A (2018) Experiences of a Mass Interinstitutional Relocation for Long-Term Care Staff, *Journal of housing for the elderly, 32:2, 160-175,* DOI: 10.1080/02763893.2018.1431582

[70] Gardner, T. M., Van Iddekinge, C. H., & Hom, P. W. (2018). If You've Got Leavin' on Your Mind: The Identification and Validation of Pre-Quitting Behaviors. *Journal of Management,* 44(8), 3231–3257. https://doi.org/10.1177/0149206316665462.

[71] Ucbasaran, D., Shepherd, D.A., Lockett, A., & Lyon, J. (2013). Life after business failure. *Journal of Managemen*t, 39, 163–202. Downloaded on 15/7/20 from http://valueoffailure.com/english-docs/Module6/LifeafterbusinessfailureJrnlofMgmt2013.pdf.

[72] Health and Social Care Board (2013) op cit. Paragraph 5.2.

[73] Schubert N & Krcic S (2020) *Here lies our beloved project, may it rest in peace - the impact of grief after project failure: An exploratory study of negative emotions within the context of project failure and their impact on emotional recovery and subsequent learning*. Jonkoping International Business School, Sweden: Master's thesis. Downloaded from https://www.diva-portal.org/smash/record.jsf?pid=diva2%3A1435957&dswid=9998 on 16 July 2020.

[74] Fang He V, Sirén C, Singh S, Solomon G & von Krogh G (2018) Keep Calm and Carry On: Emotion Regulation in Entrepreneurs' Learning from Failure. *Entrepreneurship Theory and Practice*, 42(4), 605–630. https://doi.org/10.1177/1042258718783428.

[75] Bandura A (1999) Moral disengagement in the perpetration of inhumanities *Personality and Social Psychology Review.* 3:193–209.

[76] The strategies listed within Moral Disengagement Theory are toxic when used to justify unethical behaviour. I have suggested in the main text that the same approaches may be used in 'homeopathic doses' to protect the person against the damaging effects of excess guilt, shame and personal responsibility when things go wrong. This approach has been shared with Jensen T Mecca, who has written on MDT, and she thinks this 'makes a lot of sense' and is 'an interesting way of conceptualising that construct.' For a sample of her work, see Mecca JT, Gibson C, Giorgini V, Medeiros KE, Mumford MD & Connelly S (2015) Researcher Perspectives on Conflicts of Interest: A Qualitative Analysis of Views from Academia *Sci Eng Ethics.* August; 21(4): 843–855. doi:10.1007/s11948-014-9580-6.

[77] Croydon Council (undated) op cit page 21. In a second horrific example, Unit 731 in Japan was presented to the public as a woodmill and its prisoners were called logs. 14,000 people were tortured and killed there between 1936 and 1945.

[78] Anecdotal evidence hints at occasions when Accident and Emergency nurses have stitched cuts without the use of local anaesthetic because 'they did it to themselves'. Such inhumane actions can be attributed to a failure of the nurse to integrate their conflicting emotions and instead deploying the psychoanalytic process of splitting and projection. See Angela Foster (2001) The duty to care and the need to split, *Journal of Social Work Practice*, 15:1, 81-90, DOI: 10.1080/02650530120042028. Also I have only been to A&E once because of self-harm and would not bother to go again unless I was seriously dying - and then not from self-harm - Community Care. Also https://www.madinamerica.com/2025/05/betrayal-professionals-lived-experience/.

[79] https://www.moralinjuryguide.ca/wp-content/uploads/2020/07/Moral-Injury-Guide.pdf.

[80] LGiU (2016) *Managing care home closures- management checklist*. Item 2.21.

[81] Glasby et al 2011 (op cit) p13.

[82] Bellagamba G, Michel L, Alacaraz-Mor R, Giovannetti L, Merigot L' Lagouanelle MC,… Lehucher-Michel MP (2016) The relocation of a health care department's impact on staff: A cross-sectional survey. *Journal of Occupational and Environmental Medicine,* 58(4), 364– 369. doi:10.1097/JOM.0000000000000664.

[83] Battersby L, Canham S, Krahn D & Sixsmith A (2017) *Guidelines for en masse interinstitutional relocations of long-term care homes: Supporting resident and team member well-being* Vancouver: Simon Fraser University.

[84] The Bible, Galatians 6:7.

[85] Csikszentmihalyi M(1990) *Flow: The Psychology of Optimal Experience*. New York: Harper and Row.

[86] Glasby et al 2011 comment that good links with local media can help to ensure that closure plans are reported fairly.

[87] Gibson A, Latimer AL, Silberman DR & Schuman DL (2020) Dying Online: An Analysis of End-of-Life Narratives, *Journal of Social Work in End-of-Life & Palliative Care*, 16:1, 57-76, DOI: 10.1080/15524256.2020.1721397.

[88] Vuksanovic D, Green H, Morrissey S & Smith S (2017) Dignity therapy and life review for palliative care patients: A qualitative study. *Journal of Pain and Symptom Management,* 54(4), 530–537. doi:10.1016/j.jpainsymman.2017.07.016

[89] Glasby et al 2011 (op cit) p11.

[90] The following people have kindly responded to an inquiry with comments and challenges to this discussion: Alison Giraud-Saunders, Marc Mordey.

[91] Most of the documents we read are finished pieces of work, carefully crafted and edited in private before being shared with anyone else. This is a different kind of paper – it was shared online from the first day, when the initial handful of ideas were incomplete, poorly phrased and tactless. The work has been edited many times, and, on each occasion, a revised version has replaced the earlier material online. This process is still under way, and so this paper may still be lacking crucial concepts, evidence, structure and grammar. As readers continue to provide feedback, further insights will be used to update it, so please contact the author with your contributions. This way of writing is risky, as it opens opportunities to those who may misunderstand, mistake the stopping points on the journey for the destination, and misuse or distort the material. This way of writing requires courage, as an early version can damage the reputation of the author or any of its contributors. Or rather, it can harm those who insist on showing only their 'best side' to the camera, who want others to believe that their insights appear fully formed, complete and beautiful in their simplicity. It can harm those who are gagged by their employer or the workplace culture, silenced lest they say something in a discussion that is not the agreed party line. It can harm those who want to profit from their writing, either financially or by having their material accepted by academic journals. In contrast, this way of writing can engage people who are not chosen to attend the meeting or asked for their view until the power holders have agreed on the 'right message'. It can draw in unexpected perspectives, harvest tacit knowledge, stimulate debate and crowdsource wisdom. It can provide free, leading edge resources.