How to relocate a care service

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Introduction

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Scope and purpose

Health and social care services are in a continuous process of change as demand shifts, resources are rationed, new practices emerge, provider organisations are restructured and commissioning decisions affect neighbouring provision. This is one of a pair of papers that examine the part of this evolutionary process that involves closing one service and transferring some, none or all of its activities to a new place. Here, I journey with the people who relocate, while the companion paper[1] remains in the old place and tracks the process of service decline and death.

Across the range of social care provision, most attention has been paid to the involuntary relocation of care home residents that occurs to escape a natural disaster such as a hurricane, to safeguard people when abuse is disclosed, to achieve continuity of care when a provider leaves the market or to upgrade a dilapidated building. These examples differ from the changes in care provision brought about by individual reassessment in that they are commonly involuntary, occur to people en masse, and are sometimes unexpected and so require urgent, time-limited action. Similar changes that take

place to other types of health or social care provision are no less significant for the participants but have received less attention. For this reason, some of the material in this paper is shaped by the example of care homes but is not intended to be limited to this and wider applications will be drawn out as opportunity allows.

The decision to write a pair of companion papers addressing closure and relocation respectively does not fit very well with the complexity of the real world. In particular, it fails to offer a specific focus on the hybrid situation where the impending closure of the old service triggers an active process of care review that results in some people being relocated while others are discharged from care or step down to a substantially smaller package of support. Indeed, the focus on residential care and nursing homes reinforces this, as it is hard to imagine that anyone living in a care home will be entirely discharged, while this is the reality for some other kinds of social care service that close. Both here and in the companion paper, I will attempt to include the implications for people who experience a reduction in the care they receive.

The second limitation of focusing on care home relocation is that it pays more attention to what some writers have called 'en masse interinstitutional relocation' in which a group of people receiving care and the staff who support them move all together to a new location. This focus therefore pays less attention to the alternative whereby everyone does relocate but must say goodbye to their existing in-home network prior to being 'slotted in' to individual vacancies in a large number of existing services.

Thirdly, in what is initially looking like an example of taboo practices, it is far more straightforward to find literature on relocation rather than closure, as if researchers and the authors of guidance documents have chosen to follow the hopeful journey of relocation and avoided the uncomfortable reality of closure. As a result, the relocation paper is rich in references and examples of research while the closure paper is more ruminative and speculative, drawing inferences and raising questions with less definitive, evidence-based advice.

Despite these limitations, the binary division into closure and relocation is made, and readers are invited to consider the changes that they are experiencing from both perspectives. Where feasible, further reading is listed in one or other paper rather than duplicated, although it must be acknowledged that source texts do not neatly fall into one category or the other.

Strategic values

Local authorities and others who decide to close or decommission services should set out their strategic approach in a Decommissioning Strategy[2] that aligns with broader agreements about how the different parts of the health and social care system will work together, such as the Voluntary Sector Compact[3] and how commissioners will help to shape the provider market[4]. This helps them to carry out rational decommissioning rather than reactive commissioning or, worse, decommissioning individual services at random or topslicing all budgets[5]. Such approaches lead to misaligned services that fail their communities, supply chain problems elsewhere in the system, and mistrust amongst providers and other stakeholders.

A strategic Decommissioning Strategy will be coproduced and establish core values of coproduction, fairness, and transparent and open decision making as they are applied to closure and reprovision. The presence of people who use services and their relatives may help to ensure that the

negotiations remain focused on benefits to end users and the whole social care system, rather than promoting partisan interests[6]. Principles enshrined in a Decommissioning Strategy may include:

Challenge #1

Has your local Commissioning Team published a Decommissioning Strategy?

- The Decommissioning Strategy will sit under the Commissioning Strategy and both functions may be served by a single document and will show how public money is spent to meet identified need in the local population[7]. The goals for these strategies, progress to date and next steps in achieving the strategic outcomes should be developed in collaboration with all stakeholders, so that market shaping comes as no surprise to providers or people using the service[8].

- While financial and legal obligations shape what is possible, the goal should always be to improve the lives and promote the human rights of people receiving support. The local authority act on behalf of everyone receiving registered care, although it may act to recover the costs of temporary care from self-funders and people placed by other authorities[9]. The health and wellbeing of everyone using the service should be maintained, with support from staff who know them wherever possible[10].

Challenge #2

Will closure and relocation promote equality between groups?

- Plans should have the effect of reducing disparities experienced by marginalised groups and so helping to build a fairer society and equal opportunities for all. Particular attention should be paid to people with protected characteristics[11]. As Croydon promise 'The Council will always take a strategic approach to decommissioning. Any decommissioning plans must include details of alternative service provision, risk mitigation measures and comprehensive impact assessments including equalities impact assessments.'[12]

- Services that are provided by the for-profit sector should be treated in the same way as those provided in-house or by the charitable and voluntary sector[13].

- Cost and benefit calculations should be based on the whole system and take a long view rather than narrowly consider the impact on a single agency at a single moment in time.

- Whilst written strategies and closure planning are helpful, the people involved also need permission to flex arrangements to meet the specific circumstances of the case rather than following a rigid formulaic approach. While there are advantages in terms of quality assurance in establishing a preferred provider relationship with reliable suppliers, this must not close off bespoke arrangements or restrict the support offer to a limited menu of things that have been provided for many other people already. Individuals need individualised support packages, not 'off the peg' standardised offers designed on the lie that human beings are all alike.

- Representatives of trade unions and professional bodies should be involved in the development of business continuity plans and strategies for managing provider failure or service closure[14]. This should not lead to non-unionised staff being treated differently.

Individual services must prepare their individual Business Continuity and Contingency Plan as part of the initial contracting arrangements or as soon afterwards as possible if it was not in place when the contract was signed[15]. This will include a description of what will happen in an emergency or business failure and define the circumstances that will trigger its implementation. The individual plan should adopt the principles set out in the Decommissioning Strategy and explain how they will be worked out in your context.

Challenge #3

Does your service have its own Business Continuity and Contingency Plan that includes clear triggers for when it would be activated?

There is a tension at the heart of the coproduction process where the need for consistency meets responsiveness. So on the one hand, people involved in subsequent consultations will believe in the process if it is rigorously and consistently applied without variation, while a responsive system requires there to be a real opportunity for people to influence process, timings and outcomes.

Coproduction

Relocation often brings to the surface significant differences of opinion and stereotypical assumptions about which group will take which viewpoint. For example, who would support change and who would seek continuity – people using the service or their relatives, managers or frontline workers, commissioners or local politicians? Coproduction is much easier when everyone agrees than when there are irreconcilable disagreements about both the ultimate destination and about the story to be told concerning how the process has been handled. The path is also smoothed when stakeholders share a positive history of previous closures, just as it is massively disrupted if individuals or even the whole group carries the scars of previous painful experiences[16]. Such histories need to be heard and understood, especially if the official record of these events differs from people's recollection of them.

Challenge #4

Have stakeholders lived through previous closures or relocations and what was that experience like?

More broadly, the process of coproducing the relocation will be affected by the extent to which the organisation has demonstrated integrity or has repeatedly over-promised and under-delivered, leaving frontline staff, residents and others cynical about the messages they receive and convinced that any commitments are no more than empty promises.

In a single closure process, timelines may affect different stakeholder groups, so residents who are still waiting for a move will report on their fears of the impending change, while social workers at the same time point will already have stories of other people who have successfully made the transition. The resulting strategy, as well as its implementation and progress should be clearly and consistently described so that it can be easily articulated to all stakeholders.

When people using the closing service transfer to new provision, there is the opportunity to codesign that new service. Individuals will want to direct choice of service, paint colours, furniture and daily routine, even if they are moving to equivalent provision. Continuity may be achieved by retaining a newspaper delivery or arranging personal items and furniture in the same way as before if this is what the person wants. If a group are staying together, then they will want to have a voice in decisions about what possessions, routines and practices are kept, changed or left behind in the old service. On occasions, residents whose health or functional abilities have changed will not

Challenge #5

What choice and control do people have in choosing their new setting and arranging their life in it?

have updated their self-assessment and so will choose an unsuitable care setting, but this is no reason to routinely deprive people of their right to express a preference.

Market forces drive relocation

Economists will argue that any service should be replaced if it fails to meet the highest standards of performance and safety for the cheapest price. Regulators use their powers to demand improvement or shut down dangerous services[17] while commissioners use the contracting process to refresh and upgrade the entire health and social care economy, employing contracts that include proper closure arrangements[18]. In addition, rising standards can bring unexpected costs[19] and result in providers deciding to leave the market. In some cases, an Insolvency Practitioner will be appointed to sell or wind down the business on behalf of creditors.

Williams and colleagues[20] analysed the motivation of commercial and independent providers of care homes and compared the profile of currently operating homes with the profile of 20 providers who had recently closed homes. The profit motive was more salient in the group who closed their homes. They also found that first-time owners were particularly frustrated by the bureaucracy and regulation demanded of them and so were likely to leave the field.

Challenge #6

How can the culture and practice of local commissioning change to reduce the incidence of provider failure?

Poor commissioning practice such as: excessive use of spot purchasing and inadequate funding to cover overheads, operational costs and delayed payments; moving goalposts, unrealistic performance demands, timeframes and reporting requirements; insufficient forward planning which means that providers are unable to project their future income; disproportionate negative publicity and embargoes on new clients will all precipitate provider failure[21] and perhaps even widespread market collapse[22]. In much other guidance, all these commissioner issues are ignored and providers are assumed to be at fault[23]. Business leaders are encouraged to come forward early if they are struggling[24] or simply making long-term plans[25], but it is hard to imagine that they would actually do so, as admitting their difficulties or exit plans could do them more harm than good. Glasby's team recommend that contracts should provide for the occasion when care home operators go bankrupt, preventing the receiver closing the home until sufficient time has been given for the business continuity or emergency plan to be implemented and care managers to make alternative arrangements for residents to move in an orderly manner[26] and thus granting residents similar protection against summary eviction to that enjoyed by tenants and upheld by human rights declarations[27].

This would be fine if everyone agreed and the process of recommissioning was harmless for people using the service, but sadly it may not be. These changes can destroy trusting relationships, alienate seldom-heard sectors of the community and weaken collaboration between teams and agencies. For staff and managers, making these changes diverts huge amounts of time, effort and money away from supporting people and into the change business of writing tenders, rebuilding teams and replacing letterheads. On the positive side of the equation, refreshing service provision allows the best evidence-based and values driven practice to replace outmoded approaches, and many people working in and using services would not want to turn the clock back to the old days. Change leaders have to decide if the additional freedoms and opportunities offered by the reconfiguration are worth the price of revolution, or whether an evolutionary approach would have done. In addition, they need to consider how other changes will shape the market and lead to an acceleration or slowdown in service closures.

Market forces driving for efficiency and effectiveness have a second, inevitable consequence – since larger organisations have economies of scale and capacity to survive temporary downturns, they also have an ability to oust local, small-scale providers, thus increasing the rate of closures. For example, over 90% of care home providers run only one or two homes[28] and family-owned small and medium enterprises are less likely to survive in the marketplace, especially after founder succession[29], so there is considerable potential for acquisition[30]. In a survey of 69 local authorities providing social care, 63% had experienced at least one provider failure in the previous year[31]. The standardisation and monopolistic control that large organisations produce can threaten the local service's ability to provide community-focused and person-centred care. Remote shareholders, Trustees or local politicians may instruct large public sector or private providers to divest themselves of large segments of their portfolio, resulting in widespread, coordinated closures that risk destabilising the whole sector[32], so careful spacing of closures is essential[33]. Finally, external factors such as staff shortages or changes in the cost of borrowing may increase the numbers of service that close.

The closure – relocation matrix

Closure and relocation can be treated as axes and specific events plotted on a scatter-graph to highlight the relationship between these two topics, as illustrated by the examples below.

- **Acquisition**. The management of a facility that supports its residents, inpatients or people using its service is taken over by another company in a merger[34], acquisition or outsourcing. This hardly counts as a closure at all, although the new managers may introduce different approaches and expectations and stakeholders will experience some losses due to the closedown of the old arrangements. Under this arrangement staff are transferred to the new employer under TUPE regulations[35], although these processes require a proper time period. In addition, TUPE processes provide a number of informal opportunities for managers to signal their preferences for particular staff, while frontliners may read more into their experience of the process than is intended, which sometimes creates jealousy or impairs self-confidence when moving on. There is likely to be an increase in the number of staff occupying unfamiliar and perhaps unwelcome roles who are expected to work towards goals that they do not really support or understand. This generates generating additional induction requirements and requires closer supervision to ensure that promoted staff learn their additional responsibilities while staff who have stepped down receive support to adjust. Everyone also needs to work together to carry the increased level of vacancies while senior staff support recruitment efforts. Battersby's team[36] indicate that this is a good time for senior staff to join in with frontline duties, showing that they are willing to help by sitting with a distressed person, making some tea or helping to serve a meal.

  Challenge #7

  How are TUPE'd staff supported to acquire an understanding of the culture and practices of their new employer?

  While a management takeover is perhaps the smallest of the relocation options from the perspective of the frontline, even this can melt routines. It might be an effective moment to introduce additional changes before habitual behaviours refreeze again, since everyone is expecting things to be different, while others believe that stability is the best prescription for these uncertain times, as too many changes can turn adaptive stretching into harmful panic[37]. A third option is to draw on the theory of complex adaptive systems[38] that suggests culture can survive intact throughout multiple changes in venue, technology and leadership,

so, according to these commentators, efforts to introduce changes or assumptions that the transfer of management will effortlessly deliver progress in the culture are naïve and doomed.

Challenge #8

What cultural changes do you intend to make through the closure and relocation process? How will you bring them about?

- **Mass relocation**. All residents and all staff move together to a new venue. This may be permanent or for a temporary period while the building is being refurbished ready for the same group to return to it[39]. This forced 'en masse interinstitutional relocation' is quite different from dispersal of the group into separate, permanent settings (see below). In some circumstances it is possible for an advance party to move before others do and they can be involved in introducing the building and its facilities to their peers.

- **Dispersal.** The service is closed and the people who used it are transferred to equivalent provision in another place, such as when a care home is closed, the group is broken up and each resident is transferred to fill a vacancy in another care home. Where several people move into an existing group the longstanding companionship and friendships within the relocating group can be mutually supportive, although some will need help to make connections with the established residents in the new setting, to prevent suspicion and division between the hosts and the incomers.

- **Self-funders.** The temporary duty laid upon the local authority to arrange support for people affected by the closure of a home is equally applied to self-funders and those who are publicly funded. This was not the case in 2007[40] and was introduced as part of the Care Act 2014.

Why do people object?

Once people hear about the plans for closure and relocation, they may object for a variety of reasons, including:

- **Preference**. Those who genuinely prefer the old service to the new one, even if the evidence or values base suggests that they ought to feel otherwise – the ramshackle old building is familiar, the institutionalised staff are well known, and the ineffective interventions are comforting or, contrary to the broader evidence base, they do actually work for these individuals. In situations where regulators or others have identified clear evidence of neglect or abuse, residents or relatives may reject the evidence and continue to believe that the closing service was doing a good job. Such denial parallels the blind optimism held by some change managers who reject any evidence that the closure programme has caused harm.

- **Quality**. Some opponents are right – the old ways did serve people better and the new is a change but not an improvement. Yet more are considering their own need rather than the wider population, and the change demands that they give something up so that others can get help too.

- **Relocation hazards.** There is robust evidence to show that people who move from the community into nursing care are more than twice as likely to die within six months as their counterparts who remain in the community[41], perhaps due to changes of routine, malnutrition[42], interruptions or changes in the provision of medication[43], spread of communicable diseases and the unfamiliar environment creating hazards for falls[44] and injuries[45]. The evidence for transfers from one care home to another[46] is more contested, ranging from one study where death rates more than quadrupled in the year following the move[47], to other researchers who found no increase[48]. Legal judgements in the UK rest on the need to demonstrate 'real and immediate risk' to residents which arises from the move, and this has not been found[49]. Despite this, some commentators continue to believe that forced relocation is disruptive enough to cause excess fatalities[50]. Other harms that have been observed include increased stress and decreased mood prior to the move[51] and a range of responses afterwards including deterioration in general health and psychosocial functioning[52], mood, life satisfaction and social engagement[53]. Risks increase with age and are higher for men and those with poor eyesight or hearing, low mobility, depression, anxiety or dementia[54]. Evidence from the study of Birmingham's care home closure programme[55] indicates that, with the proper support, deterioration is not an inevitable consequence, but, despite this, closures should only take place when necessary and refurbishment, training and other developmental approaches are judged ineffective. "*Providers should do all they can to prevent care homes closing*."[56] In addition, a robust risk assessment should be carried out for each individual, or this might be challenged in the courts as a breach of the Right to Life as enshrined in the Human Rights Act.

Challenge #9

What evidence are you collecting of both benefits and harms associated with the relocation?

Make every effort to listen

People expect to have a voice and the right to contribute to the decision to change or close their service, and this right is upheld in the law on consultation[57], so good legal advice is essential in planning, communicating and executing closure plans. We might hope that, in a coproduction culture, people using the service would have access to legal advice too. While it may be tempting to exclude people while the facts are unclear, the direction of travel is uncertain and the timescale is completely unknown, on examination, such approaches disempower and can even patronise.

If specific knowledge, experience and communication skills are a prerequisite for participation, then there are perhaps reasons to exclude some people who receive services and some of the relatives and staff who support them. Indeed, people living in care homes may have little in the way of up-to-date knowledge of mergers and acquisitions, property sales or personnel management and so have unrealistic expectations of decision-making processes and timeframes.

Challenge #10

How are you engaging with people that others might want to leave out?

Where people using the service have cognitive or communication challenges, it is tempting to neglect them and so fail to provide careful explanations and effective advocacy, thus reducing the total volume of opposition. This is a false economy that will reduce wellbeing, trigger the person to try using unwanted approaches to getting their message across and is discriminatory rather than inclusive. Instead, advocacy will help people to get their views heard, perhaps through deliberate listening exercises run by an independent agency. Moreover, the essence of coproduction is that it values and draws together diverse perspectives, and values lay insight as well as technical

knowledge. In addition, many people who rely on the welfare state have developed robust approaches to living with uncertainty and change and so do not need as much protection as some may think. However, staff should avoid making promises that they cannot keep[58].

Relocation requires firm leadership that listens to the most critical voices, that adopts their ideas wherever possible. Decision-makers need to be skilled at listening even when people are angry and distressed, with arrangements in place to manage rare occurrences of vexatious[59], threatening or violent behaviour. Daniels' team report an attempt to involve people using the service that, in the end, was so aggressive that the Police had to be called[60].

Communications strategy

Communication must be a two-way street, so that all stakeholders have a voice and can provide feedback and submit their ideas and preferences as the relocation project develops. Official messages from the decision-making committee to residents, relatives and the media need to be clear and focused where possible on the ways in which the change will benefit people using the service, so that people understand why it is planned and where they are in the process[61]. Clear evidence of the need for change will help[62].

Challenge #11

Who owns the information about the closure or relocation plan?

Beliefs about coproduction affect the basic stance adopted in communications with people using the service. If staff believe that the people using the service have a right to know what is happening to them and have the personal resources to deal with their circumstances, then the default position will be to share everything, unless there is clear evidence that this will cause distress. If, on the other hand, staff believe that they own the information and share it with others on a strict 'need to know' basis, then much less will be shared with residents and staff will hold the power. With this in mind, it is interesting to read the following advice from SCIE; "There is a balance to be struck between providing information that is essential at the time and that which will raise anxieties."[63]

Practical details and arrangements should be communicated clearly to people using the service, preferably in writing[64]. One guide has recommended that new residents should receive reminders as well as written information on the following: a schedule of activities in their new home, a list of rules and rights, a document on keeping personal possessions safe and a map of the layout of the building[65]. The same guidance document suggests that new residents should have the opportunity to invite a relative or friend to stay overnight or for meals in the first few days, to have a personalised induction and be encouraged to attend activities in the first week.

In relation to the provision of care and support for individuals, detailed notes and a formal handover process between the old and new team is vital in ensuring that everyone knows what is needed and the person is not neglected[66]. Soon after the move has taken place, one or more formal reviews[67] will help to highlight any difficulties that have arisen during or since relocation.

Person-centred planning

Challenge #12

Are the people receiving the service thoroughly known and understood, especially their community connections and the things that bring them joy? Are they in charge of the process of planning their own life?

Person-centred planning always begins with an unrestricted gaze at the person and their gifts, talents and passions, their history, their communities and their dreams for a better life. This must not be curtailed by reviewing what provision is on offer until one has an unshakeable grip on what would make a great day and a great life for the person. There is a real danger that the focus of the assessment and care planning process is narrowed by service eligibility requirements and loses the breadth of a true person-centred process. So, for example, an alternative care home may be deemed acceptable as the team will be able to provide the right level of nutritional support, but the move will leave a familiar neighbourhood behind, sever the person's links with local groups and reduce the likelihood that friends will visit. While close friends will keep up with multiple moves, even if made over a short period, weaker ties with friends and relatives will be broken as these people mislay the person's current address and stop sending greeting cards or calling to visit[68]. Neglecting these connections fails the person by focusing on their physical care needs rather than the whole person, a weakness of research studies that have tracked death rates rather than measuring life.

In emergency closures or settings where the care team have not adopted person-centred approaches, the assessment team may not have access to good quality information about the people using the service and so have to build it up from scratch or guess and make temporary moves, providing further disruption to the individuals affected. The most extreme of these circumstances occurs when a disaster such as a hurricane or nuclear accident triggers immediate evacuation, and this increases mortality risk, especially amongst people who are stressed by the transfer and separated from essential supports[69]. Stress will be increased if the relocation is not accomplished in a calm and orderly manner.

Care is needed to avoid making assumptions and applying stereotypes about people who use social care. For example, both researchers and campaigning groups may assume that residents would be adversely impacted by relocation stress[70], but this may not always be the case and some may experience relocation as a stimulating challenge[71], especially where the person has enjoyed many previous moves during their lifecourse[72]. Similarly, the organisation's efforts in managing the closure programme may preoccupy their vision and prevent them from seeing wider and potentially much more significant changes in the person's own world, such as increasing disability, birth of a great grandchild or the loss of a dear friend, alongside which the person sees the relocation as comparatively trivial[73].

The assessment team should also have easy access to senior management and liaison routes with neighbouring services, since the closure process can trigger other needs and increase demand for other kinds of help – GP, addiction, counselling, finance and so on. The need to relocate people from the closing service may extend waiting lists, such as where hospital patients cannot be discharged as vacancies are taken by people from the home that is unexpectedly closing due to safeguarding concerns.

People who have been using the closing service may be offered support to find a new support package. There are several possible starting points:

- Those who were on the edge of leaving anyway and had already built their plans, developed their skills and negotiated support arrangements. The people leading the relocation may view these leavers as early wins of their process, paving the way for others. On the other hand, some people may have been planning to leave but hoping to retain access to the service as a part of their transitional or post-discharge support arrangements, and the closure will shut down this arrangement, thus requiring an alternative to be devised.

- Others will rely heavily on the current service or have complex support needs and it will be difficult to find a match elsewhere. Communication can be poor between health professionals, creating confusion about what the person needs and who is responsible for providing it which can harm the resident[74]. In the short term, risks are increased even where specialist equipment and supplies has been provided in the new service, but staff and residents cannot find what they need as they are unfamiliar with the building. Residents, relatives and frontline staff will be able to advise on what will be needed in the new setting. Where the person has been using a service that lies outside the local authority's area and is closing, there may be particular challenges in achieving good communication and a consistent supply chain. Risks will be increased for people who are emotionally dependent on the old service and will find it difficult to understand and accept the change, perhaps because of autism, dementia or end of life issues. Starting early with people in this group will give the best chance of success and upskill the team as they invent new solutions that may also work for others.

- The Mental Capacity Act 2005 insists that a presumption of capacity should always be the starting point so that people are not assumed to lack capacity without an appropriate assessment. Some people receiving care will be able to weigh up alternatives and assert their preference and should be supported to do so, as well as maintaining the right to make an unwise choice[75].

- Person-centred assessments will focus on the ordinary stuff that everyone needs, rather than traditional service solutions. This means that good assessment will deconstruct the care home package into its constituent elements and consider how each need should be best met. In this way, the previous provision of a care home may not be replaced by a straight 'service to service' swap, but a consideration of the person's need for safety, good food, a private place to sleep, access to healthcare, purposeful activity and great friends.

Challenge #13

Are true person-centred planning principles being applied?

Complexity is added when one takes into account the formation of communities amongst people using the old service. A hazard in using terms like 'person-centred planning' rather than an alternative phrase such as 'network-centred planning' means that care managers and others focus on individuals rather than relationships, but guidance is clear that relocation must preserve friendships, supportive long-term relationships with staff and other relationships[76] wherever possible. This was sometimes a failing of the hospital closure programmes of the 1980s and 90s when staff failed to notice friendships and the new community-based living arrangements severed some of these contacts, adding to the transfer trauma. In contrast, a closure programme in Birmingham launched in 2007 pledged to 'keep groups of friends together if at all possible'[77].

Woolham[78] advises that people using the old service should be involved in the selection of their new service, have at least three months' notice of the move date[79], have the opportunity to visit in

person, view a virtual tour or see a scale model of the new building prior to transfer and be supported by bridging staff who work with the person in both the old and the new service. Leyland's team[80] suggest that people should have an opportunity to visit the new venue for a whole day and more than once rather than just an hour so that the potential resident gains a sense of the routine and relationships as well as location and décor. These processes are not always achievable, as where an emergency closure occurs in response to a safeguarding issue.

Grieve

Glasby's team found that, while the change journey passed through a period of distress, outcomes after a year were at least as good and sometimes better than might have been expected without the move, as long as the change is managed well[81]. Change agents needed to persevere rather than give up during the difficult phase when success looks like failure.

Challenge #14

Have people using the service and staff had a proper opportunity to mourn any losses connected with previous moves?

However, many people who have been through a service closure or substantial relocation seem to feel the need to give testimony to the losses that have been suffered. A death that follows hard on the heels of these changes is often attributed to the process, irrespective of the vulnerability of the person, and staff who made the crucial decisions or administered the changes may well feel responsible. Positive outcomes for the majority and the statistical evidence that shows that well-managed changes do not lead to excess fatalities do not cancel out these painful memories or the sense that one is in some way accountable for the death.

Staff resources for the relocation process

Challenge #15

Aside from staff, do people using the service have friends, relatives and others on hand to support them to adjust to the move?

Frontline staff. Drafting in additional staff resources for the closure period may bolster quality of care, address increased sickness absence, help people using the service who feel anxious about the move, support the assessment team with preparing transfer arrangements and assist the transfer process. Relatives may be willing to help on moving day. Departing staff will have their prospects enhanced by the offer of jobs fairs and additional training as well as secondment, trial periods and voluntary redundancy opportunities which should reduce the chaotic loss of essential personnel.

Care managers need skill and encouragement to facilitate person-centred approaches and ensure that, in a situation that is often unwelcome, the person retains as much control as possible. Leyland's team[82] recommend that a single care manager should look after all the people moving out of the old service, as this improves communication and consistency in contrast to each person relating to a different care manager. It has been suggested that the assessment team should be separate from the decision-makers who have decided to close the service, or care planning with the person will be distorted by political matters regarding the closure decision[83].

Independent advocates will have a key role in ensuring that the person's voice is heard throughout and contribute to the decision on whether to close and relocate, as well as how each person will receive ongoing support. One guide suggested advocates will help to promote a healthy

environment where conflict is kept to a minimum[84], but care will be needed to ensure that advocates are not urged to pacify people who actually want to engage in conflict and complaint about the decision to close or relocate.

A **contracts manager** who works alongside the care manager will be able to secure value for money for the funding body, prevent commercial organisations who wish to take advantage of the spike in demand inflating prices and create innovative solutions where they are needed.

Communications lead. Communication should be led by an identified staff member who considers both internal and external audiences[85] and ensures that messages are consistent and conveyed effectively[86].

Family support. An identified staff member should lead on support for families[87].

Transport Coordinator. An identified staff member should lead on transport issues[88].

Local authority lead. A lead officer must be appointed to ensure that all parts of the closure and relocation plan work together[89].

All the relevant partner organisations that have a role in the relocation process should cooperate with one another to enable the lead staff to carry out their duties efficiently.

The move itself

Staff from the new place should visit the old one so that residents get to know them, keeping in mind that it may take longer for residents than staff to acquire a sense of familiarity with them and feel reassured by their presence. If any pieces of equipment belonging to the service or sections of the building are to be packed or closed whilst in view by people using the service, then this process needs to be carried out swiftly and the minimum time pass before these items can be unpacked and re-positioned in the new place.

Friendship groups should be moved at a similar time so that there is not a long period for people to feel uncomfortable as they wait for their turn. Effective coordination with removals and utilities companies will ensure that people are treated properly and they are able to restart their lives as quickly as possible after the move.

With the person's consent, community-based utilities, services and social networks should be notified of the change of address, including pharmacy, doctor, dentist, chiropodist, optician, bank, welfare benefits and pension, Court of Protection, relatives and friends, church and interest groups, longstanding neighbours and friends. Close relatives and friends will want to know as soon as possible that the move itself has been safely accomplished.

Challenge #16

How will you ensure that things are not left behind, lost or broken in the move?

Unless there are extreme circumstances such as fire or flood, people should not move in the hours of darkness or in the worst of the winter[90]. People should not be moved out of their home until the transport has arrived and is ready to transport them immediately, so that they are not kept waiting outside[91]. The person's belongings, medication and records should be available for use until the last possible moment before being packed and should not be transported in bin bags[92], and nothing lost in transit. Each care home resident should be accompanied by a named staff member on the journey to their new home. If necessary, that same worker should help the person to unpack, although the more the person can do for themselves, the more they engage in establishing their presence in the new place and make it their own home

through the symbolic act of unpacking and positioning their belongings[93]. The worker who knows the person well can then brief the staff in the new place[94].

A designated place in the lounge and a seat in the dining room helps new residents to feel welcomed, like new staff joining a team who find that a locker, pass key and computer have been arranged in advance. Cultural traditions, such as new home greeting cards, flowers and housewarming parties can all help the person to start their life in the new place by taking the role of host, meeting new neighbours and presenting their new home to old friends who bring gifts to wish them well.

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[95] have found that the move has resulted in improvement rather than the expected deterioration. Where there is no-one on the staff team who knew the person before the move, it is harder to notice changes in mobility, mood or cognitive function.

Challenge #17

How will you protect and enhance the person's community connections and contributions?

People receiving the service will recognise more cultural differences between the old and new service. Some of these will have been revealed during initial visits, as the visitors unerringly home in on differences in the way in which staff uphold dignity, create rapport and support an active life (visit staff should take care to value these observations rather than dismiss them[96]), while others will gradually emerge as the new people settle in and make comparisons.

The settling in period varies from one person to another, and may include withdrawal, as the person acquires familiarity with the setting before venturing into relationships with new staff. Assumptions can be made at this time, as residents have a small amount of evidence on which to base their judgement about the strangers who are caring for them, and personal care can be a battleground where staff who are strangers to the person's preferences cause acute embarrassment or distress.

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. They can all be downloaded from here. Each has been co-authored[97] 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[98]. They are therefore never finished and always open to capturing tacit knowledge and proven expertise from new sources.

[1] See Bates P (2020) *How to close a care service* Available at https://peterbates.org.uk/wp-content/uploads/2020/06/How-to-close-a-care-service.pdf.

[2] See, for example, Shropshire's Decommissioning Guidance at https://shropshire.gov.uk/media/5847/decommissioning-guidance.pdf. General advice is available from Yorkshire and the Humber Joint Improvement Partnership (2010) Decommissioning and reconfiguring services:

a good practice guide for commissioners of adult social care. Downloaded from https://ipc.brookes.ac.uk/publications/pdf/Decommissioning_and_reconfiguring_services.pdf on 24 July 2020.

[3] See https://www.ncvo.org.uk/practical-support/information/collaboration/compact-agreement.

[4] Commissioners may need to offer training and support to providers to enable them to compete for new business. See *Market shaping in adult social care* at https://ipc.brookes.ac.uk/publications/Market_Shaping_in_Adult_Social_Care.pdf

[5] Donaldson C, Bate A, Mitton C, Dionne F & Ruta D (2010) Rational disinvestment, *QJM: An International Journal of Medicine*, Volume 103, Issue 10, October, Pages 801–807, https://doi.org/10.1093/qjmed/hcq086

[6] For an example of using a specific decision-making framework in healthcare to develop clear disinvestment decisions, 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.

[7] Local population need will be identified as part of the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy that Councils must prepare under the Health and Social Care Act 2012. See Department of Health (2013) *Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.* Downloaded from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277012/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-20131.pdf on 24 July 2020.

[8] Yorkshire and Humber Joint Improvement Partnership (2010) op cit. para 6.2.

[9] Legal advice and caselaw will inform local authorities about the circumstances under which costs may be recovered. 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. Pages 22, 25.

[10] SCIE (2011) *Short-notice care home closures: a guide for local authority commissioners* London: Social Care Institute of Excellence. Page 2.

[11] Equality Act 2010.

[12] Croydon Council (undated) *Decommissioning Toolkit: A best practice approach to meeting changing needs and delivering value for money*. Page 4. Downloaded from https://www.croydon.gov.uk/sites/default/files/articles/downloads/decommissioning.pdf 25 July 2020.

[13] The user guide published by the City of York Council applies equally to all providers of residential care – see City of York Council, op cit.

[14] LGiU (2015) op cit. Page 19.

[15] LGiU (2015) op cit. Page 21.

[16] See Haynie JM, Patzelt H & Shepherd DA (2013). Project Failures Arising from Corporate Entrepreneurship: Impact of Multiple Project Failures on Employees', Accumulated Emotions, Learning, and Motivation. *Journal of Product Innovation Management*, 30(5), 880-895.

[17] See for example, The Lime Trees Residential Care Homes Ltd v CQC (2019) UKFTT 433 (HESC) Care Standards, where the provider unsuccessfully challenged a CQC decision to withdraw registration from a poorly performing care home. See https://www.casemine.com/judgement/uk/5d3a99682c94e063494514e9# accessed 27 July 2020.

[18] In the 1990s, some residents were offered a 'home for life' and so public authorities gave up the right to close these facilities – see R –v- North & East Devon HA ex parte Coughlan. Legal challenges continue to be mounted against closure.

[19] A historical example occurred when the National Care Home Standards were introduced in the UK, requiring provision of an individual wash-hand basin or en-suite in each bedroom, resulting in some providers leaving the market. See Department of Health (2003*) Care Homes for Older People National Minimum Standards: Care Homes Regulations*. 3rd Edition. Para 24.2. Downloaded on 22/7/20 from https://www.dignityincare.org.uk/_assets/resources/dignity/csipcomment/csci_national_minimum_standards

.pdf. Evidence that these standards led to providers leaving the market is found in Williams et al 2002, op cit. A more recent example is the disputed decision to pay National Minimum Wage for sleepovers heard by the Supreme Court on 12 and 13 February 2020 (Royal Mencap Society v Tomlinson Blake, and John Shannon v Rampersad and another (trading as Clifton House Residential Care Home), with a decision expected in summer 2020. With a potential bill of £400 million, it will be interesting to see how many providers leave the market.

[20] Williams J, Netten A, Hardy B, Matosevic T & Ware P (2002) Care Home Closures: The Provider Perspective PSSRU Discussion Paper 1753/2.

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

[22] ADASS (July 2020) *Adult social care – shaping a better future. Nine Statements to Help Shape Adult Social Care Reform.* Page 8. Downloaded from https://www.adass.org.uk/media/8036/adult-social-care-shaping-a-better-future-nine-statements-220720.pdf on 25 July 2020..

[23] The list of possible reasons for imminent provider failure given by the East Riding of Yorkshire Council ignore commissioner-driven pressures or influences on provider sustainability. See LGiU (2015) op cit. Page 27.

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

[25] Williams et al (2002) op cit. found some providers who had spent years considering closure before following through on their plans, showing that in some circumstances there is plenty of time for everyone to make their plans.

[26] Glasby, J, Allen, K, Robinson, S. "A game of two halves?" Understanding the process and outcomes of English care home closures: Qualitative and quantitative perspectives. *Soc Policy Admin*. 2019; 53: 78– 98. https://doi.org/10.1111/spol.12412.

[27] For the European Convention for the Protection of Human Rights and Fundamental Freedoms, see http://hrlibrary.umn.edu/euro/z20prot1.html. The judgement in *Guberina v. Croatia*, delivered on 22 March 2016, confirmed that this applied to the right to accessible housing for persons with disabilities – see https://hudoc.echr.coe.int/eng-press#{%22itemid%22:[%22003-5332264-6646797%22]}.

[28] The CQC database of registered care homes was downloaded from https://www.cqc.org.uk/search/site/spreadsheet%20of%20care%20homes?sort=default&distance=15&mode=csv&f%5B0%5D=im_field_popular_services%3A3668&location=&la=&latitude=&longitude= on 18/6/20 and contained 10,021 homes managed by 5,435 provider organisations. 2,584 providers managed just one home, while 2362 providers managed two homes. The five largest providers managed 50-76 homes each.

[29] Bruce N (2019) *Founder Leadership Succession in Family-Owned SME's: A Case of HC-Co* DBA Thesis, University of Liverpool. Available at https://livrepository.liverpool.ac.uk/3059866/.

[30] IPC reported that local authorities manage only 8% of care home provision – see https://www.cqc.org.uk/sites/default/files/201402-market-stability-report.pdf. The four largest private providers held 23.7% of English care home beds – see LaingBuisson (2010) *Care of elderly people: UK market survey 2010-11 (23rd ed)* London: Author.

[31] LGiU (2015) op cit. Page 5.

[32] In 2012, Southern Cross ceased to trade, requiring new arrangements for its 31,000 residents. The following account illustrates the level of turbulence in the market. Castlebeck owned Winterbourne View where some staff seriously abused residents. After this unit closed, abuse was uncovered at Whorlton Hall, another home that had been managed by Castlebeck. Both homes were taken over by the Danshell Group which was then acquired by Cygnet Health Care(https://www.cygnethealth.co.uk/) that is a subsidiary of the American based Universal Health Services (https://www.uhsinc.com/) so the head office is on another continent.

[33] The Care Quality Commission has developed an oversight regime to monitor the viability of large providers. See https://www.cqc.org.uk/guidance-providers/market-oversight-corporate-providers/market-oversight-adult-social-care.

[34] There is a lengthy and critical history of mergers, including the following early examples. In the US, see Porter ME (1987) From competitive advantage to corporate strategy *Harvard Business Review* May 1987. For a

UK commentary, see Lilley R & Richardson E (1998) *NHS mergers, management and mayhem: 101 questions for managers.* London: Kogan Page.

[35] https://www.gov.uk/transfers-takeovers.

[36] 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. Page 11.

[37] See Karl Rohnke's Comfort, Stretch, Panic model. A change of working practices, such as the move from large congregate to family group living, and the move from shared bedrooms to singles can mean that staff spend much more time working alone in comparison to traditional arrangements.

[38] For an example of the use of complex adaptive systems theory to analyse transitions from hospital to nursing care, see https://digitalcommons.unmc.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1074&context=etd.

[39] See the Swedish example in Holder J & Jolley D (2012) Forced relocation between nursing homes: Residents' health outcomes and potential moderators. *Reviews in Clinical Gerontology*, 22(4), 301-319. doi:10.1017/S0959259812000147.

[40] 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.

[41] Ferrah N, Ibrahim JE, Kipsaina C & Bugeja L (2018). Death following recent admission into nursing home from community living: A systematic review into the transition process. *Journal of Aging and Health*, 30(4), 584–604. https://doi.org/10.1177/0898264316686575.

[42] See Bates P (2019) *Eating together: Staff and care home residents sharing food and drink*.

[43] Use of typical antipsychotics in the six months following admission to a nursing home from the community is associated with higher death rates. See Huybrechts KF, Rothman KJ, Silliman RA, Brookhart MA & Schneeweiss S (2011). Risk of death and hospital admission for major medical events after initiation of psychotropic medications in older adults admitted to nursing homes. *Canadian Medical Association Journal*, 183, E411-E419.

[44] Capezuti E, Boltz M, Renz S, Hoffman D, Norman RG (2006) Nursing home involuntary relocation: clinical outcomes and perceptions of residents and families *Journal of the American Medical Directors Association*. Oct 1;7(8):486-92.

[45] Greenwald JL, Denham CR & Jack BW (2007) The hospital discharge: A review of a high risk care transition with highlights of a reengineered discharge process. *Journal of Patient Safety*, 3, 97-106.

[46] Weaver RH, Roberto KA, Brossoie N. A Scoping Review: Characteristics and Outcomes of Residents Who Experience Involuntary Relocation. *The Gerontologist.* 2020 Jan 24;60(1):e20-37.

[47] Laughlin A, Parsons M, Kosloski KD & Bergman-Evans B (2007) Predictors of mortality following involuntary interinstitutional relocation *Journal of Gerontological Nursing*, 33(9); 20-26.

[48] Thorson JA & Davis RE (2000) Relocation of the institutionalized aged. *Journal of Clinical Psychology* 56(1), 131-8.

[49] Louisa WATTS v the United Kingdom – 53586/09 [2010] ECHR 793. See https://nearlylegal.co.uk/2010/06/care-home-closure-not-admissible-to-ecthr/ accessed 27 July 2020.

[50] Critics of the move may seek to attribute all deaths to the closure, so it is important to review excess deaths, not all deaths. See Holden C (2002) British government policy and the concentration of ownership in long-term care provision, *Ageing and Society,* 22(1), 79-94.

[51] 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

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

[53] Laughlin et al (2007) op cit.

[54] 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.

[55] Glasby et al 2011 (op cit) p19.

[56] 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. Page 3.

[57] See Bates P (2016) *How to meet legal obligations in your consultation process.* Available at http://peterbates.org.uk/wp-content/uploads/2017/04/how_to_meet_legal_obligations_in_your_public_consultation_process.pdf.

[58] SCIE (2011) op cit. Page 3.

[59] See Bates P (2018) *How to respond to vexatious behaviour*

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

[61] The City of York Council has published a guide called *Moving Homes Safely* that explains what residents can expect when a care home closes. See https://democracy.york.gov.uk/documents/s52242/Annex%206%20Review%20of%20EPHs.pdf. Downloaded on 24 July 2020.

[62] Robinson S, Glasby J, Allen K (2013) 'It ain't what you do it's the way that you do it': lessons for health care from decommissioning of older people's services. *Health & social care in the community.* Nov;21(6):614-22.

[63] SCIE (2011) op cit. Page 38.

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

[65] Health and Social Care Board (2013) *Good Practice Guide – Reconfiguration of Statutory Residential Homes Northern Ireland.* Paragraph 3.2.

[66] 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.

[67] In the process evaluated by Leyland's team, this review took place 28 days after the move. See Leyland (2014) op cit. The Health and Social Care Board in Northern Ireland recommend three reviews to check up on progress during weeks 1, 4 and 12. See Health and Social Care Board (2013) op cit Paragraph 3.2.

[68] For an examination of the impact of older adults moving house on the wider family network, see https://www.tandfonline.com/doi/pdf/10.1080/10522158.2016.1157845?needAccess=true.

[69] Willoughby M, Kipsaina C, Ferrah N, Blau S, Bugeja L, Ranson D, Ibrahim JE (2017) Mortality in nursing homes following emergency evacuation: a systematic review. *Journal of the American Medical Directors Association*. Aug 1;18(8):664-70.

[70] Walker C, Cox Curry L. & Hogstel MO (2007) Relocation stress syndrome in older adults transitioning from home to long term care facility *Journal of Psychosocial Nursing,* 45(1),1–8. Relocation stress also appears when residents move from one care home to another – see Falk H, Wijk H & Persson LO (2011) Frail older persons' experiences of interinstitutional relocation. *Geriatric Nursing*, 32(4), 245–256. doi:10.1016/j.gerinurse.2011.03.002.

[71] A study of children in the USA found that those who had experienced multiple relocations often suffered a loss of participation in social activities and a short-term loss of friendships resulting in some depression, but some of these children developed resilience and scored better on these ratings than their settled counterparts. See Edwards ME & Steinglass P (2002) Relocation as Potential Stressor or Stimulating Challenge, *Journal of Feminist Family Therapy*, 13:2-3, 121-152. DOI:10.1300/J086v13n02_07. Similarly, some residents of substandard housing who were forced to relocate through an urban regeneration project found the change to be beneficial – see Egan M, Lawson L, Kearns A, Conway E, Neary J (2015) Neighbourhood demolition, relocation and health. A qualitative longitudinal study of housing-led urban regeneration in Glasgow, UK. *Health & Place* Vol 33, Pages 101-108. https://doi.org/10.1016/j. Richard Banks described a care home move

where one resident enjoyed the move as an opportunity to gain a sea view and meet new people (personal communication, July 2020)

[72] There will be cultural as well as individual differences here. Examples include veterans who move frequently and moving is so popular in Montreal that there is a designated Moving Day.

[73] Respondents in Neary's study of young people described the salience of external changes in contrast with the minor importance of relocation – see Neary, J (2015) *Changing contexts: young people's experiences of growing up in regeneration areas of Glasgow.* PhD thesis, University of Glasgow.

[74] Boling, P. A. (2009). Care transitions and home health care. *Clinics in Geriatric Medicine*, 25, 135-148.

[75] Care is needed to interpret guidance in the light of the law. For example, *Care and Continuity* declares that "For people who may lack capacity to make good decisions about their care, extra consideration is needed" but a "good decision" does not necessarily mean a wise one, but rather a capacitous one. See LGiU (2015) op cit. Page 14.

[76] LGiU (2015) op cit. Page 23. See also SCIE (2011) op cit. Page 3

[77] Reported in Glasby et al 2011 (op cit) p15.

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

[79] Williams and colleagues suggest that the ideal timeframe for the move should be 2-6 months. See Williams, J. M., Netten, A. P. and Ware, P. (2003) *The closure of care homes for older people: relatives' and residents' experiences and views of the closure process*. Available online at: https://www.pssru.ac.uk/pub/dp2012_3.pdf

[80] Leyland AF, Scott J, Dawson P (2014) op cit.

[81] Gasby et al (2019) p19.

[82] Leyland AF, Scott J, Dawson P (2014) op cit.

[83] This is the advice from Glasby et al 2011, but it needs thinking through from a co-production perspective. Is the separation of political and care planning functions little more than a way to disempower the person?

[84] Health and Social Care Board (2013) op cit. Paragraph 2.6.

[85] NHS England (2015) op cit. Page 4.

[86] Battersby (2017) op cit.

[87] NHS England (2015) op cit. Page 4.

[88] NHS England (2015) op cit.Page 4.

[89] NHS England (2015) op cit. Page 7.

[90] Health and Social Care Board (2013) op cit. Paragraph 2.7. A local authority which ignored this advice appears at https://www.expressandstar.com/news/2010/04/30/anger-as-louisas-home-still-open/. It is notable that the featured resident had pursued legal action and the news reporter uses the term 'relocated' once in the report, alongside four references to the residents being 'evicted'.

[91] NHS England (2015) op cit. Page 7.

[92] LGiU (2016) *Managing care home closures- management checklist*. Item 7.21.

[93] For a discussion of the importance of possessions in care homes, see Bates P (2020) How to make a homely care home. Downloaded from https://peterbates.org.uk/wp-content/uploads/2020/06/How-to-make-a-homely-care-home.pdf on 29 July 2020.

[94] Leyland 2014 op cit.

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

[96] The NHS '15 Steps Challenge' inspections harness these first impressions by patients and relatives to identify areas for improvement. See https://www.england.nhs.uk/participation/resources/15-steps-challenge/.

[97] The following people have kindly responded to an inquiry with comments and challenges to this discussion: nobody yet.

[98] 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 peter.bates@ndti.org.uk 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.