**A Review of Published Literature on the Experience of Closure of Residential Care Homes in the UK**

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Executive Summary

1. This literature review was initially written in 2007 in support of the Birmingham City Council Adults and Communities Directorate (BCC hereafter) Reprovision Programme. This programme will see the closure over the next five years of all 29 residential care homes for older people currently owned and operated by BCC and the development of a series of Special Care Centres with half of the beds in each centre providing long-term stay. The centres will also provide intermediate care and rehabilitation. Extra Care Housing has been expanded, with enhancements made to existing provision and new development schemes undertaken. The review is now being republished in 2011 as part of a broader guide to good practice by the Association of Directors of Adult Social Services and the University of Birmingham in association with the Social Care Institute for Excellence.
2. This review provides an overview of policy and practice literature on issues related to the effects of closure of residential care homes for older people on their health and wellbeing, and on the policies governing the way care homes are closed. The experience of residents and their families / informal carers is prioritised, as is the role and quality of assessment.
3. No information has been made available to the research team on the needs or characteristics of the residents who will be affected by the reprovision programme, though it is expected that some, perhaps many, people will be very frail.
4. A scope of the published academic and professional literature found very little empirical research evidence on the closure of residential care homes for older people. What there is comes from a limited range of sources and concentrates mainly on the experience of closure in the independent sector.
5. An extensive review of local authority guidelines of care home closure found that few had been developed and that most were developed ‘in-house’ without reference to experience elsewhere. Consequently there are few, if any, reliable benchmarks available to the Reprovision Programme by which to compare performance.
6. Principles informing current government policy and legal obligations imposed by the Human Rights Act 1988 emphasise the responsibilities of local authorities to place service users’ needs and wishes at the heart of care plans and to implement preventive strategies where possible. In the context of closure and reprovision of residential care, this means a duty to consult properly with residents and their families or informal carers and to provide care that is appropriate and responsive to changes in individual needs.
7. The impact of resettlement on the health of frail elderly people is a natural cause of concern. It is difficult to establish a correlation however, mainly because the population under consideration is likely to be very frail in the first place and often in need of high levels of care. Such evidence as there is suggests that adverse effects can be minimised if continuity of care is maintained and there is good consultation and planning. The importance of relationships with staff, in particular key worker relationships, should not be overlooked.
8. People with cognitive impairments have preferences and wishes and should not be excluded from the resettlement process. Interpretation of cognitive ability should be undertaken with the service user’s participation and on the basis of detailed and comprehensive assessment.
9. The role of care managers is crucial in the process of reprovision. Demands placed upon them are likely to be complex and stressful. As assessors they may have to make controversial decisions or recommendations, sometimes contrary to the wishes of residents or their families, or indeed of their own local authorities. They should receive adequate support and guidance.
10. Emphasis is placed within this programme of reprovision on the role of Extra Care housing, which offers a disseminated form of provision with care and accommodation being provided under many roofs rather than one, albeit often on one site. It is more difficult to monitor and maintain levels of security and support in these circumstances. Technology can help, but should not be seen as a replacement for human contact.
11. The role and legal status of occupiers of Extra Care housing is different from that of traditional residential care services. People living in Extra Care housing are normally owners or tenants of individual properties.
12. Provision of alternative housing alone will not assure that goals of independence and autonomy are achieved. There is some evidence that residents of good quality traditional care homes are able to feel as empowered and in control as those in extra care settings of equal quality. The key here seems to be quality of care. Some older people may therefore benefit from or prefer the extra security and support offered by traditional residential care provision.
13. Staff are likely to have to work in different ways in Extra Care settings if they are to facilitate the ‘doing-with-rather-than-doing-for’ culture that is envisaged. A different relationship is likely to exist between staff and residents compared to traditional care homes. This relationship will need training and good management and support if it is to be more than tokenistic. Economies of scale may be harder to achieve in Extra Care settings.
14. Assessment provides the primary mechanism by which an individual’s need for support is determined, and as such is likely to embody not only the thresholds of eligibility offered by providers, but the philosophy and ethos of the monitoring authority and its partners and agents. It is possible that, for some, re-assessment may identify needs that are more suitably met in nursing homes or in NHS Continuing Care provision.
15. Assessments of need should not focus solely on a person’s impairments, but should take into consideration the context of the way help is provided in the environment in which they may live. They should not be used to predict workload.

**Introduction**

**Context in which this review is being written**

Birmingham City Council Adults and Communities Directorate (BCC from hereon) are undertaking a Reprovision Programme, radically changing older people’s housing and care across the city. There are 29 BCC residential homes in the city owned and operated by BCC and many of these are in a poor state of physical repair. The homes are to be decommissioned, and there will be two central strands to the Reprovision Programme:

* **Special Care Centres** are to be built (8 in total), with half of the beds in each providing long-term stay. The centres will be at the centre of each of their communities, and will provide intermediate care and rehabilitation;
* **Extra Care Housing** will be expanded, with enhancements to existing provision and new development schemes such as a 240 unit village currently under construction in Sutton.

**Sheltered Housing** will be provided by BCC Housing Directorateand nursing carewill be provided by providers attracted to the City where necessary. A third and ongoing strand will be work to attract providers of housing and care to the areas of the city where there is currently a short-fall.

The programme has its origins in a city-wide ‘Citizens Consultation’ from 2004 and a strategic review that pre-dates the current 2006 White Paper on the future of adult care and health services: *Our Health, Our Care, Our Say*[[1]](#footnote-1) and will run from 2007 to 2011. BCC is committed to:

* Ensuring quality of care during the transition
* Ensuring the programme is delivered in a caring and thoughtful way
* Basing the programme in available evidence of best practice, and developing a model of best practice for future programmes.

**Aims of the Review**

This is a complex programme, but there are some core concerns identifiable at the outset:

* What is known about reprovision programmes in other local authorities, or beyond England and the UK?
* How can staff be supported, trained, recruited and retained?
* What model of assessment will be most sensitive to the needs of older people and their families?

The programme began in January 2007 with a consultation with residents of BCC care homes to determine the order of home closure across the City. The Birmingham City Council Cabinet was asked to approve the schedule. Assessments were to begin in July 2007. Homes will not be closed until new provision is in place.

In order to support this programme and to help establish good practice from the outset, this review provides an overview of the existing policy and practice literature on issues related to the effects of closure of residential care homes for older people on their health and wellbeing, and on the policies governing the way care homes are closed. Evidence is considered from a number of points of view, but prioritises that of the experience of residents and their families / informal carers. A particular focus is placed on the role and quality of assessment, as this is a crucial mechanism by which good care is delivered to meet the needs of individuals.

It should be noted that no information has been made available to the research team on the needs or characteristics of the residents affected by the reprovision programme. The scope of this review cannot therefore address the needs of particular individuals or groups within that population. It is assumed, however, that many, if not most, will be frail, and that some will have experienced deterioration in their health and / or abilities since first entering residential care.

Although this review was first published in 2007 to support the work of BCC locally it is now being republished nationally to support other local authorities facing similar situations and to share learning more widely.

**Background**

**The role of residential care for older people in England**

Residential and nursing care occupies a significant, if declining, place in the range of services for older people. Approximately 4% of all people aged 65 and over currently live in residential care. Most homes are in the independent sector, but over two thirds of all older people in residential care are publicly funded (Williams & Netten, 2005[[2]](#footnote-2)). In recent years the range of housing options for older and disabled people has changed to include various forms of sheltered housing with differing levels of staff support. Smaller independently owned and operated residential and nursing homes are more likely to close than larger, corporate run homes, resulting in a consolidation of market supply around a smaller number of major providers (Darton, 2004[[3]](#footnote-3)). This may have consequences for the ability of providers to offer individualised care if, as Darton (op cit) suggests, those homes with “a positive social environment were among the most likely to have closed.”

The rate of care home closures has been rising in recent years and has not been matched by the number of new registrations (Willams et al, 2003[[4]](#footnote-4)). In practice the process is largely subject to Government guidance and to local protocols (Williams & Netten, op cit). However, the research evidence on the extent to which local authorities have or use local protocols suggests that in many areas there are no formal guidelines (Williams & Netten, op cit). It is thus hard to find common standards that are widely subscribed to and that can be used to measure or compare the extent to which principles are put into practice. Indeed, the literature on care home closure generally is far from extensive.

**Profile of the population of older people living in residential care in England**

No data was available to the research team on the older people currently living in residential care provided by BCC. It is evident, however, that the population of people living in care homes is both very elderly and frail. The NHS End of Life Care Programme has published a wide ranging summary of statistics on trends, demographic profile and length of stay of people living in care homes (Whelan, 2005[[5]](#footnote-5)). This is presented below, supplemented by additional references:

|  |
| --- |
| * There are currently estimated to be around 440,000 people living in care homes in England (Whelan, 2005, Office of Fair Trading, 2005[[6]](#footnote-6)).
* Currently, most residential care is provided by agencies within the independent sector, often privately owned small or medium sized enterprises.
* Local Authorities provide less than one fifth of all residential places, and over the last twenty years have seen their share of provision fall from just under half of all places (Age Concern[[7]](#footnote-7)).
* The rate of home closures rose substantially between 1998 and 2000 and appears be about five per cent each year. The net result has been a reduction in capacity, particularly in smaller homes.
* Possible common factors behind the closures include pressure on local authorities to keep fees down, the influence of increasing staff costs and new regulations to impose minimum standards in the quality of homes, and difficulties in recruiting suitably qualified staff (Darton, et al 2005[[8]](#footnote-8)).
* In many areas local authorities have transferred some or all of their provision to the independent sector. Nationally there is thought not to be a significant shortage of care home beds, though this trend may mask significant local and regional shortages or shortages in specialised residential care facilities such as those for older people with mental illness. As the proportion of older people increases in the population the need for high levels of care appropriate to the needs of very elderly people is likely to increase (Age Concern, op cit).
* Length of stay in care homes tends to be short. The median figure for men is 1-2 years, and 2-3 years for women. (Whelan, op cit).
* Half of older people admitted to care homes die within 20 months. (Whelan, op cit).
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Debate over what sort of care is appropriate for vulnerable older and disabled people has changed significantly over recent decades. Townsend provided what is arguably the first substantial challenge to the association between old age and a socially imposed decline towards dependency and passivity (Townsend, 1981[[9]](#footnote-9)). Since then, and especially in recent years, numerous challenges to the model of structured dependency have emerged in government policy as well as academic literature. The 2006 White Paper, *Our Health, Our Care, Our Say* (DH 2006[[10]](#footnote-10)), which followed on from the Green Paper, *Independence Wellbeing and Choice* (DH 2005[[11]](#footnote-11)), extended the Government’s intention to promote services that aimed to achieve the maximum degree of autonomy for individuals within a market system. The emphasis has been increasingly on the development of services that aim to promote earlier intervention and prevention of problems, alongside principles of personal choice and greater involvement in the way their own care is managed and provided. The role of the individual in their relationship with the state has thus been changing – though the extent to which it has changed, for how many and for who are debatable points.

Among key initiatives that have characterised recent trends are the development of direct care services such as rehabilitation and intermediate care services alongside enhanced home care and home-based nursing care services (see, for example, Audit Commission (2000[[12]](#footnote-12)). New financial mechanisms such as Direct Payments allow people to receive grants that empower them to commission and manage their own care services in ways that suit them and are flexible to changes in their circumstances and needs. The rhetoric of these policy initiatives focuses on the need for simpler, more ‘joined up’ systems by which people receive assessments in order to avoid unnecessary duplication and promote a more holistic awareness of the person’s needs and the complex interdependencies that exist between a person’s disabilities and their social, psychological, physical and economic environment.

**The Human Rights Act**

Public authorities are bound by the Human Rights Act 1998[[13]](#footnote-13), which recently incorporated the European Convention on Human Rights. In this context there is a duty to ensure that residents are properly consulted and informed in the event that a home needs to close. A case in 1999 found that a health authority was in breach of Article 8 in its decision to close a home because patients in the home had been told in writing that it would be a “home for life.” (Court of Appeal judgement R v North and East Devon Health Authority *ex parte* Coughlan, 1999, cited in Williams & Netten, op cit, p 7.)

While a detailed review of the legal responsibilities of local authorities considering closure of care homes is beyond the scope of this review, it is worth noting that in 2003, following legal challenges, Lancashire County Council agreed to postpone a programme of closure affecting 32 of its 48 homes to allow the risks to health to be assessed by a consultant geriatrician (Lancashire County Council and Chorley Borough Council, 2003[[14]](#footnote-14)).

**Methodology**

In the initial scoping exercise a range of searches were undertaken. Searches of ASSIA and AgeInfo using the following keywords were undertaken:

* residential OR nursing

AND

* care OR home

AND

* close OR resettle\* OR reprovision
* Search dates earliest – present
* subject area = social sciences

This found 77 items which were scanned by eye.

15 items of relevance were identified, of which five were identified as being of direct significance.

The following sources were explored and searched by eye for relevance:

* Government sources, including Department of Health websites (including DH circulars), White and Green Papers, Acts of Parliament, the website for the Office of Fair Trading.
* Websites for significant independent academic research and policy organisations, including PSSRU, Kings Fund, CSCI, SPRU, JRF, ADSS, Audit Commission, Centre for Policy on Ageing and the Healthcare Commission.
* Birmingham City Council website.
* Websites of significant providers, including Housing 21, Age Concern, Help the Aged.
* Academic journals, including Ageing and Society, Disability and Society, Health and Social Care, Journal of Intellectual Disability Research, and others.
* Community Care website.
* Previous research on re-ablement and rehabilitation undertaken by the research team were accessed.
* Google and Google Scholar were searched for items from the press and elsewhere.
* Search terms included: elderly; older people; residential, reprovision; resettlement; care homes.

Enquiries were made directly via professional networks, including contacts in the Personal Social Services Research Unit, The Older People’s Directorate in Birmingham and Solihull Mental Health Trust, Age Concern, and Birmingham Agenet (an online forum for staff within and associated with Birmingham University whose work involves older people).

Items identified as potentially relevant were obtained (in most cases by download) and read. These were prioritised as being of primary, secondary significance and ‘other’.

**Findings**

**Introduction**

This section aims to provide a summary of key points identified in the literature that are relevant to the reprovision programme. It should be noted that very little has been found that deals directly with circumstances that are similar to those under consideration.

Findings are discussed under four sections: 1) The experience of care home closure in the independent sector, including the experience of residents and their relatives, as well as care managers, and the extent and quality of guidelines developed by local authorities; 2) The effects of home closure on residents’ health; 3) the value of housing with care, including the value of extra care housing for people with dementia; and finally 4) Assessment.

The implications of these findings for the reprovision programme are discussed under Conclusions.

**The Experience of Care Home Closure in the Independent Sector**

Thishas been considered in some depth by Personal Social Services Research Unit at the Universities of Kent, Manchester and the LSE, who provide what are probably the most comprehensive and insightful analyses on the subject. As the vast majority of residential care is provided by the independent sector, albeit largely it with public funding, it is perhaps not surprising that almost no evidence was found on the experience of closure of care homes for older people provided in the public sector. What mention there is tended to focus on the lower levels of responsibility that local authorities have to residents accommodated in private or voluntary sector homes. Indeed, there is little research evidence on good practice in residential home closure for older people generally (Schofield, 2004,[[15]](#footnote-15) Williams and Netten op cit).

Since 2002 the PSSRU has been researching the experience of home closure. Their work has drawn upon surveys of Registration and Inspection Units (Netten *et al* 2002[[16]](#footnote-16)), interviews with residents, their relatives and with care managers (Williams, *et* al, 2003; Williams & Netten, 2005; Darton, *et al,* 2005).The key findings of relevance are summarised below.

***Residents’ and relatives’ concerns:***The closure programmes that were studied each imposed relocation on the residents and staff involved. The way in which residents were informed varied, some being told by their families and others by formal letter. Some first heard of imminent closure by rumour. A substantial number said that the responsibility to inform residents was left to family members. The amount of notice given ranged from about a month to a year. Almost half said that their new accommodation was not their preferred choice, and many residents and their families feared a period of temporary accommodation.

Continuity of care and the quality of any new provisions were issues of prime concern. Some found that the quality of care they received actually suffered, even to the point that the health and safety of a few residents became matters of concern. Sources of anxiety particularly focussed on issues of staffing: falling staffing levels generally, the use of agency staff or staff that were unfamiliar to residents and poor management were cited.

Openness and good communication from council staff prior to and during the closure were valued. Closure periods varied from between a month to a year, and in the worst instances residents learned about the impending closure by gossip and rumour or by articles in the local press. Others found the task of informing resident was left to family members. Some councils provided high levels of support during the closure and offered good comprehensive information on alternatives. Others did not. The differences applied to the actions of the local authorities generally, rather than whether the individual was publicly or privately funded.

The duties of the local authorities in the event of home closure differ between those residents who are publicly funded and those who are not. Those who are publicly funded have more rights to support from the local authority, for example to an assessment and to arrangement of alternative accommodation. Those who fund themselves may receive information and advice on how to find a home, and help to arrange it if the resident’s informal carers are unable to do so. This can cause confusion, particularly where both publicly and privately funded residents are living together. Local Authorities have a duty to provide a full needs assessment to all older people before they first enter a care home.

***The move:*** In general, the less the disruption caused by the actual move the better. Good planning and coordination seem to be key issues in organising the move well, not least because the lack of guidelines in many local authorities left many relatives uncertain whether it was better to tell the older person what was happening or not. Many felt that it was better to inform those with cognitive impairments than to leave them unaware, even if this was in itself distressing. Efforts to minimise or hide this knowledge from residents could prove considerable and disrupting in itself. Once a place had been secured it was better that it happened quickly, but without a rush. On the actual day it was important to allow residents the opportunity to say goodbye to friends and staff.

***Recommendations by residents and relatives:*** These are best summarised as a series of bullet points below:

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| * Notice of closure (or departure date) should be flexible and sufficient to allow time for alternatives to be properly explored and choices considered. Some establishments have waiting lists and these must be taken into account. At least two months is recommended, more in areas where there is limited supply. A specific day should not be named. The home and the local authority should be honest and open about the reasons for closure and should provide clear information about what to do to find new accommodation.
* Careful consideration should be given to how and when residents with cognitive impairmentsare informed. While such information given in advance of the event may prove distressing for some, discovery by other means at a later date could prove more so. The relatives and informal carers of such residents should be supported in this and it should not be assumed that the task of disclosure should be left to them alone.
* Information and advice. The task of seeking alternative accommodation is made easier if impartial and expert advice is available on the type and quality of services available elsewhere. Families should not be left to seek this out on their own.
* Residents’ views on new accommodation should be listened to. Time and opportunity should be provided for people to visit and try out new homes, preferably accompanied by someone they know.
* Assessment of needs should be done in a timely and appropriate manner, and the information properly incorporated into new care plans and transferred.
* Continuity of care should be maintained by the continued use of familiar routines and the maintenance of standards. Obvious signs of packing are considered distressing and visit by new owners / developers insensitive.
* Residents’ relationships with staff, where good, should be maintained as far as possible throughout the closure period.
* The actual move should be accompanied by someone familiar, and there should be someone at the new home ready to welcome the resident. The needs of residents moving from one care home to another are likely to differ from those being admitted from hospital, and this should be recognised. Residents moving home should be treated as individuals.
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***The role of care managers***[[17]](#footnote-17) is crucial to the effectiveness of home closure. They are well placed to provide help and support to older people and their families during closure and are often the first port of call for residents, relatives and providers in any negotiation or relationship with the local authority. They must provide advice and in the case of publicly funded residents arrange alternative accommodation. The level of help they may expect from providers may vary. In many types of council, this is done without the benefit of agreed guidelines.

The duties of managing the relocation of residents is often time consuming and stressful. Particularly stressful aspects include anxiety about the welfare and health of residents, and fears they may be held accountable for major problems. There was a perception that relocation could bring about the death of very frail residents, though the research programme found no evidence that this was more likely on the basis of the cases studied (see also Williams and Netten, 2005, discussed below).

In the process of relocation some residents may receive further assessment which may identify need for higher levels of support due to deteriorating health and abilities. Many care managers found themselves arguing for higher levels of fees. Some found they had to encourage residents and their relatives / informal carers to consider options that were not of their first choice and which they would not normally have done so had there been better alternatives available.

There could be tensions too between helping people find the accommodation of their choice and the most suitable accommodation. These tensions arose from differing perceptions of needs and of preferences. The importance of assessment and good communication was highlighted, but also the difficulty of undertaking that in good time. Care Managers were likely to find themselves in the ‘front line’ of conflicts about what is appropriate for an individual. Local policies or practices varied as to who received an assessment.

**The effects of home closure on residents’ health**

Residents of care homes that are forced to close for one reason or another do not choose to move, but are affected by concerns and issues that are beyond their control. There are concerns that for some such a move can be injurious to health, and the national press and other media have not been slow to highlight these fears (Williams & Netten, 2005, op cit).

The factors involved in involuntary relocation from one care home to another are complex, and though the subject has attracted interest for many years there remain substantial difficulties in establishing a link between a deterioration in health and a move *per se* (Smith & Crome 2000[[18]](#footnote-18)).

The key to successful relocation – and indeed in successful provision of residential care generally - is good planning and preparation. One might argue that the opportunities for positive relocation are substantially enhanced if there is a tradition within the organisation of good communication and involvement of staff, relatives and residents. An example of this can be found in the way the home relates to relatives of residents. Davies and Nolan (2006[[19]](#footnote-19)) found that families played an important and multi-dimensional role in helping their relative maintain a sense of continuity and identity in the home. They did this through the continuation of positive family relationships; through helping staff to get to know the resident as an individual; by monitoring the care their relative received and communicating with staff; by involvement in social events to do with the home; and generally acting as a link to the outside world. The importance of relatives as a resource within the home, particularly at times of stress such as relocation, should not be overlooked.

In their review of the roles and responsibilities of local authorities in managing care home closure, Williams and Netten (op cit) identified a number of papers that suggested recommendations for good closure based on the experience of resettlement from long-stay hospital wards. In brief such experience indicates that the procedure is likely to be complex and subject to a number of unexpected events that can cause uncertainty and anxiety. Continuity of care should be maintained (Korman & Glennerster, 1985[[20]](#footnote-20); Leonard Cheshire and Social Care Association, undated[[21]](#footnote-21); Whyld, et al, 2002[[22]](#footnote-22)) and hurried or panic-inspired moves avoided (Lane 1987[[23]](#footnote-23)). Residents and their relatives should always feel involved in the closure process (McCourt Perring, 1993[[24]](#footnote-24); Brugler *et al* 1993[[25]](#footnote-25)) and have the opportunity to visit their new home in advance of the move, and to make the transfer at the same time as familiar staff. A key worker should be established at the new home (Woolham, 2001[[26]](#footnote-26)). Residents with all but the most severe dementia are able to recall information and express appropriate emotional responses, and therefore should be included in notification, counselling or support activities (Dickinson, 1996[[27]](#footnote-27)).

**The value of housing with care**

The BCC reprovision programme involves not only the creation of new buildings but also a radically different way of providing supported accommodation to frail older people. Two reports were identified that addressed this issue and provide findings that are relevant to the programme.

The Joseph Rowntree Foundation has published a review of empirical evidence in the literature on the value and effectiveness of housing with care for older people.[[28]](#footnote-28) They found only 11 UK studies that sought to evaluate schemes.

Key findings are listed below:

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| * The term housing with care has many meanings and is identified by many terms, such as sheltered housing, very sheltered housing, Extra Care…and so on.
* While residents value the combination of independence and security that housing with care can offer, they do not always share a common vision with providers of what independence means. For providers it may mean being able to do for oneself; while for older people it may mean receiving enough support to help them live as they wish.
* Housing with care offers many opportunities for social interaction and companionship. Such opportunities may be more readily available to residents who are relatively fit and without cognitive or sensory impairment. There was evidence that less able residents were marginalised in mixed fit/frail settings.
* Housing with care is not a straightforward replacement for residential care. Some older people prefer residential care as a positive option for the sense of security it offers and its ability to meet increasing care needs.
* The ability of staff to support activities can be stretched if they must work across a number of sites. This can in effect actually limit the extent to which some frail older people access activities and community facilities. Indeed, some people living in housing with care facilities could be said to be at best living in the community but not actually part of it.
* There is evidence that many residents express positive levels of health and well-being as a consequence of living in housing with care. Such testimonies must be treated with caution. There was little evidence of objective measures of health or well being in the studies reviewed. Entry criteria to the schemes studied varied considerably, making base-line comparisons difficult.
* The evidence on cost effectiveness of housing with care was limited. Comparisons of costs are hard to measure. There is some suggestion that housing with care may be more expensive than residential care, but cheaper than care delivered in ‘ordinary’ housing settings.
* Access to health care in the form of nursing home respite care on site is not widely available, but where it is can provide useful support to older people who are frail and their carers.
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In a study of the extent to which older people living in a range of “good quality” extra care housing felt more in control of their lives compared with older people living in “good quality” care homes (Towers 2006[[29]](#footnote-29)), the PSSRU identified somewhat surprising results that bring into question easy assumptions about the ability of extra care housing to lead to a stronger sense of general well-being.

For example, the following factors (in descending order) led to a positive sense of home in both groups:

* “Being in control of when friends or relatives visit.
* Being able to live in the home or scheme for as long as you want to.
* Having control over how you spend your time.
* Being able to come and go as you please.
* Being able to arrange your room or flat to suit your own tastes.
* Being allowed to be alone of you want to.”

However, the researchers claim to have found no evidence that those living in extra care housing felt *more* at home, even though they lived in their own self-contained housing and scored more highly on objective measures of control. Moreover, those with a high *desire* for control were most likely to *feel* in control and to experience well-being. Indeed, *self-perceived* health and feeling in control were the strongest predictors of overall well-being. The overall conclusion of the study was that though Extra Care Housing could offer good quality accommodation and support, it did not in itself lead to better outcomes in terms of a sense of well-being for older people compared with good quality care homes.

**The particular value of Extra Care housing for older people with dementia**

This is considered in some detail in a report published by Housing 21, a major provider of extra care housing, in conjunction with Dementia Voice and the University of the West of England (Vallelly, *et al* 2006*[[30]](#footnote-30)*). The report summarises research carried out in a number of locations, or ‘courts’ as Extra Care Housing complexes are called, that were operating as replacements for residential care facilities and that aimed to offer a ‘home for life’ to its residents, though some people during the three year study did move on.

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| --- |
| * Extra care housing can be effective as a site for the delivery of community health services for people with complex needs. Residents of extra care housing are likely to spend less time in hospital than the general population (presumably because extra care sites are staffed and sometimes offer specialised support), and that extra care housing can serve a useful preventative role. The potentially wide range of facilities and environments within an extra care setting can be of benefit to older people with dementia, but only if staff resources are dedicated to allow time for staff to help older people access them.
* Some sites in the study provided specialist clusters of flats that were segregated from the rest of the courts. Segregation enabled residents with orientation problems to wander more freely within designated areas and to enjoy more freedom than might have been the case in integrated designs.
* In those integrated sites where people with dementia lived alongside those without and shared access to facilities there was some evidence of mixing and of positive awareness and attitude towards people with dementia. This was not universal, however, and there were reports of discrimination also. There is little empirical research into the effectiveness of integrated facilities.
* The importance of sufficient numbers of high quality, well trained, supported and motivated staff cannot be underestimated. However, increasing pressure on resources can hinder the ability of extra care services to support people as their needs change. Activities outside the courts are particularly likely to be compromised, thus bringing into question the ability of this form of care to facilitate community involvement. Where community facilities such as shops, restaurants and hairdressers are developed within the extra care courts greater integration may be expected to some degree.
* Some people found the experience of living in their own flat to be isolating, particularly as their health needs deteriorated. The report questions expectations that residents of extra care should be able to live independently throughout their tenure given that many will experience deteriorating levels of health.
* Though the sites that took part in the research all catered for older people with dementia, there was concern at the lack of specific training for staff on the needs of residents with cognitive impairments. The form of extra care housing requires staff to work in a different way from that which they might if they were in a residential or nursing home. The report notes that there are no specific training or qualification guidelines to support this, though these are reported to be under development by a number of organisations.
* Security on extra care sites depends to a large extent on effective alarm systems, and these were noted as giving many residents peace of mind. The systems require special training to enable their use with people with dementia, however, and there was concern that traditional ‘pull cord’ systems were not the most appropriate for some people. It was found that their abuse by some people with dementia had been the cause of their move away from extra care. There is a positive role for assistive technology to play in supporting people within the more dispersed environment of an extra care facility, though this is still under researched. Where alternative forms are used they should not impinge on people’s rights to autonomy and privacy, and should be deployed as a consequence of appropriate risk assessment. This principle applies also to the way staff are trained to work with people with dementia in an extra care setting. The presence of ‘challenging behaviours’ should not automatically be seen as justification for exclusion. Rather staff need to know how to recognise and understand behaviours associated with dementia and to know how to help people avoid situations that may trigger them.
 |

**Assessment**

Assessment plays a crucial role in the provision of care, particularly in the determination of who should receive what form and level of care, if any. This review has found little discussion of issues to do with assessment at the point of home closure or reprovision of the type envisaged by BCC. It may be expected that many current and future residents of existing provisions will enter or have entered their homes in some frailty and some will see or have seen a decline in their abilities. Re-assessment may be expected to identify increased levels of need in some older people, especially for health care, and may identify some people who may be more suitable for nursing home care and NHS Continuing Care.

Recent policy has emphasised the importance of making the process of assessment as simple and straightforward as possible, with the aim of reducing repeated assessments by different professionals and agencies. The National Service Framework for Older People (DH 2001[[31]](#footnote-31)) offers guidance on the content of an assessment, which includes information on social aspects of a person’s life, such as their ethnicity, family structure, the range of people or agencies supporting them, as well as clinical data and information on the older person’s own perspective on needs and solutions. The majority of the information relates to clinical or health matters, and there is a certain emphasis on risk and what the older person cannot do, rather than what they can do or what their aspirations are. Nevertheless, it provides the basic framework for a comprehensive multi-dimensional assessment that forms part of a number of standards and procedures that are intended to be required practice in all local authorities and health trusts.

There are a number of assessment tools currently in use, some of which have been employed for many years and have proven their worth in terms of reliability and validity. The DH has published a brief guide to assessment tools and their accreditation that identifies items that are recognised as fit for their particular purpose (see DH 2004a[[32]](#footnote-32); 2004b[[33]](#footnote-33)). It is beyond the scope of this review to evaluate or recommend specific tools, except perhaps to note that in order for them to function they must make measurements against certain normative levels that may not always be explicit and are likely to be based on certain cultural assumptions. The DH does make a number of principles concerning their use, which can be summarised:

* Scales should be valid, reliable and culturally sensitive.
* A literal or narrow interpretation of scores can lead to a reductionist approach that fails to serve the person’s needs holistically.
* Scales alone should not be used to determine eligibility for services on the basis of thresholds of severity; neither should they be the sole means of determining the severity of a person’s problems or needs.
* They should be properly employed by people qualified to use and interpret them. Attempts to revise a scale may have an adverse impact on its effectiveness.
* Scales may support but do not replace judgement.

DH (2004b)

It is important to know a person as well as possible if assessment is to be thorough. A single, formal, assessment interview is unlikely to be enough to identify their preferences or their needs and abilities within a range of contexts. In cases where individuals suffer communication problems much may depend on good independent observation, including social behaviour to identify friendships and other significant relationships (Oyebode, 2007[[34]](#footnote-34)). The potential for residents in institutional care to offer as well as receive help should not be overlooked.

However, consideration of the importance of knowing the individual and of the importance of unbiased observation leads on to consideration of what exactly dependency measures consist, and to what ends they should rightfully be employed. A paper by Steve George (1991[[35]](#footnote-35)), who writes as an epidemiologist, offers a particularly insightful and relevant discussion of the opportunities and risks involved in the use of dependency measures in assessing older people for residential care. The points he makes are equally relevant to the use of measurements of ‘need’ in individuals.

Central to George’s discussion is the question, what is dependency? The answer, in a nutshell is that “…dependency is a relationship rather than an individual attribute” (p180). Measures of dependency are often used, explicitly or otherwise, to determine the implications for workload and hence resources that an individual or group are likely to present; “Dependency implies a relationship between a dependent individual and a carer.” Even if different measures are used to provide a multi-dimensional or multi-professional assessment, the different causes of dependency may be obscured or overlooked if there is a wish to see in the composite measure a “single, easily interpreted whole” (p178).

Aggregation of different measures raises important problems of how to amalgamate and compare like with like. For example, the problem of inter-observer variation is widely reported in the literature on assessment scales, and there are calculations that can be made to measure the degree to which it is likely that different observers observing the same thing will achieve common scores. George notes three commonly encountered problems with inter-rater reliability:

* Different caring practices may produce different effects in the individual’s behaviour and the way they relate to carers and others.
* There are many, often subtle factors that may cause the behaviour of an individual at one time to differ from that at another.
* The quality of observation and hence assessment depends entirely on the ability of the observer to recognise and interpret phenomena correctly.

George warns against the use of dependency measures to predict workload of staff. He cites the case of an individual who has limited mobility but is mentally alert. If help is available he can get to a toilet on time and remain continent. If it is not he is incontinent. An ‘efficient’ strategy to deal with this person’s problem might be for him to be assessed as needing to wear incontinence pads, a strategy that cuts down on the need for staff support. Another example cited is that of a mildly confused resident with limited mobility who requires help with feeding. If someone sits beside her she may, with a little prompting, be able to eat largely unaided. However, this takes time. A quicker solution might be to spoon feed her, a strategy that again may increase her dependency but save staff time. Likewise, a physically able but mentally confused individual living at home may become inclined to wander outside the home, in which case the most likely consequence may be admission to institutional care where he or she can be contained without constant one-to-one attention. The level of dependency of a person therefore depends heavily on the regime in which they are living.

The question is further compounded when considering the level of ‘social dependency’ – i.e. the extent to which they need the company of others and the form in which it is needed. The issue of social dependency touches on questions of the individual’s mental and spiritual well-being as well as their direct health or care needs. Social isolation and loneliness are hard to measure, yet they are powerful factors affecting the ability of older people to live independently and enjoy a quality of life that is of their choosing (Le Mesurier, 2003[[36]](#footnote-36)).

Care must therefore be taken to recognise the link between dependency and the resources available at the time to meet its challenges. George cites evidence of the extent, in 1988, to which problems with carers was a factor in determining the need for re-admission to hospital[[37]](#footnote-37): in 14% of cases they were the ‘primary’ reason and in 83% they were cited as contributory factors.

George concludes with two points that are salient to the reprovision programme. The first is that “Without defining the objective one is trying to achieve, it is impossible to estimate what resources are needed to achieve it” (p181). The second is that, “There can be no fixed criteria which will determine who is in need of residential care and who is not. The need for such care is externally defined and is a matter of political will” (Ibid).

Morris (2004)[[38]](#footnote-38) echoes many of these points when she cites Simon Brisenden in personal correspondence, whom she describes as a pioneer of independent living, as saying, “Independence is not linked to physical or intellectual capacity to care for oneself without assistance; independence is created by having assistance when and how one requires it.” (Morris, op cit, p427-8) She goes on to voice many of the objections of the British disability movement to assessments for people with disabilities within the current community care framework:

*“In order to determine eligibility for scarce resources assessments commonly measure dependency levels: they thus often ask ‘what is wrong with this person?’ rather than ‘what is wrong for this person?’ A medical model therefore continues to underpin much of the contact between social services professionals and disabled people (Oliver & Sapey, 1999, p.[[39]](#footnote-39)). New government guidance does not provide a sufficiently strong message about needs-led assessment to change this situation (DH 2002[[40]](#footnote-40)).*

 (Morris, op cit, p.432)

Assessment should be seen in a broader context of the needs older people have for assistance to help them live lives that are of their choosing and that offer the chance for desired levels of control. Morris cites twelve basic needs that people with disabilities have over and above those of non-disabled people and that are central to achieving independent living:

* “Full access to our environment.
* A fully accessible transport system.
* Technical aids and equipment.
* Accessible adapted housing.
* Personal assistance.
* Inclusive education and training.
* An adequate income.
* Equal opportunities for employment.
* Appropriate and accessible information.
* Advocacy (towards self-advocacy).
* Counselling.
* Appropriate and accessible health care provision.”

(Southampton Centre for Independent Living, n.d.[[41]](#footnote-41),

in Morris, op cit, pp.428-9)

With the possible exception of the need for equal opportunities for employment there seems no reason to suppose that these needs are any less relevant to older people living in supported accommodation of whatever form. Indeed, if one translates the need for employment into the need for purposeful activities that enable older people to contribute to their own and others’ wellbeing within their families and communities, they are all significant and relevant to the situation and circumstances of the older people who are likely to be affected by the BCC programme of reprovision.

**Conclusions**

**Context in which this review is being undertaken**

1. The BCC Reprovision Programme is an ambitious and complex one, that offers a positive opportunity to reform the way care of elderly frail and disabled people is offered in the city. BCC are to be applauded for their willingness to embrace change and invest in new ways to provide forms of care that enhance the opportunities for older people to live lives of their choosing while receiving the support they need to accomplish their goals.
2. Central to the reprovision programme are two specific forms of care provision: Special Care Centres for long-term stay and respite care, and additional Extra Care facilities in which older people live as owners / part owners or tenants in their own flats and receive care support appropriate to their needs.
3. This review of literature has been undertaken in support of this programme. Its aims have been to seek evidence in the published and ‘grey’ literature of good practice and to identify issues of concern that may need to be taken into account in the process of planning and delivering the transfer from residential care home provision to Special Care and Extra Care facilities.

**The range of evidence available**

1. In the process of reviewing the evidence it became clear that is it difficult to disaggregate different aspects of the process of care home closure and reprovision. Inputs to one aspect may therefore be expected to have consequences for another. The complexity of the process under consideration should not be underestimated.

1. It should be noted that there is very little empirical research evidence on care home closure to guide the processes being undertaken by BCC. The PSSRU has probably conducted the most extensive coordinated series of research investigations to date, and has highlighted the fact that, though the process of care home closure is likely to be stressful and potentially controversial, few local authorities have developed any guidelines to contribute to good practice. Consequently there are few benchmarks. It is clear, however, that good planning and positive and timely consultation is essential if the process of home closure is to be carried out effectively with the minimum of distress and to contribute to better outcomes for older people.
2. Most care home provision is currently provided in the independent sector, with Local Authorities having a duty of inspection and registration. Though there were references to local authority run homes in the literature, no studies were found that directly concerned the rights, duties and performance of local authority care homes. This is in spite of the fact that there has been a substantial transfer of responsibility from the statutory to the independent sector over the last twenty years or so.

**The role of residential care for older people**

1. Current government policy emphasises the importance of personal autonomy in people’s lives and the value of coordinated multi-professional and timely intervention to prevent deterioration where possible. For those people who are especially frail and vulnerable, residential care in some form is likely to remain a positive option. However, the way in which care is provided within residential settings should be flexible enough to respond to changing needs as they occur and to provide options of choice and control for the individual and their relatives and carers. There is no reason, for example, why Direct Payments should not be an option for users of residential care to help them purchase services in addition to those offered by the care home provider (Morris, op cit).
2. The Human Rights Act 1998 (op cit) confirms certain duties on public bodies in their conduct towards people who use their services, and has recently provided legal grounds for challenges in the courts of law to the actions of certain local authorities wanting to close care homes. Discussion of the legal issues related to BCC’s reprovision programme are beyond the scope of this review. However, it seems that the Act provides further emphasis on the duty of the local authority to be seen to properly consult and inform users and the families or representatives and to take into consideration the effects to health of a programme of closure and reprovision.

**The experience and concerns of residents and relatives**

1. Care home closure is usually something that is imposed on residents and their families by factors beyond their control. The importance of good communication and consultation with residents and their families or representatives was strongly echoed in research by the PSSRU. The people affected by the care home closure should be seen as partners in the process. Better results can be achieved if all parties feel they have contributed positively to the process and the event.
2. There is good reason to believe that, while care home closure is likely to be a disruptive and in some cases distressing experience, negative effects can be minimised if serious efforts are made to maintain continuity of care and to maintain contact between residents and staff as far as possible. The importance of reciprocal relationships between residents should not be overlooked in any assessment of need.
3. There is no reason to assume that people with cognitive impairments cannot play an active part in the process or reprovision. While some people may have difficulty remembering or interpreting information they will still have preferences and wishes. Interpretation of cognitive ability should be undertaken with the resident’s or service user’s participation and on the basis of detailed and comprehensive assessment. The ability for individuals to influence their quality life can be enhanced if the opportunities and resources are there to support them.
4. The most important factor in the provision of care from the point of view of people who use services is the quality of staff and of interactions with staff. The influence of care staff should not be underestimated, as it is they who often provide the crucial point of contact between the individual and the institution or agency. Positive efforts should be made to include care staff in discussions.
5. Residents and their families or representatives are often concerned, quite naturally, with the effects that home closure and reprovision may have on the older person’s health. The difficulties of establishing reliable correlations between reprovision and morbidity or mortality are considerable, not least because the population under consideration are likely to be very frail in the first place and often in need of high levels of care. Such evidence as there is suggests that adverse effects can be minimised if continuity of care is maintained and there is good consultation and planning. The importance of relationships with staff, in particular key worker relationships, should not be overlooked.

**The role of care managers**

1. It is evident that the role of care managers is crucial to the outcome of the process of reprovision. Recognition should be made of the potential complexity of the demands placed upon care managers and they should receive adequate support and guidance.
2. The process of reprovision is likely to be stressful for care managers, who will in most cases, act as assessors and may have to deal with or make controversial decisions. In some cases residents’ preferred choices will not chime with the range of needs identified by an assessment or be available within current resources.

**The role of housing with care**

1. BCC’s reprovision plans focus strongly on the development of Extra Care and Special Care forms of accommodation. The research team are unaware of any existing protocols or guidelines within BCC to advise who is most suitable for which form of care. It should not be assumed that because Extra Care housing appears to correspond with current thinking on issues of autonomy and independence for older and disabled people it is suitable for everyone. Some older people may prefer the extra security and support offered by traditional care home provision.
2. Because Extra Care offers a disseminated form of provision, care and accommodation being provided under many roofs rather than one, there may be additional pressures placed on staff to monitor and maintain levels of security and support to individuals with a wide range of needs. Technology can help in this, but should not be seen as a replacement for human contact.
3. Staff are likely to have to work in different ways if they are to facilitate the ‘doing-with-rather-than-doing-for’ culture that is implied by the greater degree of autonomy that extra care housing imposes. A different relationship is likely to exist between staff and residents compared to traditional care homes. This relationship will need training and good management and support if it is to be more than tokenistic. Economies of scale may be harder to achieve in extra care settings.
4. There is some evidence to suggest that residents of extra care facilities who have cognitive impairments and require higher levels of support may be marginalised or discriminated against within mixed fit / frail settings. The evidence suggests this need not necessarily be the case, however. It does seem clear that if integration between residents with and without cognitive impairments is to be encouraged such integration will need to be well managed and be embodied in a ‘whole system’ ethos from the start.
5. There is no conclusive evidence on whether Extra Care or other housing with care schemes provides cheaper options than traditional care home provisions.
6. There is some evidence that residents of good quality traditional care homes are able to feel as empowered and in control as those in extra care settings of equal quality. The key here seems to be quality of care. Provision of alternative housing alone will not assure that goals of independence and autonomy are achieved.

**Assessment**

1. Assessment will provide the primary mechanism by which an individual’s need for support is determined, and as such is likely to embody not only the thresholds of eligibility offered by providers but the philosophy and ethos of the monitoring authority and its agents.
2. It should be expected that many users of BCC’s residential care homes are likely to have experienced a decline in health since admission. It is possible that, for some, re-assessment may identify needs that are more suitably met in nursing homes or in NHS Continuing Care provision.
3. Current policy emphasises the importance of reducing the number of assessments undertaken, especially where these are conducted by different agencies and cover similar ground.
4. The temptation to seek to develop or use a single assessment ‘tool’ and to assume that the full range of a person’s needs and preferences can be captured therein must be resisted. Current government guidance warns against a narrow reductionist approach to the use of assessment tools, and their use or interpretation in circumstances for which they were not designed.
5. The point made by Steve George (op cit) should be writ large in any consideration of assessment: “…dependency is a relationship rather than an attribute.” The person’s need for help should be seen in the context of the way help is provided rather than their impairments alone.
6. Dependency measures should not be used to predict workload. Such use is likely to encourage a tendency to emphasise a person’s incapacity rather than ways in which their abilities may be supported or enhanced.

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