Central
Bedfordshire
Council
Priory House
Monks Walk
Chicksands,
Shefford SG17 5TQ

02 February 2016

Dear Councillor

EXECUTIVE - Tuesday 9 February 2016

Further to the Agenda and papers for the above meeting, previously circulated, please find attached background papers for:-

8. The Future of Greenacre Older Persons Home and Day Centre

- Equality Impact Assessment; and
- Closure of Care Home and relocation of Residents – Good Practice Guidance.

Should you have any queries regarding the above please contact Sandra Hobbs, Committee Services Officer on Tel: 0300 300 5257.

Yours sincerely

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Central Bedfordshire Equality Impact Assessment

Title of the Assessment:		**Proposals for the Future of Greenacre Older Peoples Home and Day Centre**	**Date of Assessment:**	Dec 2015
Responsible Officer	**Name:**	Ramone Nurse		
	Title:	Policy and Performance Officer	**Extension Number:**	75690
	Email:	Ramone.nurse@centralbedfordshire.gov.uk		

Stage 1 - Setting out the nature of the proposal and potential outcomes.

Stage 1 – Aims and Objectives

1.1 What are the objectives of the proposal under consideration?

The Council is reviewing the future of Greenacre care home as part of a wider project to reconfigure care home provision for older people.

The proposed offer to residents of Greenacre is currently:

a. The Council is proposing to close the home and find suitable alternative accommodation for the existing residents.
b. Residents will be given a choice of homes to move to within a reasonable distance. These choices would be of homes which offer a good quality of care, modern physical and environmental standards and fee rates that are in line with the Council's fee structure or the host Local Authority rates.
c. There will be places available at Rosewood Court and Dukeminster Court to facilitate residents wishing to stay living as a group to do so.
d. Any resident who wished to move further away (for example to be closer to a relative) would be assisted to do so.

At the same time as the future of Greenacre as a care home for permanent residents is being considered there will also be a need to consider the future of the short term residential rehabilitation 'step-up step-down' facility and the day care facility.

The key objectives of the proposals are to:-

- ensure that all current users of Greenacre care home continue to receive a high quality of care, and that the impact of any potential re-provision of care is actively managed and therefore minimised.

- ensure that future service users of the short term residential rehabilitation facility and day care facility are able to access high quality and accessible specialist services in a range of locations across the county offering choice to all.

1.2 Why is this being done?

<u>Meeting the demands of an aging population</u>

Central Bedfordshire's population of older people is set to grow much more rapidly than the overall population. This is particularly true of the group of people aged 85 and over.

When asked older people consistently say that their preference is to remain living independently in their own home for as long as possible and the Council aims to support this as much as it can.

The vast majority of people will continue to live in ordinary housing throughout their lives, supported by informal carers (such as relatives and friends) and 'paid for' carers sourced privately or commissioned by the Council. Additionally, in recent years the Council has developed extra care housing schemes that are able to deliver a high level of flexible care options to support residents as and when they need it.

However, even with the provision of extra care housing, for a small proportion of older people the best place in which their needs can be met is in a care home setting. In recent years increased expectations of the facilities in care homes have lead to changes in the physical and environmental standards which new care homes need to meet.

In response to the challenges set out above the Council has undertaken the following:

1. Increased the availability of home care services in response to increasing demand and the desire by older people to remain in their own homes for as long as possible.

2. Developed both domiciliary and residential reablement services that assist older people to regain independent living skills which allow them to remain living at home even after a spell in hospital.

3. Commenced the development of extra care housing schemes for independent living in Dunstable (Priory View) and Leighton Buzzard (Greenfields) and is planning deliver a further four schemes of this type over the next six years.

4. The reconfiguration of care home provision for older people to deliver higher standards. This is the most challenging as such changes inevitably mean a degree of disruption to the lives of residents of the homes affected, the scope of the EI A falls within this area.

<u>The reconfiguration of care home provision for older people</u>

The Council owns seven care homes for older people that were constructed by the former Bedfordshire County Council between 1968 and 1982. These homes do not meet physical and environmental standards that modern homes do.

There are two new care homes in Dunstable:

a. A 75-place residential care home at Dukeminster Court, Dunstable owned and operated by Quantum Care was opened in April 2015.

b. A 66-place residential and nursing care home at The Gateway, London Rd, Dunstable is being developed by LNT Construction. The home, to be called Rosewood Court, is to be owned and operated by Only Care Ltd and is scheduled to open in February 2016.

As these are new-build homes they have modern standards of provision including en-suite bathroom facilities for each resident. This is significantly better than the standards of accommodation in the Council's homes, which do not have these facilities.

<u>Care home provision in Chiltern Vale</u>

In February 2015 the Executive considered a report on care home provision in Chiltern Vale and

authorised the commencement of a consultation on the future of one of the two homes in that area that the Council owns and operates - Caddington Hall in Markyate. The Executive received a report on the outcome of this process in July 2015 and made the decision that the home should close.

The second home that the Council has in the Chiltern Vale locality is Greenacre on Brewers Hill Road, Dunstable. The home has capacity for 42 residents.

Greenacre has 21 permanent residents and 13 vacancies. It has a further eight places allocated for a short term residential rehabilitation 'step-up step-down' facility..

Greenacre Day centre

The day care facility at Greenacre is currently used by 16 people who live in the locality. The facility averages eight customers each day. The nearest alternative facility is Houghton Regis Day Centre, which has capacity to accept additional customers.

1.3 What will be the impact on staff or customers?

Customers

There are currently 21 permanent residents who live in Greenacre care home and 16 users of the day centre.

Approximately 2400 people over 65 are in receipt of adult social care services (December 2015).

Positive:

- The current and future population of older people in Central Bedfordshire would potentially benefit from the reshaping of services for older people.
- A decision to close Greenacre would result in an improved standard of physical environment in care home provision for older people – both current and future customers
- The new accommodations will have improved facilities for people who have dementia

Negative:

- Potential disruption for existing customers

Staff

Positive:

- The potential to work in an improved standard of physical environment
- There may be some development opportunities for staff

Negative:

- The disruption and stress of potential job loss or change of employer

1.4 How does this proposal contribute or relate to other Council initiatives?

The proposal is underpinned by, and supports the Council's priorities to *"promote health and well being and protect the vulnerable"*. It also contributes, and relates to the following initiatives and strategies that promote service improvement:

Meeting the Accommodation Needs of Older People Program

Central Bedfordshire has developed a program approach towards the delivery of accommodation for older people. The vision for the program is that older people across all of Central Bedfordshire have access to a choice of local, high quality, value for money accommodation that enable them to lead healthy, independent lives within their community.

This should include a range of warm, safe and secure schemes where older people can live without losing touch with their family or community and will include:-

- Good quality sheltered housing, to rent or buy.
- Good quality independent living, to rent or buy.
- Good quality suitable general needs housing, to rent or buy
- Good quality residential and nursing care homes, provided by partner organisations.
- Good quality community facilities at these schemes that bring in the local community.

Central Bedfordshire Council Housing Strategy

The Housing Strategy aims to ensure the Council provides a comprehensive housing service, which improves the quality of life by seeking solutions to all aspects of housing need and through the creation and maintenance of stable communities across Central Beds.

The Care Act 2014

The council (and partners in health, housing, welfare and employment services) has a duty to take steps to prevent, reduce or delay the need for care and support for all local people. The council will aim to provide high quality information and advice about services that operate in the community, or commission universal services that seek to promote well-being and improve people's independence.

By seeking to improve the quality of care home places in Chiltern Vale, in the way that is being proposed, the Council is meeting the powers and duties placed on it by The Care Act 2014 and associated guidance in respect of managing the care market.

In taking forward these proposals the Council needs to be mindful of legal duties in the following areas:

- The 'duty to consult' with people most affected by proposals
- The 'duty of care' to residents, relatives, staff members and others
- The 'Public Sector Equality Duty (PSED)'.
- Employment-related duties to staff

1.5 In which ways does the proposal support Central Bedfordshire's legal duty to:

- Eliminate unlawful discrimination harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it
- Foster good relations between people who share a protected characteristic and people who do not share it

The review of Housing for Older People in Central Bedfordshire enables the council to review and respond to the needs of older people in the area and meet the demands of an aging population.

Care homes will be reconfigured to deliver higher standards and deliver modern standards of provision for older people in Central Bedfordshire.

1.6 Is it possible that this proposal could damage relations amongst groups of people with different protected characteristics or contribute to inequality by treating some members of the community less favourably such as people of different ages, men or women, people from black and minority ethnic communities, disabled people, carers, people with different religions or beliefs, new and expectant mothers, lesbian, gay, bisexual and transgender communities?

Every effort is being made throughout this process to ensure that residents, their families and staff members do not experience less favourable treatment. The consultation process provides an opportunity to explore any concerns and identify mitigating action.

Stage 2 - Consideration of national and local research, data and consultation findings in order to understand the potential impacts of the proposal.

Stage 2 - Consideration of Relevant Data and Consultation

In completing this section it will be helpful to consider:

- **Publicity** – Do people know that the service exists?
- **Access** – Who is using the service? / Who should be using the service? Why aren't they?
- **Appropriateness** – Does the service meet people's needs and improve outcomes?
- **Service support needs** – Is further training and development required for employees?
- **Partnership working** – Are partners aware of and implementing equality requirements?
- **Contracts & monitoring** – Is equality built into the contract and are outcomes monitored?

2.1. Examples of relevant evidence sources are listed below. Please tick which evidence sources are being used in this assessment and provide a summary for each protected characteristic in sections 2.2 and 2.3.

Internal desktop research

	Place survey / Customer satisfaction data	X	Demographic Profiles – Census & ONS
	Local Needs Analysis	X	Service Monitoring / Performance Information
X	Other local research		
Third party guidance and examples			
X	National / Regional Research	X	Analysis of service outcomes for different groups
X	Best Practice / Guidance		Benchmarking with other organisations
	Inspection Reports		
Public consultation related activities			
X	Consultation with Service Users		Consultation with Community / Voluntary Sector
	Consultation with Staff		Customer Feedback / Complaints
	Data about the physical environment e.g. housing market, employment, education and training provision, transport, spatial planning and public spaces		
Consulting Members, stakeholders and specialists			
	Elected Members		Expert views of stakeholders representing diverse groups
	Specialist staff / service expertise		

Please bear in mind that whilst sections of the community will have common interests and concerns, views and issues vary within groups. E.g. women have differing needs and concerns depending on age, ethnic origin, disability etc

Lack of local knowledge or data is not a justification for assuming there is not a negative impact on some groups of people. Further research may be required.

2.2. Summary of Existing Data and Consultation Findings: - Service Delivery Considering the impact on Customers/Residents

- Age: *e.g. Under 16 yrs / 16-19 yrs / 20-29 yrs / 30-44 yrs / 45-59 yrs / 60-64 yrs / 65-74 yrs / 75+*

National & International Research:

Some key points that emerged from a study by the Centre for Policy on Ageing and Age Discrimination (2009) showed that services for over 65s were worse, in respect of :

- Assumption made about needs and capabilities of older people older people
- Clear evidence of varying standards and expectations in the provision and delivery of services for older people and younger adults – with the former receiving a poorer level of service, and their social needs and wellbeing often neglected
- The focus and quality of assessments are different for older people. The pressure on resources and professional assessment of risk can inhibit the development of person centred assessments for older people..
- Some key concerns with residential care include:- loss of control, identity, and personal possessions; not being valued; cultural and/or religious needs not met,

lack of privacy; lack of activity; insufficient staff and inadequate training; care not provided at appropriate pace.

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Age UK:

- Care Home provision varies around the UK but the shortage of places is acute in some areas, particularly for people who have dementia.
- There are 394,000 older people in residential care.
- An estimated 244,185 people with late onset dementia live in care homes, or 36.5% of people with dementia.
- The proportion of people with dementia who live in care homes rises with age: while 26.6% of people with dementia aged 65-74 live in care homes, the figure is 60.8% for those aged 90 and over.

Health and wellbeing

- Around 40% of care home residents have clinical depression and more than 50% of care home residents have urinary incontinence.
- One study found that 20% of care home have no regular visit from a GP and research suggests that "almost 50% of residents' time is spent asleep, socially withdrawn or inactive, with only 3% spent on constructive activity".
- Only 29% of persons over the age of 65 who are cared for report attending any outside activity (such as a day centre or club).

CQC:

- Behaviours and attitudes of staff were identified as crucial issues in determining not only whether people felt they were treated fairly but also whether the outcome was non-discriminatory. Numerous examples demonstrated discriminatory attitudes based on age – highlighting the importance of effective staff training.
- Other forms of discrimination included incidences of staff "talking over" older people, particularly those with untreated depression.

Local Research & Data:

The total population of Central Bedfordshire is set to increase, and in line with national trends, the biggest increase will be in the 65 year old, and over with the most increase being of those people aged 85 and over. Members of this latter group are most likely to need the care and support.

70% of the residents currently in Greenacre are over 80 years old.

Table 1: AGE: Demand Forecast - 65 years and Over (Central Bedfordshire)

Category	POPULATION AGED 65 & OVER									
	2014	*% Change*	2015	*% Change*	2020	*% Change*	2025	*% Change*	2030	*% Change*
65-69	15,200	*0*	15,600	*3%*	14,800	*-3%*	16,700	*10%*	19,800	*30%*
70-74	10,700	*0*	11,400	*7%*	14,800	*38%*	14,100	*32%*	16,000	*50%*
75-79	8,500	*0*	8,600	*1%*	10,300	*21%*	13,600	*60%*	13,000	*53%*
80-84	5,900	*0*	6,200	*5%*	7,200	*22%*	8,800	*49%*	11,600	*97%*
85-89	3,400	*0*	3,600	*6%*	4,400	*29%*	5,300	*56%*	6,600	*94%*
90+	1,800	*0*	1,900	*6%*	2,400	*33%*	3,200	*78%*	4,300	*139%*
Total population 65+	**45,500**	*0*	**47,300**	*4%*	**53,900**	*18%*	**61,700**	*36%*	**71,300**	*57%*

Source: POPPI 2014

Table 2: AGE Profile of Residents at Greenacre Care Home

CATEGORY	2015	%
People aged 65-69	0	
People aged 70-74	2	10%
People aged 75-79	4	20%
People aged 80-84	**7**	**35%**
People aged 85-89	2	10%
People aged 90+	5	25%
Total residents 65+	20	

Source: CBC Customer Data – SWIFT and verified with residents(November 2015)

Table 3: AGE Profile of Residents at Greenacre Day Centre

CATEGORY	2015	%
People aged 65-69	1	6%
People aged 70-74	2	13%
People aged 75-79	**5**	**31%**
People aged 80-84	4	25%
People aged 85-89	3	19%
People aged 90+	1	6%
Total residents 65+	**16**	

Source: CBC Customer Data – SWIFT and verified with residents(November 2015)

Table 4: AGE Profile of CBC Adult Social Care

Age	Numbers	%
18-64	150	24%
65+	485	76%
Total	635	100%

Source: CBC Customer Data – SWIFT Report - December 2015)

- Disability: *e.g. Physical impairment / Sensory impairment / Mental health condition / Learning disability or difficulty / Long-standing illness or health condition / Severe disfigurement*

A) National Data:

Disability covers a wide variety of impairments such as learning disabilities, mental health conditions, mobility impairments, blindness and partial sight, deafness and hearing impairment and progressive long term health conditions. It also covers those who may not recognise themselves as having a disability, such as those with long term conditions like diabetes.

Disabled people are not a homogenous group, and issues will vary when considering standards relating to access and adaptability.

i) Age UK:

Care home residents are normally aged 80 and over and have multiple and complex healthcare needs linked to conditions like dementia, arthritis, cardiovascular disease, stroke, or a combination of these.

ii) CQC:

Disabled people experienced barriers to equality in social care services as follows:-

- Physical barriers - the most common barriers
- Environmental barriers – e.g. poor access to or within buildings
- Communication barriers - experienced by a majority of disabled people and not always related to the disabled person's impairment, e.g. providing information in accessible formats, but could be due to the communication skills of staff.
- Social inclusion barriers – with the community e.g. transport or inaccessible community facilities.
- Attitudinal barriers – another very common barrier e.g. social care staff not respecting their right to be treated equally, manifested in patronising attitudes or a lack of regard for the disabled person's rights to make choices about how care is delivered.
- Lack of regard for basic privacy or dignity – in some cases where their human rights may have been compromised.
- Disabled people are at greater risk of experiencing violence than non-disabled people. (Equality & Human Rights Commission (EHRC)
- Disabled people restructure their lives to minimise real and perceived risk to themselves even if they have not experienced targeted violence personally. (EHRC)

Local Data:

The primary need for 46% of adult social care users is personal care support needs, 19.5% of users require support related to a learning disability.

Table 5: CLIENT CATEGORY Profile of Adult Social Care Users

Main Category	Numbers	%
Physical - Personal Care Support	294	46.3
RAP Learning Disability	90	14.2
Memory & Cognition Support	86	13.5
Learning Disability Support	35	5.5
Mental Health Support	27	4.3
Physical - Access & Mobility Support	26	4.1
NOT RECORDED	21	3.3
RAP Mental Health	19	3.0
RAP Dementia	16	2.5
RAP Sensory Disability-Visual Impairment	7	1.1
Social - Social Isolation/Other Support	4	0.6
RAP Sensory Disability-Hearing Impairment	2	0.3
Sensory - Visual Impairment Support	2	0.3
CIN Primary - Abuse/Neglect	1	0.2
Personal Care Needs	1	0.2
RAP Physical & Sensory Disability and Frailty	1	0.2
RAP Physical Disability	1	0.2

RAP Vulnerable People	1	0.2
	635	

The primary needs for 12 of the of users of the Greenacre Care home is personal care support needs, 6 require memory and cognition support.

Table 6: CLIENT CATEGORY Profile of Residents at Greenacre Care Home

Memory & Cognition Support	6
Physical - Personal Care Support	12
Total	18

The primary need for users of the Greenacre Day Centre is for memory and cognition support.

Table 7: CLIENT CATEGORY Profile of Residents at Greenacre Day Centre

Memory & Cognition Support	6
Physical - Personal Care Support	1
Mental Health Day Centre	2
Dementia	1
Mental Health	1
Total	11

- Carers: *A person of any age who provides unpaid support to family or friends who could not manage without this help due to illness, disability, mental ill-health or a substance misuse problem*

National Data:

Age UK:

Older Carers may experience increased stress and depression as a consequence of their work: it is estimated that between a third and a half (33-52%) of spousal Carers of people with dementia suffer from depression.

Furthermore, long hours and intensity of work, frequently without the possibility of breaks, may well result in isolation from social networks and activity.

38% of Carers aged 65+ report that their caring duties have affected their personal relationships, social life, and/or leisure.

Of those reporting such effects, 67% say they have less time for leisure activities, 29% say they are too tired to go out, 31% say they cannot go on holiday, and 21% say their own health has been affected. 20% report less time for friends, 16% less time for a hobby or pastime, and 13% less time for other family members. 18% say they have no social or leisure activities at all.

Additionally, 18% report being more aware of the needs of the disabled because of their caring duties.

Local Data:

Support Provided to Carers by Primary Support Reason (of client)	Support Provided					
	Support Direct to Carer					Support involving Cared for Person
Primary Support Reason (of Cared for Person: most recent) - all ages	Direct Payment Only	Part Direct Payment	CASSR Managed Personal Budget	CASSR Commissioned Support Only	Information, Advice and Other Universal Services / Signposting	Respite or Other Forms of Carer Support delivered to the Cared for Person
Physical Support: Access and Mobility Only	9	20	13	6	50	22
Physical Support: Personal Care Support	14	139	111	36	115	101
Sensory Support: Support for Visual Impairment	4	3	1	3	3	1
Sensory Support: Support for Hearing Impairment	5	2	0	0	2	0
Sensory Support: Support for Dual Impairment	0	1	0	0	4	0
Support with Memory and Cognition	9	47	27	21	17	29
Learning Disability Support	3	53	11	1	17	4
Mental Health Support	32	38	10	7	53	7
Social Support: Substance Misuse Support	0	0	0	0	0	0
Social Support: Asylum Seeker Support	0	0	0	0	0	0
Social Support: Support for Social Isolation / Other	0	16	5	2	3	9
No PSR - Cared for Person not recorded or details not current	306	63	24	82	58	4

ASC Data – Support provided by Carers – 14/15 SALT return – LTS003

Carer aged under 18	0		0	0	0
Carer aged 18-64	164	164	87	68	138
Carer aged 65 to 84	191	191	101	79	161
Carer aged 85 and over	27	27	14	11	23

ASC Data - Carer Support provided during the year, broken down by the Age of the Carer, Primary Support Reason of the Client and the type of Support provided – 14/15 SALT return – LTS003

- Gender Reassignment: *People who are proposing to undergo, are undergoing or have undergone a process (or part of a process) to reassign their sex by changing physiological or other attributes of sex*

A) National Research & Data:

- 1 in 10,000 people suffer from the recognised medical condition known as gender dysphoria, generally referred to as being transgender or transsexual.
- Recent research estimates that 7% of the transgender population are aged 61 or over.
- Ensure policies, procedures & publicity include transgender people, including the need to address transphobia from staff or other people using services.
- Ensure staff training on equality includes issues for transgender people and that staff and managers have access to resources on transgender issues.
- Use the name and title (e.g. Mr, Ms, Mrs, Miss) that the person prefers.
- Allow transgender people access to appropriate single-sex facilities, which are in line with their gender identity.
- Be aware that some transgender people may have specific personal care needs and handle these sensitively

B) Local Data:

This information is not collected consistently.

- Pregnancy and Maternity: *e.g. pregnant women / women who have given birth & women who are breastfeeding (26 week time limit then protected by sex discrimination provisions)*

No issues relating to pregnancy and maternity have been identified.

- Race: *e.g. Asian or Asian British / Black or Black British / Chinese / Gypsies and Travellers / Mixed Heritage / White British / White Irish / White Other*

A) National Research:

i) Race Equality Foundation:

Research carried out to date has been remarkably consistent in its findings (see, for example, Age Concern and Help the Aged Housing Trust, 1984; Jeffery and Seager, 1993; Jones, 1994; Bright, 1996; Mkandla, 2003; Patel et al., forthcoming). Key issues that have emerged include:

- Lack of awareness or understanding among BME elders of housing options;
- Lack of understanding among service providers of specific religious and/or cultural needs;
- Lack of staff with appropriate language skills and/or cultural knowledge;
- Care home location (e.g. the importance of being near community facilities such as shops selling appropriate foodstuffs, and places of worship);
- Non evidence-based assumptions made by service providers regarding what individual preferences will be;
- The need to involve BME elders in the service-development process.

From the research carried out to date, certain key (and very basic) actions uniformly emerge as essential for service providers. These include:

- Assessing what need is out there: improving monitoring systems, carrying out research;
- Raising awareness of services available (thereby potentially boosting service take-up): outreach, promotion, translation and use of various media;
- Employing staff from diverse ethnic groups;
- Involving BME communities either directly as service providers or as part of the service-development process;
- Involving potential service users (e.g. working with BME elders groups), so that services are tailor-made to meet their aspirations and needs;
- Training staff: for example, in legislation, cultural awareness, equal opportunities, and anti-discrimination practice;
- Incorporating cultural and/or religious requirements into service design and delivery;
- Implementing clear policies and codes of practice.

ii) Age UK:

- Only around 50% of BME social care service users felt that their needs as a black and minority ethnic person were adequately considered at their last assessment.

- 25% said that they had faced prejudice or discrimination when using services, with over half the people under the age of 60yrs reporting this.

- Religion or Belief: *e.g. Buddhist / Christian / Hindu / Jewish / Muslim / Sikh / No religion / Other*

- Research has highlighted differences in the health and wellbeing of different religious communities – a finding that provides an opportunity to target services. The British Muslim community, for example, has the poorest reported health, followed by the Sikh population. For both groups, as well as for Hindus, females are more likely to report ill health, whereas for Christians and Jews there is only minimal gender difference. It should be borne in mind that this is not necessarily a case of cause and effect, but more likely is compounded with other factors such as housing and economic and social status.

- A lack of awareness about a person's religious or other beliefs can lead to discrimination. This is because religion can play a very important part in the daily lives of people. In addition there is often a perceived overlap between race and religion which needs to be taken into account:

- Sex: *e.g. Women / Girls / Men / Boys*

Table 4: SEX Profile of Residents at Greenacre Care Home

CATEGORY	65 YRS & OVER (Central Bedfordshire)	
	MALES	FEMALES
	2015	2015
Aged 65-69		
Aged 70-74	1	1
Aged 75-79		4
Aged 80-84	2	5
Aged 85-89	1	1
Aged 90 & over	1	4
Total 65 & over	**5**	**15**

Source: CBC Customer Data – SWIFT and verified with residents(November 2015)

Table 4: SEX Profile of Residents at Greenacre Day Centre

CATEGORY	65 YRS & OVER (Central Bedfordshire)	
	MALES	FEMALES
	2015	2015
Aged 65-69		1
Aged 70-74		2
Aged 75-79	1	4
Aged 80-84	3	1
Aged 85-89	2	1
Aged 90 & over		1
Total 65 & over	**6**	**10**

Source: CBC Customer Data – SWIFT and verified with residents(November 2015)

- Sexual Orientation: *e.g. Lesbians / Gay men / Bisexuals / Heterosexuals*

A) National Research Data:
Research undertaken by Stonewall indicates that older Lesbian, Gay and Bisexual (LGB) people are much more likely than heterosexual people to face the prospect of living alone with limited personal help from their families and therefore are more likely to rely on formal services for support in later life. Many older LGB people express considerable worries about the future – about having to hide their sexual orientation, about having to move into an environment that is designed for heterosexual people and about a lack of opportunity to socialise with other older gay people. These concerns will need to be considered as the standards are developed. Transgender people could also share similar concerns.

- It is estimated that 5 to 7% of the population in the UK is LGB.
- Older LGB people receiving services at home can feel unsure about the treatment they will receive.

• Three in five are not confident that social care and support services, like paid carers, or housing services would be able to understand and meet their needs.
• The possibility of needing to live in a residential care home is of particular concern to LGB people. While they share many concerns about care homes with their heterosexual peers, they do have an increased level of anxiety.
• 70 per cent of lesbian, gay and bisexual people don't feel they would be able to be themselves if living in a care home

B) Local Data:

Given the small size of the cohort, and in respect of privacy, it would be inappropriate to provide local data on LGB people as their identity may be compromised.

- Other: *e.g. Human Rights, Poverty / Social Class / Deprivation, Looked After Children, Offenders, Cohesion, Marriage and Civil Partnership*

Quality of Life in Care Homes (Help the Aged)

a) Quality of Life:
• Quality of life is notoriously difficult to define as it pervades a range of aspects of everyday life in significant and complex ways. It encompasses many dimensions and can be viewed from a range of perspectives.

• Comfort is important for care home residents, who need to feel that their environment is attractive, supportive and safe.

• Care home residents may need to continue past activities or to begin new ones. This support needs to be carefully planned and discussed with residents.

• Maintaining existing friendships as well as developing supportive friendships with other residents is important for residents and should be encouraged.

• What constitutes quality of life is distinct for every person. In order to support and enhance quality of life we must seek to understand the priorities of each individual person.

b) Quality of Care:
Promoting high-quality care within care homes requires consideration of the views and experiences of all major stakeholders: residents, families and staff.

The most recent publication on the subject of care home closures is: "Making Choices Good Practice Guide – Reconfiguration of Statutory Residential Homes" – Health and Social care Board for Northern Ireland

The abstract to this document states: The relocation of older people from one care setting to another can be particularly stressful, and there is a perception that the closure of residential homes can have an adverse effect on residents' health and wellbeing. However, research carried out by AGE NI has found that the effects a home closure has on resident's health and psychological well-being is influenced by the way in which a home is closed and how the relocation is managed.

This document outlines how best practice should be adopted pre- relocation, during relocation and post relocation. For the purpose of this document, pre-relocation refers to the time period from when the resident begins to consider moving to another residence until the actual move. Relocation refers to the actual day of transition from one residence to another; and post relocation refers to the time after the individual has moved from one residence to a new residence.

This document draws on previously published papers which outline lessons learnt in the reconfiguration of care homes in the past, both within the Health and Social Care system in Northern Ireland and in the wider UK. It also draws on examples of best practice for planned, phased or emergency reconfiguration; and on the experience of the community and voluntary sector (AGE NI and the Alzheimer's Society) who have acted as advocates in the closure of care homes in the past.

The guidance states that: "Particular care and attention needs to be shown to those residents who have been identified as most vulnerable. A risk assessment tool should be used to identify those residents who may need more support during the relocation process.

"In understanding how older people cope with moving from one institution to another various factors need to be taken into account. A risk analysis exercise can help determine those who may be most at risk... It can:

- Identify those most at risk of negative experiences arising from proposed action
- Identify those who could be harmed
- Assess level of risk
- Consider measures you can take to mitigate the risks
- Assess the level of risk remaining after mitigation measures have been taken
- Decide if the benefits outweigh the risks

2.3. Summary of Existing Data and Consultation Findings – Employment
Considering the impact on Employees

- Age: *e.g. 16-19 / 20-29 / 30-39 / 40-49 / 50-59 / 60+*

- Disability: *e.g. Physical impairment / Sensory impairment / Mental health condition / Learning disability or difficulty / Long-standing illness or health condition / Severe disfigurement*

- Carers: *e.g. parent / guardian / foster carer / person caring for an adult who is a spouse, partner, civil partner, relative or person who lives at the same address*

- Gender Reassignment: *People who are proposing to undergo, are undergoing or have undergone a process (or part of a process) to reassign their sex by changing physiological or other attributes of sex*

- Pregnancy and Maternity: *e.g. Pregnancy / Compulsory maternity leave / Ordinary maternity leave / Additional maternity leave*

- Race: *e.g. Asian or Asian British / Black or Black British / Chinese / Gypsies and Travellers / Mixed Heritage / White British / White Irish / White Other*
- Religion or Belief: *e.g. Buddhist / Christian / Hindu / Jewish / Muslim / Sikh / No religion / Other*
- Sex: *Women / Men*
- Sexual Orientation: *e.g. Lesbians / Gay men / Bisexuals / Heterosexuals*
- Other: *e.g. Human Rights, Poverty / Social Class / Deprivation, Looked After Children, Offenders, Cohesion, Marriage and Civil Partnership*
2.4. To what extent are vulnerable groups more affected by this proposal compared to the population or workforce as a whole?
2.5. To what extent do current procedures and working practices address the above issues and help to promote equality of opportunity?
2.6. Are there any gaps in data or consultation findings
2.7. What action will be taken to obtain this information?

Stage 3 - Providing an overview of impacts and potential discrimination.

Stage 3 – Assessing Positive & Negative Impacts					
Analysis of Impacts	**Impact?**		**Discrimination?**		**Summary of impacts and reasons**
	(+ve)	(- ve)	YES	NO	
3.1 Age	X	X		X	The proposal aims to better meet the needs of older people, in particular those of 80 years and above – the group most likely to need a care home setting. The risk of adverse impacts relating to relocation increases with age
3.2 Disability	X	X		X	Most older people living in a care home are likely to have a disability, so a consistent provision of disability access in both private and communal rooms needs to be available. This is more likely in homes with modern standards of

					accommodation. The relocation of older people from one care setting to another can be particularly stressful and there is a perception that the closure of residential homes can have an adverse effect on resident's health and wellbeing. However, the effects a home closure has on resident's health and psychological well-being is influenced by the way in which a home is closed and how the relocation is managed. The risk of adverse impacts relating to relocation increases with the level and type of impairment. Particular care and attention needs to be shown to those residents who have been identified as most vulnerable
3.3 Carers	X				
3.4 Gender Reassignment					
3.5 Pregnancy & Maternity					
3.6 Race					
3.7 Religion / Belief					
3.8 Sex					
3.9 Sexual Orientation					
3.10 Other *e.g. Human Rights, Poverty / Social Class / Deprivation, Looked After Children, Offenders, Cohesion Marriage and Civil Partnership*					

Stage 4 - Identifying mitigating actions that can be taken to address adverse impacts.

Stage 4 – Conclusions, Recommendations and Action Planning

4.1 What are the main conclusions and recommendations from the assessment?

- A good understanding of the needs and preferences of each resident, along with detailed transition plans that reflect these needs are important in reducing the risk to residents.
- A high level of communication and engagement with residents, relatives and staff is important in helping to deal with issues as they arise and manage people's anxieties.
- The relocation of older people from one care setting to another can be particularly stressful, and there is a perception that the closure of residential homes can have an adverse effect on residents' health and wellbeing.

4.2 What changes will be made to address or mitigate any adverse impacts that have been identified?

- A number of steps have been taken to ensure the move does not have an adverse impact on residents; lessons learned from other similar projects have been used to make improvements for the residents in Greenacre. These include:
- Implementing a person centred approach to minimise risk to reduce potential for adverse impacts for protected groups who may be moving.
- The risks of a move to each resident will be assessed (both before and after mitigation measures have been identified and put into place) and this information will be available to decision-makers when determining the future of the home.
- Each resident will have an assessment undertaken by both medical and social work professionals as part of the transition process, should the decision be made to close the home.
- Throughout the process a high level of communication and engagement with residents, relatives and staff will be maintained.

4.3 Are there any budgetary implications?

No

4.4 Actions to be taken to mitigate against any adverse impacts:

Action	Lead Officer	Date	Priority
The actions outlined above were identified prior to the completion of the EIA and incorporated into the planning of activities. No additional actions were identified.			

Stage 5 - Checking that all the relevant issues and mitigating actions have been identified

Stage 5 – Quality Assurance & Scrutiny:
Checking that all the relevant issues have been identified

5.1 What methods have been used to gain feedback on the main issues raised in the assessment?

Step 1:
Has the Corporate Policy Advisor (Equality & Diversity) reviewed this assessment and provided feedback? *Yes*

Summary of CPA's comments:
The essential points have been captured.

Step 2:
5.2 Feedback from Central Bedfordshire Equality Forum

Stage 6 - Ensuring that the actual impact of proposals are monitored over time.

Stage 6 – Monitoring Future Impact	
6.1	**How will implementation of the actions be monitored?** Monitoring and follow up work with the people directly affected.
6.2	**What sort of data will be collected and how often will it be analysed?** Qualitative feedback from customers/residents, relatives and carers.
6.3	**How often will the proposal be reviewed?** If and when feedback or data indicate that a review may be required. .
6.4	**Who will be responsible for this?** MANOP Head of Service
6.5	**How have the actions from this assessment been incorporated into the proposal?** The actions outlined above were identified prior to the completion of the EIA and incorporated into the planning of activities. No additional actions were identified.

Stage 7 - Finalising the assessment.

Stage 7 – Accountability / Signing Off
7.1 Has the lead Assistant Director/Head of Service been notified of the outcome of the assessment **Name:** **Date: 22nd January 2016**
7.2 Has the Corporate Policy Adviser Equality & Diversity provided confirmation that the Assessment is complete? **Date: __ 28th January 2016 _____**

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Central Bedfordshire Council
www.centralbedfordshire.gov.uk

Closure of Care Homes and Relocation of Residents

Best Practice Guidance

Best Practice Guidance

Introduction

1. The purpose of this document is to provide best practice guidance for closing a care home and relocating residents. Research and experience has shown that with careful planning, effective partnership working and the full involvement of residents, their relatives, staff and other professionals, the potential adverse effects from moving residents can be greatly minimised.

2. This document aims to provide guidance that will allow a home closure and relocation of residents to be undertaken in a sensitive, person-centred, tailored way that accounts for the needs of individuals and keeps the health and well being of residents as the primary focus throughout the process.

3. In this document some common risks relating to moving residents have been identified and mitigation measures to manage these risks have been suggested. It is important to note that each home closure will be different and there will be some risks that are unique to that particular home and its residents. It is therefore always important to undertake a full risk review during consultation and monitor throughout each home closure.

4. This document covers the period from the decision to consult on closing a home, through the consultation process, to the decision to close and the relocation of residents to alternative accommodation.

5. Underpinning this guidance are local and national experience, ‘best practice’, research, government circulars, statue, regulations and case law. Several sources of useful information are listed in the Acknowledgements section.

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Principles and Rights

1. There are a number of legal aspects that need to be fully considered when contemplating closing a home. There are three areas of law which are most significant:
    a. The duty to consult: there is a requirement that the Council conducts a consultation before making a decision.
    b. Obligations under the Human Rights Act 1998 (HRA): the Council has obligations to ensure that any actions it takes do not infringe the human rights of residents in the home.
    c. The Public Sector Equality Duty (PSED): in coming to a decision about the future of the home the Council must be aware of its duty to promote equality.

2. The HRA sets out a number of rights that we all have. Most relevant in relation to the closure of a care home are:
    a. Article 2 – the right to life.
    b. Article 3 – the prohibition of torture or inhuman or degrading treatment.
    c. Article 8 – the right to privacy.

3. A decision which potentially restricts a human right does not necessarily mean that it will be incompatible with the HRA. Public bodies need to take into account other general interests of the community, not just those directly affected by a decision. Some rights can therefore be restricted where it is necessary and proportionate to do so in order to achieve a legitimate aim. Provided a restriction of such a right has a legitimate aim and the restriction itself does not go any further than necessary to protect this aim, then it is likely that it will be compatible with the HRA. In this way the HRA recognises that there are certain situations where a public body is allowed to restrict individual rights in the best interests of the wider community.

4. Should the Council identify that it may be appropriate for one of the homes it owns to close and the capacity at their home is to be provided elsewhere, then closing a home is not incompatible with the requirements of the HRA, proving the Council has done all it reasonably could to minimise the negative impact on the residents.

5. An Equality Impact Assessment (EIA) should be completed in respect of a potential home closure and relocation of its residents. The Council has a statutory duty to promote equality of opportunity, eliminate unlawful discrimination, harassment and victimisation and foster good relations in respect of eight protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

6. Closing care homes and relocating residents is a sensitive issue as it is widely recognised that if not properly dealt with, it can have an adverse effect on the health and well being of the residents involved. It is best practice to keep the number of moves between homes to a minimum.

7. By following the principles below the risk of harm to residents can be reduced to an acceptable level:

a. Clear, open and honest communication with residents, relatives and staff.

b. Communication should be regular and be both proactive and reactive as the situation demands.

c. Communication should be personalised and take into account the language and communication mode appropriate to the individuals involved (language, sensory and other impairment needs etc.). Information should be made available in a variety of accessible formats and people should be given time to reflect on the information they have been given.

d. When undertaking activities and communicating with residents, relatives, staff and stakeholders it is important to remember that the care home is not just a building to the residents, it is their home.

e. Residents should be sensitively encouraged and facilitated to take part in the consultation process about the future of the home in ways that are compatible with their needs and abilities. Professional assessment of their ability to participate and the potential harmful effects of participation should be made.

f. Residents should have access to advocacy.

g. Residents who fund their own care should be entitled to the same advice and assistance as those funded by statutory organisations.

h. All residents should have comprehensive assessments undertaken by appropriate professional(s) and the recommendation of these assessments is to be taken into account in the choice of accommodation offered and in planning their move.

i. Residents and their relatives should be offered the opportunity to visit other homes and given time to make an informed decision.

j. In planning moves particular attention should be paid to those residents identified as most vulnerable or at risk.

k. Consider and protect friendship groups when planning new placements for residents.

l. Residents should be given practical help and support to move.

m. Residents should not be moved if there is medical advice that to do so would put them at imminent risk. If this is the case moves should be postponed until the risk had been mitigated.

n. Regular reviews should take place to monitor the health and well being of the residents who have transferred to the new accommodation.

8. Agencies should work together cooperatively and take account of the following principles when relocating residents:

    a. Safety

    b. Safeguarding

    c. Minimising distress and disruption of services

    d. Dignity

    e. Choice and control

f. Independence
g. Least restrictive options
h. Respect for family life
i. Equality and Diversity
j. Privacy
k. Realising Potential

Overall Management of Transfers and Care Home Closure

9. Each care home closure and subsequent relocation of residents should be treated as an individual project, adopting 'project management principles'.

10. There should be a named person, who will be accountable for the project, also known as the Project Sponsor. They must have sufficient authority to be able to make decisions, resolve issues and allocate resources. In the Council it is likely that this would be the Assistant Director of Adult Social Care.

11. A Project Board should be established and should be comprised of representatives from the relevant services and specialisms required to deliver the project. These representatives, also known as Workstream Leads, will be responsible for the delivery of actions relating to their service area or specialism.

12. Suggested Workstream Leads to include on the Project Board are:

- Building
- Communications
- Finance
- Human Resources
- Operational Management of Home
- Transitions
- Legal

13. Depending on the individual circumstances of the home it may be appropriate to include other representatives on the Project Board.

14. The Project Board will make all key decisions, approve plans, manage activities and manage risks and issues.

15. The project should have a Project Manager, who will be responsible for the successful delivery of the project. They will work with Workstream Leads and the Project Sponsor to ensure that work is planned and completed in accordance with agreed criteria.

16. The following project documents should be produced to provide transparency and aid delivery of the project:
    a. Project Initiation Document (PID)
    b. Project Plan
    c. Project Risk Register and Issues Log

17. The Council has standard project document templates which are available from the Social Care, Health and Housing Service Development Team.

18. Project staff will have a presence in the home to ensure successful delivery of the project and support to those directly affected, without interfering with operations and delivery of care within the home.

19. See Appendix 1 for an example of a checklist for the safe and sensitive relocation of residents.

Consultation

20. As previously mentioned in this document the Council has a duty to consult on the future of any proposal to close one of its care homes.

21. Case law sets out a number of principles for the conduct of consultation:
    a. The consultation must take place when the proposal is still at a formative stage;
    b. Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response;
    c. Adequate time must be given for consideration and response;
    d. The product of consultation must be conscientiously taken into account by decision-makers
    e. The consultation and decision-making processes relating to the closure of a home and relocation of residents must be designed to ensure that these principles are honoured.

22. In addition vulnerable people affected by the proposals (normally the residents) should be supported and facilitated to participate in the consultation process.

23. Staff, as one of the key stakeholders, should be included in the consultation on the future of the care home and should be given the opportunity to submit their reviews and responses. However, the formal HR consultation relating to the future of their employment, would be separate and cannot commence until the decision has been made by Executive to close the home and following the call in period.

24. The Cabinet Office Consultation Principles (last updated 5 November 2013) state that the timescale of consultation should be proportionate and targeted. A care home closure would usually require a 12 week period of formal consultation to enable meaningful engagement with residents, families, carers, staff, general public, Trade Unions and other stakeholders and to provide them with sufficient time to respond.

25. Consultation can be on a specific preferred or 'in principal' option. If there is an amended proposal arising from responses to the consultation, there is no need to start the consultation process again (i.e. views have been listened to). If however, it is a 'new' proposal, then there will be a requirement for further consultation. Whether a proposal is an 'amended' one or a 'new' one requires advice from the Council's legal and consultation experts before any action is taken.

26. It is recommended that a Consultation Plan is produced, that outlines the proposal, the stakeholders and the communication, engagement and consultation activities

required, who will undertake them and by when. Support to produce this is available from the Partnership and Engagement Team in Social Care, Health and Housing.

27. Consultation documents need to be produced, outlining the options considered as part of the evaluation process and the preferred option. It is important to provide sufficient detail to enable people to understand the proposal and the reasons behind it, in order to give their views and make suggestions. However, it is important to recognise that some people may not have the time or the capacity to read a long detailed document so a summary document should also be considered.

28. Consultation and decision-making should be as open and transparent as possible. Residents and relatives and other stakeholders/stakeholder groups directly affected must be involved throughout.

29. Under the principles of the Mental Capacity Act residents may need support to make decisions. The principles of the MCA must be applied when carrying out consultations. Some residents may need support from family members, staff, advocates or Social Workers to be involved in the consultation process. Every effort should be made to gain the views of residents. Following this process, where it is clear that someone lacks capacity, Best Interest decisions need to be made on their behalf.

30. IMCA services should be made available to support residents who lack mental capacity to be involved in the consultation process and who have no next of kin or advocates.

31. Consultation should not be rushed and must be genuinely entered into, with face-to-face contact explaining the reasons for closure being among the methods employed. Residents should be offered an advocacy service (and access to legal advice) if required.

32. The timing and manner of informing residents is critical. It is important that residents, relatives and staff hear the message from Senior Managers in the Council (Director and Assistant Director) rather than through general consultation publicity or the media.

33. Residents' families or close friends may also have feelings of guilt and anxiety and may need special attention and support. Building in enough time to support people is crucial.

34. The Council should keep people well informed every step of the way, making sure the residents, relatives, advocates and staff are among the first to know of any developments. Proactive and reactive communication will be required. People need to be told the facts in a straightforward way, without the use of jargon and in a form that is most accessible to those concerned. In having their say, those involved can share in how and what decision is made and the shaping of any future or alternative provision.

35. A detailed account of the consultation should be maintained throughout the process and a written Consultation Report containing an analysis of all the responses should be produced when the consultation has finished. The Consultation Report would be

made publically available, sent to relevant stakeholders that wish to have a copy and would be used to inform decision-making.

36. Throughout the consultation, consultees will be advised of the timescales involved and it will be stressed that no decision has yet been made.

37. Consultation on the future of a home would need to be completed, a decision made to close the home and call in period before a formal HR consultation can take place with staff at the home about their future employment.

Communication

38. A communications plan should be developed to include consideration of the most appropriate methods, frequency, content and style of communications with residents, relatives, friends, carers, staff, and other stakeholders. Communication methods to consider should include small group meetings, notice board updates, one-to-one and family group meetings and written correspondence.

39. For each home closure project a stakeholder analysis should be undertaken as part of the Communications Plan, to identify the stakeholders and outline how, what and when to communicate with them. The stakeholders that are likely to be included for a care home closure and relocation project are:
    a. Residents
    b. Relatives of residents
    c. Manager and staff at the home
    d. GPs (existing and future)
    e. Community Nurse
    f. Local community
    g. Other Care Home providers
    h. Advocacy services
    i. MPs and Councillors
    j. Action Groups
    k. Interest Groups
    l. Local media

40. GPs should be briefed and involved at an early stage. Multi- disciplinary/agency working is a key requirement to a successful home closure. The relocation may result in a change to the residents' GPs so both the existing and the new GPs would need to be involved.

41. Staff should be supported through group meetings, one to one meetings, staff surgeries, notices on staff noticeboards and written communications. The Home Manager, HR and the Unions should provide key support to staff. It is important that staff understand the different purposes and processes for the consultation on the future of the home and the HR consultation on the future of their employment.

42. Other care homes that the Council contracts with should be kept informed about what is happening. It is important to explain to them how and when it may be appropriate for them to be involved, if at all. If a decision is made to close the home, social workers who would be working with the residents to find them alternative

accommodation, would need to have up to date information on vacancies and care quality.

43. The Communications Plan should include the Council's approach to the media, pro-active and reactive press statements and questions and answers.

Risk Management

44. Risks at a strategic, organisational and individual level need to be considered when closing a home. It is critical to assess the risks and undertake mitigation measure to reduce the negative impact of risks and maximise the benefits.

45. Risks should be considered at the start of the project and updated throughout. The production of contingency plans may be required for some risks.

46. There should be a Project Risk Register to document project risks and this should be reviewed regularly by the Project Board.

47. Detailed Risk Assessments should be carried out for the individual residents to assess the specific risks of the move on their health and well being (see Appendix B for a risk assessment template). The assessment should include key risk factors such as heart and lung disease, Parkinson's Disease, previous breakdown, liability to falls/reduced mobility, incontinence, impaired vision/hearing, anxiety/depression/paranoid thoughts, obesity, multiple medication and a history of chest infection (and/or combinations of the above).

48. Although some risks may apply to more than one resident, the way in which the mitigation measures are undertaken will be personalised and tailored to the individuals. It is crucial to incorporate the mitigation measures into the detailed move plan and share with the new home(s) to ensure the negative impact on residents is minimised.

Project Risk Management

49. The way in which a care home closure is carried out can reduce the risk to residents. The following best practice should be considered:
    a. Allow sufficient time to undertake careful, sensitive and person-centred planning for the closure and relocation of residents. It is suggested that up to 6 months is scheduled for this.
    b. Have a dedicated social worker who would co-ordinate moves and provide an overarching view of the process and the residents.
    c. Be flexible and willing to delay a move if a medical assessment of a residents deems them too ill to move or if additional risks are identified that require control measures to be put in place.
    d. Focus on the needs of individuals rather than looking at the resettlement of the residents as a whole group. Residents should have individual move plans that are co-ordinated as part of the whole move process.
    e. Move a maximum of 1 resident per day. However, if groups of friends express a wish to move together and suitable staffing arrangements including travelling support can be arranged, then this should be explored as it may be beneficial to the residents. This may be a particular issue towards the end of a managed

closure when the worry of being one of only a few residents left at the originating home may outweigh concerns about the transfer.

f. Identify and deploy any additional staff required leading up to and during the relocation. Staff in the receiving homes should also be considered and external resources such as advocacy may be required.

g. The social worker should have oversight of the resident in the week up to their planned move. Staff should look for any changes in physical or mental wellbeing which may indicate a higher risk on transfer e.g. loss of appetite, onset of confusion, changes to regular toilet habits etc. If required, medical advice should be sought.

h. Continue engagement with residents and their relatives following the move as the time immediately after the relocation and during the first 3 months in the new environment are identified as when the impact of a move is greatest.

Resident Risk Assessment and Management

50. Risk assessments and appropriate health and clinical assessments should be completed in relation to moving residents to new accommodation.

51. Some residents will be more at risk from the move than others. The table below details some of the higher risk residents and the mitigation measures that could be undertaken to reduce the risk of harm to an acceptable level.

Higher risk residents	Mitigation Actions
Residents with dementia and confusion, particularly where there is frailty or an underlying illness.	Good social care practice requires explanation, support, reassurance and more explanation. This may need to be repeated. Use visual aids to help familiarise with new staff and environment before move. Medical examinations on initial assessment and prior to move where appropriate. Follow best dementia practice. Face to face handover between medical and health practitioners if required. Post move ensure additional time spent with resident to help them orientate themselves in new environment. Have familiar layout in new rooms. Include familiar items and music.
Residents requiring specific equipment, (such as pressure relieving mattress, mobility aids, ceiling track host and hi-lo bath)	Review of equipment needs prior to move. Identify what equipment can be transferred with the resident. Equipment provision to be checked at new home before moving. Ensure staff at the receiving home are trained to use the equipment.
Residents with special dietary needs and those who require	Support plans to be reviewed to ensure full information is included.

support to eat or use artificial feeding (such as PEG) methods.	Briefing and training of staff at receiving home by current staff. New staff to understand the likes and dislikes of residents.
Residents that suffer from stress and anxiety over changes.	Full briefings on effects of stress and anxiety to all involved in supporting residents. Ensure all staff (current and new) can recognise and manage stress and anxiety. Involvement of the resident and relatives in the choice of home and options. Facilitate visits to new homes wherever possible. Introduce new care staff before the move. Friendship groups will be considered and protected. Receiving home to allocate key worker to support people prior, during and following the move.

Social and Health Care Assessments:

Individual Residents

52. Establishing effective relationships at the start of the process and sustaining them is important. A Social Worker should be identified at an early stage and should see the project through to the end, supporting the transfers and undertaking the post move reviews.

53. An up-to-date care and support assessment should be completed for each resident as the main way of identifying a suitable care setting/supported housing option as an alternative to the originating home. The assessment should also specifically address the impact of a move on the resident. The resident would be involved in the assessment process in line with the principles of the MCA (e.g. supported decision making).

54. The nominated care manager should ensure that all relevant health professionals contribute, including an Occupational Therapist. The views of family/next of kin should also be sought. The resulting support plan should address all aspects of care, but must also include information such as dietary needs and “likes/dislikes”, spiritual and/or cultural needs and other specific requirements which may be particularly important to the individual resident. This information will be shared with the receiving home.

55. The Social Worker in collaboration with health colleagues should complete a CHC checklist if it is deemed that the resident may have nursing needs.

56. In the event of a safeguarding concern within the existing or new home, the practitioners should follow normal practice, must seek the advice of the Safeguarding Team and respond accordingly.

57. Each resident should be individually assessed for their suitability to transfer and to ensure that any new provider agrees that their needs can be fully met in the receiving home. The support plan should be reviewed a few days immediately before transfer to ensure that it is completely up to date.

58. Clear arrangements for the medical transfer of each resident must be made prior to any relocation. A patient summary should accompany the resident to their new residence, on the day of transfer.

Safeguarding

59. The resident's safety is paramount during the period of transition. Central Bedfordshire Council has a suite of multi agency safeguarding policies and procedures to support practitioners in assessing safeguarding risks and putting in place appropriate protection plans. Refer to the Council's Safeguarding Handbook for detailed guidance. The Council is the lead agency for safeguarding adults at risk, but all agencies working with adults at risk within Central Bedfordshire are required to work within the safeguarding policy and practice framework.

60. The definition of an adult at risk is: a person 18 years and over (whether or not eligible for community care services) who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation. The definition of safeguarding adults at risk is: all work which enable an adult who is or may be eligible for community care services to retain independence, well being and choice and to access their human right to live a life that is free from abuse and neglect.

61. If practitioners believe they are working with a person who is at risk from abuse, neglect, discrimination, harm or exploitation, they must report the concern to the safeguarding team or report the concern using the safeguarding alert form. If concerned about a crime or the immediate safety of a person, practitioners should call the police.

Mental Capacity Assessment

62. In the Mental Capacity Act 2005 Section 1 it states that a person must be assumed to have capacity unless it is established the he or she lacks capacity. In seeking to determine whether a person has sufficient mental capacity to make a particular decision the following principles must be followed;

    a. A person must be assumed to have capacity unless it is established that he lacks capacity
    b. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
    c. A person is not to be treated as unable to make a decision merely because he makes an unwise decision
    d. Any action carried out, or decision made, under this act or on behalf of a person who lacks capacity must carried out, in his best interests.
    e. Any action carried out on behalf of the person who lacks capacity, must be the least restrictive option. It is important that residents understand why they have to move and what is involved in moving. Should practitioners have any doubt

about a person's capacity to make a decision or informed choice, a Mental Capacity Assessment should be undertaken to determine the client's ability to;

- Understand and retain the information relevant to the decision
- Make a decision based on the information, at the moment a decision needs to be taken
- Communicate a decision or view of how they want to receive care

63. Practitioners should involve other professionals, advocates, family and carers as appropriate to assist with making a judgement about a person's capacity.

64. Guidance on the MCA and a copy of the Mental Capacity Form can be found in the Council's Safeguarding Handbook or from the Mental Capacity Act 2005 Code of Practice.

Best Interest Assessment

65. If a person lacks the mental capacity to make a decision, then action must be taken in their best interest. A best interest assessment must take place. 'Best Interest' is not defined in the Act but certain factors must be taken into account in order to decide what is in a person's best interest.

66. Some of the factors to take into consideration when carrying out a Best Interest's assessment are:
    - Do not discriminate. Do not make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect their behaviour.
    - Take into account all relevant circumstances
    - If faced with a particularly difficult or contentious decision, it is recommended that practitioners adopt a 'balance sheet' approach
    - Will the person regain capacity? If so, can the decision wait?
    - Involve the individual as fully as possible
    - Take into account the individual's past and present wishes and feelings, and any beliefs and values likely to have a bearing on the decision
    - Consult as far and as widely as possible.

67. Again, it is vital that the best interests decision is recorded. Not only does this concur with good professional practice, but given the evidence-based approach required by the MCA, there will be an objective record should the decision or decision-making processes later be challenged. For more detailed information refer to the Mental Capacity Act Code of Practice

Deprivation of Liberty Safeguards (DoLS)

68. The deprivation of liberty safeguards provide legal protection for those vulnerable people who are, or may become, deprived of their liberty (within the meaning of article 5 of the Human Rights Act) in a hospital or care home. They do not apply to people detained under the Mental Health Act 1983. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable, but in a person's best interests.

69. A DoLS would need to be requested by the new home in the following circumstances;
    a. If someone lacks the capacity to say whether or not they want to be in the care home in order to receive care or treatment
    b. If someone is not free to leave the care home
    c. If they are under continuous supervision and control

70. Further details can be found in the Council's Deprivation of Liberty Safeguards Code of Practice.

Arrangements for Residents to Transfer

71. An identified Social Worker should be available for each resident and their relatives/carers to provide advice and support on vacancies, preferred area and choice of accommodation.

72. Plenty of time and opportunity should be provided for residents to visit and try out new homes, preferably accompanied by someone they know. This process should not be rushed, but taken at the pace of the resident.

73. Discussions should take place between the home's management team, the social worker, residents and their families regarding the best way to transfer from one home to another. The homes' management team would need to ensure that sufficient staff are available to support the transition. This would normally mean not more than one resident moving per day.

74. Following assessment, the individual support plan should be reviewed and updated within 1 week prior to transfer. A formal review of each resident should be conducted within 2 working days of transfer and at approximately 4 weeks, 3 months and, as business as usual 12 months after transfer. A re-assessment should take place if needs significantly change within this time frame. As is standard practice for formal reviews, all relevant parties would be invited to be involved and adjustments will be made to the support plan if required

75. It is good practice to undertake life story work with residents. The aim of the life story is to enable people to affirm and maintain their identity and personhood through the creation of their own life story. Writing down their words is a way of capturing the things that have been and remain important to them in their life. As well as helping residents to reminisce it is also a way of bringing the person to life for staff who do not know them. This model is in line with policy initiatives to develop more person-centred care and enabling individuals to exercise choice and control. Knowing people better as individuals enables staff to provide more tailored and appropriate care, which can reduce frustration and agitation.

76. Visits to prospective homes or supported living homes should be arranged where practicable. Having a meal at the new home may also be a good way of the resident getting to know a prospective home.

77. Originating care home staff members should spend time with the individual resident in their new environment as an important part of the settling in period. The new

home's should also become familiar with the resident and their support plan prior to transfer – including familiarity with dietary and other relevant needs.

78. The social worker should oversee the move plan and any documentation for individual residents and ensure that it is fully developed and accurate, for transfer with that resident to their new accommodation.

79. In setting up the arrangements for transfer, it should be made clear to the registered manager of any receiving residential or nursing care home that they are empowered to refuse the transfer of a resident if they are not happy that all suitable arrangements have been put in place and that the support plans etc. are absolutely clear.

80. The social worker should ensure that contact is made with each of the receiving homes/housing providers in the 24 hours before the date of the planned transfer of any individual as a final check to ensure they are fully prepared to accept the older person the following day.

81. Transport arrangements should be made ensuring that the vehicle is suitably equipped to accommodate the needs of the individual resident. Ideally a carer, family member or a trusted member of staff would accompany the resident and offer support during the journey.

82. Any resident who is considered not to be physically well enough to move should have their transfer date put back until well enough to transfer to the new home. Appropriate medical involvement should be sought and appropriate staff involved in the assessment and treatment of the person. The social worker, registered manager or identified member of the care home management team on duty at the originating home on the day of transfer would have the authority to cancel or postpone the move of a resident if they have any doubts as all that it is appropriate or safe on that day. They should have the support of senior managers to take this decision.

83. The clothing, possessions and furniture of residents should go with them to the new establishment so that their new environment is as familiar as possible from their day of arrival. Suitable bags would be available, ideally suitcases, either the resident's or relatives or purchased by the Council. These would be made identifiable through labelling. On no account should black bin bags be used.

84. Those with visual impairments should be assisted by making the layout of the surroundings similar to that they have been used to. They are likely to need time and help to get used to the new layout. Photographs may be taken of the current room and added to the care plan/life story to ensure the layout is correct.

85. The residents should be allowed the opportunity to say goodbye to friends and staff in their own time. Staff may want to say goodbye so they would be kept informed about the moving arrangements.

86. The new care staff should offer support with unpacking and provide emotional support.

87. The social worker should liaise with the Department of Work and Pensions if needed to aid the transfer of pensions and avoid delays following transfer unless the resident or family member/other with legal status prefer to manage these arrangements.

88. The social worker should identify, in liaison with the resident, relatives and carers, who needs to be informed of the change of address and new contact details for the re-locating resident. Moving cards could be provided to inform relevant others of their new address.

Move Plan

89. The move plan must include the following details;

    a. Name of the person moving
    b. Name and address of their new home
    c. Name of social worker responsible for overseeing the move
    d. Name(s) of family or friend who wish to be involved in the actual move
    e. Date and time of the move
    f. Name of the person responsible for making an inventory of the resident's belongings
    g. Details of the transport required and any specific mobility needs
    h. Name of the person responsible for;
        a. redirection of mail
        b. informing DWP of new address
        c. health assessments
    i. Name of current funding authority
    j. Details of Local Authority if moving out of area

90. A move plan template is attached as Appendix D.

Transfer of Health Care Data and Responsibilities

91. The residents' own GP should be asked if they have any medical advice to give concerning the transfer and where possible should be asked to continue the care of the person after the move.

92. Arrangements should be initiated by the receiving home for a GP to be appointed as soon as possible after the transfer of any resident to a new care home.

Communication with Relatives, Friends and Carers

93. Consideration should be given to the impact of care home closure upon carers and any other people, especially those in vulnerable people. This information should inform the consultation and equalities impact assessments, and contribute to the decision making process.

94. Throughout the process of announcement, consultation, decision-making and implementation, relatives, friends, representatives and carers should be offered appropriate information, advice and support. This should include one-to-one meetings, group meetings correspondence and information in the home, as appropriate to the circumstances and the wishes of the people concerned.

95. Having a regular presence of people involved in the process in the home will allow for residents, relatives and staff to receive informal and responsive advice and support and will also allow members of the transition team to get a fuller picture of the needs and preferences of residents outside of the formal assessment processes.

96. Monitoring and review of the wellbeing of vulnerable adults should be undertaken at appropriate intervals. This will underpin the identification of further good practice and lessons to be applied in the continuous updating of this guidance and our procedures.

Follow-Up

97. Acknowledgment and thanks to be given to those involved in the process, for their cooperation and assistance following all moves.

Debrief, Feedback and Lessons Identified

98. Formal team debriefing, longer term review of residents and evaluation of the closure, procedures used and lessons learnt should be reviewed within six weeks of the closure.

99. Residents' views of the relocation process should be sought within three months of the transfer to the new home. This will provide evidence of the effect the closure has had on residents and will feed into the overall evaluation of the reprovision.

100. It is recommended that this guidance is reviewed and updated following changes to best practice, relevant legislation, Council policy and experience of undertaking the work.

Acknowledgements

Association of Directors of Adult Social Services*: Achieving Closure, Good practice in supporting older people during residential care closures*, 2011.

Personal Social Services Research Unit: *Guidelines for the closure of care homes for older people*, October 2003.

Sandwell Metropolitan Borough Council, *Best Practice in Sandwell, Protocol for Care Home Closure and Transfer of Vulnerable/Frail Residents,* 2009.

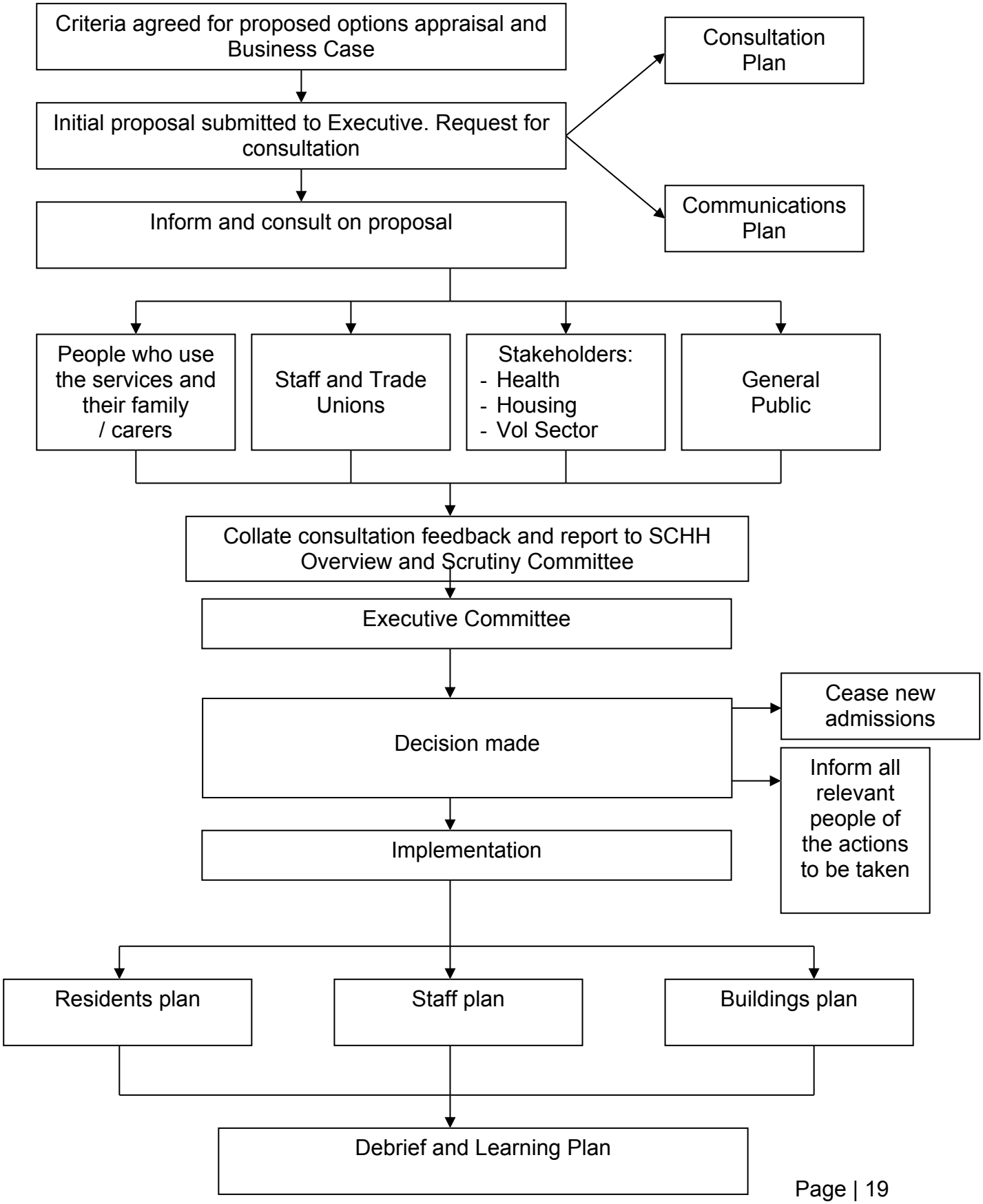
Social Care Association, *Managing Care Home Closure*, 2011.

South Gloucestershire Council, *Better Support for Older People Project - Protocol for Care Home Reprovision and the Relocation of Residents*. 2007.

Central Bedfordshire Council: *Closing a Care Home, Good Practice and Learning 2014*

Appendices

Appendix A Example Process for In-House Planned Closure



Appendix B Resident's Risk Assessment and Mitigation Template

Vulnerability factors	Yes	No	Details	Level of risk H/M/L	Mitigation Measures	Level of Risk after Mitigating Measures H/M/L
Complex Health needs? Eg: lung/heart disease, chronic conditions						
High Waterlow score?						
High MUST score?						
Concerns re BMI?						
Mobility risks: falls/non weight bearing?						
Visual impairment?						
Hearing impairment?						

Vulnerability factors	Yes	No	Details	Level of risk H/M/L	Mitigation Measures	Level of Risk after Mitigating Measures H/M/L
History of UTI?						
Has the resident's health deteriorated recently?						
Has the person capacity to choose where to move?						
Anxiety/depression/paranoia/ Dementia/confusion?						
Behavioural Concerns?						
Risk of isolation as a result of the move?						
Are there concerns from						

Vulnerability factors	Yes	No	Details	Level of risk H/M/L	Mitigation Measures	Level of Risk after Mitigating Measures H/M/L
health professionals regarding the move **Has this information been shared and discussed with the GP?**						
Any other concerns?						

Appendix C **Pre-Move Evaluation**

Name:	**Swift ID**	**Date**

Question	Answer	Mitigation Measures
What things are important to you to take place **before the move**?		
What things are important to you to take place **during the move**, e.g. possessions/people/information?		
What are your concerns about the move?		
What things are important to you to take place once in your new home?		
Is there anything else we need to take into account		

Appendix D **Resident's Personalised Move Plan and Checklist**

Name of Resident:	Curent Home: Name of New Home:	Current Room No. New Room No:
Name of Family /Friend/ advocate involved and contact numbers.		
Name of Social Worker Responsible for overseeing the Move and contact number.		
Name of Professionals involved and contact numbers.		

Name of Resident:				
Details of action required	Completed Date/initials	Comments	Outstanding issues	Completed
Meet with residents and relatives to discuss the final decision of the future of the home and plan for move to new residence				
Complete MCA regarding choice of new home and arrange advocate if required (IMCA)				
Completion of pre move expectation evaluation				
Social work assessment of need and risks (Care and Support Assessment)				
Application for Continuing Healthcare (CHC) if appropriate				
Update resident's move risk assessment				
Professional Assessments • Assessment by manager of new				

Name of Resident:				
Details of action required	Completed Date/initials	Comments	Outstanding issues	Completed
home • Occupational Therapy (OT) • GP • Community Matron/District Nurse • Psychiatrist • Other				
Complete integrated care and support plan				
Identification of new home				
Gain funding approval				
Notify finance of new residence (BSU form)				
Inform family of contact details of new home				
Familiarising residents of new homes, e.g. photos, verbal descriptions etc.				
Life story work				
Identify key worker from				

Name of Resident:				
Details of action required	Completed Date/initials	Comments	Outstanding issues	Completed
new home				
Arrange visits from key worker/carers from new home				
Arrange for visits to new home where able				
Identify appropriate equipment and vehicle for resident transfer				
Identify transport for furniture				
Confirm time and date of move to new home				
Arrange residents' transport date and time				
Confirm who will accompany resident to new home				
Arrange transport date and time for furniture to be moved				
Arrange for receipt of				

Name of Resident:				
Details of action required	Completed Date/initials	Comments	Outstanding issues	Completed
furniture at new home				
Identify who will pack and unpack belongings				
Inventory of belongings/clothing				
Inventory of furniture				
Labelling of belonging, clothing and furniture				
Ensure appropriate suitcases/packing materials in place				
Ensure equipment in situ in new residence				
Pack belongings				
Ensure GP patient summary (list of medication) is ready to transport with resident				
Ensure Medication stock/prescription transfer sheet complete and ready to transfer with resident				
Ensure continence pad supply in place at new				

Name of Resident:				
Details of action required	Completed Date/initials	Comments	Outstanding issues	Completed
residence				
Hearing aids checked and supply of spare batteries in situ				
Existing home to close personal allowances and return any money to families				
Organise moving cards				
Out of County;				
Liaise with other local authorities re contract rates				
Identify new home options at contracted rates				
Panel request if CBC resident moving out of county				
Completion of Brokerage form to notify of new residence (BSU)				
Inform new home of finance contact				
Identify arrangements re				

Name of Resident:				
Details of action required	Completed Date/initials	Comments	Outstanding issues	Completed
reviewing placement				

Appendix E Post-Move Checklist

Name:	**Swift ID:**	**Date:**
Question	Answer	Issues to Address
How have you/your relative settled in?		
Was everything ready for you before you moved to your new home?		
How was the move - what went well?		
What didn't go well during the move?		
Was everything ready for you when you arrived at your new home?		
Is there anything else we should be aware of?		

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