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

03 July 2015

EXECUTIVE - Tuesday 7 July 2015

Further to the Agenda and papers for the above meeting, previously circulated, please find attached the following additional report(s) which the Chairman has agreed to take as an urgent item of business:-

9. The Future of Caddington Hall Older Persons Home

Attached is the background paper – Home Closure Guidelines.

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 Council
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Closure of Care Home Relocation of Residents

Best Practice Guidance

Closure of care home, relocation of residents 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. The guide 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 a home closure 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. It is therefore always important to undertake a full risk review at the start and throughout each home closure.

4. This guide 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 on page19.

6. This guidance will be useful for Central Bedfordshire Council, Bedfordshire NHS, East London Foundation Trust (ELFT), voluntary and independent sector partners and colleagues, and the Care Quality Commission (CQC).

Principles and Rights

7. 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.

8. 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.

9. The consultation and decision-making process relating to the closure of a home and relocation of residents must be designed to ensure that these principles are honoured.

10. The principles of the Mental Capacity Act 2005 (MCA) must be applied when carrying out consultations. Some residents may need support from family members and/or an appropriate representative, staff, advocates or Social Workers to be involved in the consultation process. Every effort should be made to gain the views of residents as they will be directly affected by the decision. Following this process, where it is clear that someone lacks capacity, Best Interest decisions would need to be made on their behalf.

11. Independent Mental Capacity Advocate (IMCA) services will be accessed to support residents who lack mental capacity and who have no next of kin or advocates to be involved in the process. Advocacy support will be available.

12. Staff, as one of the key stakeholders, will be included in the consultation on the future of the care home and will have 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 take place until the decision has been made by Executive to close the home.

13. 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.

14. A decision which potentially restricts a human right does not necessarily mean that it will be incompatible with the HRA. Public bodies also need to take into account other general interests of the community. 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.

15. 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.

16. An Equality Impact Assessment (EIA) should be completed in respect of a potential closure of the home 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 nine protected characteristics; age

disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

17. Closing care homes and relocating residents is a sensitive issue as it is widely recognised that it if not properly dealt with 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.

18. 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 would be made.
    f. Residents should have access to advocacy.
    g. Residents who fund their own care will 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 will 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. Moves would be postponed until this risk had been mitigated.
    n. Appropriate methods should be put into place to monitor the people who have transferred.

19. 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

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

21. 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. It is likely that it will be the Assistant Director of Adult Social Care.

22. 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.

23. Suggested Workstream Leads to include on the Project Board are:
    a. Adult social care operations
    b. Care home management
    c. Facilities and asset management
    d. Care home contract management
    e. Legal
    f. HR

24. Depending on the individual circumstances of the home it may be appropriate to include other representatives on the board.

25. The board will take all key decisions, produce and approve plans, manage activities and manage risks and issues.

26. 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.

27. 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

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

29. 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.

30. See Appendix 1 for an example of the actions that would be required to deliver a home closure and relocate residents.

Consultation

31. As previously mentioned in this document the Council has a legal duty to consult on the future of a care home and its preferred option to close and relocate residents. There are four minimum requirements of consultation
    a. It must be when proposals are still at a formative stage
    b. Sufficient information must be given to permit informed consideration and response
    c. Adequate time must be allowed
    d. Consultation must be meaningful and conscientiously taken into consideration in reaching decisions

32. 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.

33. 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.

34. 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 is available from the Consultation and Engagement Team in Social Care, Health and Housing.

35. Consultation documents would be produced that outline the options considered as part of the evaluation process and the preferred option with the supporting reasons. 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.

36. 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.

37. Under the principles of the MCA 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 would need to be made on their behalf.

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

39. 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.

40. 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. It is recommended that staff, residents and if appropriate relatives/representatives are told at the same time but in separate meetings, as they have different priorities and questions and need to be free to react without worrying about the other being present.

41. People must be allowed to go through the various stages such as shock, denial, anger and finally acceptance with skilled staff and others on hand to assist individuals through this. 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 through the stages is crucial.

42. 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.

43. 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.

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

45. A consultation on the future of a home would need to be completed and a decision made to close the home before a formal HR consultation can take place with staff at the home about their future employment.

Communication

46. 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.

47. 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 Caddington Hall
    d. GPs (existing and future)
    e. Community Nurse
    f. Local community
    g. Residents, relatives and staff at other Council-owned homes
    h. Other Care Home providers
    i. Advocacy services
    j. MPs and Councillors
    k. Action Groups
    l. Interest Groups (e.g. Older Peoples Reference Group)
    m. Media

48. 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.

49. Staff would be supported through meetings, one to one meetings, staff surgeries, notices on staff noticeboards and written communications. The Home Manager, HR and the Unions would 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.

50. 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.

51. A media strategy should also be produced at the start of the project. It will need to be refreshed and updated as the project progresses. It should include the Council's approach, pro-active and reactive press statements and questions and answers.

Risk Management

52. 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.

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

54. There should be a Project Risk Register to manage project risks which should be reviewed regularly by the Project Board.

55. 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. The assessment should be in respect of key risk factors such as heart and lung disease, Parkinson's Disease, previous breakdown, age, male gender, 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).

56. 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 to ensure the negative impact on residents is minimised.

Project Risk Management

57. The way in which the council delivers the closure can also reduce the risk of harm to residents. Some suggested best practice is to:
    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 'Transitions Manager' 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 resident deems them too ill to move or if additional hazards are identified that require control measures to be put in place to reduce the risks.
    d. Focus on the needs of individuals rather than looking at the resettlement of the residents as a whole group. Residents will have individual move plans that will be 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 will be explored as it may be beneficial to the residents. This may be a particular issue towards the end of the managed closure

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

f. Identify and deploy additional staffing resources required leading up to and during the relocation. Staffing resources in the homes residents are relocating should also be considered and external resources such as advocacy may be required.
g. The Transitions Manager will have oversight of the resident in the week up to their planned move. Staff will 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 will 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

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

59. 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 should 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. Additional medical assessment immediately prior to move to assess if fit to move. Follow best practice dementia guidelines. 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 to eat or use artificial feeding (such as PEG) methods.	Support plans to be reviewed to ensure full information is included. 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

60. Establishing effective relationships at the start of the process and sustaining them is important. A Social Worker will be identified early on who then supports the transfer and undertakes the reviews.

61. An up-to-date care and support assessment would 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 on the resident of a possible move. The resident would be involved in the assessment process in line with the principles of the MCA (e.g. supported decision making).

62. The nominated care manager would ensure that all relevant health professionals contribute to this. An Occupational Therapist would contribute to the assessment process. The views of family/next of kin would 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. As identified elsewhere in this guidance this information will be shared with the receiving home.

63. The Social Worker in collaboration with health colleagues would complete a Continuing Healthcare (CHC) checklist if it is deemed that the resident may have nursing needs.

64. In the event of a safeguarding concern within the existing or new home, the Social Workers would seek the advice of the Safeguarding Team and respond accordingly.

65. Each resident would 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 care home or supported housing option. A support plan would be developed jointly between the social worker, their existing home and any new provider which would be reviewed a few days immediately before transfer to ensure that it is completely up to date.

66. All residents should have a full physical examination no more than 1 week prior to transfer, with a follow up examination in the new home if there are concerns

67. The pre-transfer medical assessment would specifically address fitness of the resident to move and any special precautions which may need to be taken in each.

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

Safeguarding

69. 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.

70. 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.

71. If practitioners believe they are working with a person who is at risk from abuse, neglect, discrimination, harm or exploitation, you must report the concern to the safeguarding team on 0300 300 8122 or report the concern using the safeguarding alert for. If concerned about a crime or the immediate safety of a person, practitioners should call the police.

Mental Capacity Assessment

72. 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. An act done, or decision made, under this act or on behalf of a person who lacks capacity must be done, or made, in his best interests.
e. Before the act is done or the decision is made, regards must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of activity

73. 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;

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

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

75. 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

76. 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.

77. Factors to determine 'best interest', Section 4, Mental Capacity Act 2005. The person making the determination must consider all the known and relevant circumstances which the person is aware of and those that would be reasonable to regard as relevant.

78. More details can be found in 'A Short Guide to Mental Capacity Assessment'.

Deprivation of Liberty Safeguards (DoLS)

79. 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.

80. 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

81. Further details can be found on the Council's intranet Deprivation of Liberty Safeguards Code of Practice.

Arrangements for Residents to Transfer

82. 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.

83. Plenty of time and opportunity should be provided for people 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.

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

85. Following assessment including the appropriate risk assessments, the individual support plan will be reviewed and updated within 1 week prior to transfer. A formal review of each resident should be conducted at approximately 48-72 hours, 4 weeks and 3 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. A representative from the care home or the Council would visit the resident in their new accommodation within 1 month of transfer wherever feasible.

86. A good example of including the resident in the process, whilst ensuring the new home knows and understands the resident transferring is by producing a life story. 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 people reminisce about their life it is also a way of bringing the person to life for staff who have not known them previously. 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 sensitive and appropriate care that can reduce frustration and agitation.

87. A visit/several visits to a prospective home or supported living environment should be arranged. Having a meal with overnight stay would be preferable for some people and would be undertaken if possible. Originating care home staff members would spend time with the individual resident in their new environment as an important part of the settling in period and any new providers' staff to become familiar with the resident and their support plan prior to transfer – including familiarity with dietary and other relevant needs.

88. If groups of friends express a wish to move together suitable staffing arrangements including travelling support can be arranged. This may be a particular issue towards

the end of the managed closure when the worry of being one of only a few residents left as the originating home may outweigh resident's and relatives concerns about transfer.

89. The social worker will 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.

90. In setting up the arrangements for transfer, it would 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.

91. The social worker would contact 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.

92. Ongoing contact would be maintained with the receiving home for an appropriate period following the transfer, according to the needs of the individual.

93. Transport arrangements would 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. Early discussions would take place with the ambulance service so that they are on hand to support the closure and available to move residents and vital equipment when required.

94. Any resident who is considered not to be physically well enough to move would have their transfer date put back until well enough to transfer to the new home. Appropriate medical involvement would 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 would know that they have the support of senior managers to take this decision.

95. 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.

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

97. The residents would 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.

98. The new care staff would offer support to the residents by encouraging them to unpack themselves, where possible, or seeing where everything is put and encouraging to talk about how they are feeling.

99. The social worker would liaise with the Department of Work and Pensions as 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.

100. The social worker would 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.

Move Plan

101. The move plan must include the following details;

a. Name of the person moving
b. Name and address of their new home
c. Visiting arrangements to their new home – if unable to visit the new home, pictures and full description to be provided
d. Name of social worker responsible for overseeing the move
e. Name(s) of family or friend who wish to be involved in the actual move
f. Date and time of the move
g. Name of the person responsible for making an inventory of the resident's belongings
h. Details of the transport required and any specific mobility needs
i. Name of friends and social groups wishing to remain together
j. Name of the person responsible for;
    a. redirection of mail
    b. informing DWP of new address
    c. health assessments
    d. ensuring two weeks supply of medication is supplied
    e. heath transfers i.e. new GP, Community Nurse
k. Name of current funding authority
l. Details of Local Authority if moving out of area

Transfer of Health Care Data and Responsibilities

102. 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.

103. Arrangements would be initiated for a GP to be appointed as soon as possible after the transfer of any resident to a new care home.

104. Residents would have a full physical examination no more than one week prior to transfer and the report would be made available to the receiving home.

105. A transfer letter would be sent with the resident, identifying any critical issues relating to their nursing care or therapy needs.

Communication with Relatives, Friends and Carers

106. Consideration would be given to the impact of care home closure upon carers and vulnerable people. This information would inform the consultation and equalities impact assessments, and would therefore contribute to the decision making process.

107. Once a decision has been announced that a specific care home will close, relatives, friends, representatives and carers would be invited to an individual resident by resident meeting to ensure that individual needs of the resident are the focus with details of the next steps discussed. This would include correspondence, updates and, face-to-face interactions.

108. Relatives, friends, carers, representatives and advocates (where identified as required) are to be involved and communicated with throughout the managed closure period. This may be through a progress and information board in the home. This would include photographs of the new home(s) and key staff involved in the process. The suggested staff to include on the board would be the Customer Transition Manager, Social Workers, new care staff and members of the project team who may come in contact with the relatives, staff and residents.

109. Monitoring and review of the wellbeing of vulnerable adults will 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.

Advocacy

110. Independent advocacy would be offered to all residents throughout any managed closure process.

Follow-Up

111. 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

112. Formal team debriefing, longer term review of residents and evaluation of the closure, procedures used and lessons learnt would be reviewed six weeks after the closure.

113. Resident's views of the relocation process would be sought within three months of the transfer to the new home. This would provide evidence of the affect the closure has had on residents and would feed back into the overall evaluation of the reprovision.

114. 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.

Conclusion

115. A number of factors influence the outcomes for vulnerable adults in transition from one care setting to another including the individuals' physical and mental frailty, the

adequacy of social and health care assessment prior to transfer, timescales and arrangements for transfer, support systems and effective partnership, consultation and communication.

116. Understanding that some frail people would be particularly vulnerable to the stress of relocation, the guidance outlined above is proposed as a way of ensuring that these issues are planned for and robustly addressed in a timely fashion. It is intended for use by lead officers to ensure that closure and transfers are handled sensitively and responsibly and to provide confidence to residents, relatives and others that individuals will be treated with dignity, humanity and respect with the ongoing wellbeing of the individual paramount.

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*

Achieving Closure, Good practice in supporting older people during residential care closures, *2011.*

Appendices

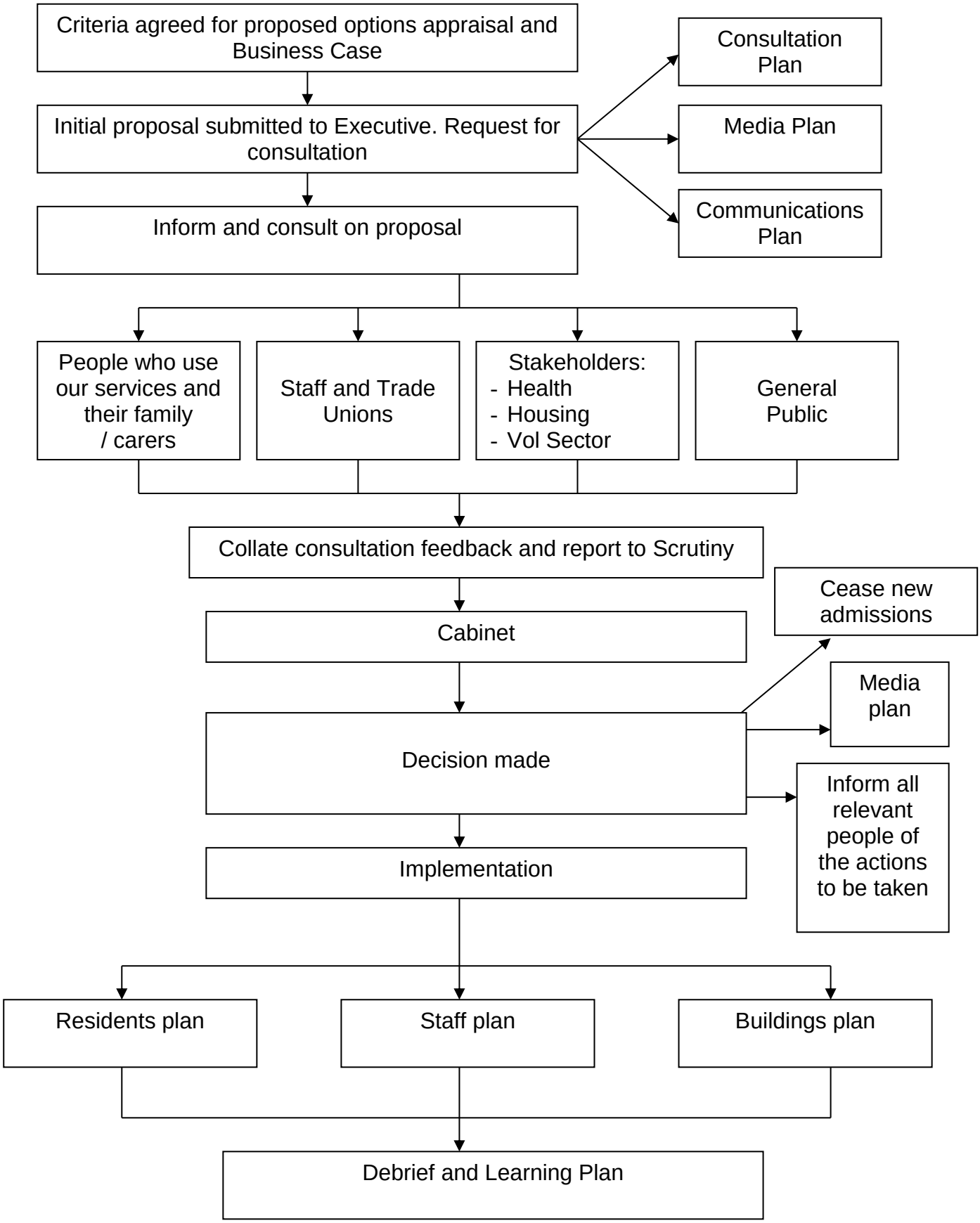
Appendix 1 Facilities management and actions for closure

WHAT	ACTION REQUIRED	LEAD PERSON	TIME SCALE	PROGRESS UPDATE
Gather all relevant stakeholders information	Contact/write to • CQC • Day Centres • PCT/LCC • SW/GPs • Agencies • Utilities • Community nurses • Transport • Trade directories • Neighbours			
Keys	Collect keys from any key holder			
Signage	Remove all signage			
Credit cards	Cancel all credit cards			
IT	Inform any IT department • Remove access to network • Phones to be diverted • Computers to be removed			
Insurance	• Inform building and contents insurers if building is to be empty • Liability and indemnity insurance cancelled			
Vacancy rates	Apply for vacancy rates			
Utilities	Take a reading of gas/water and electric. Ask for final phone bill and broad band bill			
Portable and electrical equipment	Remove all small electrical equipment, i.e. TVs music systems, microwaves			
Inventory	Check inventory against any checklists			
Fridges/ Cupboards	Empty cupboards and fridges, leave fridge doors open			
Mail	• Inform bands and other correspondents • Inform Royal Mail and have mail diverted to appropriate address			
Medicines	Remove all medicines and record			

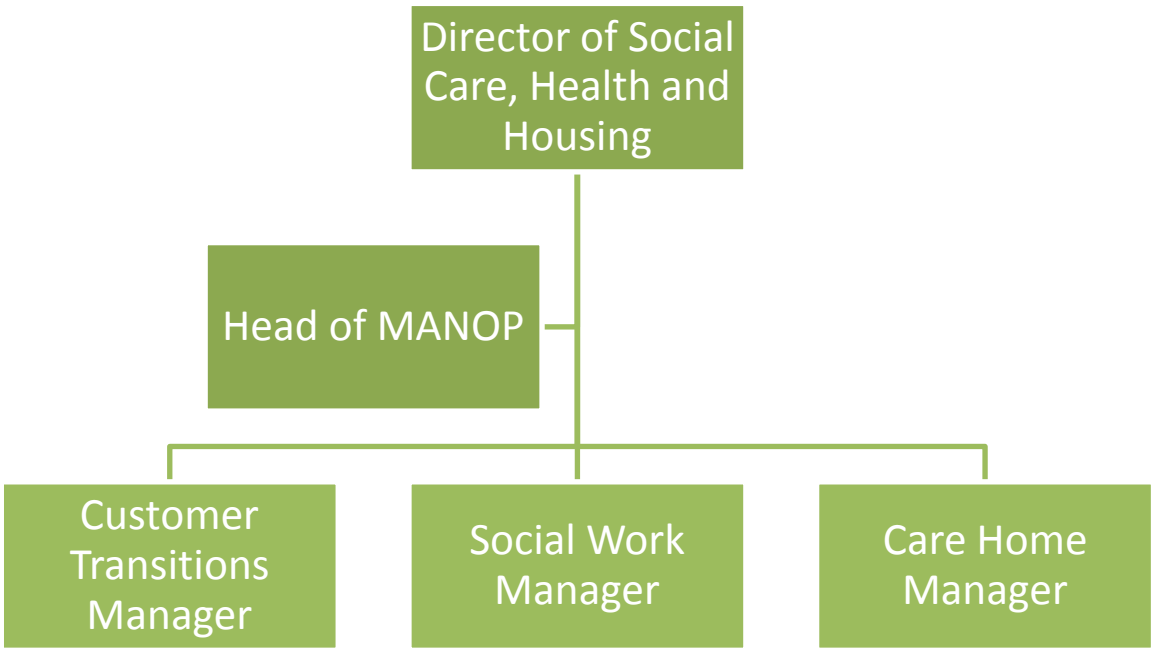
	disposal accordingly			
Confidential files	Remove all confidential files and archive according to current legislation			
Stationery	Remove all stationery			
Contractors	Consult services contracts. Inform contractors of termination. Serve notice if required			
Minibus/cars	Cancel insurance/contract			
Rubbish	Remove all rubbish from site/unit			
Cleaning of unit	Cleaners to action			
Petty cash	To be signed off			

Table 2: From: Achieving Closure, Good practice in supporting older people during residential care closures, *2011.*

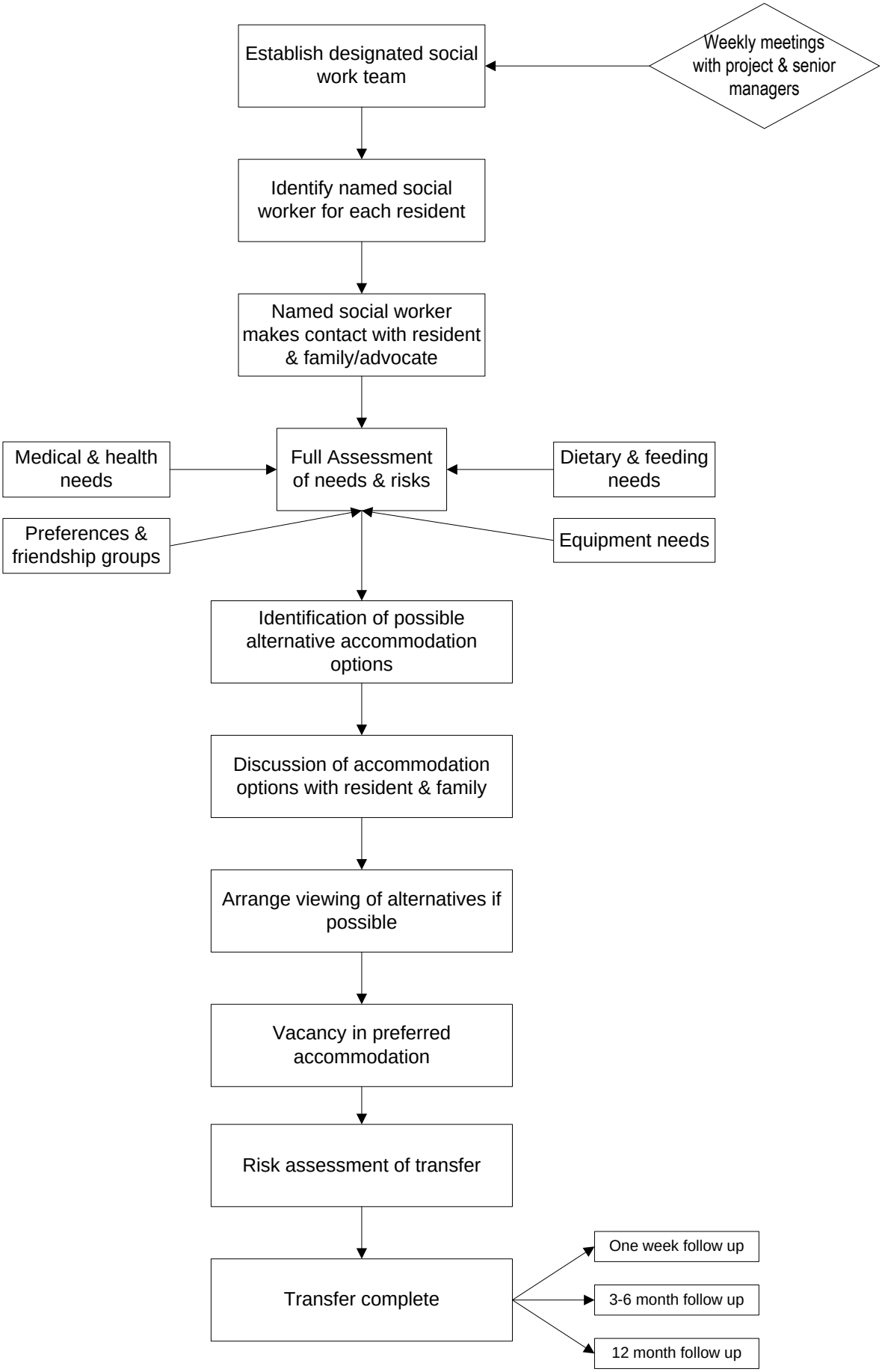
Appendix 2 **Example Process for In-House Planned Closure**



Appendix 3 Example Governance Structure



Appendix 4 Example Role of Designated Social Worker



Appendix 5 Examples of Checklists and Action Plans

A. Checklist for Senior Management, Registered Manager or Project Manager (Immediate Actions)

Actions	Yes/No	Named Person	Comments
1. ON ANNOUNCEMENT OF CLOSURE			
Is there an up to date contact list of all relatives, including email, telephone numbers and addresses			
Have all residents involved been given a written statement:			
✓ Detailing the actual facts?			
✓ Stating the reasons for the decision?			
✓ Ensuring that the future is clear?			
✓ Ensuring that they know where they stand?			
✓ Describing the communications plan?			
✓ Detailing the timescales?			

✓ Detailing the next steps?			
Have all staff involved been given a written statement:			
✓ Detailing the actual facts?			
✓ Stating the reasons for the decision?			
✓ Ensuring that the future is clear?			
✓ Ensuring that they know where they stand?			
✓ Describing the communications plan?			
✓ Detailing the timescales?			
✓ Detailing the next steps?			
2. HAS IMMEDIATE CONSULTATION WITH TRADE UNION AND PROFESSIONAL ASSOCIATIONS COMMENCED? Will these ensure:			
✓ Adequate measures for redundancy?			

✓ Or: continuity of employment?			
✓ That the staff group are retained intact for the whole of the closure and subsequent settling down period?			
✓ Full agreement with all staff on personnel issues?			
3. WILL YOU ENSURE THE INVOLVEMENT OF RESIDENTS AND STAFF IN THE PLANNING PROCESS? How will your approach to project management ensure:			
✓ Maintenance of professional standards			
✓ They have a clear sense of requirements?			
✓ Risks are assessed and the possible harmful impact on residents is minimised?			
4. HAVE CQC, COMMISSIONERS AND OTHER LAs BEEN INFORMED OF THE CLOSURE PLANS?			
✓ Plans for closure and timescales			

✓ Alterations required to Registration status			
✓ Commissioners notified of relevant residents			
5. HOW DO YOU PLAN TO WORK WITH RESIDENTS AND THEIR FAMILIES?			
✓ Have you made verbal/face to face contact with every relative – to ensure continuity of message and valued inclusion in the process?			
✓ Have you given adequate notice of meetings and offered times to suit, i.e. evenings/weekends?			
✓ Are you providing regular written communications?			
✓ Is your key worker system effective?			
✓ Are reviews up-to-date including for self-funders?			
✓ Do you have access to advocates?			
✓ What is your approach to people with dementia?			

B. Checklist for members of the care staff team

Actions	Yes/No	Named Person	Comments
1. IN RELATION TO COLLEAGUES, ARE YOU:			
✓ Providing a supportive environment?			
✓ Helping them to be able to adapt to change?			
✓ Helping them to retain a sense of personal worth?			
✓ Helping them to participate in establishing a new sense of structure?			
✓ Helping them to look to needs beyond the stress of immediate problems?			
✓ Examining and sharing common problems?			
✓ Planning to work through new requirements?			
✓ Discussing issues in open staff forums?			

✓ Endeavouring to create and maintain positive experiences?			
✓ Promoting a sense of realism?			
✓ Being honest?			
✓ Supporting each other?			
✓ Thinking positively?			
✓ Considering requirements for good practice?			
✓ Endeavouring to establish/maintain professionalism?			
✓ Examining factors which will/are preventing good practice?			
Endeavouring to minimise the damaging effect of:			
✓ Low morale?			

✓ Limited options?			
✓ Lack of information?			
✓ Fear/anxiety?			
✓ Lack of encouragement?			
✓ Conflicting interests?			
✓ Insensitivity/tiredness?			
2. AS SOON AS THE RESIDENTS ARE FIRST TOLD ABOUT A CLOSURE DECISION HAVE YOU ESTABLISHED:			
✓ A network of support for the residents?			
✓ Involved significant others?			
✓ Relatives?			
✓ Friends?			

✓ Field social workers?			
✓ Any others involved?			
3. 48 HOURS AFTER THE INITIAL ANNOUNCEMENT HAVE YOU:			
✓ Enabled residents to show their emotions freely?			
✓ Enabled residents to draw mutual comfort from each other?			
Discussed with relatives their fears and uncertainties about their family members' circumstances - for example:			
✓ Fears about moving?			
✓ Fears about changing key workers?			
✓ Concerns about personal finance?			
✓ Set up any sessions required for counselling residents and others?			

✓ Set up procedures/sessions for formal “reviews”?			
✓ Made provision for the continuity of care of residents?			
4. IN RELATION TO FUTURE NEEDS OF RESIDENTS HAVE YOU:			
✓ Developed a strategy to deal with any projected variation in residents numbers over the transition period?			
✓ Planned necessary group experiences and events?			
✓ Enabled residents to assess options and choices available to them e.g. by arranging visits to possible new establishments?			
✓ Enabled personal financial advice where required?			
✓ Enabled residents to keep in touch with any who may have already left?			
✓ Enabled residents and their relatives to talk freely to each other and to staff about their			

experiences?			
✓ Enabled continuity of experience for all residents?			
✓ Enabled residents to maintain contact with significant adults so as to maintain guidance or reassurance?			
COMMENTS			

C. Example Checklist for pre moves day

Actions	Yes/No	Named Person	Comments
Has the new home allocated a key worker/resident buddy?			
Has the care plan been prepared for transfer?			
Has the residents' medication been prepared for transfer? Are there adequate amounts?			
Has the inventory of clothing and personal belongings been prepared for transfer?			
Has the life story/background likes/dislikes been prepared for transfer?			
Has a call been placed the day before the move to ensure the new home is ready to accept the resident?			
Have appropriate suitcases been provided for possessions and clothing?			
Have boxes, labels, tape and scissors been allocated?			
Ensure the relative or care staff can travel with the resident			
Ensure the transport is booked and aware of the sensitive nature			
Are care staff aware of the date of the move to enable them and the residents to say goodbye			
Ensure the key worker at the new home has time allocated to welcome the new resident and help them unpack in the residents own time.			
Arrange for the social worker to visit the resident the day after the move			

E. Example Checklist for moves day

Actions	Yes/No	Named Person	Comments
Has the medical assessment authorised a move?			
Is the Care plan ready for transfer?			
Is the residents' medication ready for transfer? Are there adequate amounts?			
Is the inventory of clothing and personal belongings ready for transfer?			
Is the life story/background likes/dislikes ready for transfer?			
Have possessions been packed and labelled in appropriate suitcases?			
Ensure care staff are given enough time to enable them and the residents to say goodbye to each other.			
Have the resident's belongings arrived complete and the inventory list checked and signed?			
Have the care plan and medication been handed over and signed for?			
Has the resident unpacked and settled in?			
Ensure the GP, previous care home and any other bodies are advised that the resident has successfully moved			

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