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Review Article

A Scoping Review of the Costs, Consequences, and Wider Impacts of Residential Care Home Closures in a UK Context

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Background. Between 2015 and 2020, 1,578 care homes in the UK closed, displacing nearly 50,000 older and disabled people with very significant care and support needs. It is widely thought that relocation can have a significant impact on the health and well-being of older people. Yet, evidence is limited due to sensitivity and logistical difficulties with data collection. This study aimed to review the published literature in order to (i) identify evidence on the costs, consequences, and wider impacts of care home closures, for older people, family members, care home staff, and local authorities and (ii) understand the causes of and processes surrounding the closure of residential care homes in the UK. **Methods.** Eight electronic databases (Medline, Embase, Web of Science, Scopus, ASSIA, HMIC, AgeInfo, and SPP) were searched from 1st January 2000 to 9th February 2023; Google and Google Scholar were searched for guidance/policy documents from the grey literature. Data on the objectives, methods, and main results were extracted, and the findings were narratively reported. **Results.** Eighteen records, comprising guidance documents and academic publications (quantitative, qualitative, and mixed-method approaches), met the inclusion criteria. We found a lack of good quality evidence on costs of closure and no consideration of outcomes for staff. Studies reporting on outcomes for residents suggest there may not be any long-term adverse effects on their health, in contrast to often-expressed views that care home closures result in harm. **Conclusion.** Future research should consider the stress and anxiety experienced by staff and families as relevant outcomes and show caution with respect to the use of proxy reporting of resident health outcomes. Given that a sizable portion of the costs associated with care home closure falls on local authorities, an evidence-based approach to closures that includes an assessment of cost-effectiveness will help to improve future outcomes and guide the most efficient use of limited public resources.

1. Background

Care homes in the UK are estimated to house 421,000 residents and employ almost 700,000 workers [1, 2]. By 2031, it is anticipated that the age group with the greatest care needs—those who are 80 and older—will account for just under 8% of the population in the UK [3]. Despite this predicted increase, 1578 care homes closed in the UK between 2015 and 2020, forcing nearly 50,000 older people to relocate [4–6]. Some studies attribute the decline in the number of care homes to poor quality. Others believe that pressure on local authorities (LAs) to keep prices low, as well

as national policies which raised costs, such as the National Minimum Wage and the National Care Standards, were factors [7, 8]. There are typically three types of closures for care homes: planned, unplanned, and emergency. The definitions and timelines are widely debated and usually depend on the reason behind the closure [9].

Over the past 30 years, there have been multiple changes to the provision and financing of health and social care in the UK. The first reform of social care, explicitly to promote market competition, was implemented in 1993 [10]. The reforms transferred the national government's funding of independent sector residential and nursing home care to

local authority social services departments. The legislative changes aimed to promote care in people's homes or homely environments, while also addressing the challenge of bringing a rapidly escalating central budget under control by devolving it to local Councils with limited budgets.

The 2001 National Minimum Standards for English care homes mandated the implementation of minimum physical standards relating to the percentage of beds in single rooms, door and corridor sizes, and staff qualification requirements, as well as standards for home choice, health and personal care, daily life and social activities, complaints and protection, and management and administration [11]. Homes built before April 2002 were only required to maintain environmental standards instead of meeting the requirements of newly registered homes, which could have helped to ease the financial burden and prevent widespread closures. However, although the standards were designed to ensure the protection of service users and to promote their health, welfare, and quality of life, they present obvious contributions to the costs of running a new home thereafter and a number of older care homes struggled to bring themselves up to these standards.

The latest reform which was to come into effect from October 2023, would have allowed private payers (self-funders) to request councils to arrange care on their behalf at lower local authority rates [12]. It intends to introduce a new "Fair Cost of Care," which aims to raise care fees paid by councils to providers to make the care market sustainable [12]. According to LangBuisson, the government's budget underestimates the need for additional funding and could put the sustainability of care homes across the nation at risk and result in their closure [13]. This reform was later delayed potentially indefinite, and such issues remain unresolved.

Recent events have put further pressure on the financial stability of care homes. During the pandemic, care homes were unable to accept new residents, and families were reluctant for their relatives to move into a care home. As a result, the number of empty beds has increased, leading to permanent care home closures [14]. In addition to the pandemic, there are the potential effects of Brexit in a sector which has relied heavily on the labour of migrant care workers [15]. Over time, the government's austerity agenda, coupled with rising need and demand, has led to significant shortfalls in local government funding, contributing to significant financial, service, and workforce pressures across the whole of the sector [16]. With money so tight, there is very little room for manoeuvre, given that staff costs represent a substantial proportion of total costs [17]. Most recently, there have also been concerns regarding increasing inflation and energy costs.

Given the inevitability of continued closures within the climate of increasing economic pressure, there is a need to minimise both the tangible and intangible costs of care home closures to all parties involved. The tangible costs include the equipment, resources, and staff that are required to close a care home [18]. Intangible costs are defined as costs that can be identified but cannot be quantified or easily estimated and relate to changes in health status brought about by public service interventions (in this case, a care home

closing) [19]. This is part of a broader study into how best to manage care home closures, seeking to estimate costs, improve outcomes, and minimise risks for all those involved. As part of the overall project, a separate review explored evidence on outcomes from a non-economics perspective and with particular attention to whose voices are heard/unheard during the closure process [19]. The aim of this scoping review was therefore to identify and synthesise evidence both from the academic and grey literature (guidance documents) relating to the costs, consequences, causes, and processes of care home closures for future use in economic analysis (modelling). By gaining a better understanding of the costs, consequences, causes, and processes experienced by different parties involved in care home closures, this review will provide a crucial foundation for informing economic modelling, which would involve the mapping out of possible closure pathways and their associated costs and outcomes. In addition to providing a strong foundation for future economic modelling, this review is critical for establishing a comprehensive understanding of the topic and identifying gaps in existing literature. The overall programme of work will enable decision makers to access the relevant evidence necessary to make effective policy decisions and develop strategies for managing care home closures.

2. Methods

We conducted a scoping review guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) [20]. Alongside the scoping review, we also conducted a pragmatic search to identify the key cost drivers associated with operating a care home (see Appendix A); the motivation for this pragmatic search was to contextualise findings from the scoping review.

2.1. Search Strategy. The search strategy was designed with the help of an information specialist to be as broad as possible, including a search of grey literature. The following electronic bibliographic databases were searched from 1st January 2000 to 9th February 2023: Medline, Embase, Web of Science, Scopus, Applied Social Sciences Index and Abstracts (ASSIA), Health Management Information Consortium (HMIC), AgeInfo, and Social Policy and Practice (SPP). Google and Google Scholar were searched for guidance/policy documents and items from the press.

We used the following key words: *care homes* OR *residential homes* OR *homes for the aged* OR *older people* AND *closures* OR *closing* OR *closed* OR *relocation* OR *resettle* OR *transfer* OR *transition* AND *economic* OR *costs* OR *impact* OR *outcomes* OR *consequences* OR *cost-effective* OR *cost analysis* OR *cost utility* OR *healthcare expenditure* OR *healthcare financing* OR *quality of life* OR ICECAP OR *wellbeing* OR ASCOT. ICECAP and ASCOT are commonly used measures of quality of life and social care-related quality of life, respectively, which have been endorsed for use in social care by the Social Care Institute for Excellence

(SCIE) and the National Institute for Health and Care Excellence (NICE).

A two-stage process was used to organise relevant papers according to some predetermined themes, adapted from the approach of Roberts and colleagues [21]. Quality assessment criteria were not applied to prevent studies from being excluded because there was not a suitable checklist for critiquing the expected diversity of foci from the studies and the expected results. Furthermore, preliminary scoping searches indicated that there would be few relevant papers found, so every effort was made to prevent losing the only existing information. For each paper included, the reviewer extracted data about the source of the paper, the aim of the study, the methods used, the perspective adopted, the primary focus, and the timing of the closure. The data were tabulated, and the findings of individual papers were compared narratively.

2.2. Inclusion and Exclusion Criteria. Studies/documents were included if they met the following inclusion criteria:

- (i) Relate to care home closure (or relocation)
- (ii) Published in the year 2000 to 2023.
- (iii) Published in English language
- (iv) Provided information on the costs, consequences, causes, and process of care home closures (or relocation)
- (v) Contained sufficient information to permit meaningful data extraction (i.e., not a conference poster or abstract)

Studies/documents were excluded if they met the following exclusion criteria:

- (i) Focused on nursing home closures or homes with people of working age
- (ii) Published prior to the year 2000
- (iii) Conference poster or abstract
- (iv) Not published in English language

Papers published prior to 2000 were excluded due to the implementation of national minimum care standards the following year. The exclusion of nursing homes and homes with working-age individuals was motivated by the higher level of complexity and cost implications of their closure. Given their large volume and distinct difference from nursing homes, we focused solely on residential care homes to ensure feasibility and minimise heterogeneity. Only studies from the UK were included in this review because the structure and financing of social care are specific to the UK. We did not impose any restriction with respect to perspective; perspective defines the scope of the included costs and outcomes, in terms of who bears the cost or is impacted by the outcome.

2.3. Selection of Papers for Review

2.3.1. Stage I: Initial Screening and Categorisation of Results. Screening was conducted based on an inspection of the titles and abstracts and following the inclusion/exclusion criteria detailed in Section 2.2. All studies/documents meeting the inclusion criteria were further categorised under one of the themes below (A–F); studies/documents meeting the exclusion criteria were categorised under heading G or H. The reason for categorising papers at this stage was to understand the topics covered in the literature and prepare for data extraction according to the stated objectives of the scoping review.

- (A) Paper discusses the types of homes closing or the causes of care home closures
- (B) Paper reports the costs and/or consequences of care home closures, from any perspective
- (C) Paper presents experiences, recommendations, protocols, or guidance
- (D) Paper is an economic evaluation (a comparative analysis of two or more options with respect to costs and outcomes)
- (E) Paper does not fall clearly into categories (A), (B), (C), or (D) but could have relevant information
- (F) Paper presents the impact of moving between residential settings though not necessarily to do with a care home closure
- (G) Paper is solely related to nursing home closures or homes for people of working age
- (H) Paper did not provide any relevant information on the costs, outcomes, procedures, guidance for care home closures, or moving between residential settings

2.3.2. Stage II: Further Screening and Categorisation of Results. All studies falling into categories A, B, C, D, E, and F were read in their entirety to determine if they were true to the groups they were assigned to. The following are the final group classifications:

- (1) Paper discusses the types of homes closing or the causes of care home closures
- (2) Paper reported the costs of care home closures from any perspective
- (3) Paper reported the outcomes and experiences of care home closures from any perspective
- (4) Paper presents processes, recommendations, protocols, or guidance
- (5) Paper was not relevant

Papers that fell into category 5 were excluded and all others were included.

3. Results

A total of 16,118 papers were identified through the initial searches. Prior to screening, 1053 duplicate records were removed and an additional four papers were added from the grey literature. A further 15,036 (categories G and H) were excluded based on the title and abstract (Stage I screening and categorisation). The remaining 33 papers were taken forward to Stage II screening, at which point they were read in full (see Figure 1). At Stage II screening, further 16 were excluded (either because they were not relevant, the full paper was not available, or papers were related to the same academic study), leaving 17 that were deemed relevant to the objective of the review. One additional paper was identified through a parallel search, bringing the total number of papers included in this study to 18.

3.1. Summary of Selected Papers. The eighteen studies that met the inclusion criteria were a combination of journal articles ($n = 10$), discussion papers ($n = 3$), reports ($n = 2$), and guidelines ($n = 3$). Fifteen of the papers were based on primary research, of which ten were based on primary data. The papers represented a range of perspectives including, residents, relatives, care staff, local government, and care home providers, with some studies exploring more than one of these perspectives. Appendix B shows a year-by-year distribution of papers with no obvious peak of interest at any point.

Four themes were identified from the eighteen studies: (i) the causes of care home closures ($n = 3$), (ii) the costs of care home closures ($n = 1$), (iii) the outcomes and experiences of care home closures ($n = 6$), and (iv) care home closure processes, guidance, protocols, and recommendations for closure ($n = 8$).

Tables 1–4 present details of the papers including aims and context, the source of the paper, the perspective, the health outcomes used in the paper, and whether any financial costs were mentioned.

3.1.1. The Causes of Care Home Closures. Factors associated with care home closures were discussed by three studies in this review (see Table 1).

Two studies were part of a wider investigation into the supply and causes of care home closures and were funded by the UK Department of Health in the early 2000s (as new care standards were being introduced) [22, 23].

The first of the three studies was conducted by Netten et al. [23] who investigated home closures in England from the perspective of providers. Three-quarters of the providers interviewed in this study cited the cost implications caused by the adoption of national standards as a significant factor in closures. Other factors included low occupancy levels due to reduced demand for publicly funded places and the local authority price regimen, which providers felt did not cover the true costs of running the homes. Furthermore, eight (40%) of the twenty providers interviewed identified low demand for care home places as a factor, with four from the Southeast and the remaining four from the Southwest, West Midlands, North Yorkshire, and Trent region.

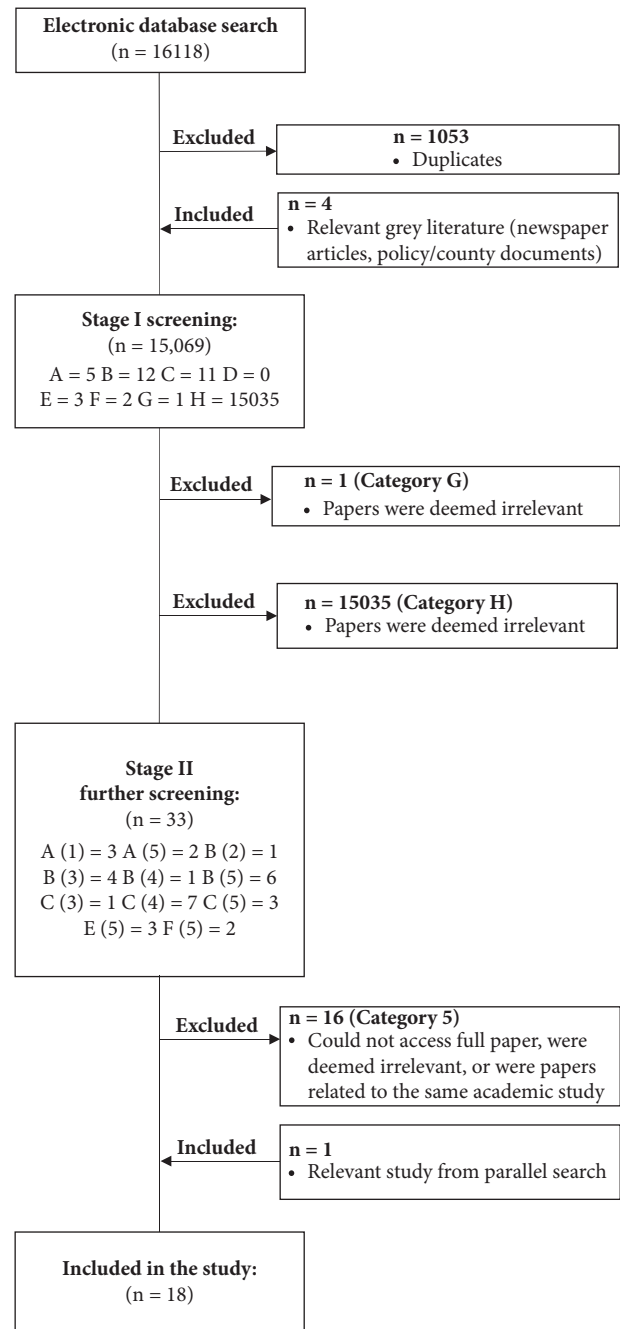


FIGURE 1: Flowchart of various stages in review showing the number of papers at each stage.

In a subsequent study, Netten et al. [22] examined care home closure causes from the perspective of regulators, discovering that while a smaller proportion (6%) blamed low demand for closures, a larger proportion (30%) blamed oversupply in regions similar to those mentioned above. There appears to be no obvious regional variation in the demand and supply of care homes, but it is unclear from the evidence whether low demand is the predominant issue for closure because it represents a smaller proportion of homes from the regulator's perspective compared with the provider's perspective. Other reasons for closures conveyed by

TABLE 1: Summary of causes of care home closure papers.

Author/year	Aims and context	Source	Primary focus	Perspective	Methods	Data
Allen and Forder 2015 [7]	This study investigates the causes of care home closures in the English care home/nursing home market	Journal article	Causes	Not required	Three empirical models: IV probit model, averaged probit model, and random effects probit model	The analysis used data from the CQC at two different time points (2008 and 2010) $N = 9324$ and $N = 9330$. Data from CQC were augmented with commercially available data from care home specialists, LaingBuisson. The closure status was made by identifying whether each CH remained open on the register at the subsequent time point, so any change in ownership/organisation was ignored. Quality was measured using the CQC star rating measure. Competition was measured using a distance-time and travel-time weighted Herfindahl-Hirschman index (HHI)
Netten et al. 2002a [22]	Describes the results of the first phase of a study on the causes, processes, and consequences of home closure	Discussion paper	Causes	Regulator	Followed up a national survey of homes conducted in England in 1996. Managers from the registration and inspection units (R&I) were telephone interviewed between April and June 2001. Interviewers asked open-ended questions about the 2 most recent closures in the manager's area.	$N = 21$
Netten et al. 2002b [23]	A study was conducted investigating the factors and circumstances that lead to homes closing from the perspective of independent providers	Discussion paper	Causes	Provider	The R&I unit managers from Williams et al. 2002a were asked to supply contact details of people who had been involved in a closure during the past two years. One to one structured interviews were conducted	$N = 20$ Mixture of proprietors, managers, owners, owner/manager, regional manager/director, and consultee representing owner

TABLE 2: Summary of costs of care home closure papers.

Author/year	Aims and context	Region/council	Source	Primary focus	Perspective	Methods	Data	Costs
Read and Crawford 2015 [6]	Examines the future residential care home services in England and the impact on the NHS	All of England	Report	Costs	Not specified	Economic analysis model	Data were collected from secondary sources. Office of national statistics, local government association, the health and social care information centre, and the consumer price index	The cost of 37,000 lost care sector beds to the NHS would be £3 billion per year if care homes continued to be underfunded

TABLE 3: Summary of outcomes and experiences of care home closure papers.

Author/year	Aims and context	Region/council	Source	Primary focus	Perspective	No. of closures	Methods	Data
Duff et al. 2002 [24]	Explores the impact of residents when temporarily moved while their premises are refurbished	South East-Surrey	Journal article	Guidance/process	Residents Care staff Relatives	One temporary closure. Implied it was a planned closure	Interviews	Primary data Does not specify sample size
Gascoigne and Mashhoudy 2011 [9]	The objective of the study is to see if those who moved home involuntarily had a higher mortality rate within a year of their move than those who had just moved into a home	Coventry	Journal article	Outcomes/experiences	Not required	14	Logistic regression	Treatment group: N = 71 Control group: N = 412
Glasby et al. 2018 [25]	Examines the perceptions of older people, families, care staff, and social workers, as well as long-term outcomes for older people, from a UK care home closure programme	West Midlands-Birmingham	Journal article	Guidance/process	Residents Care staff Relatives	One linked day centre closure and one care home closure	Semistructured interviews with older people, families, care staff, and social work assessors. Older people asked to fill 2 questionnaires (EQ5D) at 3 time points	Primary data Interview: N = 49 Questionnaires: N = 74
Leyland et al. 2016 [26]	Investigates the impact of following a protocol on the experience of relocating residents from various perspectives	Not specified	Journal article	Guidance/process	Care staff Relatives Local authority Residents	Two local authority operated care homes. Implied it was a planned closure		Primary data N = 34 Staff = 13 Residents = 11 Relatives = 2 CH managers = 6
Williams et al. 2003 [27]	Describes relatives, “informal carers,” and residents’ views about their experience of care home closure and their recommendations for how the process might be better managed	Two shire county authorities, two metropolitan district councils, and a shire unitary authority participated	Discussion paper	Outcomes/experiences Guidance/process	Residents Relatives	Seven care home closures carried out in four local authorities. Implied that all care home closures were planned with notice ranging from one month to 2 years	Seven case study sites in addition to non-case study sites where relatives and informal carers who recently experienced a closure were interviewed	Primary data N = 43 CS residents = 10 CS relatives = 28 NCS relatives = 7
Ibrahim et al. 2022 [28]	Examines the experience of a care home relocation in which staff and residents are relocated together, using existing published guidance	Not specified	Journal article	Outcomes/experiences Guidance/process	Residents Care staff Relatives	One care home closure	Semistructured interviews. Baseline interviews were conducted 6 to 8 weeks after the move, and follow-up interviews were conducted 10 to 12 months later	N = 27 Baseline: Residents = 4 Relatives = 7 Care staff = 8 Follow up: Residents = 2 Relatives = 2 Staff = 4

TABLE 4: Summary of guideline, process, and recommendation papers.

Author/year	Aims and context	Region/country/country	Source	Primary focus	Perspective	Methods	Data	Type of closure	Pathway identification
Agencia Consulting 2011 [29]	A meeting was held with 10 members of staff, including the home manager. Staff spoke freely about the impact of closure proposals on themselves and residents	East Midlands -Derby	Report prepared by consultancy from the LA	Findings from interviews of pre-closure consultation with staff members	Care staff	Interviews with staff members	N = 10	Implied it would be planned	Care staff were given options to re-interview for positions or be re-deployed
Gloucestershire County Council 2014 [30]	Procedure and guidance on moving residents between care homes under different circumstances	South West-Gloucestershire	Document prepared by adult social care for Gloucestershire County Council	Diagrams showing the procedure for moving homes and the various circumstances under which a resident would be forced to relocate	Implied local authority	Not specified	Not specified	Not required	Article provides information which could contribute towards a pathway for the LA
Kennedy and Colley-Bontoft 2016 [31]	This report provides a list of good practice and lessons learnt following a closure in Nottingham	East Midlands -Nottingham	Report	Summarises the actions taken by the provider during the closures, in addition to the lessons learnt	Local authority	Not specified	Not specified	Implied it was a planned closure	Not a complete pathway but identifies who from the council is involved with closures
NHS England 2016 [32]	A guide for managing care home closures	All of England	A practice guide for LAs, clinical commissioning groups, NHS England, CQC, providers, and partners	Bullet pointed actions for care home closure and conditions which they would close (unplanned and planned)	Not specified	Not specified	Not specified	Unplanned closure	No
Robinson et al. 2013 [33]	Drawing on local knowledge and best practice examples, this article highlights lessons and themes identified by those decommissioning care home services	Mix of urban and rural authorities and two-tier and unitary authorities from different parts of the country	Journal article	Experiences of decommissioning care home services	Local authority	Interviews with directors of adult social services and senior staff from the local authority. Interviews were carried out over the phone. Researchers identified four themes from interviews	N = 12	Participants had experienced either planned or unplanned closures	Article provides information which could contribute towards a pathway for the LA

TABLE 4: Continued.

Author/year	Aims and context	Region/country/country	Source	Primary focus	Perspective	Methods	Data	Type of closure	Pathway identification
Williams and Netten 2005 [34]	Examines council powers and responsibilities, as well as residents' rights during care home closures, before describing the prevalence and content of existing council guidelines	All of England	Journal article	Identifying the extent to which English councils had guidelines for managing care home closures and to identify their plans and recommendations	Local authority	Councils were contacted in March 2002 and asked if they had a protocol for independent care home closures and if so to provide a copy. Documents were reviewed to identify their format, scope, and content	N = 2 Guidelines from councils with 100 or more independent residential homes N = 7 Guidelines from councils with fewer homes	Implied that the protocols examined discussed planned and unplanned closures	Article provides information which could contribute towards a pathway for the LA
Williams et al. 2007 [35]	Reports case study research that set out to identify what care managers do during independent care home closures	Not specified	Journal article	To understand care managers' experience of care home closures, their activities, and views of the process and how it might be improved	Local authority	Semistructured interviews 4 weeks after relocation. The software package QSR NUDIST (non-numerical, unstructured, data, indexing searching, and theorising) was used for the qualitative analysis	Selected councils for being large. There were 8 care home closures across 4 councils. Interviews were with 16 care managers, 5 team managers, and 3 senior strategic managers	Not specified	Article provides information which could contribute towards a pathway for the LA
Woolham 2001 [36]	Paper offers guidance on good practice based on evidence from several studies of involuntary relocation in the UK and elsewhere	UK and elsewhere	Journal article	Guidance for care home closures based on previous studies	Not specified	Not specified	Not specified	Not specified	Article provides information which could contribute towards a pathway for the LA

TABLE 5: Costs of care homes, £ prpw, 2008/09 and 2021/22.

Cost heads	2008/09	2021/22
<i>(A) Staff, including employers' on-costs</i>		
Care assistant staff cost per resident (including activities)	£144	£206
Catering, cleaning, and laundry staff cost per resident	£46	£66
Management/admin/reception cost per resident	£40	£57
Agency staff allowance-care assistants	£2	£3
Training backfill	£2	£3
Total staff	£234	£335
<i>(B) Repairs and maintenance</i>		
Maintenance capital expenditure	£19	£27
Repairs and maintenance (revenue costs)	£11	£16
Contract maintenance of equipment	£3	£4
Total repairs and maintenance	£33	£47
<i>(C) Other non-staff current costs</i>		
Food	£23	£33
Utilities (gas, oil, electricity, water, telephone)	£22	£32
Handyperson and gardening (on contract)	£7	£10
Insurance	£5	£7
Medical supplies	£3	£4
Registration fees (including CRB checks)	£3	£4
Recruitment	£2	£3
Direct training expense net of grants and subsidies	£2	£3
Continence products	£0	£0
Other non-staff current expenses	£6	£9
Total non-staff current expenses	£79	£113
<i>(D) Capital costs (12% return on capital)</i>		
Land	£43	£62
Building and equipment meeting physical NMS for new homes, extensions, and 1st registration since April 2002, including start-up losses	£149	£213
Total capital costs	£192	£275
"Ceiling" fair market price for homes meeting all standards for "new" in National Minimum Standards for Care Homes for Older People, 2nd edition February 2003	£538	£771
Maximum capital cost adjustment factor for homes not meeting physical standards for "new" homes	£74	£106
Floor fair market price for homes which do not exceed the interim physical standards for "existing" homes in National Minimum Standards for Care Homes for Older People, 2nd edition February 2003	£463	£663

Source: Laing [17].

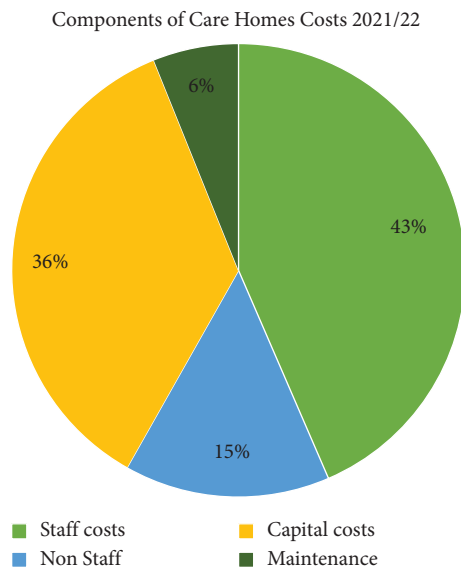


FIGURE 2: Components of care home costs (2021/22) (amended from Laing [17]).

TABLE 6: Hourly pay for staff employed at care homes (amended from Laing [17]).

	Private sector care homes (2008) £ per hour	Private sector care homes (2020/21) £ per hour	NHS agenda for change pay bands for 2007 £ per hour equivalent	NHS agenda for change pay bands from 2022 £ per hour equivalent	£ per annum
Domestic, housekeeping, catering assistant	£5.82	£8.72	£7.25-£7.89	£10.27-£10.90	Band 1: £12,182-£13,253
Health care assistant	£6.07	£9.01	£7.49-£9.24	£10.27-£10.90	Band 2: £20,270-£21,381

Sources: Laing [17]; Skills for Care [2]; Health Careers [39].

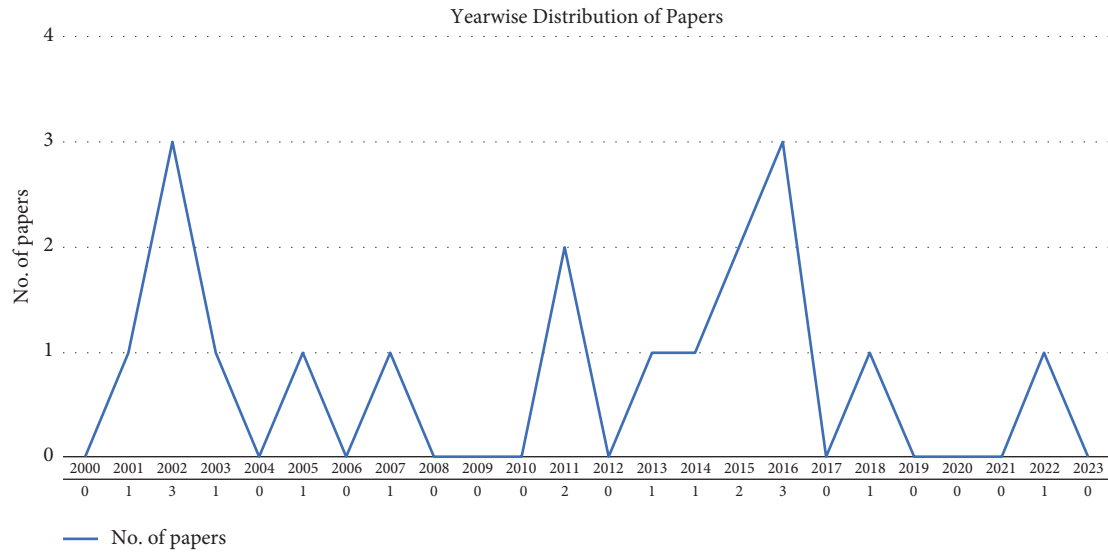


FIGURE 3: Year-wise distribution of papers.

regulators included an immediate financial crisis, current and expected care standards, and the personal circumstances of owners. It was notable that several respondents claimed that rather than just one of these factors, home closures typically occur because of a combination of them.

The third study that looked particularly at closures [7] used statistical analysis to examine the determinants of care home closures and discovered that low quality and high competition significantly increased the likelihood of closure. Additionally, the authors' model controlled for the region where the care home was located, but this was found to be insignificant.

3.1.2. The Costs of Care Home Closures. Only one study specifically focused on the costs of care home closures (see Table 2).

The UK study comprised a model-based analysis which explored the future of residential care home services [6]. This study was conducted in conjunction with some of the UK's largest independent healthcare providers. The difference between the funding available and the cost associated with the demand was projected to create a £1.1 billion funding gap by 2020/21. A third of this estimated gap was due to the implementation of the National Living Wage (NLW). It was estimated that the amount of care funded in 2020/21 would result in the loss of 37,000 care homes, a loss which, if diverted instead through the hospital sector, would cost the UK National Health Service (NHS) up to £3 billion per year. The reported findings are based on the expectation of reduced funding, increased demand from an ageing population, and an increase in the prevalence of long-term conditions. The authors did not provide details of the methods used to obtain these figures but suggested that the assumptions needed to be received with caution and that the funding forecast is optimistic. This study suggests that a significant portion of the expenses related to closing care homes will go towards alternative services/accommodation.

3.1.3. The Outcomes and Experiences of Care Home Closures. Six papers using similar approaches discussed the outcomes and experiences of residents forced to relocate (Table 3) [9, 24–27]. All the studies identified in this section are in response to planned care home closures.

A study that used statistical analysis to examine the long-term impact of a closure programme on the residents' self-reported health quality of life found some improvements for some people [25]. According to the authors, participants felt their health and well-being either remained the same or improved up to a year after moving to new services. The health status of the individuals reported at the initial assessment may have been lower than "normal" because residents were informed of the move before initial outcome data were collected, and this could have inflated the size of the positive effect that the study discovered about the move. Acknowledging the limitations, this was the only study to use a validated instrument (EQ5D) to document health outcomes after a closure.

Similarly, in the case of temporary closure, Duff et al. [24] supported the findings of those by Glasby et al. [25]. The authors described a period of disorientation after moving to their temporary residence; however, most residents recovered well with some showing improvements in both physical and mental health. Thus, both studies [24, 25] suggest residents are unaffected by closures in the long term, with some residents even showing signs of improvements.

The only study that measured the mortality rate one year after care home closures found no statistical significance between the mortality rates of those who were involuntarily relocated and those who had just moved home [9]. The authors did not control for physical and mental diagnoses of residents, nor did they address whether the effect was causal.

Studies looking at the different perspectives of the impact of closure and relocation of residents highlighted a disparity between the views of residents, relatives, and staff [26, 27]. Leyland et al. [26] asked relatives and staff opinions on the impact of the closure on residents' health and received

mixed responses. Although relatives believed that residents' health had improved or remained the same since moving, staff reported deterioration in mobility, speech, and general health. Williams et al. [27] interviewed residents and family members about their experiences with care home closures from various sites. While more than half of the residents (a total of 43) involved in the closures were described as "ok" or "fine," the authors found that the health of eight residents was said to have deteriorated. However, the authors did not say whether this was because of the closure or because of preexisting medical conditions. The study did not distinguish between the opinions of residents and relatives, but it did report that a greater percentage (70%) of those interviewed were relatives. There may be an issue here in relation to proxy reporting of changes in health.

A more recent study that looked at residents and care staff moving homes after a closure conducted interviews after the move and found that residents had mixed reactions to the relocation [28]. Residents who had lived at the home for a longer time were unhappy, whereas those who had only lived there for a few months were more positive and welcoming of the move. Although there was no focus on residents' health outcomes specifically, the authors discovered that all respondents—residents, staff, and family members—felt that time was crucial for adjusting to and settling into the new care home.

To summarise, most of the studies in this section found that residents' views of their health remained largely unaffected by the closure of a care home. Only those studies in which relatives and staff were interviewed on behalf of residents reported a perceived negative impact on residents' health. This may be an indication that various viewpoints do not capture the true feelings of the residents, or that the worries and anxiety that staff and family members are feeling affect how they perceive residents are reacting to the closures. Furthermore, it appears that the timings of interviews and data collection may influence the overall outcome of residents relocating. Williams et al. [27] followed up on participants 1 to 5 months after closures and reported deterioration in the health of a small number of residents. The study by Glasby et al. [25] appears to confirm this, as they found long-term outcomes differed from those collected in the middle of the closure. The implication here is that 1 to 5 months may not be long enough for a resident to adjust to their new home and for the real impact to be measured, and the true effects may be overshadowed by the distress experienced during the closure.

3.1.4. The Recommendations and Guidance on Care Home Closures. Table 4 presents a summary of papers' recommendations and guidance with respect to care home closures from eight papers [29–36].

An NHS guide published in 2016 developed a checklist/process for local authorities, clinical commissioning groups, NHS England, Care Quality Commission (CQC), providers, and partners to refer to in the case of an unplanned emergency closure [32]. The checklist included (i) informing the appropriate parties, such as family members and

residents about the closure, and (ii) conducting a rapid needs assessment and (iii) safe transfers to an alternative care setting and reviewing the process and its effectiveness. There were no formal references cited, and the guides' development process was not explained in any detail. Separate guidance based on evidence from studies on involuntary relocations by Woolham [36] suggests that residents who are vulnerable to stress about the closure should be (i) identified from the beginning, (ii) properly prepared, (iii) offered visits to potential new homes, (iv) having written information about them for care staff at the new home, and (v) encouraged to move with staff members.

In describing the process of closing a care home, two additional reports by local authorities were found to broadly concur and reiterate the NHS guidance [29, 31]. The process advised in both papers includes (i) a needs assessment, (ii) a decision on a new home, (iii) care planning, and (iv) move coordination. Kennedy and Colley-Bontfont [31] emphasise the importance of having additional transportation services available on the day of the move and the importance of not moving on Friday because some resources and staff are typically unavailable. No apparent updates exist for either of these reports since their publication, nor any information on the outcomes of following such processes. Neither paper discusses the development of any one of these protocols.

Williams and Netten [34] reported that the protocols for closures that exist across local authorities in England differed on several issues, including (i) the length of notice required and (ii) the allocation of roles and responsibilities. One protocol stated that when a closure is enforced, the regulator is responsible, and when it is voluntary, the local authority is responsible. "Most" protocols recommended that care staff should be encouraged to be involved in the home closures. Many of the protocols reviewed by Williams and colleagues suggested that follow-up reviews should take place within four to six weeks of relocation.

For the studies reviewed in this section, there was typically no explanation of how the guidelines or protocols were developed, or whether they were based on previous closures or existing evidence. There was no information about when the guidelines were created, nor was there any information about when they were last updated or how frequently they are updated. Notably, three of the guidance papers were based on research from the early 2000s, which might be viewed as a different period for policy and such guidance might not be considered relevant today.

4. Process and Pathway

It was not possible to identify a single, clear, or optimal process and pathway to care home closure, from any perspective, from the papers identified in the review. From the guidance and protocol literature in the preceding section, we extrapolate an example of a potential closure pathway, from the viewpoint of the local authority.

Williams and Netten [34] and Leyland et al. [26] provided some insight into the process of closure from the perspective of the local authority. The local authority protocols discussed in Netten et al.'s [23] study referred to in the

previous section suggest that at the beginning, a notice of closure must be issued. The protocols suggest giving at least one month's notice, if not more. Following that, roles and responsibilities must be assigned, with the allocation of roles varying across protocol documents. Care staff should be involved in the process and should accompany residents on the day they move to the new home if possible [34]. Care managers/social services staff should then find a list of alternative accommodation from which residents and relatives can choose. Some of the protocols identified by Williams and Netten [34] recommend temporary accommodation in case of an emergency closure or if places in the resident's preferred home are unavailable. A needs assessment is usually performed next, with protocols varying depending on how much care and support self-funders are entitled to. The residents will then be moved to their new homes. The last step is to follow up with residents and review the closure process, with most protocols agreeing that reviews should take place within 4–6 weeks of relocation. From the outcomes and experiences section of this review, it was apparent that changes to health could take place over the course of a year; therefore, a follow-up review should be conducted at 12 months. The four stages covered in the study by Leyland et al. [26] include re-assessment, choosing a new home, moving to a new home, and reviewing the move.

In summary, despite some studies using similar closure processes, no single recommended processor pathway to which all closures adhere exists. Instead, some steps in the closure process have been articulated and seem essential, though no ordering of these steps is currently advised. There is no evidence to suggest that these steps are the most appropriate or efficient; they are described but not analysed in the papers.

5. Findings from Pragmatic Search “Costs of Operating Care Homes”

A separate pragmatic search was carried out to better understand the operating costs of care homes and whether these expenditures are related to the articles found in this study (Appendix A). The search yielded three articles that investigated the costs of running a care home. A report by Laing [17] found that staff costs are the largest costs to homes, accounting for nearly half of care home expenditure. Laing [17] appears to have made the fundamental assumption that these costs are fixed, while Romeo et al. [37] have shown that other factors such as personal characteristics, cognitive ability, and dependency can influence them.

6. Discussion

6.1. Summary of Main Findings. This scoping review identified eighteen papers relating to the closure of care homes. Studies included in the review covered diverse topics, including costs, consequences, causes, and processes, with most of the literature focusing on protocols, guidelines, and experiences of care home closures. The papers differed significantly in their methods, perspectives, and sources. This review found no studies reporting economic evidence or cost-effective pathways or process for care home closure.

A key motivation for the review was to ascertain the component costs and/or resource use associated with a care home closure from the perspective of a range of stakeholders, but evidence of this sort was not identified. The automatic and wholesale diversion of unmet needs due to care home closures into the health care system (used as the basis of the cost calculation reported by Reed and Crawford [6]) is not credible, although there may be some associated resource use (and hence cost) falling upon the health care system, which has not yet been accurately recorded. Although it is likely that many residents remain in the residential care sector, there were no papers that specifically examined how care home closures affected the demand for community-based support and services. Given their statutory responsibilities and the significant role specified for local authorities to play in cases of care home closure, as specified in the protocol/guidance documents that we identified, it can reasonably be estimated that a significant proportion of the cost burden associated with care home closures will fall upon local authorities.

The outcomes of care home closures on residents varied depending on who was asked and when they were asked. Participants in the study by Glasby et al. [25] self-reported QoL and it was discovered that outcomes stayed the same or improved up to a year after switching to an alternative residence. The improved outcomes may be the result of residents in their new homes receiving better care or living in more modern, purpose-built buildings. Based on the limited evidence, this seems like the obvious assumption to make, but there is not enough information to know if that assumption is supported. However, when care staff were asked, they believed residents' health might decline because of the closure. The degree to which care staff projected some of their feelings during these interviews may have contributed to the difference in views between residents and staff. Studies on outcomes and experiences were all based on planned closures; therefore, it is unclear whether the same effects would occur if it were an unplanned or emergency closure. While it is reasonable to assume that residents who were able to self-report their QoL may have better health at baseline data collection, Glasby et al. [23] reported that a large proportion of residents in their study had high levels of mental health needs.

While staff and family members were asked to report proxy responses for residents in the studies identified, no study explicitly looked at the outcomes and costs experienced by staff and family members, which would presumably include anxiety, staff searching for new employment opportunities, and family members' involvement in the relocation of residents. Geography and the extent of competition/supply would presumably impact both employment prospects for staff and relocation and future travel costs for families, but these factors were not explored in the studies we identified.

The findings on the causes of closures revealed a variety of reasons for a care home's closure; however, the reasons varied depending on who was asked. Allan and Forder [7] were the only researchers to use quantitative methods to analyse the causes of care home closures and found that high

competition and low quality increased the likelihood of a home closing, supporting the regulators' views on closures. The difference in views may relate to the different priorities and motivations of those involved in the closures. Closures of poor-quality homes in areas of excess supply are entirely in keeping with market forces and are likely to increase the quality across the sector as a whole. This may explain improved outcomes for displaced residents in the long term.

Due to the lack of statutory guidance on care home closures, local authorities have developed their own guidelines and protocols. The contents of guidelines varied across authorities, suggesting that LAs differ in their approaches when closing a care home. There is insufficient evidence to determine which policies both minimise costs and improve outcomes for those involved in the closures. Most guidelines and protocols in this review do not state the methods informing their development, whether they were influenced by earlier closures, how regularly they are updated, and how many closures have followed the protocol successfully.

6.2. Strengths and Limitations of the Study. This is the first study to focus on the economic evidence associated with care home closures and has revealed that there is a dearth of evidence on the economics of care home closures. A strength of our approach is our systematic search strategy and inclusivity. The limitations associated with this review relate to the heterogeneity of the few studies that do exist on this subject and their multiple objectives which made identifying relevant studies (with defined and consistent search terms) more challenging, potentially increasing the risk that some relevant papers may have been missed. The inclusion criteria were deliberately inclusive, to mitigate this risk, and input from an information specialist informed our search strategy. It was also difficult to compare studies and draw conclusions about the differences between them because of their heterogeneity.

6.3. Comparison with Other Studies. No previous scoping reviews have sought to collate knowledge on the economics of care home closures. Our (separate) pragmatic search (see Appendix A) uncovered studies reporting the costs associated with running care homes, and these suggest that staff costs and capital costs represent the biggest proportion of costs. The "few" studies identified in the current review do not refer to either staff, capital, or even running costs as a key component contributing to closure. Furthermore, the effect of Brexit on staff supply [37], the minimum wage [15], and the current energy crises in Europe [38] may well be anticipated to have a detrimental impact and potentially compound difficulties in the care home sector, but these recent events will take time to follow through into the literature and reveal any evidence of their impact.

6.4. Implications for Current Practice and Future Research. This review highlighted the paucity of consideration given to the economics of care home closures and the challenges of researching this. There was a lack of information about and

consideration of the costs of care homes in the papers identified through this scoping review. As a result, the significance of these factors has not been explored, nor have they been considered as potentially significant contributing factors in the case of future care home closures. Care homes were severely affected by COVID-19, and the aftermath of the pandemic is continuing to prevail. It is urgent to understand the effects of closures and how to make them as minimally disruptive as possible given the effects of Brexit on staff availability and the disruption and trauma caused by COVID-19 in the sector as well as the impending financial crisis brought on by rising energy and electricity prices.

7. Conclusion

This is the first study to systematically identify and narratively summarise papers/documents reporting the costs, consequences, causes, and processes of care home closure in the UK, adopting an economics perspective. It appears that key factors driving care home closures historically (i.e., as discussed in the literature post 2000), relate to poor quality provision (provision not meeting changing national standards) and excess supply in the market. It has been documented that staff costs represent a significant proportion of operating costs for care providers, but studies exploring care home closure to date have made little reference to staff costs or workforce constraints as factors influencing the decision to close. Future care home closures are likely to be driven by constrained income streams (where funding is from the public sector), rising operating costs (as high price inflation is experienced), and/or workforce constraints.

If poor quality is a factor explaining care home closures (as suggested in the literature), this may explain why self-reported health-related outcomes for displaced residents in one study were reported not to have deteriorated in the long run (there is transition from poor to better quality care/residential environments), although the same finding was not reported in cases where there were proxy-reported changes in health (reporting on behalf of the resident by staff or family members). Future research should account for staff and family anxieties and stress as relevant outcomes in their own right, and caution should be exercised in terms of proxy reporting of resident outcomes by families/staff who are themselves experiencing stress/anxiety.

No credible evidence was identified regarding the key cost drivers (itemised resource use) associated with the process of closing care homes and associated monetary values; this is an important knowledge gap. Given that a high proportion of the cost burden is likely to fall upon local authorities, an evidence-based approach to care home closures, accounting for cost-effectiveness, could help improve future experiences and inform the best use of scarce public funds. Currently, there is no evidence of protocols and guidance documents for care home closure being evidence-based, or even updated. Information obtained from this review and planned future research could contribute towards modelling costs and outcomes associated with a plausible set of care home closure pathways, hence forming an evidence base to inform future practice.

Appendix

A. Costs of Operating a Care Home

A1. Introduction. This section discusses the literature discovered through a pragmatic search. Google Scholar and AgeInfo were searched using the following terms: *costs*, *running*, and *care homes*. The search yielded two relevant articles. The costs of running a care home were examined in [17]. Both papers differ in terms of the costs they determine; Laing [17] examines the major cost components incurred by care homes, whereas Romeo et al. [37] investigate the cost of care for people with dementia in institutional care settings. One additional report was identified from the references of the articles above.

A2. Literature. The operating costs of effective care homes are calculated in Laing's [17] report using a set of transparent and robust underlying assumptions. The sources used to calculate the costs included mailed surveys of care homes, data from large care home groups, and telephone surveys of major business transfer agents. They based their analysis on the costs per resident per week (prpw) being calculated under the premise of an effective operational scale, which they identified as 50 beds. Four main costs associated with care homes were identified: staffing, maintenance and repairs, other current costs not related to staff, and capital expenses. Table 5 illustrates the inflated costs for 2021/22 that were estimated in the Laing [17] report, and Figure 2 shows the proportion of these expenses.

Staff costs are the largest cost, accounting for nearly half (43%) of care home expenditure. 1.5% of the staff costs were allocated for an agency usage allowance, which was calculated to cost £3 per resident per week. This comes out to £150 per week (£3 multiplied by 50 residents), which is significantly more than the £52 per week agency cost Curtis et al. (2007) estimated, demonstrating that there is some variability in estimating staff costs. Laing [17] did not factor in the costs of external services (GP visits), but Curtis et al. (2007) calculated that they would cost £16 per week.

Capital costs account for 36% of care home expenditure. Capital expenses vary in line with build and equipment costs and land prices. They are the most difficult to measure. Laing [17] assumed that good quality care homes sell in the open market at a multiple of about 8–8.5 times operating profit, which implies that purchasers of care homes are seeking an annual return on their gross investment of 12%, reflecting their assessment of care home operation as a moderately risky business. Other current costs not related to staff such as food and utilities account for 15% of total care home expenditure. The costs represent a stand-alone care home without the benefit of group negotiated discounts. Repairs and maintenance represent 6% of total expenditure.

Laing [17] presented the different pay rates between the private sector and the NHS; this information has been updated to reflect current rates as shown in Table 6. The gap in pay between care homes and other sectors may contribute to the high turnover of staff in the care sector, which causes

homes to incur additional costs for hiring and training replacements.

The cost of care for people with dementia in institutional care settings was examined by Romeo et al. [37] to understand the major cost drivers. The authors built three models, one for the total costs of both types of homes (residential and nursing) and two using each type of care home. Next of kin was the only significant variable in residential care homes and was associated with higher costs. This was opposite to the results of the model that included both types of homes. This implies that the cost of residents' care is increased by the presence of family members or friends. Sensitivity analysis was conducted by replacing the total cost variable with non-residential costs (all costs not inc residential fees) as the dependent variable. Costs were significantly higher for residents who did not speak English as their first language, had been in the care home for a shorter period, had sensory issues, and had more needs identified. The authors did not make explicit the number of residents who were either self-funded or receiving public funding, or which model sensitivity analysis was applied to. Hospital expenses were discovered to be 1.76 times higher for residential care home residents than those in nursing homes. It should be noted that all study participants had dementia. However, this expense could be decreased by giving residential home staff members additional training to cut down on unnecessary hospital admissions.

A3. Summary. This search produced three articles which examined the costs of care homes. A detailed report by Laing [17] provided a breakdown of the four main cost categories. They appear to have made the fundamental assumption that these costs are fixed, but Romeo et al. [37] have demonstrated how the cost of care can vary and how personal characteristics, cognitive ability, dependency, and other factors can impact it. Laing [17] did not address external expenses, despite Romeo et al. [37] finding them significant. This may be because the cost of external services like GP visits and hospital admissions typically does not fall on the care homes themselves.

B. Year-Wise Distribution of Papers

Figure 3 depicts the year-wise distribution of 18 papers in the period of 2000–2023. The number of papers published varied from 0 to 3. The highest number of papers, i.e., 3, was published in 2002 and 2016. There is no obvious peak of interest at any point.

Additional Points

What Is Known about This Topic and What This Paper Adds?.

(i) Much of the care home provision in the UK is by the for-profit sector. (ii) Nearly 50,000 older and disabled people with care needs were displaced from UK care homes due to closure in the five years preceding 2020. (iii) Local authorities commission care in some cases and have a statutory responsibility to safeguard vulnerable groups. (iv) Although

relatively little evidence on the consequences of care home closures was identified, evidence suggests resident outcomes are not necessarily/always adverse in the long term. (v) The few studies reporting costs failed to adequately describe a robust methodology. (vi) Where sufficient evidence can be identified to inform parameters, economic modelling could inform the comparison of different closure pathways and hence future policy.

Conflicts of Interest

AI, PK, and TR declare that they have no conflicts of interest.

Authors' Contributions

TR, JG, and DT were responsible for conceptualisation and design. AI wrote the original draft. AI, PK, and TR were responsible for review and analysis. All authors were responsible for review and editing.

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