

**A REPORT TO THE HIGH COURT OF JUSTICE  
QUEEN'S BENCH DIVISION  
ADMINISTRATIVE COURT**

**IN THE MATTERS OF**

**REF: CO/2278/2002**

**LANCASHIRE CARE ASSOCIATION  
AND OTHERS (CLAIMANTS)**

**AND**

**LANCASHIRE COUNTY COUNCIL (DEFENDANTS)**

**AND**

**REF: CO/5147/2002**

**JESSE JACKSON  
AND OTHERS (CLAIMANTS)**

**AND**

**LANCASHIRE COUNTY COUNCIL (DEFENDANTS)**

**This Report Prepared by:**

**PROFESSOR DAVID JOLLEY**

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**Penn Hospital, Wolverhampton**

**February 2003**

## **INTRODUCTION**

1. I was approached by Yvonne Hossack of Hossacks Solicitors on 11 February 2003 with a request that I prepare a report to help the Court in their consideration of these matters.
2. The Terms of Reference outlined the situation whereby the parties are engaged in litigation in relation to the lawfulness of certain decisions made by Lancashire County Council, which may require elderly residents of certain residential care homes to move out of those homes and into other residential care homes to facilitate refurbishment and other changes in the overall provision of residential care homes within Lancashire.
3. The Court wishes to have evidence explaining the likely effect of such moves on, and risks to, the physical and mental health of older people, including the risks to their lives.
4. I have provided with a copy of the principal decision taken by Lancashire County Council, the Terms of Reference provide a summary:

There is to be a phased programme of closure and refurbishment of the council run care homes plus the building of a new care home in Preston. The current number of such homes will be reduced from 48 to 17, all of which will be new or refurbished to meet national standards and at least 13 other homes will remain in use for alternative services for old people. The scheme envisages that the current residents of homes scheduled for refurbishment will be relocated temporarily in other homes and that all the current residents of each district will ultimately be placed in the refurbished home or homes located within that district.
5. The programme is phased to take place over 5 years, which should allow for a considerable flexibility and it is assured that:
  - (i) no resident currently in a council run care home will be required to move to a non county council residential home;
  - (ii) no resident will be required to move to a home outside the district in which they currently reside;
  - (iii) residents will generally be required to move on one occasion only, and that the maximum number of moves will be two.
6. The decision requires that officers prepare individual care plans for every resident based on assessments of their individual care needs, which include their social and

family needs. These assessments will take into account the wishes of residents to move with groups of friends. It is not envisaged that any individual currently residing in a care home will be assessed as suitable for living outside residential care but it is possible that some will be assessed as needing nursing home care.

7. At least one home is to be kept open in each district in the county.
8. I have received details of the bed plan arrangements and a summary of this within the Terms of Reference.
9. **My task is:**

To prepare a report which addressed the likely effect of such moves on the physical and mental health of elderly residents of care homes. To help in this I have been provided with a copy of GP reports in respect of some individual claimants. The practicalities of time have meant it has not been possible to undertake personal assessments of these individuals, nor to discuss the reports with their GPs. The report is to be directed to the general question of the effects (positive or negative) on and the risks to the physical and mental health of elderly, in some cases very elderly, residents of residential care homes in the circumstances.
10. It is directed that the report should identify and include my views as to the risk factors relevant to the physical and mental health and mortality of care home residents, such as these involved in such moves. I am also directed to give my views as to steps which may be taken in relation to the nature and means of effecting such moves: for example, whether block moves in ‘friendship groups’ of residents improves or alleviates the risks to those residents. Finally, I am directed to include my views as to whether elderly residents with moderate to severe dementia can be properly and adequately prepared for such a move.
11. The report must comply with the provisions of the Civil Procedures Rules 1998, Practice Direction 35 paragraph 2, the details of which are set out in the Terms of Instruction.

**QUALIFICATIONS**

12. My name is David James Jolley. I am a Consultant Psychiatrist and have specialised in Psychiatry of Old Age since my first appointment as a Consultant in 1975 to South Manchester Hospitals. I worked in South Manchester for 20 years and in 1995 arranged to be seconded and then later permanently transferred to work in Wolverhampton. In Wolverhampton I have continued in this role as a Consultant Psychiatrist in the Care of Older People to the present time, and since 1995 have been the Medical Director of Wolverhampton Health Care NHS Trust, and most recently Wolverhampton City PCT.

I qualified in medicine MBBS of London University at Guy's Hospital, London. I undertook postgraduate training in psychiatry in Manchester, qualifying with the Diploma of Psychological Medicine of the London Conjoint Board, and then the Diploma of Psychological Medicine of Manchester University, and I became a member of the Royal College of Psychiatrists in 1973 and later became a Fellow of the Royal College of Psychiatrists.

In 1992 I obtained a Certificate of Health Service Management and in 1996 completed a MSc within the University of Manchester. The Masters programme was a taught programme addressing computational methods being used in medicine with a dissertation using materials from the Salford Case Register to investigate life expectation amongst mental health patients with a diagnosis of organic brain disease. I have been an active member of the Royal College of Psychiatrists Section, latterly the Faculty of Old Age Psychiatry and was its Secretary and then its Chairman up to 1994.

I have been a member of the British Geriatric Society since 1975 and remain active in the liaison special interest group of the BGS on Cerebral Ageing and Mental Health.

I am primarily a clinician but throughout my career I have been involved in academic work and was an Honorary Lecturer and then Honorary Reader in Mental Health in the University of Manchester, and more recently an Honorary Chair in Psychiatry of Old Age at Wolverhampton University.

I have published of the order of 200 papers and chapters in books.

Since the spring of 2000 I have been Director of Dementia Plus, which acts as a source of information, training and support for professionals working in the Care of Older People with mental problems within the West Midlands.

My research interests have included the health, particularly the mental health of older people in residential care situations, and I have retained a clinical responsibility for older people in residential care and nursing home situations throughout my clinical career.

As an expert witness I understand my prime duty is to provide an objective report that may assist the Court and be of a value to all parties.

**LITERATURE AND OTHER MATERIALS MADE AVAILABLE TO ME**

13. A considerable amount of material has been made available to me, which is already declared or known to all parties involved in this matter:
- (a) Commissioning Strategy for Services to Adults, Lancashire County Council 2002/03
  - (b) Consultation on the Future of Residential and Day Care Services for Older People, provided by Lancashire County Council (no discernible date but I would presume 2002 from its contents)
  - (c) A copy of the decision made by the full Council (Lancashire County Council) 26<sup>th</sup> September 2002, together with a copy of the Bed Plans. These all provided to me with a covering letter from Ian Young, Assistant Head of Legal Services, County Hall, Preston, 14<sup>th</sup> February 2003.
  - (d) A bundle of research studies cited by the claimants in their index for further evidence:
    - (i) Aldrich and Mendkoff 1963, Relocation of the Aged and Disabled, Journal of the American Geriatrics Society, Vol.XI, No.3, pages 135-194
    - (ii) Morriss R et al, The Mortality of Long Stay Patients following inter-hospital relocation, British Journal of Psychiatry, Vol.152, pages 705-706
    - (iii) Robertson et al 1993, Relocation Mortality in Dementia, The International Journal of Geriatric Psychiatry, Vol.8, pages 521-525
    - (iv) McAuslane and Sperlinger, The Effects of Relocation on Elderly People with Dementia and Their Nursing Staff, International Journal of Geriatric Psychiatry, Vol.9, pages 981-984
    - (v) Lyons et al 1995, Partnership Nursing Home Care for Dementia, International Journal of Geriatric Psychiatry, Vol.10, pages 557-600

- (vi) Manion and Rantz 1995, Relocation Stress Syndrome, Geriatric Nursing (May/June), pages 108-112
- (vii) Dickinson 1996, Can Elderly Residents with Memory Problems be prepared for Relocation, Journal of Clinical Nursing, Vol.5, pages 99-104
- (viii) Castle N 2001, Relocation of the Elderly, Medical Care & Research Review, Vol.58, no.3, pages 291-333

A brief synopsis of the first 7 of these articles has been made available within the copy of materials from the bundle.

14. Materials relating to the closure of Granby Way Residential Care Home for Older People in Plymouth

Report and findings of the Extraordinary Complaints Panel - Closure of Granby Way Residential Care Home for Older People, Plymouth.

His Honour, Sir Jonathan Clarke, Chairman, Mrs Annie Stevenson, Mr Brian Parrott, 4 November 2002

15. A copy of the Independent Medical Report on Residents of Granby Way Care Home, Devonport, prepared by Dr Peter Jefferys. This is in two parts – an original assessment of residents, July 2001, and a follow-up of surviving residents, October 2001. This material is provided in confidence. It was made available at the request of Dr Gillian Dalley and is accompanied by a letter from Dr Peter Jefferys, 4 February 2003, in which he says:

*'I am agreeable to providing these reports subject to the following conditions, which are imposed because these reports contain substantial confidential clinical details about individuals. Many have since died and the remainder lack capacity to consent to revealing their details. In these circumstances I must insist on the following restrictions:*

- (1) *the reports will only be made available to Dr Gillian Dalley for the sole purpose of preparing her report for the High Court. She must not copy them for any other person without my explicit consent.*
- (2) *In any report that she makes for the High Court, she shall not reveal clinical details of any individuals in my report that could lead to their identification.*

*This includes specific details of their life stories as well as specific medical information about them.'*

16. A bundle of letters from General Practitioners responsible for the health care of 17 individuals resident in Lancashire County Council residential homes affected by the proposed closure/refurbishment exercise. These letters are addressed to solicitors representing those individuals. They are dated October and November 2002, and appear to be written in response to requests from the solicitors for advice concerning the general health, including the mental health, of the individual and the likelihood that a move would be hazardous to that individual, together with a request for guidance on whether or not the individual has capacity to instruct the solicitor.
17. Report from Dr Gillian Dalley in the matter of Jesse Jackson and others v Lancashire County Council, reference CO/5147/02 prepared 2003. Dr Dalley cites a number of published articles, some of which are listed in the previously described bundle and some which are not.

In addition to the materials already shared by the parties in preparing for this hearing, I would draw to attention a short series of additional materials:

- (i) Blocked beds cost NHS £1m every day by Nigel Hawkes, The Times newspaper, 12 February 2003.
- (ii) Nursing home patients given tranquillisers needlessly, research shows, by John Ezard, The Guardian newspaper, 10 February 2003.
- (iii) Care fee Saving of £88 'Killed Widow' by Simon de Bruxelles, The Times newspaper 13 February 2003
- (iv) Moved to Tears by Ruth Winchester, Community Care 28 June 2001
- (v) PSSRU: Closure of Care Homes for Older People, Summary of Findings No.1, February 2002 (website [www.ukc.ac.uk/pssru](http://www.ukc.ac.uk/pssru))
- (vi) Proctor, Silverman and Murphy – 9 February 1987 – Mood and Behavioural Problems following the Relocation of Elderly Patients with Mental Illness, Age & Ageing Vol.16, No.6, pages 355-365
- (vii) Thornton D and Robinson L, Design and Dementia, Report on the Transfer of Residents from Riverside House to Meadow Bank, Age Concern, Northern Ireland, 2001.

**ANALYSIS**

18. I instruct my analysis and report to follow that of Dr Gillian Dalley to facilitate comparisons.

The policy background.

19. It is understood that the combined impact of strategies to improve the quality of environments within residential care, nursing home care, and other specialised care environments for older people, whilst at the same time reducing the number of old people including very old people who move into such environments, is producing perverse effects. While the aims and objectives of these initiatives are to improve services for older people and the experience of older people who have disabilities and need for care, there is widespread evidence that very vulnerable old people are being greatly disturbed and disadvantaged by transitional and enabling schemes such as that described in Lancashire. I have included newspaper cuttings and other articles, which describe the distress and the difficulties being encountered by individual older people. There is a clearly accepted view that moves are not only distressing but on occasions are lethal. On the other hand, some care environments and some care regimes are deemed to be incompetent and sometimes positively harmful, so there is an acceptance of a need to improve matters.
20. The PSSRU report describes a systematic approach to collecting information about home closures, both in their number and distribution, and eventually on their impact.
21. The National Audit Office report drawn attention to in The Times article suggests that closure of residential home beds is being pursued ahead of the provision of appropriate and adequate alternatives. Indeed it is not clear that one can make available adequate and appropriate alternatives within the capacity required by the turnover here in the acute NHS beds.
22. In these circumstances, authorities such as Lancashire County Council find themselves in a very difficult position. If they pursue a programme of closure and refurbishment but overall reduction in the numbers of available beds, then it is likely that individual older people and groups of older people in residential care will be disadvantaged and distressed, and that others will be disadvantaged and distressed by being required to stay in hospital or other inappropriate care situations for want of an appropriate placement. On the other hand, if they fail to comply with requirements to improve standards and to reduce beds, they are likely to be in receipt of censor.

### The Factual Background

23. The facts are not in dispute. Lancashire County Council's plans include the proposal to reduce its provision of homes from 48 in total to 17 with a programme of refurbishment over a period of 5 years. One new home will be commissioned and the programme will produce a set of residential care homes that are of high standard and will meet the predicted registration requirements. There are assurances that individual residents will not be required to move more than twice; that they will remain in council accommodation; and that they will not need to leave their local district. So a great deal of care has been taken in preparing the programme so that the long-term outcome in terms of the residential care stock will be very good and the inconvenience to current residents will be minimised. In so doing, of course, Lancashire County Council is quite properly accepting that the programme, in itself, is an intrusion on the lives of the current residents, carries a considerable stress for them, and that they therefore require and deserve such careful individual and group considerations.

### The Literature

24. A considerable number of published papers and reports, addressing directly the issue of morbidity and mortality associated with relocation, are shared between us for consideration. Before looking at these it would be best first to stand back and reflect upon the issue of life events, stress and their impact on morbidity, both physical and mental, and survival in the population at large.
25. Older people in residential care are like any other human beings and find some life events stressful. In the literature of life events, studies look at the impact of changes in life circumstance upon on the health and well being, including mental health and physical health and mortality, of people experiencing changes. It is a common experience and expectation that events that include loss are followed by symptoms of anxiety, depression, and sometimes these are intermediaries for the precipitation of physical health problems and even death. The original model for such events and their aftermath is bereavement where an individual is distressed and dismayed by the loss of a close relative, the strongest impact being with the loss of a spouse or another similarly close relation. Other losses having a similar impact include loss of a job with its associated status and income; loss of a partner by divorce or separation; the break-up of friendships, and so.

26. Whilst losses such as these are anticipated by common experience and common sense to be followed by morbidity and even mortality, life event studies have made it clear that even changes that are viewed as positive and desirable can, on occasion, precipitate illness and distress. In essence, any change from an established routine can be received as stressful and illness provoking within individuals and indeed in any living creature.
27. Some individuals are strong, well suited by constitution and life's experience to withstand and even prosper in the light of change. Others are less robust and may have demonstrated by breakdowns in response to stress in the past that they are vulnerable to such stresses. In addition, the presence of concurrent frailty or impairment of physical health, mental health or sensory competence, make adjustment and compensation to change more difficult and less likely to be achieved.
28. Amongst the life events recognised to be particularly stressful is move of accommodation. This is true whether an individual is moving from one house to another either in an enforced way or in a planned way, and as Dr Jefferys remarks in paragraph 48 of his report of October 2001 *'for older people in particular moving residence is amongst the highest risk factor for triggering an anxiety response and possible depression. It is only marginally less significant than death of a spouse'*.
29. Turning again to the literature of the impact of relocation of older people from residential home to residential home or similar institution to similar institution: Dr Dalley has produced a helpful and scholarly review including detailed analysis of some of the papers made available to the Court, as well as reference to some of the work. It is important to put the published literature into context. Papers and special reports are put together and offered for publication with a view to conveying particular messages or making particular points. As Dr Dalley points out, there are no circumstances in which older people with or without evidence of frailty would be exposed by design in a controlled experimental way to the stresses associated with closure of homes, relocation to alternative environments, and perhaps relocation back to newly refurbished accommodation. There would be no justification for such an experiment; it would be deemed economically impractical and ethically unacceptable.
30. What we have is a selective reporting of experiences that occur when relocations are required as a consequence of unplanned tragedies such as a fire in a home, the discovery of safety problems, etc, or in response to alternative practical considerations such as the non-viability financially of a sponsoring organisation or a requirement

such as that operative in the present case to improve standards, to reduce the overall beddage of a particular component of the care sector.

31. Many such closure and relocation programmes will occur without being reported to the literature. Indeed, it is one of the worries and tragedies of the situation that there is not a systematic collection of outcome data on the consequence of such closures and relocations. As outlined in one of the studies cited by Dr Dalley and to which I was co-author:

Halliwell C, Morris J, Jolley D, 1994 – The Closure of Residential Homes: What Happens to Residents, Age and Ageing, Vol.23, page 2

The realities of transfer experiences are often extremely traumatic, despite the best intentions of everyone concerned. So materials that come into the public arena are represented as selected sample. Some are selected by authors wanting to make the point that moving old people puts them at risk and seeking to document and quantify that risk and its impact. Others wanting to make the point that despite the common understanding that moves are stressful and can cause deterioration in health and bring forward death, it is possible by taking careful thought and planning, engaging the individuals and their families and the care staff in making suitable arrangements, to minimise the adverse impact of relocations.

32. In summary statements, Dr Dalley reflects:

Paragraph 5.2 – *‘where research has been undertaken, the evidence is equivocal’* and in paragraph 6.1 – *‘broadly, the epidemiological evidence suggests that, under optimal conditions, relocation from one care setting to another does not significantly increase the risk of mortality or morbidity’*.

My own view is that from common experience, from my clinical experience, and from an informed review of the literature, it is an inescapable truism that relocation is a stressful event and can precipitate problems of mental health, physical health, and even bring forth death. There are published examples of good practice that when every care and consideration is taken into account in planning and conducting moves, and where matters are not confounded by unplanned or unforeseen complications, the impact of this stress can be minimised. Achieving ‘optimal conditions’ for individuals and groups of individuals is, in practice, very difficult to achieve and cannot reasonably be guaranteed.

33. The impact of a move is probably greatest in the 3-6 months after the move. However, as pointed out in some of the papers made available to the Court, simply to know that a change is being contemplated or planned is, in itself, a stressful experience and there may be increased morbidity and mortality in the anticipatory period. In the major review article from Nicholas Castle (Medical Care Research and Reviews, Vol.58, No.3, pages 291-333, 2001) 7 out of the 14 studies reporting on mortality up to six months show an increased mortality within the relocated groups. For three studies mortality is equal in those relocated and those who are not, and in four studies there is an increased death rate amongst those not relocated. Studies which look at mortality at one year or longer after the relocation are less likely to demonstrate increased mortality and studies of morbidity follow a similar pattern, i.e. the greatest impact is in the period immediately after the relocation. It is important in considering studies to be aware of the nature of the ‘controls’ for it is very likely, as Dr Dalley points out, that the controls are not exactly similar in their constitution, background and current health and circumstances to the people who are moved. It is always possible that the more vulnerable people are held back and not involved in a move. It is always possible that in before and after studies there are additional changes to environment or circumstance, which might have an impact upon the morbidity and survival of individuals over and beyond the impact of relocation.
34. Some individuals are more susceptible to the impact of relocation than others. They are likely to be more susceptible to any life event. Characteristics which identify people likely to encounter the greatest difficulty include
- evidence of previous breakdown in response to stress
  - age – with very advanced age making it more difficult to adapt to change
  - gender – men by and large adapt less well to change and stress than women
  - the presence of pathological impairments – these might produce physical impairments, reduced mobility, and incontinence of urine.
  - they may make it more difficult to understand the environment – reduced eyesight or blindness, reduced hearing or deafness, or other loss of sensory facility.
  - The presence of depression, anxiety or a demonstrated vulnerability to such symptomatology is likely to be exacerbated by any move.
  - The presence of cognitive impairments, i.e. impairment of the facility to understand, comprehend, remember and reason with the information that a

move is to be made makes the individual particularly vulnerable, for no matter how much work is done to explain the situation and to help them come to terms with the situation, all that work may be lost because of the failure to register and to remember. In addition, fragments of an understanding and the anxieties associated with that understanding or half understanding, may come back repeatedly to haunt the individual.

Combinations of these vulnerability factors increase the risk of adverse reactions to the relocation stress and, of course, such combinations are not uncommon amongst individuals who are living in residential care.

35. It is important now to consider the circumstances of older people living in residential care. Very few will have planned to spend their last years in residential care. Most people have it in mind that they will much prefer to spend their last years in their own homes. In practice, however, large numbers of people who survive beyond their 80<sup>th</sup> birthday find that the realities of life in very old age mean that they cannot live in private households. They are increasingly likely to find themselves alone, perhaps alone for the very first time. It is extremely likely that the occurrence of episodes of physical ill health and accumulating disabilities sometimes associated with multiple pathologies, will have made it appropriate to give up their lifelong held view that they should remain at home and opt for care in a residential home. It is not uncommon for this decision to be made precipitantly in response to an acute illness requiring hospitalisation. As outlined in earlier paragraphs, policy and practice require that people spend a relatively short time in hospital and are expected to find alternative care almost as a matter of social responsibility. So, in coming to terms with the idea of life in a residential home, an individual older person is likely to have had to accept that the greater good of everyone else, including on occasion members of their own family, has to take precedence over their own wishes. In their new accommodation they will have had to become used to life as one of a number of individuals in a shared environment, rather than being able to dominate and determine exactly what happens. They will have had to become used to life with limitations of their physical health, mental health and sensory capacities, and they may well have had to come to terms with some limitations in the facilities and care regime offered within the home that they have chosen to enter. Of course, it will have remained open to them if they find that care environment or the care regime to be unacceptable to them, to move on to another location. If they have decided to stay, it is likely that they will have it in

mind that this will be their home and the home in which they will die. It is extremely unlikely that in coming first to this home or in the weeks and months after that decision, they will have had it in mind that their anticipated tranquillity will be intruded upon by aspirations of the government or the local council or the care industry, which might be seen to be designed to mean that there is no surety that this home can be a home for life and death.

36. The letters from general practitioners describing some characteristics of 17 individuals subject to the present relocation exercise makes clear their vulnerabilities. At least 12 out of the 17 individuals are aged 80 and above, and the individuals who are younger carry at least as much pathology as those who are elderly. 14 out of the 17 are female and most are widowed or otherwise alone. 7 out of 17 are deemed by the general practitioners to have capacity to instruct their solicitor, others are either so obviously impaired by dementia that they are unable to instruct their solicitor (5) or else there is no comment on their capacity (5). One individual is known to have suffered schizophrenia for many years and at least 2 have suffered episodes of depression. One is recognised to be blind and others have hearing impairments. In summary, 10 of the individuals are deemed by their general practitioners to be obviously at risk of an adverse reaction in response to relocation, and only in 2 instances does the general practitioner confirm that they feel their patient would cope without an adverse outcome from the relocation. In making these judgements the general practitioners reveal a variable familiarity and understanding of the literature of relocation but all clearly understand that it is a stressful event, and all reveal the sound, in-depth, multi-dimensional understanding of the individual patient concerned that characterises the medical method and medical responsibility.
37. So there is a great deal of information available, which confirms that an enforced relocation will be hazardous for the majority of the elderly people resident in the current homes. If relocation is to occur, then what can be done to minimise its impact? The first consideration has to be to examine again whether it is necessary or inevitable that the relocation proceeds. There is little doubt that the best interests of these individuals will be served by continuing to live in the environment that they choose, have chosen and have not moved from.
38. The next consideration is to deal with each individual as an individual, investigating the situation carefully with them and with their families, their medical practitioner advisers, and anyone else who is relevant, so that they can be made aware as far as

they are able of the proposals and their implications and the alternatives. Some will choose to move to alternative accommodation of their choice rather than remain in a situation of uncertainty and potential conflict. In doing so, they will have to reflect on the loss of friendship and comfort in an environment that they have become used to, and anticipate the possibility of new friendships and perhaps an even better environment elsewhere. It is unlikely they would choose somewhere that is less conducive from their current accommodation. In conducting this exercise the particular needs and characteristics of individuals will determine the best approach. Certainly the presence of memory impairment and more severe cognitive impairment will make the whole exercise much more difficult, and maybe repeated discussion and reassurance supported often by written materials and explanations suitably couched and readable to be available for reflection at times when others are not available. There may be advantage in group discussions so that residents and their families and staff can share their thoughts, compare their reading of the situation, and learn from each other on what might be the best way to go forwards.

39. Others will choose to remain in their present care environments and to accept changes that will occur within that environment and the programme of relocation presented to them by the authorities. For these individuals, the authorities have additional responsibilities. It is clear that if individuals or groups of individuals are to move from one environment to another, then the receiving environment must be at least as well physically attuned to their needs as the one from which they are moving. It must be warm and comfortable and have suitable facilities, and to be accessible by friends and relatives who would wish to visit. Where it is possible for groups of friends to move together, then this has every advantage for the friendship circle will be sustaining both in anticipating the move, coping with the move, and reflecting on its aftermath. Similarly, where it is possible for staff to move as a group with their charges, there is every advantage. The familiarity of a trusted carer or nurse is extremely reassuring to the individual. Older people with multiple pathologies have multiple needs based on those pathologies as well as upon their personal preferences and styles. These are known to those who care for them and carrying that expertise from one situation to another reduces and minimises stress. There may be advantage in brand new and special equipment but there is also advantage in carrying with one favoured and trusted comforts, which might include a chair, table, radio, etc. It is extremely important when such relocations are being contemplated, that extremely

careful arrangements are made for continuity of medical care and support. If it is possible for one practice to continue to be the provider, that is maybe ideal. If there is to be transfer from one practice to another, it is important that all information is conveyed from the donor practice to the receiver practice well in advance, preferably by personal contact. It is important that a receiving environment is well prepared in advance of the day of a move. It may be possible to move all residents from one home to another on a particular day but it is a difficult logistical task. There is a requirement for staffing at both ends as well as staffing to conduct the transfer. The involvement of people's families in the process can be very helpful. It is important not to try to do too much all in one frantic move. It may be necessary to undertake a series of moves of a modest number of individuals so that everyone's needs can be properly attended to. There are considerations of the time of year and climate. Moves during the cold of winter are hazardous and should be avoided for cold is stressful and deaths preferentially occur in the winter months.

In summary, I have been tasked to provide a report reviewing the likely effect of moves from one residential home to another upon the physical and mental health of elderly residents of care homes; to identify and include my views on the risk factors relevant to the physical and mental health and mortality of care home residents subject to moves; to offer my views on steps which may be taken to ameliorate the impact of such moves including the impact upon residents suffering from dementia. This, in the context of some residents of care homes in Lancashire appealing against Lancashire County Council's decision that they should move from their current homes as part of a programme to reduce the number of care home places, refurbish and replace current homes over a period of five years.

Their claim is that –

This decision infringes their rights under the European Convention on Human Rights;

Their right to life under Article 2;

Their right not to be subjected to inhuman or degrading treatment under Article 3;

Their right to a family and private life under Article 8.

In common with Dr Dalley, who has also produced a report on these matters for the Court, I have pointed out that directions from Central Government to reduce the capacity of the care homes sector and improve the quality of environments within care homes, is producing a perverse impact which exposes current residents of homes and potential residents of homes, and other components of the elderly care sector, to considerable stress.

I have reviewed what is known about the impact of relocation as an example of a stressful life event upon the mental and physical health of individuals and its impact upon their likely survival. Within this I reviewed the common sense understanding of the impact of such stresses, the clinical acceptance that such stresses have adverse effects, and I have provided comments on the published literature drawing attention to its limitations and likely biases. In essence, what is understood is that moves are stressful; they do produce physical and mental health morbidity and they can produce increased mortality. The latter is greatest in the first few weeks after a relocation and the impact is greatest on very old people who have shown previous vulnerability and who have concurrent pathologies, particularly multiple pathologies.

Even raising the prospect of a move can, in itself, be seen to be stressful and when raised by others, can be seen as an intrusion on the private life of an individual. Such an intrusion followed by a requirement to move without the choice to continue a preferred lifestyle reflects a lack of respect for the individual who is required to move. It is possible to adopt strategies, which will minimise the impact of the relocation programme. These require

tailored programmes of counselling and preparation for each individual and their families, and need to take into account their special vulnerabilities. These might include a vulnerability to anxiety and depression or mental infirmity associated with dementia. If individuals choose to remain within a group that will be relocated, there are specific considerations with regard to the timing of moves, the preparation of individuals and groups for the move, the preparation and provision of staffing and transport arrangements, and particularly the arrangements for continued and properly informed medical support.

All these procedures are designed simply to ameliorate the impact of the stress of a relocation but they cannot take away that impact, and the impact will be greatest on the older people who have the greatest vulnerability.

Statement of Truth

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion.

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Professor David Jolley  
Consultant in Old Age Psychiatry

Friday, 21 February 2003