Health and Social Care Committee

Inquiry into residential care for older people

RC72 – Centre for Innovative Ageing, Swansea University

THE CLOSURES OF CARE HOMES FOR OLDER PEOPLE IN WALES: PREVALENCE, PROCESS AND IMPACT

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EXECUTIVE SUMMARY

There are generally two types of care home closure; enforced and voluntary. Enforced closures are typically the result of failure to meet or comply with care and environmental standards and are enacted under the Care Standards Act 2000. Voluntary closures are due to other reasons or as a result of the actions of receivers or creditors. In 2009 the Welsh Government (WG) developed guidelines entitled "*Escalating concerns with, and closures of, care homes providing services for older adults*". The WG guidance sets out local authorities', local health boards' and NHS trusts' responsibilities in this area and suggests ways in which these responsibilities can be discharged. The introduction of Welsh Government (WG) guidelines provided us with a timely opportunity to examine the way that care homes are closed, and to explore the process from the view of various stakeholders including older residents, relatives, statutory regulators of care, care managers and care home owners.

The research **aimed** to

- Identify the rate of closure of care homes for older people, the types of homes closing and the reasons for closure from 1 June 2009 to 31 May 2010
- Examine the process surrounding the closure of care homes in 2010/11 especially with regard to adherence to/deviance from the guidance issued by the Welsh Assembly Government in the public and private sector
- Explore the consequences for and the experiences of providers, key workers, older people, their relatives and carers during and after relocation because of the closure of a care home.
- Explore the consequences for and the experiences of older people, their relatives and carers, providers and key workers in care homes that have been announced as 'under threat' of closure.
- Examine the process where care homes avoided closure especially with regard to adherence to or deviance from the Escalating Concerns guidance and local authority procedures.

This research was conducted between 1st June 2010 and 30th November 2011. It used mixed methods including (i) secondary data analysis of CSSIW data (ii) semi-structured telephone interviews with CSSIW inspectors and managers/owners of care homes that have closed (iii) documentary analysis of minutes of meetings (iv) case studies and in-depth interviews with providers, older residents, relatives and carers during the closure of care homes, and in care homes saved from closure.

In this report we identify the rate of closure of care homes for older people, the types of homes closing and the reasons for closure from 1 June 2009 to 31 May 2010. We examine the process surrounding the closure of care homes, and the process leading to saving care homes from closure in 2010/11, especially with regard to adherence to, and deviance from the guidance issued by the Welsh Assembly Government in the public and private sector. Furthermore, we explore the experiences of providers and key stakeholders in care homes under the threat of closure, and during and after the closure of a care home.

We make a series of recommendations based on our findings. Some of our recommendations are directed at the various statutory agencies involved in escalating concerns and home closure, but a majority relate to local authority protocols and the need to ensure that these are fit for purpose. Given that the Local Authority protocols have been developed in response to the guidelines on *Escalating Concerns With, and Closures of, Care Homes Providing Services for Adults* (WG 2009), we have redrafted these guidelines by weaving together the best practice form the Local Authority protocols from within Wales. We have amended the existing guidance to include extra clauses, and to clearly distinguish which elements of the policy apply to escalating concerns, enforced closure and voluntary closures. We have also made sure that the policy is relevant to closure in the independent and public sector.

In terms of monitoring and reporting on care home closure in Wales we recommend that:

1. CSSIW should undertake more in-depth analysis of the data on care home closures (or saving care homes from closure). Specifically we recommend that CSSIW should:
    a. triangulate deregistration data with the Joint Interagency Monitoring Panel (JIMP)/Home Operational Support Group (HOSG) reports to provide more detailed information on pathways to closure (or saving homes from closure),
    b. analyse JIMP/HOSG reports to identify lessons learned from care home closure process (and for those care homes saved from closure),
    c. distribute this information to statutory organisations annually so that (where necessary) amendments can be made to WG guidance and/or local protocols to improve practice.

We found that the spatial distribution of care homes in the independent sector is problematic when one care provider has several care homes within a fairly small areas (e.g. within one Local Authority), or has many care homes within a region. We recommend that:

2. WG legislates for the maximum proportion of care homes that a single independent provider can supply within a single local authority (or other geographically defined region).
3. Should WG legislate for the maximum proportion of care homes that a single independent provider can supply within a single local authority (or other geographically defined region), then CSSIW should enact the legislation through the controlled registration of independent providers.

The vulnerability of the independent sector is further aggravated, in some circumstances, by a lack of financial stability. In other sectors that provide public services, systems and checks are in place to monitor the financial health of providers. We recommend that:

4. WG legislates that the financial health of an independent provider should become a factor that is taken into consideration before registration as a care home provider: financial health should be a *National Minimum Standard for Care Homes for Older People* (WG 2004).
5. CCSIW assesses the financial health of independent providers before registration to understand the degree of risk they may represent to the WG or Local Authority/LHB if they do not have the financial resources to continue operation.
6. CSSIW monitors the financial health of providers and as part of their duty, keep the level of balances under review. If the financial health of an independent care provider deteriorates and the risk of closure increases, the CSSIW should report this to the JIMP within a Local Authority who will take action necessary when a care home is under 'threat of closure'.

We think that self-funders should be protected from being overcharged, especially by independent providers setting self-funding fee levels in order to supplement the fees paid to the care home by the Local Authority for publicly funded residents. Thus, pricing of care homes should be regulated in a similar manner to the regulation of profitability in public utilities. We recommend:

7. WG should commission an economist to consider a formula for a ceiling on self-funding fees (possibly the fee calculation set by Laing (2008) plus X%) to ensure that self-funders in independent care homes are not excessively charged for their care.

Considering the WG guidelines for *Escalating Concerns with and Closure of, Care Homes Providing Services for Adults*, in the main section of the document we recommend that the following amendments are made:

8. The document should be amended to make it clear that it applies to voluntary and enforced closure, and that action should be instigated when the threat of either type of closure is detected.
9. The JIMP is required to meet when the threat of closure is detected. This is not confined to the threat of closure because of poor care, or the potential for escalating concerns, but in all instances which may result in the closure of a care home.
10. The HOSG should be independent from the care home for which it is managing change or closure, thus, in the case of the threat of closure in the independent sector the HOSG will be chaired by the Local Authority, in case of the threat of closure in the public sector the HOSG will be chaired by someone independent of the public sector.
11. Legal duties in relation to closures should specify the requirements placed on the Local Authority concerning the proper conduct of public consultation.
12. We recommend that the threat of closure (i.e. duration of escalating concerns, CAPs and DAPs or consultation in the public sector) and the process of closure should not exceed six months, thus limiting the period that residents, relatives and other stakeholders are placed under duress.
13. Local Authorities should not enforce informal embargos through decreasing referrals to a care home. Independent providers should be able to challenge Local Authorities to justify decreases in referrals.
14. With regard to 'Minimum Requirements' the WG guidance should clearly guide the Statutory Agencies to the relevant Annexes that describe how their functions should be discharged.
15. The development and use of disclosure plans for individual residents should be included in the guidance. Plans should be developed with input from specialists (clinical psychologist/psychiatrist with expertise in the care of older people) who can help decide how and when residents with cognitive impairment should be informed about the threat of, or closure of the care home. It is not acceptable to assume a policy of non-disclosure to all residents within a care home.
16. The guidance should stipulate in the 'Minimum Requirements' that **all** residents should have access to independent advocacy services (not confined to statutory Independent Mental Capacity Advocacy service), and other such services to support service users as appropriate. The registered provider must support and enable approved advocacy services to meet with service users to identify their wishes and offer appropriate support.

17. The development and content of individual relocation plans should be clearly specified. In particular, the individual service user relocation plan should be developed with the resident (or advocate working on behalf of the resident), and relatives, taking into account the decision of the multidisciplinary team assessment of mental capacity. Furthermore, the plans should take into account social and psychological needs of the resident (such as the maintenance of social relationships formed in the care home), as well as the need for any physical personal and nursing care.
18. Individual relocation plans should reflect (where possible) the wishes of the resident concerning the choice of alternative accommodation. Thus, all residents (or advocates working in behalf of the resident) and relatives should be told of the range of accommodation available (including extracare sheltered housing, residential care homes and nursing homes, both in the public and independent sector). The types, levels (ceilings), and costs of care and support that each facility provides should be explained fully. Residents (or advocates working on behalf of the resident) should be offered the opportunity to visit alternative accommodation in order for a properly informed choice to be made.
19. Where a JIMP has been made aware of the threat of closure, at the end of the process (whether this results in the closure or continued operation of the care home), the JIMP and HOSG will meet to evaluate the whole closure process and to identify lessons learned. The Chair of the JIMP will prepare a report on the home closure or the methods by which a care home was saved from closure. A copy of the report must be provided to CSSIW.
20. The role of the CSSIW should be redefined, especially concerning the actions that are required with regard to in-depth analysis of the data on care home closures (or saving care homes from closure) (see 1 above), and where independent oversight is required (chairing HOSG) in the closure of homes in the public sector.

Although the recommendations constitute fairly minor changes to the main document, we have made major changes to the Annexes of the document which were designed to provide examples of how the statutory agencies should discharge their responsibilities. In particular, we have taken care to ensure that the several stages of the process are separated from each other. Thus we have a section describing monitoring and proactive actions to prevent escalating concerns and home closure (Annex 1). We describe when a Joint Interagency Monitoring Panel (JIMP) should be either established or take action during the 'threat of closure' (Annex 2). Annex 3 provides an example of the process that should be adopted

during escalating concerns, whilst Annex 4 describes the arrangements during the threat of Voluntary Closure of care homes. Finally Annex 5 describes the process of care home closure for all sectors. Annexes 2-4 are supplemented by flow charts which describe the actions and outcomes of the process. These together provide much clearer guidance to the statutory agencies. Finally we recommend that:

21. The WG seriously considers adopting the amendments to the guidance, and issuing the Annexes to aid all statutory organisations in discharging their duties during the threat of closure, or closure of care homes in the independent and public sectors.

1
INTRODUCTION

Care home closure is often the subject of media coverage and campaigning and it can be an extremely emotive topic for those (staff, residents and relatives of residents) that are affected by closure (Powell 2009; UNISON 2009). The concerns of pressure groups, relatives and carers of people residing in homes that are due to be closed often focus on the potential harm that relocation can cause to an older person (Castle 2001; Meehan et al. 2001; Smith & Crome 2000; Hodgson et al. 2004). The impact of relocation from care homes is commonly believed to have an impact on the health of residents including mortality of those who have been involuntarily transferred. Although analysis of research since 1963 shows no statistically significant increase in mortality (RAGE 2003) evidence is often ambiguous and there are considerable methodological and ethical difficulties (Smith & Crome 2000) Anecdotal evidence, and legal cases link relocation to premature death (Jolley 2003; RAGE 2003). Consequently, the closure of care homes has high policy relevance because of the impact on the well being of older people and potential litigation.

There are generally two types of care home closure; enforced and voluntary. Enforced closures are typically the result of failure to meet or comply with care and environmental standards and are enacted under the Care Standards Act 2000. Voluntary closures are due to other reasons or as a result of the actions of receivers or creditors. In England in 2003, the most frequently cited reason for care home closure was financial. Although there has been a mapping task conducted in England (Netten et al. 2003; Williams & Netten 2003), to date we do not know the trends in, or reasons for closure of residential care homes in Wales. Thus, this project aims to address this gap in knowledge.

In response to the need for protocols to safeguard residents welfare, and to decrease the likelihood of litigation against local authorities, the Welsh Government (WG) have recently developed guidelines entitled "*Escalating concerns with, and closures of, care homes providing services for older adults*". The WG guidance sets out local authorities', local health boards' and NHS trusts' responsibilities in this area and suggests ways in which these responsibilities can be discharged. The guidance provides the following definition: *"escalating concerns arise where there are accumulating issues relating to the operation of, or quality of care provided in, a registered care home providing services to adults*" (WG 2009, p. 1).

The guidance provides a summary of the legal context and the roles, responsibilities and accountability of the key agencies (CSSIW, Local Authorities, LHBs) in relation to escalating concerns and home closures. The importance of having appropriate and effective systems and processes in place to prevent escalating concerns, and potentially the closure of care homes, occurring is emphasised in the guidance. It lists a number of key steps that health and social care services must take in order to secure improvements in practice e.g. having effective quality control and monitoring systems and to establish mechanisms for joint working and information sharing between agencies in order to avoid escalating concerns and home closures wherever possible.

Where escalating concerns arise, the guidance requires Local Authorities, NHS Trusts and LHBs to establish a 'Joint Inter-agency Monitoring Panel' (JIMP) which is the lead body for managing the escalating concerns process. The JIMP can establish Development and Corrective Action Plans (DAP & CAPs) in order to address the escalating concerns with the DAP being proactive in providing a way forward in specific areas of quality and practice while the DAP is required where reactive action is required to take immediate action to ensure the safety of service users and/or staff. The WG guidance also makes reference to the power of Local Authorities and LHBs to apply an embargo to a particular home stressing the need for a clearly evidenced rationale for their usage and that when used they must do so in accordance with existing embargo policies and applied consistently.

With regards care home closure the guidance makes a distinction between two main categories namely 'voluntary' where the home chooses to close and 'enforced' where it is forced to close although the procedure for closure remains the same. The JIMP is responsible for the operational management of home closures and must appoint a Chairperson to establish a Home Operational Support Group (HOSG). The HOSG co-ordinates and manages the care home closure in line with the 'Closure Plan' and 'Individual Relocation Plan'. WG guidelines note that when home closures occur it is important for the relevant agencies to work with service users and their families (or other representatives) to prepare them for, and make the transition to a new home. They identify some key issues to ensure that the transition to a new location is successful, including access to support staff, and an opportunity for service-users and their families to contribute to the design of new care plans.

In order to facilitate home closure, WG guidelines outline the processes that should be followed in each Local Authority. Each Local Authority should work within a framework of practice and have an agreed operational home closure procedure (WG 2009, pp. 8-9). The procedure should ensure that agencies can quickly and effectively establish a viable home

'Closure Plan' and 'Individual Relocation Plan' for service-users. The WG guidance emphasises the importance of service users having access to independent advocacy services including the statutory Independent Mental Capacity Advocacy service throughout the process. Within one month of closure of a care home, the JIMP and HOSG are required to evaluate the closure process, and prepare a report which is sent to the CSSIW and other key senior stakeholders. While the guidance assists statutory bodies in determining how their existing functions and responsibilities might be fulfilled it does not introduce any new or additional statutory responsibilities and does not provide information on good practice for each of these organisations. There is no equivalent guidance in England aimed specifically at the way in which care homes close.

The introduction of Welsh Government (WG) guidelines in May 2009, provides us with a timely opportunity to the examine the way that care homes are closed, and explore the process from the view of various stakeholders including older residents, relatives, statutory regulators of care, care managers and care home owners. Williams and Netten (2003) have noted that "ideally policy and practice would be supported by further research that established whether positive outcomes for residents, and their relatives and carers, are associated with particular processes, arrangements and practices during a care home closure" (p. 32). Consequently, this research also explores the impact of the planning processes on the outcomes for the various stakeholders.

The research **aimed** to

- Identify the rate of closure of care homes for older people, the types of homes closing and the reasons for closure from 1 June 2009 to 31 May 2010
- Examine the process surrounding the closure of care homes in 2010/11 especially with regard to adherence to/deviance from the guidance issued by the Welsh Assembly Government in the public and private sector
- Explore the consequences for and the experiences of providers, key workers, older people, their relatives and carers during and after relocation because of the closure of a care home.

During the course of the project, it became apparent that several care homes in Wales were under the threat of closure and either had not agreed a date for final closure or the date of anticipated closure did not fall within the study period. Furthermore, several care homes were identified that had been 'saved from closure'. It was not clear if the latter was directly attributable to the impact of the WG guidance. The research was extended to explore the

impact of the planning processes on the outcomes for the various stakeholders in care homes under threat of closure or saved from closure. The amended research had two further aims, they were to:

- Explore the consequences for and the experiences of older people, their relatives and carers, providers and key workers in care homes that have been announced as 'under threat' of closure.
- Examine the process where care homes avoided closure especially with regard to adherence to or deviance from the Escalating Concerns guidance and local authority procedures.

The final **objectives** of the research were

1. To systematically acquire and record information about care home closures in 2009/2010 through,
    a. Analysis of data collected by Care and Social Services Inspectorate Wales (CSSIW) to identify prevalence of closure (number of homes closed and residents relocated), reasons for closure and type of homes closed.
    b. Semi-structured telephone interviews with CSSIW inspectors, and managers/owners of homes that have closed to supplement and enrich CSSIW data
    c. Semi-structured interviews with local authority commissioners of care home providers regarding their involvement in and experiences of care homes that avoided closure in 2009/10.
2. To acquire and examine local authority protocols for care home closure in order to,
    a. Compare these to the guidelines issued by the WG to identify gaps in the protocols
    b. Identify common views of best practice and variation in good practice
    c. Compare most commonly defined best practice topics to those established in England and measure against the actions, issues and objectives identified in academic literature.
3. To undertake case studies of the process (or announcement of possibility) of closure of six care homes (two in the public and four in the private sector) to explore outcomes and associations with the planning process through,

a. An examination of the minutes (or observation of the meetings) of the Joint Inter-agency Monitoring Panel (JIMP) and the Home Operations Support Group (HOSG).
b. In-depth interviews with providers, key workers, older residents, relatives and carers during closure and after relocation.
c. In-depth interview with providers, key workers, older residents, relatives and carers where announcement of possibility of closure has been made.

4. To undertake case studies of care homes that have been saved from closure (two in the public sector; four in the private sector) to explore outcomes and associations with the process through,
    a. In-depth interviews with older residents, relatives, care staff and providers after the care home has been saved from closure.

2
METHOD

This research was conducted between 1st June 2010 and 30th November 2011. It replicates elements of a study conducted in England in 2003 commissioned by the Department of Health and extends this research to look at outcomes for those involved in the closure of care homes. It used mixed methods including (i) secondary data analysis of CSSIW data (ii) semi-structured telephone interviews with CSSIW inspectors and managers/owners of care homes that have closed (iii) documentary analysis of minutes of meetings (iv) case studies and in-depth interviews with providers, older residents, relatives and carers during the closure of care homes, and in care homes saved from closure. Phase 1 uses a concurrent triangulation strategy in an attempt to confirm, cross-validate and corroborate findings within a single study phase. The Phases 2 and 3 of the study use qualitative methods to provide comprehensive coverage of the research topic. Below each phase of the study is described in turn (with sample sizes, response rates and analysis discussed for each phase). The chapter concludes with a discussion of ethical approvals obtained for the study.

Phase 1: The prevalence of and causes of care home closure

Data collected by the Care and Social Services Inspectorate for Wales (CSSIW) was used to establish the prevalence of care home closure in Wales during the period from 1st June 2009 until 31st May 2010. This data was also used to establish whether care homes closed voluntarily, or whether closure was enforced due to contravening regulations.

In addition to the data on prevalence and reasons for closure gleaned from the CSSIW data, CSSIW inspectors and owners and/or managers who had been involved in care home closures during a 21 month period (1st March 2009 – 31 December 2010) were interviewed. The longer time period for qualitative data collection allowed the research team to explore and better understand the complex reasons and circumstances surrounding the closure of care homes with a broader range of participants that would have been achieved within the shorter (one year) time frame used for establishing the prevalence of closure.

The semi-structured schedule that was designed by the English team (Williams et al. 2002) was adapted for use in Wales. This allowed us to compare our findings with previous

work ensuring that similar topics were explored across all interviews, whilst also allowing interviewees to incorporate other important precursors to home closure. Telephone interviews were conducted, and interviewees were asked which factors were relevant in the decision to close the care home including: commissioning arrangements; competition; demand; relationship between registration, inspection and provider; financial viability; property market; staffing; personal circumstances; motivation and the regulatory and administrative environment. Interviewees were asked to discuss each selected factor in detail. Interviewers completed interview schedules during the course of the interview and the responses to open ended questions were audio-recorded. The voice files from the interviews transcribed by a professional service and the resulting manuscripts were imported into NVIVO 8 software for analysis.

Sample and response rates

Thirty adult service inspectors (100%) in the four regional CSSIW inspectorates (North Wales, South East Wales, Mid and South Wales, South West Wales) were contacted to establish which had been involved in one or more care home closure in the previous 21 months. All five inspectors who had been involved in care home closures were interviewed by telephone to identify the reasons for closure of care homes for the two most recent care home closures under their jurisdiction over the last 21 months (see Table 1). At the end of the interviews regional inspectorates were asked to either (a) supply contact details or (b) send a letter to owners, managers or directors of the care homes that had closed in the last 21 months.

Contacting and interviewing owners and managers of homes that have closed was likely to be problematic as they may have moved away from the area or may not want to talk about an event that was possibly challenging, emotional or stressful (Netten et al. 2002). The Personal Social Services Research Unit (PSSRU) managed to obtain interviews with managers and owners in 20 of 69 closed homes in England (29% response rate) (Williams et al. 2002). Based on the response rate from the PSSRU study we anticipated contacting and interviewing around 8 managers or owners who were involved in care home closures.

In addition to the problems identified by PSSRU, we had the additional difficulty that we were trying to access managers/owners through CSSIW inspectors. In some instances the CSSIW inspectors were insistent that the managers would not want to participate, and did not provide us with contact details. This was usually based on a poor quality relationship between CSSIW and the care home managers. In other cases the CSSIW inspector explained that a

visceral relationship existed but did give us contact details. Three managers/owners were contacted directly by CSSIW but only one agreed to be interviewed. Eight owners/managers were contacted by the research team (email or telephone) and of these seven agreed to participate. In total, we interviewed eight managers or owners of the 27 homes that closed in Wales during the extended study period 1st April 2009 - 31st December 2010 – a 27% response rate. Thus combining the interviews with CSSIW inspectors and care home managers we obtained data on the reasons for closure for 16 of the 27 care homes that closed during the study period.

Table 1. Sample of CSSIW inspectors and owners/managers of care homes that closed between 1st March 2009-31st December 2010

Respondents	Interviewed	Refused
CSSIW inspectors	5	0
Owners/Managers	8	3

Analysis

Data collected by CSSIW was analysed using simple descriptives to identify prevalence of closure, reasons for closure and type of homes closed. Given the small numbers of closing homes, it was not necessary to perform extensive quantitative analysis.

The data was analysed using content analysis. Content analysis is based on the examination of the data for recurrent instances of oral text which was used to answer to the research questions posed above. Furthermore, we examined more complex relationships between multiple reasons for closure (pathways to closure).

Phase 2: The process of care home closure

As noted in Chapter 1, in order to facilitate home closure, WG guidelines outline the processes that should be followed in each Local Authority. In May 2010, all twenty-two local authorities in Wales were approached to request a copy of the operational home closure procedure for older people. In addition, all reports submitted to the CSSIW in the period 1 June 2009 to 31 May 2010 from joint Inter-agency Monitoring Panel (JIMP) and the Home Operations Support Group (HOSG) following the closure of a care homes were requested. Due to an initial lack of response a further two follow up letters were sent (26th July 2010 &

21st September 2010) with one of these being directly from the Older Peoples Commissioner for Wales.

Sample and response rates

Of the 22 local authorities contacted, twelve supplied local protocols, two supplied checklists only, six local authorities stated that they did not have local protocols while the remaining two failed to respond. Of the twelve local protocols supplied three of these pre-date the introduction of the WG guidance and so, for the purposes of this research, these have been discounted and the research will focus on remaining nine protocols that were developed following the WG guidance.

We illustrate the use of local authority protocols in practice through analysis of the data collected in interviews with Local Authority commissioners of care, and from documentary analysis of minutes of the Joint Inter-agency Monitoring Panel (JIMP) and the Home Operations Support Group (HOSG).

We conducted 3 interviews with Local Authority commissioners who had been involved in situations where care homes had avoided closure. One of the care homes was in the public sector and two were in the independent sector. The local authority care home avoided closure as a result of a campaign of opposition from residents and relatives who sought legal help to identify a contractual clause that prevented the local authority from closing the home whilst residents wished to remain there. The other two care homes avoided closure through the instigation of escalating concerns procedure.

The research team received one JIMP reports and one HOSG report on the closure of an independent care home. Three care home closure (lessons learnt) reports that had been submitted CSSIW were also received.

Analysis

Protocols and reports on the process of home closure were examined using content analysis. Firstly the aims and scope of the local authority protocols were compared to the guidelines issued by the WG and gaps identified. Secondly, local authority protocols were reviewed for principles of good practice. Common views and variation in good practice were be identified. Thirdly, reports on home closure submitted to CSSIW by the local HOSGs were examined and compared to the protocol in the local authority in which the home was located. JIMP and HOSG documents were examined for intertextuality in order to trace the procedures that lead to the operationalisation of the home 'Closure Plans' and 'Individual

Resettlement Plans'. Analysis identified adherence to and deviation from the local protocol, and lessons learned from the closure process.

Phase 3: Consequences and outcomes for stakeholders

Closing care homes

We aimed to conduct four case studies in care homes in the process of closure: two each in the public and private sector. It was anticipated that the case studies would examine the minutes (or observe the meetings) of the Joint Inter-agency Monitoring Panel (JIMP) and the Home Operations Support Group (HOSG) and the development of the home 'Closure Plan' and 'Individual Relocation Plan' for service-users. In addition, building on previous research, case studies would describe the strategies used by care-home staff to manage moves, and to explore older people's experiences of relocations. Two in-depth interviews were to be conducted with owners/managers (N=1 or 2), older residents (N=2), their key support workers (N=2), relatives and carers (N=2) during the process of closure and relocation in each of the four case study settings that have been selected as homes that are closing. These would be conducted (i) shortly before move and (ii) after relocation (Total 28+ x 2 interviews). Four separate interviews were designed (one for each stakeholder group). These were based on the semi-structured schedules that was designed by the English team (Williams et al. 2002) but was adapted for use in Wales. The owners'/managers' interview schedules covered the following topics: characteristics of the care home, reasons for closure, plans for process of closure. Interview schedules for staff in the closing care homes covered the notification of closure, the staff members role in the closure process, feelings and views about the closure and plans for the future. The interview for residents and relatives covered topics concerning how the closure was announced, feelings about the care home closure, and the provision of support during the process of finding new accommodation and relocating.

Sample and response rates

Stringent efforts were made to ensure that the research team were aware of imminent care home closures by gathering intelligence from an established network of CSSIW inspectors, local authority commissioners and care provider organisations in addition to scouring media websites and newspapers. However, the speed at which care homes closed, particularly in the independent sector meant that in many cases by the time the research team had been made aware of the closure, it had either already passed or was imminent. In other

instances, refusals to take part in the research were generated by the managers. The managers of care homes in the process of closure were often reluctant to engage with the research on the grounds that the presence of the research team would add to the distress felt by those involved in the closure and relocation process. In the homes that refused to participate, older residents had not been approached as the care home manager or owner had acted as a gatekeeper. Contact information about older residents was not divulged to the research team and therefore, it was not possible to provide project information directly to residents for them to make their own decisions about whether or not to participate.

Due to the difficulties noted above, it was not possible to undertake any case studies in closing homes in the independent sector. However, two case studies were conducted with closing care homes in the public sector. At the time of the interviews the two local authority run care homes (1 North Wales; 1 South Wales) that were in the process of closure had already rehoused several residents. One care home had 8 residents remaining (out of a capacity of 10) whilst the other had 15 remaining (out of a capacity of 29). In both cases, the care homes were being closed as a result of a strategic plan to develop Extracare sheltered housing as an alternative to traditional residential care. One care home was being decommissioned due to structural issues which made it too costly for the Local Authority to update and maintain to meet care standards and regulations. Between 22 and 25 staff were employed at each home.

In total, two managers and three care were interviewed before the care homes closed. No interviews were conducted with either managers or care staff after closure, as the homes were still in operation at the end of the study period, and consequently these staff had not moved or experienced the closure of the facilities (Table 2).

Older residents and their relatives were initially identified and approached to take part in this study by the care home manager. Four older residents were recruited to the study from the two local authority care homes in the process of closing (identified above) and interviews were undertaken before the care homes closed (Table 2). Three interviews were conducted with four relatives of residents (one interview was answered by a son and daughter-in-law jointly) before closure. Two of the relatives interviewed were not related to participants in the study, but were related to residents who were too cognitively impaired to be able to participate in the study as interviewees.

Although the two care homes selected as case studies were both closing, they were at different points in the process and closure was not imminent. This meant that final closure date was due to take place after conclusion of the research. Thus, not all of the interviewees

moved from the care home during the study period. Consequently only two older residents and two relatives were re-interviewed approximately one month after the older resident had relocated to a different care home (Table 2). In both cases, the older resident had made the decision to move before a final closure date had been announced. The moves were prompted by vacancies becoming available in chosen alternative care homes.

Table 2. Anticipated and achieved sample of stakeholders interviewed in closing care homes in the private and public sector, before and after closure

	Before closure				After closure			
	Private sector		Public sector		Private sector		Public sector	
Participants	Expected	Actual	Expected	Actual	Expected	Actual	Expected	Actual
Managers	2	0	2	2	2	0	2	0
Key workers	4	0	4	3	4	0	4	0
Residents	4	0	4	4	4	0	4	2
Relatives	4	0	4	4*	4	0	4	2*

*Two relatives (a couple: son and daughter-in-law) were interviewed using only one interview schedule.

Care homes under the threat of closure

Following the amendment of the research proposal in November 2010 we aimed to conduct two case studies of care homes under threat of closure. It was anticipated that the case studies in the two homes under threat of closure would adopt the same protocol as outlined above (for closing care homes), but with only one in-depth interview conducted with owners/managers, older residents, relatives and carers in homes under threat of closure. This would provide the opportunity to explore the views and experiences of those living with the threat of closure and the process of support and preparation which may differ from the cases where closure did occur.

During the course of the study Gwenda Thomas, Deputy Minister for Children and Social Services produced a written statement on behalf of the Welsh Government (12 July 2011) which provided official notification of the financial situation regarding the residential care provider *Southern Cross*. The statement noted that *Southern Cross* had made an announcement to the Stock Exchange on the 11th July 2011 temporarily suspending its shares. The landlords of *Southern Cross* care homes indicated their intention to leave *Southern Cross*

and to find new operators for their homes. These changes were planned to be undertaken over the course of four months (July–November 2011) in a managed and planned manner. Although the intention was to find new landlords and new operators for all care homes, the situation in July 2011 was that care homes owned and run by *Southern Cross* were 'under threat' of closure as successful transfer depends on new operators being found. Although the fieldwork phase of the project had been completed the proposed changes to *Southern Cross* operations provided a unique opportunity to explore the experiences of older residents, key workers and relatives in care homes under the threat of closure in more depth. Consequently, we proposed to extend the fieldwork for four months to try to include case studies from the 33 *Southern Cross* care homes in South Wales. We anticipated interviewing at least 4 older residents, 4 relatives of residents, 4 key workers and 4 managers in a selection of these care homes.

Sample and response rates

During this phase of the research we identified two homes that were under threat of closure. However, we were refused access to one, and the other was going through a process of public consultation which meant that official announcement of closure (or not) would occur after the end of the research project.

We regard to undertaking research in *Southern Cross* care homes under threat of closure, initially, several of the care home managers who were approached appeared interested in engaging with the research but needed to obtain approval from head office. Following repeated attempts to engage with *Southern Cross* at executive level it was revealed by one care home manager that the head office had made a to the effect that they were not prepared to engage with the research. As we were unable to get consent from any *Southern Cross* homes in Wales to participate within one month of the extension being granted, the extension of the project was terminated.

As we were unsuccessful in recruiting care home that were under threat of closure, we did not interview any managers, key workers, residents or relatives in this facility (Table 3). However, we believe that the retrospective interviews conducted in care homes that were eventually 'saved from' closure (see below) provide an indication of the experiences of the threat of closure for staff, residents and relatives.

Table 3. Anticipated and achieved sample of stakeholders interviewed in closing care homes under threat of closure.

	All sectors		Southern Cross	
Participants	Expected	Actual	Expected	Actual
Managers	2	0	4	0
Key workers	4	0	4	0
Residents	4	0	4	0
Relatives	4	0	4	0

Care homes 'saved' from closure

Following the amendment of the research proposal in November 2010 we aimed to conduct six case studies in care homes that were saved from closure (two in the public sector; four in the private sector). We anticipated adopting the same protocol as outlined above (for closing care homes), but with only one in-depth interview conducted with owners/managers, older residents, relatives and carers in homes saved from closure.

Sample and response rate

We recruited a single independent provider that faced the threat of closure for financial reasons but avoided closure following a judicial review into the fee levels paid by the local authority. The independent provider had five care homes, four of which were for older people (three residential care home and one nursing home). The provider supplied residential and nursing care to 87 people and employed 120 people. At the time of the interviews, 81 beds were occupied across the four care homes for older people. The ratio of residents who were funding their own placement versus those who received local authority funding was roughly 50:50.

Following discussions with the care home providers, interviews were conducted in the three residential homes only. Two care providers (owners), one care home manager and seven care staff were interviewed within the single provider case study. Four older residents and four relatives were interviewed across three homes. The relatives interviewed were not related to the older residents interviewed as part of this sample.

Table 4. Anticipated and achieved sample of stakeholders interviewed in care homes saved from closure

	Public sector		Private sector	
Participants	Expected	Actual	Expected	Actual
Managers/owners	2	0	4	3
Key workers	4	0	8	7
Residents	4	0	8	4
Relatives	4	0	8	4

Analysis

Interpretative phenomenological analysis was used to provide insightful interpretations into the experience of actual and threat (past or present) of care home closure and relocation and anchored these interpretations into the participants' accounts of their experiences. The analysis focused on meaning and contextuality (i.e. what is distinct in each interview), but also balanced this against experiences and meanings that were shared across participant groups.

Ethics

Throughout the research process, the study adhered to the Social Research Association and British Society of Gerontology ethical codes of practice. These addressed issues of informed consent, data protection, confidentiality and anonymity, protecting the interests of subjects, ensuring safety and minimising risk of harm to field researchers.

Ethical approval was granted by NHS South West Wales Research Ethics Committee on 22nd October 2010 (Appendix 1). A substantial amendment to the submission was made in order to include care homes that were under threat of closure. The amendment was approved by the South West Wales Research Ethics Committee on 18th January 2011 (Appendix 1). A final amendment was made regarding extending the sample to include homes saved from closure. As none of these facilities were nursing homes (and thus fell beyond the remit of the NHS ethics committee) the amendment was submitted to and approved by the College of Human and Health Sciences Research Ethics Committee on 26th November 2010 (Appendix 1).

Frail and/or cognitively impaired residents may present particular challenges and the ability of participants to understand and make decisions about their participation in the

research required careful assessment. Our protocol stipulated that people displaying mild to moderate dementia with communicative ability, without a visual or hearing impairment or severe agitation would not be excluded from the study. This was addressed in discussion with the care home staff who identified possible participants. Residents selected by the care home staff were given participant information sheets about the study (by the staff). They were encouraged to discuss the study with family, friends and staff and to ask questions which could be passed on to the research team. Only when residents were comfortable with participation were the research team given permission to visit and discuss the study in more detail.

Consent was considered as an ongoing process (see below) and was obtained before each interview. Following the methods used in a similar study (Williams & Netten 2003) the negotiation of informed consent had several stages, beginning with discussion of a written summary of the project, and culminating in recorded verbal consent. No objections were raised during any part of the study procedures, and no participants were withdrawn from the study.

All of the research team had a Criminal Records Bureau check prior to starting fieldwork. The researchers were trained to assess if the interview was causing the participant distress and were able to respond to this situation in a variety of ways, e.g. using methods to uplift the mood, or ceasing the interview and debriefing the participant. Researchers adhered to the protocols developed by the Centre for Innovative Ageing, concerning 'disclosure of abuse' and 'safety for researchers'.

3

THE PREVALENCE AND REASONS FOR CARE HOME CLOSURES IN WALES

Introduction

This chapter examines the prevalence and causes of care home closures in Wales. It identifies key pathways to closure, and looks at the association between causes of closure and other aspects of the closure process (i.e. length of process and multi-agency working). It concludes by comparing the reasons for closure identified in Wales, with the causes of closure reported in a similar study conducted in England.

As noted in the introduction, this study replicates elements of a study conducted by the Personal Social Services Research Unit (PSSRU, University of Kent) in 2001. This study explored the prevalence and reasons for care home closures in England. Netten et al. (2002) noted that "one of the attributes of a mixed economy of care is that inevitably some homes will go out of business, with consequent costs for the individuals involved and the regulating authorities" (p. ix). The study in England was undertaken shortly after the publication of the *National Minimum Standards* for care homes in England (Department of Health 2001), which required care homes to meet a set of minimum standards for accommodation by 2007. It was anticipated that several homes would encounter financial difficulties in implementing the minimum standards, and were closing before they incurred substantial losses. Thus, the research team at PSSRU were concerned about a rise in the prevalence of care home closures and the potential consequences for the "capacity of the care home sector and the effects on current residents" (Netten et al. 2002, p. ix). The *National Minimum Standard for Care Homes for Older People* (WG 2004) have now been in place in Wales for seven years and any closures that pre-empted the standards will have taken place. However, there are other reasons to study the prevalence of care home closure in the Principality. In particular, the global economic downturn (2008-2009 and 2011) may have precipitated a rise in care home closure, whilst the implementation of the WG guidance on escalating concerns may have had the opposite effect and prevented home closures.

As well as studying the prevalence of home closures, PSSRU also explored the causes of care home closures in England. 39 regional inspectors of Registration and Inspection Units were interviewed to explore the reasons for care home closure in their area (Netten et al. 2005). The inspectors most frequently cited financial problems and personal circumstances as the reason for the closure of care homes in their regions. On the whole, the inspectors did not

attribute financial problems to Local Authority pricing structures for care home fees. More frequently the inspectors related financial difficulties to the viability of the home: either the bank was foreclosing or the proprietors were over-stretched.

In addition to conducting interviews with regional inspectors, the research team in England undertook interviews with twenty proprietors of care homes that had closed in the previous year (Netten et al. 2005). The proprietors' views on the reasons for care home closures were somewhat different from the views of the inspectors. In this respect, the most frequently cited reason for closure were the fees paid by the Local Authority and the cost of investment required to improve facilities to meet care standards (which were to be implemented in the following year). The care homes closed to avoid further financial loss rather than going bankrupt.

In addition to the impact of Local Authorities fees on the viability of care homes, proprietors also cited reduction in demand, difficulties with recruitment and retention of care home worker and property prices as influential in the decision to close (Netten et al. 2005). A reduction in the demand for places was mentioned by proprietors in six of the 11 residential care homes and two of the nine nursing homes that had closed. Difficulties in recruitment and retention of care home workers were not cited as a primary reason for closure, but were influential in some cases. Furthermore, in one quarter of care home closures property prices were important. In this respect, high property values at the time of the study presented proprietors with the opportunity to sell up and make a profit. This was especially attractive when it was clear that the business could not be sold as a viable 'going concern'.

We expected to find similar reasons for care home closure in Wales as had previously been found in the English study (Netten et al. 2005). However, at the time of the study, property prices in Wales had fallen by -9.6% in 2008, followed by a further drop of -11.6% in 2009 (Lloyds Banking Group 2011). Thus, we did not expect to find that care homes had closed because owners were seeking to make a profit on the property.

Although CSSIW publish the prevalence of 'voluntary' adult home closures in Wales, we feel that it is important to understand the more complex causes of closure. Without this information we do not know if there are ways in which care home closures could be avoided.

The prevalence of care home closure

Sixteen care homes were identified as having closed between 1st June 2009 and 31st May 2010 and are discussed in this report. This was significantly fewer than expected. Twelve of these closures were initially reported by the CSSIW using its own data recording

processes for the annual report period 1st April 2009 – 31st March 2010. The other four were identified by the research team via its own investigations. Although three care home closures were outside the CSSIW reporting timeframe (1st April 2010–31st May 2010), one that closed in the reporting period was not captured by their reporting mechanisms. Following the research teams investigations, the publication of the CSSIW Chief Inspector's report for 09/10 stated that 40 care homes had 'voluntarily ceased to operate' (CSSIW 2011, p.16). This included 18 providing services to older adults and 22 providing services to younger adults (Table 5).

The research team wrote to CSSIW and invited them to explain the reasons for the variation in the prevalence of home closures between CSSIW inspectors self-report; the numbers of closures the research team had uncovered and the number officially stated in the CSSIW Chief Inspector's Annual Report for 09/10. No response was initially received from the CSSIW, but after a Freedom of Information request, the CSSIW conducted an internal investigation and admitted that the number reported in their annual report was incorrect and that the actual number of adult care home closures during the 09/10 annual report period (1st April 2009 – 31st March 2010) was in fact 23, and 14 of these were older adult care homes. The CSSIW also noted that 'serious recording issues' were revealed as a result of this matter, which they are now taking steps to address.

Table 5. Anticipated and achieved sample of stakeholders interviewed in care homes saved from closure

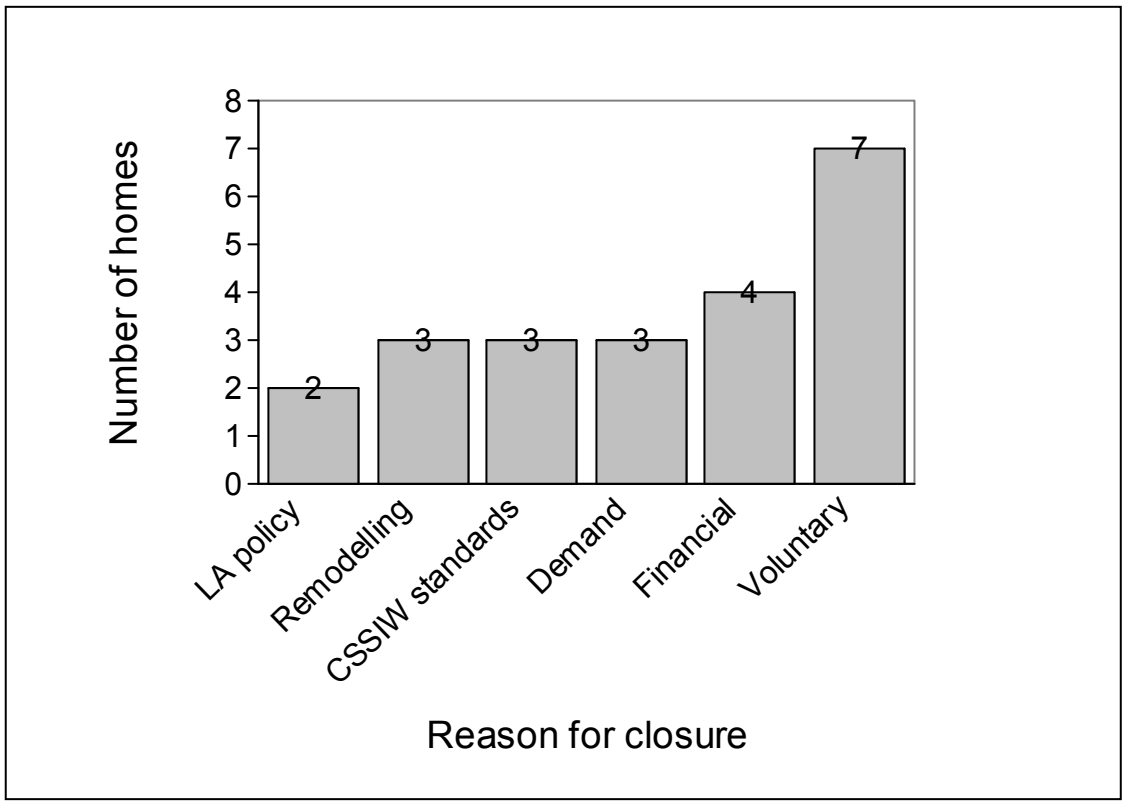
	Reported in 2009-10 Annual Report	**Recorded on regulatory system post Annual Report 2009-10**	**Actual number following checking recording status**
Older adults care homes	18	24	14
Younger adult care homes	22	23	9
Total	40	47	23

The reasons for care home closures

Figure 1 provides a summary of the reasons for the closure of the sixteen care homes between 1st June 2009 and 31st May 2010. Unfortunately for seven of the closed homes

recorded by CSSIW the only reason provided was 'voluntary closure'. The remaining nine homes closed for a range, and often multiple reasons.

Figure 1. Reasons for closure of care homes between 1st June 2009 and 31st May 2010



Twenty-seven care home closed during a 21 month period (1st April 2009 – 31 December 2010) and interviews were conducted with CSSIW inspectors and managers regarding 16 of these homes. The 16 homes were located in ten different Local Authority areas and were equally split between the public and private sector: eight in each. Twelve of the homes were residential care homes, one was a nursing home and three had dual registration. In all sixteen homes most of the residents were publicly funded. Thirteen of the homes had been on the local authority approved provider list prior to closure.

Figure 2.Reasons for closure of sixteen care homes between 1st April 2009 and 31st December 2010.

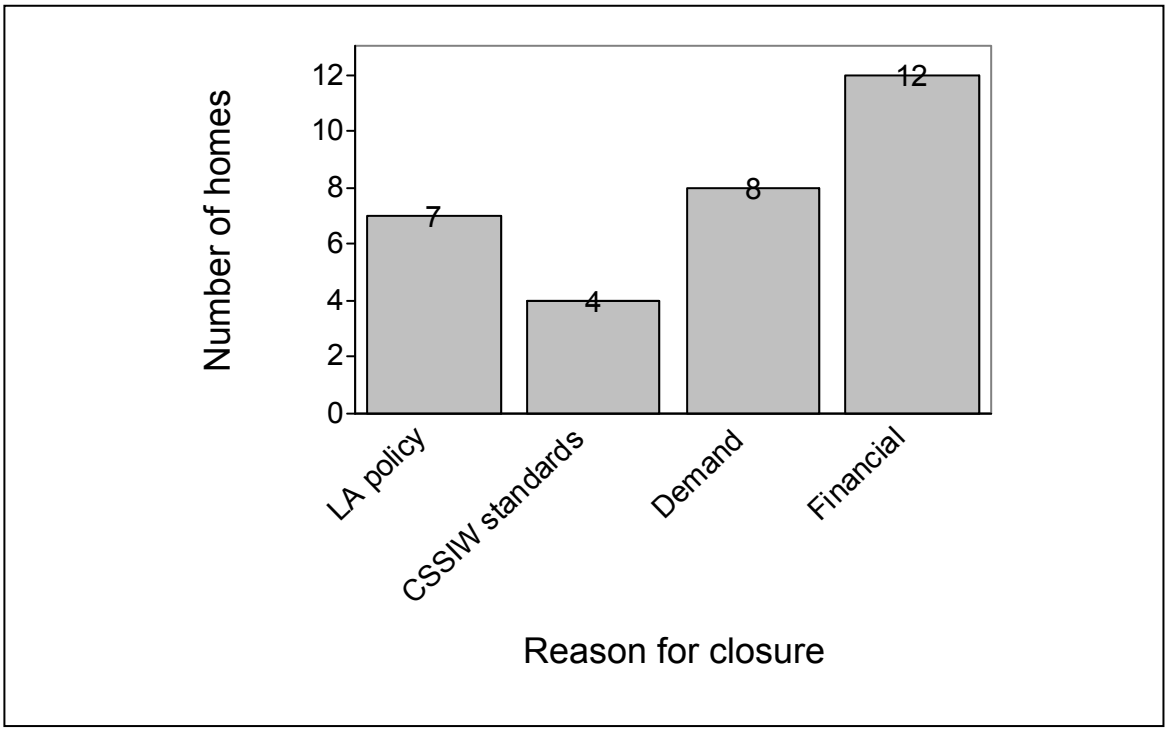


Figure 2 provides a summary of the (multiple) reasons for the closure of the sixteen homes. The most commonly cited reason for closure was financial viability. This was a factor in the closure of twelve of the care homes. This is not surprising given that finance plays such a fundamental role in care home provision and delivery and can be both a cause and effect of other reasons for closure. For example, financial difficulties can make it difficult for owners to tackle disrepair or conversely, lack of demand for care home places can cause financial problems. Consequently, in all twelve instances where financial viability was cited as a reason for closure, this was not the sole reason but was inexorably linked to other issues.

In four care homes financial viability was primarily linked to demand issues. In each case reductions in referrals from the local authority compromised the financial viability of the facility. In one home the Local Authority ceased making referrals and despite efforts by the home manager to address this by holding meetings with social work managers the problem persisted until the home was no longer financially viable. In two other homes, the low referral rates may have been attributable to other factors. In one care home, the CSSIW inspector noted that the client group that the care home catered for was not clear to social workers,

whilst in a second, the remote rural location may have restricted the number of potential local placements. The manager/owner noted,

> *"lovely home located in a remote, rural area but there was a reduction in referrals which resulted in under occupancy and this, in turn, made the home non financially viable."* (Manager/owner)

Financial viability and levels of demand were also factors in the closure of a number of care homes that also closed for policy reasons or for not complying with CSSIW standards, albeit not the primary factor.

With regards to the seven (public sector) care homes that cited a Local Authority policy decision as a reason for closure the quality of care was deemed to be 'excellent' prior to closure and none of them had any outstanding CSSIW compliance notices when the home was closed. However, the interviews indicate that despite the high quality of care, the physical characteristics of the accommodation itself was lacking in certain respects. Five care homes were closed because the Local Authority had decided that the homes were outdated and no longer fit for purpose and it was not financially viable to upgrade the homes. Three of these homes were located in the same Local Authority area and the interviewee explained that:

> *"we decided the homes were outdated, not in good condition and needed updating. They complied with CSSIW standards but were becoming increasingly run down and too costly to update."* (Manager/owner)

In these three cases the interviewee explained that all residents were rehoused appropriately and in one case a new home was built on the same location and residents were able to take up occupancy there once completed. Two interviewees explained that the other two homes (also located in one Local Authority) were also outdated, specifically that the bedroom sizes were slightly smaller than required by CSSIW. One of the interviewees was keen to emphasise that:

"The main reason for closure was that the Local Authority was forward thinking in terms of the importance of home and community care and having appropriate care."

(Manager/owner)

A policy decision had been made to demolish the two homes and replace these with two high standard purpose built residential homes on the same sites. Although care was deemed to be 'excellent' in the homes that closed due to policy decisions, it is clear that at least in five of the seven homes, there were issues around the quality of the accommodation and whether it could continue to meet CSSIW standards.

Of the remaining two homes closed for policy reasons one was closed because of a Local Authority decision to reduce provision. Demographic changes in the area meant that there was an increasing surplus of beds and thus the decision was made to close the home and re-house residents in alternative vacant accommodation. The final home was being closed as part of the Local Authority's reconfiguration strategy to move towards an extracare model of provision for care of older people.

In the four homes where failure to comply with CSSIW standards was given as the reason for closure, the standard of care was deemed poor. A variety of reasons were provided for this including POVA and safeguarding issues (*n*=3), the standard and condition of the property (*n*=3), health and safety issues including risk assessment (*n*=2), and the absence of individual care plans (*n*=1). The concerns about the quality of care are echoed in the comments of two of the interviewees:

> *"I had grave concerns about the standard and quality of care being provided and the home was failing to comply with a raft of standards"* (Manager/owner)

> *"Poor care for people with dementia. Pressure areas were reported but the new provider had no understanding of care regulations and ignored compliance notices"* (CSSIW inspector)

In at least one of the homes where failure to comply with CSSIW standards was given as the reason for closure, CSSIW recorded the reason for closure as 'voluntary'. It seems that this is probably because the owner terminated the business due to lack of financial viability before the closure process was enforced by CSSIW. This example serves to illustrate how the current classification categories of 'enforced' or 'voluntary' closure do not capture the interplay between complex events. Furthermore, Chapter 6 illustrates the reluctance of the JIMP (or equivalent) to take decisive action to close homes where they continue to fail to meet minimum standards, leaving it to the providers to cancel their registration and thus able to set up the same type of business (care home provision) in the future.

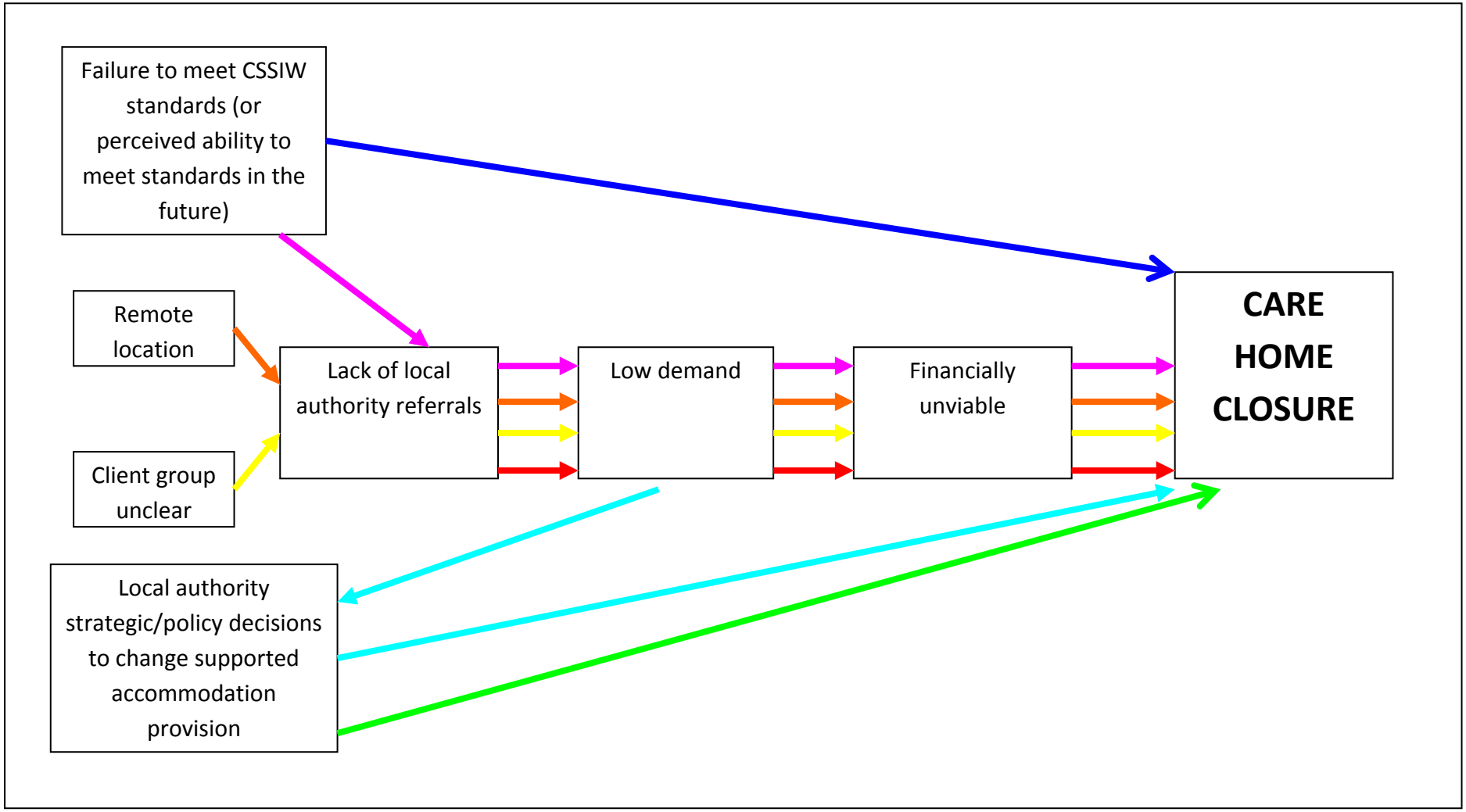
Figure 3 provides a visual representation of the relationships between the factors leading to care home closure that were described in the interviews. A failure to meet CSSIW standards (or the perceived ability to meet standards in the future) may lead directly to the decision to close a home. On the other hand, the failure to meet CSSIW standards may lead to a lack of referrals from the local authority, resulting in low demand for places in the facility and a lack of financial viability, ultimately resulting in closure. Regardless of care standard issues, other homes may close because a lack of local authority referrals. This may be a consequence of the location of the care home, or the lack of clarity around the client group, but on other occasions, no precipitating reason was given. However, the result was the same: a lack of referrals, led to low demand, lack of financial viability and closure. An alternative pathway to closure was through local authority strategic/policy decisions to change the types of supported living arrangements within the county. On one occasion the change in local authority strategy was pre-empted by lack of demand in the care facility, but in a majority of cases, the local authority's decision to change the supply and type of supported living provided in the area led directly to home closure.

The impact of the reasons for closure on the process of closure

The in depth interviews regarding the sixteen home closures also provided information about the home closure process. There were wide variations in the timescale within which the homes closed ranging from three weeks to three years. The reason for closure had a significant bearing on the closure notice period with those homes closing due to non compliance with CSSIW standards closing within the shortest timescale and those being closed because of the Local Authority policy decision taking the longest. It should be noted that those that were closing because they were unable to meet Minimum Standards were classified as voluntary closures (not enforced). The final decision to close was made by the independent provider (sometimes to avoid costly financial implication of meeting standards, or staying open during an enforced closure process).

The reasons for closure as well as the closure notice period were also significant factors in the level and nature of the involvement of various agencies as well as the extent of consultation with residents and families that occurred during the closure process. Of the 16 care homes eleven reported a good relationship with CSSIW while four either had a poor relationship or some difficulties with CSSIW. Three of those that reported a poor relationship with CSSIW were homes that were being closed for non-compliance with care standards. In

Figure 3. Seven pathways (indicated by different colour arrows) to care home closure identified in the in-depth interviews



all four homes being closed for failing to meet care standards, CSSIW offered advice and assistance throughout the closure process.

CSSIW was also involved in the closure of two of the homes being closed for policy reasons as evidenced by the following comment made by one of the managers/owners*: "CSSIW were very supportive, approachable and offered advice as and when required."* One of the homes being closed due to lack of demand and financial viability also had regular meetings with CSSIW regarding the closure process.

Some interviewees also commented on the level of multi-agency cooperation that took place during the home closure process. In the case of three home closures (one public sector and three private sector) the interviewee made specific reference to the fact that a JIMP and HOSG had been convened, in accordance with the escalating concerns guidance which had the effect of initiating extensive multi-agency intervention. Multi-agency working was also commented upon by interviewees in relation to another three homes (two public sector and one private sector) with one stating that they were *"extremely impressed by the level and quality of multi agency working"* (Manager/owner).

With regards to the level of resident and relative/carer consultation and involvement this was greatest in the public sector homes closed for policy reasons. From the outset regular information was provided and individual and group meetings and interviews with residents, relatives and carers continued throughout the process. It is clear that CSSIW inspectors and managers believed that the consultation process was important and benefitted residents:

> *"A number of consultation exercises were undertaken with residents, relatives and staff. All those involved were kept fully informed of what was happening"*
>
> (Manager/owner)

> *" Detailed information was provided and consultation undertaken with all parties affected. The dignity, choice and rights of residents were upheld at all times."*
>
> (Manager/owner)

> *"The closure process went well and the key to this was the individual interviews, suitable alternative options and the involvement of all those involved. It is essential to have a plan to ensure a smooth and satisfactory transition for all those involved".*
>
> (Manager/owner)

It is worth noting that consultations regarding care home closures are not necessarily perceived to be beneficial by residents and relatives. In Chapter 4 we indicate that a lengthy consultation period may cause distress and anxiety. Furthermore, where local authorities make strategic decisions to close public sector care homes, relatives are sceptical about the influence that consultees have over the process.

Differences between reasons for closure in England and Wales

The data on causes of care home closures in Wales had some similarities and some differences to the reasons identified for closure of care homes in England in 2001 (Netten et al. 2002). Firstly, with respect to the differences between the two set of data, in our interviews with managers/owners and inspectors we did not find any mention of personal circumstance, property prices, difficulties with retention or recruiting care home workers or Local Authority fees contributing to care home closure. However, the latter is addressed separately in Chapter 5 where we describe the impact of Local Authority pricing structures on financial viability in several care homes that were eventually saved from closure. On the other hand, in Wales we found that the Local Authority strategies to change the provision of supported living impacted on care home closure. This was not cited as a reason for care home closure in England (Netten et al. 2002).

One major core pathway was identified in Wales, this involved lack of referrals from the Local Authority, lack of demand for places within the care home, decreased financial viability followed by home closure. Although the pathway is not described in the English study, the various factors were cited as reasons for home closures. In the present study, some factors were identified as precursors to the lack of referral (e.g. remote location of the care home, and lack of clarity around the client group), but the one bearing most similarity to the causes of closure identified for English care homes was related to *Minimum Standards.* In the study by Netten et al. (2002) care homes were closing to pre-empt the financial outlay required to ensure that the accommodation met legislative standards. Similarly, in Wales we found that public sector care homes closed because of the anticipated financial outlay required to continue to meet standards over the coming years. On the other hand, private sector homes began to financially fail because of a decrease in referrals from the Local Authority that was directly attributable to their inability to meet the minimum standards. Ultimately, both pathways to closure were attributable to the *National Minimum Standard for Care Homes for Older People* (WG 2004).

Summary

This chapter has reported on the prevalence of care home closure in Wales. We found that 16 care homes closed during a 12 month period. Our investigations highlighted discrepancies between the number of closed care homes identified by the research team and those identified by the CSSIW. The discrepancies draw attention to problems with CSSIW reporting mechanisms.

The chapter has reported on the reasons for closure and pathways to closure for 16 of 27 care homes that closed during a 21 month period. Although superficially it seems that financial reasons are the major cause of closure, on closer inspection the Local Authority plays a major role in financial viability of care homes. Ultimately, the Local Authority is responsible for referring clients (funded by the public sector) and can bankrupt care homes in the independent sector by decreasing referrals. In the examples presented in this chapter, as far as we are aware the care homes were not 'officially' embargoed. We believe that some of the issues that were precursors to the decrease in referrals could have been tackled through discussion between the care home and the Local Authority perhaps facilitated by CSSIW through the escalating concerns process (e.g. defining the client group clearly, and supporting care homes to raise care and accommodation to meet minimum standards). On the other hand, the process of escalating concerns, and ultimately the closure of the care home, is in some cases unnecessarily slow and allows the care home provider to voluntarily close and operate as a provider in the future, despite serious concerns regarding the protection of vulnerable adults, or the provision of adequate care. The process of closure is examined in Chapter 6.

4

THE CLOSURE OF CARE HOMES: IMPACT AND CONSEQUENCES FOR STAKEHOLDERS

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Introduction

The decision of an owner, private company, or the local authority to close a care home may have been reached over a long period of time. However, the process of reaching this decision is not necessarily shared with residents or staff of the care home over the same period of time. The minimum notice required to de-register a care home under existing regulations is 28 days. As a result, the announcement of closure may often come as a surprise to residents, relatives and staff and create a situation of urgency whereby alternative care placements for older residents need to be established within a short space of time. The closure of care homes in the private/independent were undertaken very quickly and meant that the research team were unable to recruit any case studies from this sector.

The failure to recruit closing care homes from the independent sector resulted in a sample comprised entirely of local authority care homes in different stages of decommission and closure. Wary of the potential for legal challenge, most local authorities instigated lengthy consultation processes and closure plans, some spanning a number of years. Although the stated intention was to avoid the anguish of sudden relocation, this study found that in some cases, a prolonged closure period of uncertain duration in itself created distress and anxiety to those involved. This chapter describes the experiences of care manager, key worker, older residents, and their relatives during the process of care home closure.

The case studies

During the interviews, the research team made observations about the physical environment and the general atmosphere of the homes that were closing. In the first case study care home, the care home manager reported that one of the reasons for the home closing was because the property was falling below minimum standards, specifically with regards to the size of bedrooms, maximum allowed occupancy and *en suite* facilities. Therefore, only essential maintenance was being carried out prior to closure and although living standards within the home appeared comfortable, the care home itself had a neglected feel. Conversely, the second closing care home selected for the study was in very good condition and boasted a very pleasant outlook. This care home was in the process of closure

as part of the Local Authority's decision to develop extracare sheltered housing in the area. The extracare sheltered housing facility was being built in sight of the existing care home. The decision to close this care home was deeply unpopular and evoked distress and emotions amongst residents, relatives and staff. Unsurprisingly, both homes shared a melancholic atmosphere due to the nature of the decisions to close. This is also documented in the earlier study conducted in England by Williams et al. (2003) concerning care home closure where relatives spoke of an 'unhappy atmosphere' (p. 41).

From our discussions with care home managers and from our observations within the care home, in both settings there appeared to be a high prevalence of dementia amongst the residents. Even amongst the older residents who were interviewed and had the capacity to consent and participate there was some degree of cognitive impairment (perhaps dementia) or short-term memory problems which made it difficult to recall certain information and detail. There was also a sense that the older residents were reluctant to give much information which might be construed as complaining or being critical of the care they were receiving. This is well documented in research involving older people or disabled service users who do not like to reveal abuse (or neglect) or to complain, for fear of retribution from service providers, withdrawal of services or a decrease in the quality of care provided (Hendey & Pascall 1998; Tax & Brown 1998).

The views and experiences of care home managers in closing care homes

Two managers of local authority run care homes that were in the process of closure were interviewed. In both care homes, the process of closure was being managed centrally by the Local Authority that was dealing with the possible redeployment or redundancy of staff. Both homes had an initial onsite meeting conducted by a senior representative of the Local Authority and attended by all staff employed at the home. At this meeting the timescale of closure was outlined, and queries and concerns were answered. Following this meeting, further information was relayed to staff via the care home manager who attended monthly closure meetings with the Local Authority. One care home manager reported that although she found these monthly meetings 'with head office' valuable, she was not at liberty to divulge all of the details of the meeting to the staff. This created a sense of frustration because although she was trying to offer as much reassurance to the staff as possible she was simultaneously required to withhold key information.

In general, the care home managers reported satisfaction with the level of support and information they received from their line managers in relation to the closure plans. As both

care homes were under the jurisdiction of the Local Authority, the plans had been subject to consultation for some time. In both cases, the possibility of closure had been discussed for some years prior to the decision being taken (in one case up to 10 years before).

At the time of the interviews, only one of the homes had a fixed closure date. The other care home was located within a local authority that had made a commitment to ensure that all of the older residents would be offered a full choice of alternative care homes. Some of the alternative care homes in the area had long waiting lists and so it was likely that relocation might not occur for some time. This meant that the closing home was unable to fix a closure date.

> *'No, not a definite date because of the difficulty in placing people…we've got people here with different needs, it's not as though they're all residentially fit because they're not and one move is traumatic enough I think…so we're trying to make sure every placement is very suitable for that person, as opposed to just moving them into a space.'*
>
> Carly (Care home Manager)

Although on the surface this may sound like an admirable approach to finding alternative accommodation for the residents of the closing home, the manager expressed concerns. In particular, the manager noted that it was proving difficult to ensure staffing continuity as they were unsure of whether to look for other jobs or stay. Another consequence of not having a final closure date was that some relatives were not actively looking for alternative placements. One manager felt the relatives were *'burying their heads in the sand'* especially in light of the limited number of independent providers in the area.

The care home managers' perspective on how the older resident's reacted to the news of the closure was quite different to the reports from the four residents (see below). In both homes, the managers noted that the confirmation of the decision to close came as a shock to residents, relatives and staff;

> *'They [residents, relatives and carers] were very upset, especially some of the residents, they weren't sleeping at night, they were worried…'*
>
> Jill (Care Home Manager)

Both of the managers that were interviewed reported that, with time and support from relatives and care staff, the older residents eventually came to terms with the news of the closure.

Typically, relatives of residents were informed of the decision to close the care home either by letter or directly by the care home manager. Unsurprisingly, following the announcement of the closure, there was an influx of queries from relatives directed at the managers. Both care home managers felt equipped to deal with the general queries directed at them by older residents, relatives and staff. However, one care home manager felt that they were not able to deal with more complex issues such as the relocation of older residents with dementia and the coordination of multidisciplinary assessments. This manager noted that the involvement of social workers in the relocation process came too late, and there were unresolved complex issues that were creating distress for the older residents and tension for the staff.

Tom's situation is an example of a particularly complex situation which would have benefited from the expert input of a social worker. In this instance, Tom and his wife were both residents in the closing care home. The manager explained that whereas Tom would be suitable for placement in an extracare sheltered housing facility his wife has advanced dementia and would not necessarily be catered for in this type of living environment. However, both wished to be relocated together and their options were unclear. Another example included two male residents who have forged a close friendship over their time at the home, also wanting to be relocated together.

On the whole, the process of choosing an alternative home and organising the relocation was left to relatives. From our data, it is not possible to ascertain whether social workers were involved in re-assessing individuals whose level of care had changed over time and those who had no relatives or friends to act on their behalf. Both care home managers reported that in their opinion, the process of preparing older residents with dementia for relocation did not differ to that of other residents. This meant that relatives were expected to communicate news of the closure, provide support and organise alternative accommodation. Mangers did not explicitly mention of the need for social work or advocacy involvement with older residents with dementia during care home closure and relocation.

Neither of the two care home managers in the case study sites was interviewed after closure of the homes (as both care homes in this sample remained open beyond the end of the research). However, Chapter 3 reported on the telephone interviews with owners and managers of care home that closed in 2009/10.

The views and experiences of care staff in closing care homes

Three care staff were interviewed in the two local authority run care homes that were closing. Care staff had been informed of the likelihood of closure between 3 months and 5 years prior to the interview. As noted by the managers, in each case, a meeting was called for staff with senior management in attendance to explain the reasons for the closure and options for their redeployment or redundancy. Staff felt they had received a sufficient amount of time to get used to the idea of closure. News of the closure was met with a general sadness particularly concerning the implications for the residents who would have to relocate and for the employees in terms of finding alternative employment.

The care staff involved in lengthy closure plans reflected certain misgivings over the arrangements regarding the uncertainty of closure dates (as did the care home managers noted above). Their concerns centred on the potential to create additional stress and anxiety for both the older residents and the staff.

> *'Well the only thing with the longer notice is they've [older residents] got more time to dwell on it. It might make them ill, sleepless nights; you know it'll affect them.'*
>
> Sian (carer)

With regard to the impact on the care workers as employees in a care home, the uncertainty of the final date of closure was unsettling for the staff.

> *'...not knowing; it's just not knowing what's going to happen and they haven't given us a timescale when this is going to close, so we're in limbo really'.* Sharon (carer)

Despite the uncertainty surrounding the length of employment in the care facility, only one carer expressed a sense of demotivation. She noted that there would be a crowded local job market with several staff (with different levels of experience or tenure) all vying for a small number of jobs and creating tension and bad feeling. For example, in the one study site where an extracare sheltered housing facility was being nearby, it was clear this was the most popular redeployment option amongst staff creating a great level of competition for employment. Other care workers were happy to consider other jobs in the community such as homecare services.

In all cases, care staff felt that it was important to maintain a professional, *'business as usual'* approach to continuity for the older residents during the process of closure. Care staff also noted that older residents and relatives turned to them on a daily basis for support and reassurance regarding the closure and relocation. This was particularly difficult for staff when they felt that they were unable to give their true opinion of other care facilities that they believed to be inferior the closing care home.

> *'It's just hard really. I'm still a care assistant but then we've got the residents asking questions and families coming up to you and asking. They're going to look at such and such a place and then deep down I don't want them to go there because I know the reputation, but I can't tell the family that.'* Cathy (carer)

Although some care homes expected care workers to provide reassurance to residents this was not the practice in all closing facilities. Carers reported that the home had adopted a policy of minimal discussion with the residents about the situation, leaving the reassurance to the relatives;

> *'Well they don't say anything. Nobody talks about it. I think it's just a taboo subject now…'* Cathy (carer)

> *'We leave that to their families. If they do mention it to us then we do try and reassure them, but it's mostly left to the families…'* Sharon (carer)

The staff recounted the different ways in which the older residents reacted to the news of the impending closure: some were upset by the news, others were more stoical. However, our interviews with residents suggest the stoical nature of residents may be superficial (see below). In the case study site where extracare sheltered housing was being built next to the care home, staff noted that this was causing a great deal of distress to the older residents and care staff. One care worker noted that one resident was so upset that he asked to move rooms so he would not overlook the construction site. Care staff also recounted some of the ways older residents with dementia reacted to the news of closure. Some residents were unable to retain the information or comprehend the situation, whilst at the other extreme one man with dementia packed his bags daily as he continually thought that moving day had come. One

staff member reported that the relatives were far more upset than the older resident over the news.

In general, staff felt well supported during the process of closure although they believed that they should have been given more information more regularly. A number of the staff were unconvinced that closing the council's care homes was the best option for residents, particularly where extracare sheltered housing facilities were being developed to replace the residential care facility.

The views and experiences of older residents before and after relocation

Residents before Relocation

Four residents were interviewed in two different local authority care homes that were in the process of closing, before their transfer to another supported living environment. The length of time the older residents had been living in a care home ranged between five months and ten years. Two of the older residents had already experienced care home closure and relocation from another local authority care home that had closed. The other two residents had entered residential care directly from their own home. All of the residents we interviewed cited increasing physical and mental frailty as reasons for deciding to enter long-term care as they could no longer manage, despite formal and informal support at home.

Most of the older residents had difficulty recalling much of the detail of when and how they were informed that the care home was to close. However, the details they were able to recollect, suggested that they were informed either directly by the care home manager, a representative of the Local Authority or relatives. In both care homes, the possibility of closure had been public knowledge for some time and subject to a period of consultation. Therefore when the final decision was made to close, the news did not come as much of a shock to the older residents. However, as Tom suggests, with passing time and no definite news of closure, the urgency of the situation subsided and life settled down until further news filtered through;

> *'We knew that there would be a change a long time ago but as the year goes round and nothing happens, well you seem to settle down'.* Tom, 90 (Older Resident)

It was difficult to get a sense of the older residents' true feelings about their situations as they appeared reluctant to go into detail about their experiences and the impact these had upon their lives. Some were almost blasé about the closure and relocation, presenting a

seemingly stoical attitude to the forthcoming changes. Other reactions could be interpreted as powerlessness or a concealment of their true feelings. For example, Arthur notes that the first move into residential care was as distressing as the anticipated closure of his current care home.

> *'I was no more disappointed that it was closing than I was disappointed at having to come in [to care] in the first place'.* Arthur, 83 (Older Resident)

For Gloria, her stoicism may have been a superficial act: putting on a brave face in order to quell the anxieties of her relatives. For example, she made reference to her age and proximity to the end of life as a means of mitigating the impact the situation might have upon her;

> *'Well the thing is I'm 90, I ain't got much farther to go so I think why worry about it I may not see it at all. I'll maybe go to bed tonight and not wake up in the morning.'* Gloria, 90 (Older Resident)

However, the quote below suggests that internally Gloria was distraught about the move, but did not want her son to know the extent of her emotional distress.

> *'Well he [son] doesn't like to see me upset about anything so I try not to be upset. I think that's the main thing you know.'* Gloria, 90 (Older Resident)

Gwyneth expressed her reaction to news of the closure conveying, at the other extreme, a sense of powerlessness and resignation to the fact that they had to move and that she could do nothing to stop the process of closure.

> *'I was gutted at the time but can't do much about it.'* Gwyneth, 85 (Older Resident)

Gwyneth's son was dealing with all the arrangements and decision-making concerning her move. Whilst she stated she was happy for him to do this, her feelings of powerlessness were again highlighted when she responded to the question of whether she had a say in what was happening to her during the process of closure;

'I don't really know as it is difficult when I don't know what is happening'.

Gwyneth, 85 (Older resident)

This suggests that, although older residents involved in home closures are supported by relatives, they are not always included in key decisions or plans that directly impact upon their welfare.

The main sources of physical and emotional support for older residents during the process of closure were primarily from relatives with care staff (including the care home manager) providing more general reassurance and comfort. None of the older residents interviewed were able to say for definite whether or not they had spoken with a social worker or advocate (despite one manager stating that a local advocacy service had been commissioned). Most of the older people interviewed had relatives and/or a close friend who supported them through the process and the care home managers had made an implicit assumption that the relatives were the most appropriate and best equipped to provide the older residents with emotional and practical support. Only one of the older residents interviewed was without either a relative or a close friend who was actively involved in the relocation: Tom had no family other than his wife who was also resident at the care home. Whilst Tom and his wife had regular contact with friends who lived nearby, they were not receiving practical or emotional support concerning the move. Tom's wife had advanced dementia and although this was currently managed by the staff at the care home, she required a high level of support and supervision. Tom only required minimal care and was concerned that this could potentially result in them being relocated separately to different care establishments. In this case, Tom stated that he turned to the care home manager and the staff for support during his relocation. However, there was no mention of the involvement of a social worker or advocate, which may have been more appropriate on this occasion to represent the couple's needs.

Despite feeling that they were well supported, either by relatives or care staff in the run up to the closure of the care home, all of the residents interviewed stated that they would have preferred to remain at the care home that was closing and had a generally positive opinion of the care provided. Many residents spoke of the importance of having basic activities of daily living such as meal preparation and laundry taken care of in the care home in which they resided. Despite these being standard types of care provision and support within care facilities, residents' quotes suggest that there was an implicit concern that they would not received these services elsewhere or that the standard of services would be lower

than their current levels of provision. However, the older residents were not explicit regarding how they believed that the care that would be offered in the future may differ from the current care provision;

> *'Well, we get a lot of our meals done here; we have our washing done here. There is very little for us to worry about in that way…you just ring the bell, day or night and they're sure to come'.* Gywneth, 85 (Older Resident)

> *'Well they come 'round in the morning and help you…when we come down our breakfast is ready and these things happen all day. When you're living independently, you have to think about all these things.'* Tom, 90 (Older Resident)

The residents' comments also suggest that they had low expectations of what life within a care home would be like so that even the provision of basic services was considered noteworthy. For example, one older resident spoke of her surprise at having her room decorated.

> *'The staff are all very nice…they've done this room up for me which I never expected…'* Gloria, 90 (older resident)

Despite this, residents reported an overall satisfaction with the care they received although for Arthur, the relationship with staff was a major factor in how he perceived good quality care. When asked whether he thought he received good care at the home, his response was *'That's a difficult one to answer, the variation between carers would confuse…there are so many different personalities amongst them'.* Arthur had an unconstrained character with strong personal opinions and certain intolerances that he was not afraid to share. There were distinct undertones in some of his responses to the questions that suggested he thought himself irksome and unpopular within the staff in the care home;

> *'My demeanour drags them to tolerate me better than they would. My sense of humour, I drag them into a sense of humour which they didn't have, it appeared before I came in'.* Arthur, 83 (Older Resident)

Arthur stated his move occurred quickly, which he attributed to the staff at the home '*wanting to get rid of me'*. This suggests that older people's personalities might influence the way they are treated during the process of closure, and that certain characteristics may lead staff to perceive that some residents are well-equipped to deal with major life changes such as relocation. Arthur's self-confessed belligerence may have accounted for the fact that he felt unsupported in the process of his relocation. However, the interview revealed that he was as distressed by the relocation as he was about having to enter residential care in the first place.

Residents after Relocation

Only two older residents relocated during the course of the research and were interviewed approximately four to six weeks following relocation. Gloria's relocation was managed entirely by her relatives, although they later reported that they were offered assistance by staff in both the closing home and the new home. Arthur's relocation was managed by staff in the closing care home: the staff packed his belongings and transported him to the new home where the staff in the new care home unpacked his possessions and helped him to settle in. When we first interviewed Arthur, he made several mild suggestions that he was not particularly happy with the general service he was receiving at the previous care home but would not go into further detail. In the follow up interview however, Arthur was more openly critical of the previous care home and clarified his reasons for being reticent to identify the shortcomings of the closing home in the previous interview and to the staff within the care home;

> *'No, I didn't [complain] because you don't want to cause, it causes ripples, big waves. They wouldn't take it on board what you were trying to say and of course they take to criticism badly...'* Arthur, 83 (Older resident)

After the move, both Gloria and Arthur appeared to be settled with no major concerns reported about the actual move. Arthur and Gloria said they had been made to feel welcome in their new home, in fact Arthur mentioned that the first three carers he saw as he entered the building were grinning at him causing him to think he had 'come to a funny farm'. Although both said they were warmly welcomed to the new home, neither spoke of plans or arrangements to keep in touch with residents or staff at the previous home which is perhaps unsurprising as neither person appeared to have formed any special attachments there. For example, Arthur stated that the level of cognitive impairment of other residents in the closing

care home had been a barrier to him building any lasting friendships. However, because of our small sample, we cannot be sure whether any plans for the maintenance and continuation of social relationships were made for residents who had friends in the closing home and who were subsequently relocated to different care facilities.

The views and experiences of relatives before and after relocation

Relatives before relocation

We interviewed four relatives (in three interviews), including a son and daughter-in-law. The four relatives were related to three of the four older residents interviewed as part of this study. Relatives were informed of the possibility that the care home might close either by letter from the Local Authority or directly by the care home manager. Following the initial announcement, public meetings were arranged by the Council where details of the closure plans and implications for the residents were discussed in more depth. In most cases, the relatives informed the older resident that the home was to close although care home staff reported that not all of the older residents were told about the closure because of their ability to understand or retain the information. Non-disclosure of care home closure was also reported in the study conducted in England (Williams et al. 2003) where relatives and care home staff were often unsure whether to tell the older residents for fear of upsetting them or triggering an adverse reaction.

The relatives held positive opinions of the closing care homes and none were supportive of the decision to close the home. Most felt that the decision to close the home was based on saving money rather than providing better care. In one home, the relatives were not surprised that there were plans to close it as they were aware of the construction of a new supported living environment (an extracare sheltered housing facility) in the vicinity. As work had already started on the new extracare facility, relatives were understandably sceptical about the consultation process, and were dubious about the impact that voicing their views would have upon the decision to close the care home. The relatives believed this was a 'check box' exercise by the Local Authority without adequate feedback provided from consultation sessions.

> *'Then we had a big meeting...but we felt that no matter what the family of the residents here said, that they wanted to close it and that's it, but we feel strongly against it.'* Sally (Relative)

'We had the chance to ask questions and they were answered but we weren't given a definite, you know, they were like passing the buck, if you know what I mean'.

Sarah (Relative)

All of the relatives we interviewed stated they were responsible for locating suitable care home vacancies and choosing the alternative accommodation. Most of the relatives had a good idea of what was available in the local area and has spent some time looking at other care homes. Generally, the older residents were given the opportunity to visit the 'shortlisted' homes but not all took this up. For example, Gloria told us that she had not seen the new care home prior to moving as she had left this decision to her son and daughter-in-law. Her relatives believed that she was happy with the outcome. However, Gloria's interview prior to moving suggests that she was putting on a brave face in order to quell the anxieties of her relatives. Consequently, the relatives' opinion of Gloria's acceptance of the new care home may not be based on her true feelings.

Relatives spoke of the importance of the new care home's location. Some relatives wanted the care home to be proximate so that they could visit frequently and reduce journey times.

'I wouldn't want her too far away. If there's something wrong I'm on the phone, I'm here in 10 minutes in the car...' Ken (Relative)

'But it's more travelling time for us to go and visit her. We won't be able to go…as often as we do when we come down here.' Sally (Relative)

Other relatives believed that it was important for the care home to be in the same community that the resident had lived in, so that they would be familiar or acquainted with other residents or staff.

'Well it's because of the community and she knows the workers here and she feels safe with them. She knows the other residents here too...' John (Relative)

Where residential care was being closed to make way for new extracare sheltered housing provision, some relatives discussed with the Local Authority the possibility relocating older residents into the new facilities. For some relatives this remained an

unresolved issue. Whereas some older residents were convinced that this was where they would be moving to, the relatives were unconvinced that the facility would be suitable and able to offer the same level of care that they currently received in the care home. We noted above that residents were unclear regarding expectations of care provision in a new care home facility (implying that standard services such as meal provision or personal care may not be provided in other facilities). Additionally, for relatives, there appeared to be a general ignorance surrounding the different levels of care, services and types of social activities that residents should expect to receive in nursing homes, compared with residential care homes or extracare supported housing environments, and which type of facility may be best suited to their needs.

> *'They said with this new place that - well it's going to be three different care facilities. One for the ordinary, then if they're worse - and if they're worse again and they'll have their own key to lock the door but on me mother's behalf she doesn't want that...she's come from a place like that to be in a place that people can check on her every two or three hours. Even though they said they can do that there...I think if this place closes her health will deteriorate terrible.'* Sally (Relative)

> *'But we didn't think it was for her...she'd be more isolated, she can't walk very far and it could have been an upstairs room...she'd be terrible in a lift.'* Sarah (Relative)

Despite an indication that often residents tried to hide their distress about the imminent closure of a care home relatives reported that they felt the impending closure was impacting upon the health and well-being of the older residents and 'playing on their minds'. In terms of provision of emotional and practical support, relatives felt that information and advice provided to them had been fairly minimal. Some relatives spoke of social work involvement in terms of reassessing the resident's needs and advising on the availability of alternative care providers. However, none of the relatives interviewed mentioned advocacy services or the involvement of CSSIW. Despite the apparent lack of formal or statutory support, relatives felt that they should be the main source of support and preparation for the resident during the process of closure and relocation;

'Well it couldn't be explained [to the resident] better than I did it…but I didn't have the answers to why this one was closing. I just blame the Government; they want these new fandangle homes, so close the old ones. That's my view on it'.

John (Relative)

Relatives after Relocation

Only two relatives (son and daughter-in-law: Ken and Sarah) were interviewed approximately 1 month after the older resident had relocated to an alternative care home. In this particular case the decision was taken to relocate was made because a vacancy became available in a neighbouring local authority home which was close to the family. On reflection, the relatives felt they had been given very little support concerning the practical aspects of the move. Although they had been in contact with the care home manager leading up to the move they reported that they had not been in contact with a social worker, an advocate or CSSIW.[1]

The relatives in this case had looked around a number of homes in the area. Although they were not accompanied by the Gloria (resident in the closing home), she had authorised them to choose a care home they thought most appropriate. When the vacancy at the new care home became available, the relatives were contacted by the manager of the new home, advising them that it was being offered to the older resident. The relatives recounted offers of practical help from the staff at the closing home with regard to packing belongings and arranging transport and the opportunity for the older residents to say goodbye to other residents and staff at the home before they left. Gloria was given the opportunity to say goodbye to other residents and staff at the closing home, however, she had not made reference to any social ties that she had formed whilst at the care home.

Whilst neither Gloria nor her family mentioned any special friendships at the care home she was leaving, her family placed great emphasis on the potential for improving her social network in the new care home. They saw the move as a positive choice as the location of the care home was much closer to her family and community-dwelling friends which would result in increased social contact. Furthermore, a number of staff from the closing

[1] Despite the relatives' assertion that they had not seen a social worker the older resident was in receipt of local authority funding for the care home placement and so the social worker should have been involved in providing a list of alternative care providers and ensuring the selected alternative placement was suitable by reviewing or reassessing the older person's care needs. The social worker should also be responsible for securing contracts with the new home and liaising with family and other allied health care professionals involved in the care of the older person to facilitate a smooth transition between care settings1.

home were employed in the new home so there was also an element of continuity and familiarity with the care staff.

The relatives also reflected on the condition of the facility and the services that were provided. They believed that the new care home was in better condition and less run down than the previous setting and that the resident's personal accommodation was of a higher standard (for example, with *en suite* bathroom). Gloria's relatives also commented on an improved standard of care at the new home: the care home staff took a lot of interest in Gloria, finding out her medical history, sorting out overdue medical appointments and booking appointments with a chiropodist.

Summary

From our discussions with stakeholders experiencing the closure of care homes there are certain themes that stand out, these concern (i) residents' low expectations of services which is closely allied to the residents' and relatives' lack of knowledge regarding the types of services that are provided in the range of supported living environments; (ii) residents' sense of powerlessness over the process of relocation; (iii) the absence (or at least visibility) of social workers and advocates in supporting the process of relocation, especially for residents without relatives or those with cognitive impairment; (iv) the potential detrimental effect of a drawn out closure process on staff and residents.

Older people who make the decision to enter residential care do so with very low expectations of services and treatment. This is illustrated in the statements regarding their gratitude for personal care services that should be fundamental aspects of care provision in residential and nursing homes. Furthermore, the inability for residents and relatives to discern between the different living environments in terms of their appropriateness to meet needs "is not surprising given that there has been a consistent failure within policy to define the objectives of residential care, sheltered housing or extra care sheltered housing" (Burholt & Windle 2007).

The themes that emerged from the interviews with older people in closing homes, suggests that they had come to view themselves as objects to be placed elsewhere. On the face of it, attitudes may be construed as stoic but there was an underlying sense of disempowerment and powerlessness. This suggests that there is an erosion of the older person's sense of worth and empowerment whilst in the care system and this makes them particularly vulnerable when care homes close. Despite this, our study highlighted the

absence (or at least low visibility) of social workers and advocates in supporting older people and relatives through the process of closure and relocation.

The Mental Capacity Act (2005) enshrines the principle that people have capacity unless otherwise proven. Furthermore, even when capacity is limited there is an expectation that older people should be supported to make choices or decisions, not as in the case of many of the residents in the two case studies, be kept in the dark about the possibility of care home closure. Our observations of care home closures suggest that the imperative to 'manage' the process of closure and relocation of older residents has resulted in a failure to properly engage with older residents and their relatives in a meaningful way. There was a tendency to view older residents (especially those with some degree of cognitive impairment) as a homogenous group, regardless of their individual strengths and needs. There was also an implicit assumption that relatives were best equipped to provide all the necessary emotional support whilst the relatives we spoke to struggled with the process and felt unsupported practically and emotionally.

Finally, the lengthy Local Authority consultations that were adopted in the case study sites were problematic. Residents and relatives perceived that the outcome of the consultations were forgone conclusions, and that the process was merely a check box exercise for the Local Authority. Furthermore, the lengthy process had the opposite affect than intended: rather than quashing worries (that were anticipated if a quick closure had been undertaken), the uncertainty about a final closure date increased the levels of anxiety of residents and relatives.

5

CARE HOMES THAT AVOIDED CLOSURE: IMPACT AND CONSEQUENCES FOR STAKEHOLDERS

Introduction

This chapter explores the views and experiences of older residents, relatives; care home providers, managers and staff in care homes that avoided closure. We identified a single independent provider that faced the threat of closure for financial reasons. The independent provider had five care homes, four of which were for older people (three residential care homes and one nursing home).

The threat of closure had arisen because the residential fees paid by the local authority were insufficient to maintain business viability, despite full occupancy across the four residential care homes. The fee levels local authorities pay to independent providers varies across the authorities in Wales, and is often a contested topic. In this case the provider had been lobbying for an increase in fees for several years. Although the local authority had engaged in discussions about the financial difficulties facing the provider, annual increases in fees were in the region of £5 per person, per week.

The provider had considered pressing for a judicial review for some time but the decision to proceed to court was expedited when the provider's bank began levying financial penalties upon the business. Despite being at full occupancy, the business was falling below the bank's expected profitability margin; that is, for every £1 paid on the mortgage the bank expected another £1 to be made in profit. Subsequently, the provider had no option other than to challenge the Local Authority fee they were being paid or face further financial penalties and possibly foreclosure of some or all of their care homes. However, the provider did not challenge the bank, whose decision to impose financial penalties led to the care home facing the risk of closure. The judicial review found in favour of the independent sector and ruled that the Local Authority should increase fees for residential care places to £448 per week. The level of fees is still below the amount requested by the independent provider (£480) and at the time of writing this report it is unclear whether a second judicial review will be instigated. However, this case received a significant amount of media attention and was viewed as a landmark ruling for other care home providers across the UK. Thus, it set a legal precedence for independent providers to challenge other Local Authorities regarding the level of fees.

The views and experiences of care home providers

We interviewed two partners that owned and operated four care homes that had been saved from closure. Residential care is means-tested and if an older person has savings or assets which exceed the maximum amount stipulated by the local authority's charging policy (£22,250), then they are liable to pay the full amount of their care directly to the care provider until their capital reduces below this threshold. Care providers are at liberty to charge different, often much higher rates, to those who pay for themselves (self-funders) than they receive from the local authority. In this case there was a difference of £90 per week between provider's account of the 'true cost' of care (£480) and the fees paid by the local authority (£390). Although the ratio was approximately 50:50 with regards to residents funding their own placement to those who received local authority funding, the care providers had started to favour self-funders as opposed to local authority funded residents in order to improve their income stream.

Until 2008 the Local Authority had historically paid weekly rate for residential care that they had increased annually to reflect inflation. At the end of the 2008 financial year the weekly fee paid for residential care places was £368. Prior to the threat of closure the providers were able to keep operating by increasing the occupancy levels to cover their costs. However, once they reached 100% occupancy they were unable to increase their income any further. At this point in 2008, the provider realised that they were facing an uncertain future: costs to provide care to the residents were increasing but fees were not. Consequently, the provider initiated discussions with the Local Authority. The Local Authority responded by revising the fees based on the Laing model (Laing 2008). Laing had developed a toolkit for calculating fair fees for residential and nursing homes based on market prices (Laing 2008). However, the care providers felt the toolkit was not used properly as the outcome (£390 per week) was below what they had predicted (£480) and considered fair. Specifically, the providers claimed that the Council had not used the methodology correctly for the following reasons:

1. "It failed to deal properly with the calculation of capital costs in relation to the assessment of the provider's costs;
2. It failed to use appropriate local data in relation to the average number of care hours spent on each resident per week by staff members, it relied on benchmark figures and did not take into account local variations in staffing levels;

3. It failed to recognise that some residents received both nursing care (paid for by the local health board) and non-nursing care (paid for by the Council) and did not differentiate between the levels of non-nursing care required by those residents who required nursing care and those who did not;
4. It based its calculations on data from homes with 20 or more registered places and failed to take into account data from smaller care homes, which represent a significant proportion of the care homes in the Local Authority and
5. It failed to take into account inflation and the introduction of the new Working Hours' Regulations which increased the minimum holiday entitlement of staff and resulted in real terms in a cut in the fee rate compared to the previous year" (Austin & Brown 2011).

Following the unacceptable revision of fees, the care providers engaged a legal team to challenge the Local Authority's decision and spent the next three years trying to negotiate a rise in fees.

As noted in the introduction to this chapter, the independent provider's care homes came under threat of closure when the bank notified them of a default on their loan/mortgage. Within the loan agreement there was a covenant stating that for every £1 spent on the mortgage there should be £1 profit. Although the bank had previously waivered this covenant in 2008/09 they decided to enforce it. The resulting default penalties increased the provider's mortgage payment by £3000 a year. Furthermore, an administration charge of £7000 was made by the bank. This administrative fee could be charged every three months whilst the provider was unable to meet the banks demands. The providers noted that other care homes in the independent sector had also been placed in a similar position and were consequently facing serious financial difficulties and the threat of closure.

Following the notification from the bank about the default on the mortgage, the independent provider contacted a solicitor and the decision was made to apply for a judicial review. This was deemed necessary, as the care homes had good inspection reports, 100% occupancy and yet were not financially viable. In the providers opinion this was primarily because of the lack of adequate funding forthcoming from the local authority.

The Local Authority was advised that the care homes were at risk of closure and that the providers were taking the matter to court. The providers received a copy of the WG escalating concerns guidance and checklist for the closure of care homes from the Local Authority. The provider also set up a meeting with CSSIW to discuss the situation. The partners noted that they received a standard response from CSSIW (a closure pack), which they found of little use as they were already following the escalating concerns guidance. The

partners explained that they expected to receive support from CSSIW during the court case. However, they felt that the CSSIW observed rather than played an active role. On the other hand, there was a strong and helpful presence from the office of the Older People's Commissioner for Wales who took an active interest in the case.

The threat of closure for the chain of care homes initiated a lot of media coverage. Journalists from the local and national press were trying to infiltrate the care homes and the providers were concerned about the way they were portrayed in the media. For example, the press suggested that the providers had taken the case to court to maximise profit rather than keep afloat. The providers had to deal with the media in a sensitive way, publicising their cause whilst at the same time protecting the privacy and dignity of the residents.

The care providers wanted to set up good communication with staff and the families of older residents. However, once the story hit the media, 'panic set in'. Generally the partners felt that they were able to effectively communicate with families via letter and email. However, they noted that on one or two occasions this did not work as well as anticipated, especially for those relatives living abroad.

The providers stated that the majority of relatives and practitioners/professionals were supportive of the campaign. One of the care homes provided specialist care for people with severe dementia and the providers felt there was more of a 'human outcry' at the possibility of this particular closure due to the vulnerability of the residents there. The providers felt that this was rooted in the relatives' concern about what would happen to the older residents if the home closed. It was clear that if all of the care homes closed at the same time there would not be sufficient vacant places in other care homes in the county to accommodate all residents. Subsequently some relatives were concerned that they would be expected to take the older residents in and provide care for them.

> *'There's only one thing worse than having bad care, and that's having our family living back with us. They couldn't cope. So I think there was a motivation there to say well if this home closes where do they come? They come back here. We would never be able to cope. So what do we need to do to keep this place open? I think there was that element in it.'* (Care home provider 1)

Across the four care homes, only two residents moved out as a result of the threat of closure, one to a care home in a neighbouring local authority and one to a care home nearer to her family in London. In both cases relatives explained that they preferred to act on the

possibility that the care home would close rather than be faced with an emergency situation, particularly at Christmas.

The providers expected staff to leave or look for other jobs during the period that the home was under threat of closure. However, to their surprise the staff remained constant. The staff were aware that the care providers felt that they were underfunded and had been campaigning for higher fees for several years previously. Thus, the news that the matter was proceeding to court and that there was a risk of closure came as no surprise.

> *'We have kept staff fully informed about the fight for fees and how we felt underfunded. This has always been a reflection in their pay rates. So they always knew we were going down the road of going to court.'* (Care home provider 1)

> *'We did try our best by high levels of communication with the staff – staff meetings…kept them informed and they became part of it.'* (Care home provider 2)

The views and experiences of a care home manager

One care home manager was interviewed in one of the four residential care homes that was saved from closure. The care home manager had worked for the business for 11 years, working her way up from care worker, senior carer, and deputy manager until finally becoming manager. The care home was registered for residential care and had 24 places, four of which were vacant at the time of interview. Of the 20 residents at the home, eight were self-funding. The care home also provided day care and respite care, the latter dependent on whether places were available.

As noted above, at the time of the interview the care home had four vacancies. The manager reported that this was unusual and was unsure whether the publicity surrounding the threat of closure had had an impact on referral rates. Although she admitted this was a cause for concern , she reflected that it was not unusual to have quiet periods.

At the time of the interview there were 20 care staff employed at the home, four were part-time and the rest full-time employees. The manager noted that the providers ensured staff was kept informed of the impending court case that the threat of closure which appeared to create a 'shared ownership' of the problem, work-place solidarity and staff dedication to ensure 'business as usual'. The care manager noted (as had the providers) that during the period of threat of closure the staff group remained stable. Although some employees (including the manager) ,looked around to see what other jobs were available, none left and

eventually a sense of solidarity formed amongst the staff and later, residents and relatives. The care home manager also reported an unexpected increase in applications for work over the Christmas period.

The manager reported that she had received support from the care home providers, particularly with regards to the methods of dealing with the concerns of families and staff and responding to media requests. However, she reported that she did not receive any support from CSSIW who were 'unable to comment on the situation'. No special arrangements were made by social workers for the review or reassessment of residents at the home.

The ways in which the older residents were informed about the threat of closure varied. The manager stated that she was confident that the care home was not going to close. Subsequently, she decided not to widely broadcast the threat of closure to the residents, believing that this would avoid causing them distress. Furthermore, the manager decided not to tell older residents with dementia about the threat of closure. Following the announcement of the judicial review, many of the residents' families got in touch with the manager to seek reassurance and information about the situation. A few relatives told some of the older residents about the threat of closure, whereas others read about it in the local paper. The manager reported that on the whole the staff tried to keep the care home running normally, which included preparing for festive activities at Christmas.

The manager reported that only one resident relocated in response to the threat of closure. The resident's family were concerned that she would have to move in with them if the care home closed at Christmas, and found her alternative care home accommodation in England. However, the resident's son later contacted the manager to say they had acted hastily, as the older resident had deteriorated quickly since relocating to the new home.

Aside from her concerns regarding the potential for unemployment, the manager was concerned for the residents wellbeing, and relocation options should the care home close (as there would have been insufficient care home places available within the Local Authority). Furthermore, she was anxious that angry relatives may visit the care home and vent their frustrations on her. She was also worried that news of a potential closure might spark a mass exodus of residents and staff which would result in the home closing anyway. Ultimately, none of these scenarios transpired. The manager attributed the lack of major crises on the low profile that was maintained regarding the home closure, and that 'everyone'[2] (sic) was kept informed.

[2] Staff and relatives

Seemingly contradicting earlier statements (in which the manager noted she was worried about the relocation options for residents should the care home close) she revealed that she had been made aware of a contingency plan in the event that the fees were not revised following the judicial review. The contingency plan was to increase the fees paid by self-funding residents to cover the shortfall for Local Authority funded residents. Whether this would have alleviated the provider's financial difficulties in the long-term is unclear and certainly raises ethical and moral issues around charging for care.

The views and experiences of care home staff

We interviewed seven care home staff about their views and experiences in three of the residential care homes that faced the threat of closure. Despite knowing about the providers' battle with the local authority about fee levels, most of the staff reported being shocked when they heard of the impending court case and the realisation that the care homes could close if the case was lost. The staff reported that they were called to a meeting and told about the court case only a few days before it was due to start. Some felt that this was out of the blue and would have liked more notice. This was contrary to the views of the providers who thought news of the threat of closure came as 'no surprise' to the staff (see above).

Staff reaction to the news ranged from disappointment, concern and worry both for the older residents and for themselves. Redundancy would have significant consequences for staff with families and other financial commitments. One of the care staff interviewed was particularly worried as she was applying for permanent residency and was worried about what would happen to her application if she lost her job and could not find other work. Only one or two care home staff mentioned looking around to see what other employment was available but none of them applied for other jobs.

The care staff felt very well supported and informed throughout the judicial process. One care staff mentioned being 'inundated' with information but felt this was important in maintaining staff confidence and trust. Care staff spoke of being able to contact the care home providers for reassurance or further information. As reported by the manager, the care workers noted that the staff group supported each other contributing to a sense of solidarity. None of the care staff reported any demotivation in their work during this time and felt that it was more important than ever to maintain a 'business as usual' approach.

The care staff spoke of a formal policy within the homes not to speak about the situation openly with the older residents as it was believed that few would be able to understand the situation;

'We did try to tell them…but it wasn't sinking in so we told the family. So they didn't want to distress their family members [older residents] so the majority of them weren't told. Because they wouldn't remember within five minutes so why distress them.'

Elaine (care staff)

The care staff reported that following news of the threat of closure, they became involved in providing basic support, advice and reassurance to relatives. One member of staff recounted the reaction of one relative to the threat of closure;

'There was a certain person, he was devastated because he was happy that she [mother] was there [care home] and she was safe and he felt secure that she was there. He also loved the social element of coming to see her at the home and everything like that. So I know he was personally devastated.'

James (care home employee)

This suggests that for some relatives (and possibly residents), the care home is not just a building in which care and support is provided, but that an attachment to the home has been formed. The types of attachment noted by James (social and appropriateness of the environment) have been described elsewhere in the descriptions of emotional bonds that people form with places (Burholt 2012).

The views and experiences of older residents

We interviewed four older residents in three residential care homes that had been under threat of closure. The residents had lived in the care homes for between 3 and 10 years. We were informed by the care home staff (see above) that very few of the older residents had been informed of the threat of closure because of the belief that the level of cognitive impairment (dementia) would mean that they would be unable to comprehend the information. In such cases, the care home provider contacted relatives by letter or email to advise them of the impending court case and the threat of closure. Subsequently, the decision whether to inform the older resident was left to the discretion of the relatives.

Older residents who were able to understand the situation received the news of the threat of closure in a variety of ways. Two older residents said they had been told by the care home staff, but one knew nothing about the threat of closure until it was reported in the news

on the television. Subsequently, she asked a member of staff about what she had seen. One other resident, Ethel, said she had no knowledge of the threat of closure until after the court case. A degree of subterfuge was adopted by the care home, as Ethel discovered that her friend who visited her regularly knew about the threat of closure, but was told not to disclose this information to her;

> *'She [friend] knew before me and they told her not to tell me because they weren't telling anyone in here. They didn't want them upset.'* Ethel 85 (older resident)

The ways in which the older residents reacted to news of the potential closure were similar to the reactions of older residents in care homes that were in the process of closure; initially shock then for some, stoicism, for others worry and concern. One older resident, Jenny, conveyed a stoical approach to the situation and understood that someone (although she did not know who) had the responsibility of finding her alternative accommodation;

> *'Well I thought they'd have to do something with us. Couldn't just leave us could they? They'd have to find homes somewhere... As I say, I'm not a worrier. I just believe in what will be will be, one day until the next'.* Jenny, 89 (older resident)

For others, there was a sense of a loss of security and deep concern about where they were going to go and what was going to happen to them. Several of the older residents spoke of having sold their homes and now having *'nowhere to go'* if the care home closed.

> *'I was a bit shocked. I didn't want to leave here and go anywhere else…I thought, oh goodness, where will I go?'* Ethel, 85 (older resident)

> *'Well I was a bit worried really because I didn't know where else I was going to go then, you know?'* Mabel, 79 (older resident)

> *'...my home has been sold and all now. So I haven't got a home. So I'd rather stay here; nowhere else to go'.* Doreen, 87 (older resident)

As mentioned earlier, the threat of closure of the care homes under the control of the one provider received high profile media attention and was regularly reported upon in the

local and national press. Some of the residents (and relatives) said they used to turn the channels over when the story came on the news as they found it upsetting and worrying. In spite of this, within the home there was a sense of solidarity amongst the care home staff and the older residents and relatives. Those older residents who were aware of the situation received regular updates from the care home staff and some even accompanied the providers to the court hearing.

Older residents (particularly those without relatives) said that they received a lot of reassurance and emotional support from the care home staff. Some older residents sought emotional support and reassurance from the care home manager or provider, whilst others formed a bond with a particular carer. However, these supportive relationships were not always unproblematic. For example, intergenerational issues were highlighted between the older residents and the younger care staff. Several of the older resident referred to the care staff as 'girls' which denoted generational divisions, and may suggest that some older residents were not connecting with the 'young' care staff as they would with peers or mature members of staff. It is also unlikely that the interactions with the care staff that the residents clearly identify as immature, would foster an emotionally supportive relationship.

For one older resident, intergenerational differences were exacerbated by not being able to converse properly with immigrant care staff who had accents or limited English. Subsequently, communication between the resident and her carers was difficult;

> *'I've never had any trouble [with the staff] until these girls came. But you see, they're only kids really. They're 17 or 18 and they're foreigners. I don't mean that unkind, nothing wrong about that, but I can't hear what they're saying and they haven't got patience.'*
>
> Ethel 85 (older resident)

In addition to intergenerational difference, and difficulties with communication, it was also apparent that the characteristics of older residents impacted on how they were treated by carers. One older resident spoke of being labelled 'unsociable' by a carer because she preferred her own company to spending a lot of time with other residents, most of whom had high levels of dementia;

> *'...they'd have me go downstairs you know and mix but it's not because I'm not sociable, although one little girl said 'you're not sociable are you?'*
>
> Mabel 79 (older resident)

Labelling a resident as 'unsociable' may impact on the support provided by carers during the threat of care home closure. In other interviews in closing care homes (see Chapter 4), the personality of at least one of the residents had a bearing on how he was supported during relocation. Furthermore, the resident in the closing home attributed his swift relocation from the home as staff '*wanting to get rid*' of him.

The views and experiences of relatives

We interviewed 4 relatives, none of whom were related to the older residents interviewed in the previous section. The relatives were told of the threat of closure and impending court case either by letter or email from the care home provider. At the same time, the Local Authority also wrote to the relatives advising them of the situation and forewarning them of the possibility that the home would close within one month. Only one or two stated they had been aware of the negotiations taking place between the care home providers and the Local Authority concerning the fee levels prior to receiving the official notification. For some relatives, the letter from the provider arrived after the letter from the Local Authority so they were shocked to learn of the gravity of the situation. Both Jude and Colin were unaware of any issue around the financial viability of the home and they were distressed by the Local Authority letter (that arrived first) advising them that the care home may close at Christmas;

> *'They hadn't said anything to us about any of the negotiations that they'd been going through for two or three years. There was nothing - I suppose I can understand in a way that they didn't want to worry us because it did turn my stomach and I didn't know what the heck I was going to do. They've actually promised to keep her [resident] right to the end - they won't put her in hospital or anything like that. It was just sheer panic.'* Jude (relative)

> *'I'd actually gone away out of the country on holidays and when I came back... there was this letter from the Council... that was the first time... I thought, what the hell is this? So I came up the next day and she [provider] explained everything. I was a bit concerned because I'm thinking what happens? So it was like one minute I knew nothing and the next I'm getting Council letters saying it [care home] could be closed by Christmas.'* Colin (relative)

None of the relatives interviewed had told the resident of the threat of closure, nor were they aware of anyone else having provided this information. The relatives felt that the older residents would not be able to retain or understand the information due to levels of cognitive impairment (dementia) and that they may become distressed;

'I don't think my mother would know even if you told her [about the closure]... you could tell her but it just wouldn't mean anything to her... if she grasps it she would panic and it's pointless at her age.' Jack (relative)

'She wouldn't have taken it in, Mam can't retain much at all memory wise.'
Steve (relative)

'Our mother has probably been told but she will forget 10 minutes later anyway.'
Keith (relative)

'She wouldn't understand, I didn't want to upset... We never talked about it in front of her.' Christine (relative)

All of the relatives were positive about the standard of care within the supported living environments and some remarked upon their homely atmosphere. However, their main concerns were regarding where the older resident would move to in the event the care homes closed. Relatives were also concerned that there would be a domino effect whereby other care providers would also close down, leading to a shortage of placements in the local authority. Others were concerned that the closure might occur at Christmas which would make it more difficult to find an alternative care home. One relative was confused about the funding arrangements and concerned that the move would have financial implications upon the older resident and the family in terms of losing local authority funding and being forced to pay privately for care. Only one relative mentioned the impact that the relocation would have upon the older resident's health.

From their responses, the relatives appeared 'burdened and confused' by the practical and financial implications of potential relocation, particularly with regards to finding an alternative placement and sorting out finances. There was general confusion over whether any of the residents' care needs had been reassessed as a result of the threat of closure and

relocation. One relative had no idea whether his mother had been either reviewed or reassessed. Another claimed his mother had only received one care needs review in the three years she had been resident at the home. Furthermore, this was undertaken whilst he was out of the country despite his request for it to be delayed until he returned. Other relatives spoke of brief or basic needs assessments or reviews taking place.

Summary

The case study of one provider with four residential care homes and one nursing home situated in a single Local Authority, provides a useful insight into the complexity surrounding the management of the threat of care home closure. The care home provider in this case study went to great pains to ensure that they put in place processes to ensure clear communication and support was available to staff and relatives. Perhaps those who were least supported were the older residents who were largely shielded from the reality of the situation. Although this approach may have been underpinned by what is believed to be the best interests of the individual, it does suggest that providers, managers and care staff have a view of older residents as a homogenous group that should be shielded from the truth and infantilised. In most cases it was left to relatives to decide whether or not to inform relatives of the threat of care home closure. It is clear that more work needs to be done to support care providers and staff in both independent and public sector in making better decisions with regard to how to support older residents in situations where care homes are either in the process or under threat of closure.

In the cases studies where care homes were saved from closure, one other key issue for residents and relatives that was identified. This concerned the development of attachment to place with regard to the formation of social ties (social attachment to place) and the safety and security that was afforded by the care home (attachment to place in terms of the appropriateness of resources (Burholt & Naylor 2005; Burholt 2006, 2012)). The escalating concerns document does not provide guidance on how deal with the potential severance of an emotional attachment to a care home.

Key issues for providers of care homes in the pathways to the threat of closure relate to the role of the Local Authority in setting the level of fees for care home residents, and the role of the financial sector in penalizing the independent sector (small to medium size enterprises (SMEs)) when they are unable to achieve unrealistic profit margins. This pathway to closure was not identified in other interviews regarding closing or closed care homes (see chapters 3 and 4). However, the case study also highlighted issues concerning the level of

support provided to the independent sector by CSSIW. Following the announcement of the threat of closure and the instigation of escalating concerns, the WG guidance states:

> "*If CSSIW becomes aware of a planned voluntary closure or has concerns about the welfare or safety of service users, especially those concerns that might lead to an enforced closure, it will inform the local authority in whose area the home is situated in line with the published protocol between CSSIW and local authorities. Local authorities will be expected to notify any others that were funding other patients or service users in the home.*" (WG 2009)

Although limiting the involvement of CSSIW to 'informant' to the Local Authority may be sufficient in cases where minimum care standards need to be addressed, in this case where the threat of 'voluntary closure' was partially due to the Local Authority and resulted in litigation, it seems that the care home would have benefited from a greater involvement from CSSIW (as independent from the Local Authority). This would be especially important with regard to facilitating "inter-agency arrangements for discussing and agreeing action in relation to escalating concerns, closures and the longer term development of residential care" (WG 2009) that may be particular difficult to achieve when two parties are engaged in a litigious battle.

6

THE EFFICACY OF THE WELSH GOVERNMENT STATUTORY GUIDANCE AND LOCAL AUTHORITY PROTOCOLS

Introduction

The Welsh Government (WG) guidelines entitled '*Escalating concerns with, and closures of, care homes providing services for older adults*' outlines local statutory bodies responsibilities with regards to escalating concerns and the closure of care homes in Wales and suggests ways in which these responsibilities could be discharged (WG 2009). The WG guidance requires that Local Authorities, Local Health Boards and NHS Trusts ensure that appropriate local arrangements are put in place to deal with these issues when they arise. The arrangements should fall in line with the statutory guidance and existing legislative responsibilities. To this end each Local Authority should work within a framework of practice and have an agreed operational home closure procedure (WG 2009, pp. 8-9). We illustrate the use of local authority protocols in practice through analysis of the data collected in interviews with Local Authority commissioners of care, and from documentary analysis of minutes of the Joint Inter-agency Monitoring Panel (JIMP) and the Home Operations Support Group (HOSG). The purpose of this chapter is to undertake an analysis of the efficacy of the WG guidance and its application at a local level within Wales, by comparing the Local Authority protocols with the WG guidance and identifying good practice which can be used to inform future guidance.

Local Authority Protocols

Of the twelve local protocols received nine (Caerphilly, Torfaen, Monmouthshire, Newport, Neath Port Talbot, Rhondda Cynon Taff, Conwy, Wrexham, Powys) had been written since the introduction of the WG guidance while the remaining three (Blaenau Gwent, Cardiff, Merthyr Tydfil) pre-dated the WG guidance. For the purposes of this research only the nine local protocols written since the introduction of the WG guidance are discussed in this chapter.

It is also noteworthy that as well as variations in content, which is discussed in detail in the following sections, there are differences in the layout and number of documents supplied. Some Local Authorities supplied one all-encompassing local protocol whilst others submitted two or three separate protocols for escalating concerns, home closure and provider performance monitoring. Where more than one protocol or document exists these are cross

referenced and it is made clear that they must be read in conjunction with each other. A detailed breakdown of the responses received, including a list of the documents supplied, are contained in Appendix 2.

Efficacy

The purpose of the WG guidance was to: "*establish and clarify common systems and requirements which will help shape the response of local statutory bodies when confronted by escalating concerns and in some cases impending home closure"* (WG 2009, p. 7). The WG guidance places great importance on having effective processes in place to address escalating concerns stating it will, *'warrant proactive or reactive intervention from those commissioning services, possibly from one or more commissioning agencies, designed to improve the quality of services and, where possible, prevent what might be avoidable home closures'* (WG 2009, p. 1). Thus, under the WG guidance an effective local response would involve the use of proactive measures to both prevent and address escalating concerns as well as reactive measures to deal with escalating concerns and, where necessary, manage the closure of a care home. In order to achieve these objectives the guidance suggests a number of structures and processes to be used by local agencies. We believe that the local protocols of five Local Authorities – Caerphilly, Neath Port Talbot, Rhondda Cynon Taff, Powys and Torfaen – are examples of good practice and are central to this section of the report. In considering the efficacy of the WG guidance and the local protocols, this section focuses on how well the documents enable practice to reflect the objectives (to prevent and address escalating concerns; and manage the closure of a care home) and will focus on the three key areas: (i) proactive quality control and monitoring systems, (ii) reactive procedures in escalating concerns and (iii) home closure processes.

Proactive Quality Control and Monitoring Systems.

It is encouraging that the WG guidance makes some reference to the importance of Local Authorities having preventative measures in place in an attempt to avoid escalating concerns and subsequent care home closure:

> *"Health and social services need to ensure that they work towards preventing escalating concerns developing, and potentially home closures occurring, whenever possible and put in place quality control and monitoring systems"* (WG 2009, p. 6).

The guidance makes some limited reference as to how this can be achieved: that health and social care agencies should jointly develop and implement clear arrangements for contract monitoring and that during the care management process local agencies should place greater emphasis on the importance of placement monitoring and review (overseen by senior management). With regards to any further detail as to local agencies commissioning and contracting functions, the WG guidance refers to separate guidance being developed as part of the implementation of '*Fulfilled Lives, Supportive Communities'* (WG 2009, p. 7).

The importance of contract monitoring and review in preventing escalating concerns and home closure is mentioned in many of the local protocols and five – Powys (*Provider Performance Monitoring Protocol* (Powys CBC 2010a), Caerphilly (*Provider Performance Monitoring Protocol* (Caerphilly AAPC 2010a), Torfaen (*Escalating Concerns Policy*), Rhondda Cynon Taff (*Escalating Concerns: Protocol for Contract Monitoring, Patient Assessment and Residents Reviews at Independent Sector Care Home Settings in Rhondda Cynon Taff* (Rhondda Cynon Taff CBC 2010a), Neath Port Talbot (*Neath Port Talbot Interagency Policy for Managing Escalating Concerns in Accordance with Assembly Government Statutory Guidance: Appendices A*) (Neath Port Talbot CBC et al. 2011) & *Appendix* B (Neath Port Talbot CBC 2011a) - include substantial written guidance on the action local agencies should take to achieve this. The guidance in these five authorities is more comprehensive than that provided by WG in its statutory guidance. For example, in Caerphilly a series of baseline audits and discussions with key partners revealed that the response to concerns about the quality of care needed to *"be more proactive and at an earlier point"* (Caerphilly AAPC 2010a, p. 1).

At a local level, in all of the five Local Authorities with substantial written guidance there are on-going arrangements in place to monitor care home contracts. These operate on a multi-agency basis, with close co-working by the key statutory agencies, and clear written guidance of the different officers' roles and responsibilities within the monitoring process. In all instances the emphasis is on preventing concerns escalating, and promoting early intervention to enable good care practices to be established and maintained. These are not reactive arrangements, and regular contact and meetings are maintained. As Powys' protocol states:

> *"Agency partners aim to work in a proactive and preventative manner, rather than wait to respond to a service that has deteriorated resulting in inadequate care, abuse or neglect"* (Powys 2010a, p. 2).

Three Local Authorities; ***Caerphilly, Torfaen and Powys*** have a very similar protocol, separate, yet complementary to the home closure one, which emphasises the importance of monitoring and review processes. To this end a multi-agency quality assurance meeting is held on a regular basis to share information, ensure the use of monitoring and review systems to achieve improvement, record escalating concerns and make recommendations for action. It also enables good practice to be shared as well as recording improvements in care services. The meetings, *"facilitate early identification of patterns of concern or risk that can be addressed through the ordinary activity of adult services department before the significance of the issue or risk escalates"* (Caerphilly AAPC 2010a, p. 5).

In ***Neath Port Talbot*** preventative action is undertaken via its 'Joint Purchaser Monitoring Procedures' (also referred to as the Joint Contract Review (Neath Port Talbot CBC 2011a) whereby officers from the Service Purchasers (social services and LHB) conduct joint annual contract compliance visits to homes in order to undertake a series of checks to ensure that the service provider meets its statutory obligations and provides an appropriate service to its residents (Appendix 3). Following the visit social services and the LHB write a joint report detailing the findings and where the service provider is failing to meet standards, agree an action plan. The service purchasers offer support and advice to the provider in an attempt to rectify problems and prevent the instigation of escalating concerns or home closure. Further review visits, where necessary, may be carried out according to the issues identified.

In addition to the JIMP and HOSG ***Neath Port Talbot*** has established a 'Care Interagency Forum' the purpose of which is for regulators and service purchasers to *"discuss and address contracting and regulatory issues and share strategic and or policy developments in the care provider sector in Neath Port Talbot"* (Neath Port Talbot CBC et al. 2011, p. 1). The forum is divided into two groups with a Strategic Group focussing on fees, commissioning, strategic development, policy and planning and an Operational Group which discusses such issues as Protection of Vulnerable Adults (POVA), complaints and contractual compliance. Both groups include representatives from health, social services and housing, the LHB and CSSIW. The Strategic Group meet on a six monthly basis and the Operational Group meet on a bi-monthly basis. These meetings provide a useful means to monitor the care settings and enable early identification of any issues or concerns enabling the LA and LHB to support and advise the home to reach the required standards.

Another example of good practice is ***Rhondda Cynon Taff*** where, in response to the WG guidance, a specific protocol for contract monitoring, patient assessment and residents reviews in independent sector care homes has been developed in order to strengthen the monitoring arrangements between the LHB and Local Authority. In a similar way to Neath Port Talbot's 'Joint Purchaser Monitoring Procedures' (Neath Port Talbot CBC 2011a) the protocol includes proactive measures aimed at preventing escalating concerns and home closure. Joint visits to care homes are undertaken by the Nurse Assessors, Reviewing Officers and Contract Monitoring Officers with the aim of *"improving and ensuring the overall quality of the services provided in care home settings*" (Rhondda Cynon Taff CBC 2010a, p. 2). Depending on the outcome of the visit findings are provided to the Responsible Individual, CSSIW and social work teams and an action plan for improvements (where necessary) agreed. A summary of the issues of concern are also provided to a Multi-Agency Operational Group whose responsibility is to evaluate the issues, monitor progress and award an overall risk rating. In some instances, this may result in the instigation of the escalating concern procedure.

Reactive Procedures in Escalating Concerns

Some useful structures are proposed within the WG guidance to enable statutory agencies to lead the escalating concerns process, most notably the Joint Interagency Monitoring Panel (JIMP) established by Local Authorities, NHS Trusts and LHBs. This is the lead body for managing the escalating concerns process. The JIMP is responsible for Development Action Plans (DAPs) and Corrective Action Plans (CAPs) in order to address the escalating concerns. A DAP is used where there is a shortfall in the quality of service and action is needed to move forward in these areas. A CAP is required when immediate action is needed to ensure the safety of service users and/or staff. The DAP and CAP can also work alongside each other where both preventative and remedial action is required in critical areas of performance.

This emphasis on the escalating concerns process is reflected to some degree at a local level with seven Local Authorities including reference to a JIMP, CAPs and DAPs in their protocols. Five Local Authorities – Powys (*Provider Performance Monitoring Protocol* (Powys CBC 2010a), Caerphilly (*Provider Performance Monitoring Protocol* (Caerphilly AAPC 2010a)), Torfaen (*Escalating Concerns Policy* (Torfaen CBC 2010)), Rhondda Cynon Taff (*Memorandum of Understanding: Arrangements for the Local Management of Escalating Concerns in Care Home Settings in Rhondda Cynon Taff* (Rhondda Cynon Taff

CBC 2010b), Neath Port Talbot (*Neath Port Talbot Interagency Policy for Managing Escalating Concerns in Accordance with Assembly Government Statutory Guidance: Appendices A* (Neath Port Talbot CBC et al. 2011)*, Appendix E* (Neath Port Talbot CBC 2011b) *& G* (Neath Port Talbot CBC 2011c))- have developed separate protocol documents which focus on the escalating concerns process. These are very helpful, because they offer far more detailed guidance than the WG guidance, and include elements of good practice but they also make a clear distinction between escalating concerns and the home closure process which are not considered as discrete pathways in the WG guidance. The five good practice local protocols for dealing with escalating concerns (see below for further detail) all have risk rating/assessment systems for identifying levels of concern, provide detailed guidance on how such concerns are identified, and the bodies responsible for determining the way forward through action plans (CAPs or DAPs) or contract monitoring processes. In contrast the WG guidance gives no guidance in relation to the level of seriousness of different issues or on the method or appropriate level of response that should be taken.

Rhondda Cynon Taff has developed a 'Memorandum of Understanding' which clearly sets out the local arrangements to deal with escalating concerns in care homes (Rhondda Cynon Taff CBC 2010b). Information, concerns and issues are logged electronically by local agencies on a 'live' shared information database. A Multi Agency Operational Group (MAOG) is responsible for monitoring all issues and concerns logged and decide which action should be followed to address the issues identified. A risk assessment tool is used to award a risk rating to the care home with green/yellow awarded to less serious situations which will be monitored by the MAOG while the more serious cases are classed as orange/red and forwarded to the JIMP with recommendations from the MAOG to be authorised for action. The MAOG also provides the JIMP with timescales within which to respond to its recommendations.

The JIMP membership in ***Rhondda Cynon Taff*** is drawn from senior managers in the LA, LHB and CSSIW. It is responsible for authorising a range of actions made by the MAOG including implementing DAPs and CAPS, placing embargos on homes, withholding provider payments, and where necessary, establishing Home Operations Support Group (HOSG). It also meets with providers to convey its concerns and to discuss action points. The JIMP may take a number of courses of action including authorising the recommended action made by the MAOG or request information from the MAOG or even direct alternative action to be taken. The JIMP decision is made in writing on an 'Escalating Concerns Recommendations and Decisions Form' which is signed by the Chair and CSSIW where regulatory action is

required. The form is returned to the MAOG who implement the decision of the JIMP. Progress is monitored via regular MAOG meetings with the risk rating adjusted as required, The JIMP kept informed and involved as necessary.

While escalating concerns is mentioned only very briefly in the policy document, the strength of ***Neath Port Talbot's*** protocol lies in its seven appendices. Terms of Reference and details of constituent members from a wide range of agencies are provided for the JIMP (Neath Port Talbot CBC et al. 2011). This is compliant with the WG guidance. In order to determine if a service provider is at escalating concern status a risk rating system is used by the JIMP. This Risk Rating Matrix determines the level of risk and consequently the course of action required (Neath Port Talbot CBC 2011c) (see Appendix 4). Care homes with less significant issues are given a lower rating (1/2 and Green) and the issues are addressed via the normal monitoring process while homes with significant concerns are awarded a higher rating (4/5 and red) and require a CAP which is overseen by the JIMP. When a DAP or a CAP is required a useful template is provided on which the JIMP records actions required, methods that actions will be achieved (inputs), the timescale, details of responsible individuals or agencies for the specific actions, the likely outcome and any review required (Neath Port Talbot CBC 2011b).

When significant or escalating concerns are identified in ***Caerphilly, Powys and Torfaen*** (each of which have largely the same protocol), a Multi-agency Provider Performance Meeting (equivalent to the JIMP) is held to discuss the issues and enable shared decisions about remedial actions. Responses and time frame for action is determined by the type of issue and the level of risk. Responses can include single or multiple actions including, speaking or writing to the provider to establish their proposals for remedial action, undertaking monitoring visits, preparing an action plan or placing an embargo on referrals. Particular attention is paid to the needs and safety of service users and a review of care by the provider and statutory agencies may be undertaken.

Detailed guidance is provided about the use of action plans which are encouraged to be *'used as a method of setting out the improvements required for the care provider'* (Caerphilly AAPC 2010a, p. 10*)* and, in accordance with the WG guidance, involve the use of development actions (DAPs) and corrective actions (CAPs). A risk rating system/matrix is used to score the issues and concern in terms of the likelihood of occurrence and potential impact. Thus the overall risk rating is determined by multiplying the likelihood of the risk (on a scale of 1 to 4) by the consequences of the risk (on a scale of 1 to 4). A matrix colour codes the current level of risk (likelihood x risk) using green, amber and red. Similarly to Neath

Port Talbot CBC (2011b), Caerphilly use an action plan template to detail actions, start and target dates, and the person responsible for undertaking action (Caerphilly AAPC 2010b) (see Appendix 5).

In Caerphilly, the Multi-agency Provider Performance Meeting (equivalent to the JIMP) reviews and monitors progress of the action plan and levels of risk at regular intervals. The action plan template is used to record sources of evidence of improvement and progress (Caerphilly AAPC 2010b). Where targets are not being met, or where risks are increasing, the Multi-ageing Provider Performance Meeting decides whether to extend target dates or apply sanctions. The Caerphilly *Provider Performance Monitoring Protocol* also includes a very helpful 'Provider Performance Checklist' that indicates which agency partners, service users and representatives should be contacted and kept informed through the monitoring process (Caerphilly AAPC 2010c) (see Appendix 6). When sufficient improvements have been made written confirmation is supplied to the provider and the Multi-agency Provider Performance Meeting is closed.

Home Closure Process

The WG guidance does provide some helpful suggestions as to how the home closure process should be managed (WG 2009, Annex 1). For care homes that have experienced escalating concerns the structural arrangements can be useful, with the JIMP responsible for appointing a Chairperson to establish a Home Operational Support Group (HOSG). The HOSG is then responsible for co-ordinating and managing the closure process in line with the 'Closure Plan' and 'Individual Relocation Plan'. The WG guidance re-iterates the importance of relevant agencies working with service users and their families (or other representatives) to prepare them for, and make the transition to a new home. The guidance identifies some key issues to ensure that the transition to a new location is successful. This includes ensuring that every service user is allocated a care manager or equivalent and has a needs assessment. Furthermore WG guidance stipulates that service users and their families should be kept aware of the closure process, have an opportunity to contribute to the design of new care plans and have access to support staff. As highlighted in Chapter 4, the guidance suggests that service users should have access to independent advocacy services. Furthermore, the Mental Capacity Act 2005 stipulates that advocates should be made available to residents who lack mental capacity.

After residents have relocated following the closure of a care home the WG guidance states it is necessary to construct a new care and service-delivery plan to meet a person's

needs and agree transitional support, monitoring and review arrangements (WG 2009, p. 14). Finally, the WG guidance requires that the JIMP and HOSG hold a meeting *"to evaluate the whole closure process and to identify lessons learned*" (WG 2009, p. 14) and to prepare a report which is sent to the CSSIW and other key senior stakeholders (see below for an analysis of some of these documents).

Nine Local Authorities supplied Home Closure protocols. All of these complied with the WG guidance although there were some variations in terms of content and style. Six Local Authorities (Caerphilly, Torfaen, Monmouth, Newport, Powys, Rhondda Cynon Taff) made a clear distinction between home closure and the other processes by having a separate document solely concerned with the home closure process. It is noteworthy that four of these (Caerphilly, Torfaen, Monmouth, Newport) are located with the same LHB (Aneurin Bevan) and had worked in partnership with each other and the LHB to create an agreed, consistent 'Home Closure Protocol'. In the remaining Local Authorities (Neath Port Talbot, Wrexham, Conwy) home closure was covered within one protocol encompassing escalating concerns and home closure.

All nine protocols were very similar to that contained in Annexe 1 of the WG guidance and follow the same process whereby the JIMP established a Home Operational Support Group (HOSG) to co-ordinate the closure, agreed a Home Closure Plan setting priorities and key tasks and undertook individual service user re-location planning. However some of the protocols expanded upon the WG guidance and contained additional detail and good practice guidelines. For example, several of the protocols (Rhondda Cynon Taff, Torfaen, Caerphilly, Newport, Monmouth) listed the constituent members of the HOSG. The composition of HOSG in each of these authorities is similar and is expected to include: service managers, POVA coordinator, commissioning managers, care managers, CSSIW inspector, nurse manager, a responsible individual and the registered manager of the care home.

There are further examples of good practice in Conwy, Caerphilly, Torfaen, Monmouth, Newport, Powys, Neath Port Talbot and Rhondda Cynon Taff. These include referral forms for care homes that are being considered for closure; a variety of checklists regarding the responsibility of the HOSG, key tasks to be completed during the process of closure and a very comprehensive 'Service User Relocation Checklist'; supplementary guidance on the content of the Closure Plan and Individual Support Plan; and guidance on the contracting and commissioning issues associated with home closure. Descriptions of these additional elements of good practice are outlined below.

Conwy has devised a useful referral form for the JIMP to provide to the HOSG. (Appendix 7) (Conwy CBC et al. *no date*). The Home Operational Support Group (HOSG) is instigated by the chair of JIMP where escalating concerns has reached a critical point and both the DAP and CAP have not had the desired effect putting service users. At this point, the JIMP completes the referral form outlining their findings. The form includes recommendations from the JIMP and the evidence on which these were based, the timetable for closure and any other actions for the HOSG. However, there is a certain lack of clarity regarding the purpose of the form (when and how to use it) that is not explained in the Conwy protocol. While several sections seem to relate to the closure of an individual care home, other sections suggest that the form is intended for individual residents within the care home (asking for the service user's name and key risk factors details of individual and others).

The protocol adopted by ***Caerphilly, Torfaen, Monmouth, Newport,*** includes two useful checklists. The first of these is concerned with the key responsibilities of the HOSG and provides a list of the specific action required e.g. obtaining a list of current residents, undertaking a review and risk assessment of all existing residents, considering the role of advocates and developing a communication strategy. Alongside the checklist of action required there are columns which must be completed to identify the lead agency for each action (Appendix 8) (Monmouthshire CC 2010a). The second checklist relates to home closure with key tasks listed, including risk assessment of service users, the role of advocates, arrangement of suitable transport, and the development of strategies to support service users following their move. For each task, a lead person is named and a date agreed by which the action will be completed. These checklists enable and encourage a detailed, coordinated and thorough approach to home closure. Specifying the required tasks as well as the responsible individual/agency should ensure that the process covers all possible issues and assigns responsibility for these to be fulfilled (Appendix 8) (Monmouthshire CC 2010b). Similarly, ***Powys'*** protocol provides some additional guidance on the content of the Closure Plan and Individual Support Plan (Powys CBC 2010b). With regards the Closure Plan it specifies the issues that the Service Operations Support Group (equivalent of HOSG) should cover and for each of these requires that the detail be recorded about the action needed, the individual/agency with lead responsibility and the timescale for completion. The list of issues to be covered are not as detailed as those provided in the protocols of ***Caerphilly, Torfaen, Monmouth, and Newport***. However, the Powys' protocol provides a list of issues to be covered in Individual Support Plans, that are not included in the other protocols. This list

includes objective details of the client, including mental capacity, support needs, contact details of the family or next of kin, and practical arrangements for relocation. However, it also includes subjective information on the service-user views on the care home closure, preferences regarding relocation, and the impact of the closure on the resident's wellbeing. The list also specifies that information should be supplied to the new provider, and indicates that continuing support should be provided following the move.

Although the Powys' protocol provides an action list for Individual Support Plans (Powys CBC 2010b), ***Neath Port Talbot*** is the only Local Authority to provide a comprehensive 'Service User Relocation Checklist' which builds upon the WG guidance (Neath Port Talbot CBC 2011e). The Service User Relocation Checklist provides more detail about the actions required during the closure of the care home, and the relocation of the resident and allocates responsibility for actions both before and after relocation. Its strength lies in the detail it gives to practical issues such as identifying service users requirements including support from Independent Mental Capacity Advocates (IMCA), care re-assessments and Occupational Therapy support. It also makes reference to changes in registration with a General Practitioners (when necessary), transfer of personal property and transportation. Furthermore, it stipulates that the closing care home should provide information for each resident on an individual basis (to the facility that the resident is relocating to) concerning medication records, outpatient appointments, GP/pharmacy and transfer of care arrangements, an inventory of personal property, personal files (including care plans), and monies/financial arrangements (Appendix 9) (Neath Port Talbot CBC 2011e).

More detailed guidance on the contracting and commissioning issues associated with home closure is provided by ***Rhondda Cynon Taff's*** protocol. The Purchasing and Contracting Team are responsible for communicating with external commissioners including relevant internal teams within the Local Authority and LHB, the Pan-Wales Commissioning Network and any other Local Authorities (i.e. in the case of service users who have been placed in the closing care home from out-of-county). Where closure has taken place the protocol highlights the need for anomalies in payment to be identified and addressed; the rights of the Local Authority and LHB to repossess any equipment; and for individual care contracts to be terminated and new ones drawn up by the transfer home.

While the WG guidance does make reference to some of these items outlined in this section, these examples of good practice are a very useful addition inasmuch as they require all agencies involved in the care home closure to focus on clearly identified issues and set clear responsibilities and timescales. Using a combination of these protocols should ensure

that closure plans and individual support plans are detailed and given the attention and level of importance that they require.

Roles, Responsibilities and Multi-Agency Working in Escalating Concerns and Home Closures

The WG guidance provides a useful summary of the existing roles and responsibilities of the key agencies that will be involved in the escalating concerns and home closure process, namely CSSIW, Local Authorities and Health Services (WG 2009, pp. 4-6). This clarification is beneficial to local agencies when formulating local protocols because it provides a good reference point to assist in determining the precise nature and scope of specific roles and responsibilities during the escalating concerns and home closure process. The nine Local Authorities that developed protocols since the WG guidance have accurately reflected the roles and responsibilities of these three agencies in their local protocols. Five (Conwy, Caerphilly, Torfaen, Monmouthshire, Newport) include a similar summary of the existing roles and responsibilities as contained in the WG guidance .

The WG guidance places emphasis on the importance of multi-agency working and states explicitly that local authorities and LHBs

> *'...are required under this statutory guidance to have jointly agreed local arrangements in place to manage escalating concerns and closures.'* (WG 2009, p. 9).

This requirement has been adopted at a local level with five of the nine protocols clearly stating that the documents have been prepared jointly by the Local Authority and Local Health Board (Caerphilly, Torfaen, Monmouthshire, Newport, RCT). Conwy and Neath Port Talbot go further with the Local Authority, Local Health Board and Care and Social Services Inspectorate Wales (CSSIW) working together to produce an agreed local protocol thus reflecting the WG guidance that local agencies need to "*communicate and work jointly with CSSIW and agree how they will manage their distinctive responsibilities."* (WG 2009, p. 8).

In one Local Health Board area (Aneurin Bevan), four of the five Local Authorities that come within its remit have worked together with the LHB to develop one overarching protocol which they have all adopted, albeit with some minor variations to reflect the local area. This is clearly good practice in that it encourages a consistent and co-ordinated approach both between the LHB and Local Authorities as well as between neighbouring Local Authorities while at the same time acknowledging that there may be some differences in approach at a local level.

The importance of multi-agency working extends to all relevant agencies involved in the escalating concerns and home closure process. The WG guidance states that appropriate arrangements and mechanisms should be put in place to facilitate this. In order to ensure that agencies respond appropriately and effectively to the needs of service users and providers they will need to secure:

> *"Effective multi-agency communication and co-ordination, with agreed protocols on information exchange and handling of escalating concerns and home closure"*
>
> (WG 2009, p. 7).

This is reflected at a local level with Quality Assurance meetings, Multi-Agency operational Groups and Provider Performance Meetings in the different authorities, alongside the JIMPs and HOSGs. The WG guidance also makes reference to a wide range of agencies and professionals that should be involved at each and every stage of the process. As noted above, some local authorities have taken the utmost care to ensure that protocols provide the methods of recording accountability/responsibility for actions, and clearly defined lines of communication.

Examples of Local Authority protocols in practice

We conducted three interviews with Local Authority commissioners who had been involved in situations where care homes had closed or avoided closure. One of the care homes was in the public sector and two were in the independent sector. Only one of the commissioners was located in a local authority identified as having a 'good practice' protocol for closing care homes (see above). These interviews form the basis of three examples of Local Authority protocols in practice. The research team received one JIMP report and two HOSG reports on the closure of two independent care homes. One HOSG report corresponded with the JIMP report and an interview with a Local Authority Commissioner and is included below in the third example of a Local Authority protocol in practice.

Example 1

One of the interviews with a Local Authority commissioner related to a Local Authority run Elderly Mentally Infirm (EMI) nursing home which was due to close as the building was not fit for purpose. The cost of improving the facilities at the home to meet the care standards that were implemented in 2010 (e.g. size of bedrooms; availability of *en suite*

facilities etc) was prohibitive. However, the Escalating Concerns procedure was not implemented. The Local authority developed a plan to relocate the services and residents to a purpose-built property which was more modern with better facilities. Upon announcement of the intention to close, a campaign was launched by residents and relatives opposing the closure. This resulted in an extended and extensive consultation process. Whilst a number of the older residents agreed to move to the alternative accommodation, twelve did not wish to move. Two weeks before the closure date, solicitors acting on behalf of the residents and relatives opposed to the closure identified a legal clause in the contract of residence which stated that residents could "remain at the home for as long as they wanted". Consequently, the closure plans were suspended. However, the Local Authority no longer accepts new referrals to the home and it is being gradually "run down".

In this example the escalating concerns process was not instigated. However, had the care home been in the independent sector and the building was not meeting minimum standards, it is likely that escalating concerns would have been initiated. In this case it was in the power of the Local Authority to improve the building and the facilities. The case study serves to demonstrate that the WG guidance does not adequately cover all examples of care home closure and fails to provide direction to Local Authorities that make strategic decisions to close care homes. In this case, legal intervention was required in order to act in the best interests of residents.

Example 2

The second care home was saved from closure and was located in a local authority area identified by the research team as an example of 'good practice' (see Chapter 6). In this example, the protocol stipulates an inter-departmental and inter-agency approach to the closure process, with clear targets, actions and details of accountability.

In 2009, a HOSG was working with the care home on a Corrective Action Plan (CAP). However, this had limited success, and improvement was negligible. Regular provider performance meetings were conducted between the provider, the Local Authority, CSSIW and Local Health Board to continually monitor progress. In addition there was frequent communication between partner agencies to share information and facilitate multi-agency assessments of the direct risks to vulnerable adults. Despite concerted efforts, concerns remained in relation to poor and neglectful practice in the provision of nursing care. In particular, the storage of medication were a major cause for concern with some drugs remaining unaccounted for. In addition, the property was in a severe state of disrepair with

no hot water in one unit and a faulty boiler in another. There were several health and safety breaches including a lack of radiator covers and faulty fire closure on doors Furthermore, there were a number of vulnerable adult referrals lodged with the local authority and a criminal investigation underway concerning the management of the home.

As noted above the care home was monitored closely by members of the HOSG group which included the Local Authority, Local Health Board and CSSIW. In this case, the CSSIW indicated their intention to issue a closure notice with the full support of the partner agencies, but they also informed the HOSG that another care provider had expressed an interest in leasing the home. This development threw the process of closure into disarray.

Members of the HOSG were unsure whether the prospective provider was a registered care provider. Furthermore, they were unclear about the status of the lease arrangement for the property, and whether there was 'business' between the existing and prospective provider. The HOSG reported that they felt 'led' by the CSSIW on this matter. Subsequently, there were delays in reaching an agreement over whether the care home was to remain open or not, generating uncertainty and challenges in responding to residents' needs within a variable timeline.

Finally, the registered manager was suspended, and subsequently resigned. The new care provider took over the home as planned and resolved all of the issues that were outlined in the action plan. The achievement was noted by the CSSIW inspector as a particularly positive result for the HOSG team.

Despite the positive outcome, the uncertainty surrounding the closure of the home raised concerns about the impact on residents (for further examples, see also Chapter 5). The prospective provider had introduced himself to staff and residents giving the impression that the home would avoid closure. Subsequently, residents were reluctant to consider alternative accommodation, even in situations where the risk of harm to the resident (brought about by a period of neglectful care) was significant enough to warrant immediate relocation.

Although this example starts by reflecting the 'good practice' outlined in the Local Authority protocol, the CSSIW decision to introduce a new provider introduced challenges that could have been handled better. All members of the HOSG have different responsibilities within their own professional groups and thus have the opportunity to act outside the HOSG. However, the HOSG are responsible for the operational management of the process of care home closure (and whilst under the threat of closure). In this case the CSSIW should have communicated more effectively with the HOSG regarding the status of the provider, the leasehold on the building and any business relationship between the new and old provider.

The HOSG should have made the decision regarding how and when to introduce the potential new provider to residents and other stakeholders, so that the situation could have been properly described.

Example 3

The third example (extracted from interviews with a Local Authority Commissioner, CSSIW inspector and JIMP and HOSG reports) concerned an independent care home that closed. This care home was not located in a Local Authority identified as having 'good practice' guidelines. This Local Authority had a basic 'checklist' which outlined the composition of the HOSG and processes for 'care home closure and the enforced removal of residents'. This checklist was based on a standard care home closure plan.

The dual registered care home was purchased by the provider as an ongoing concern. The care home was located in an old terraced Victorian property with outstanding compliance notices requiring the provider to comply with 85% single occupancy as outlined in the *National Minimum Standards for Care Homes for Older People* (WG 2004). The new owner expected to make structural changes in order to update and extend the property to accommodate more residents and generate a greater income. However, planning permission for the extension was refused. Compliance with the single occupancy standards without the extension to the property would mean that the provider would lose places rather than increase them. Subsequently, the provider decided that it was not a viable business and should close and issued a notice to cancel the care home registration.

The notification of intention to cancel registration resulted in the CSSIW convening a JIMP. The JIMP was comprised of CSSIW inspector; social work team leader and senior practitioner with responsibility for care homes; contract monitoring officers; protection of vulnerable adults' coordinator; lead nurse for long-term care and nurse assessor (LHB).

There were thirteen residents in the care home at the time the decision to close was made. Three were receiving residential care; eight receiving nursing care (six were funded by the local authority and two were privately funded); and two residents were in receipt of continuing healthcare funding. Thus, the majority of older residents had high nursing care and support needs. There was a suggestion in the JIMP report that some older residents had been discharged from hospital to the care home which was ill-equipped and unable to meet their complex health needs. The WG guidance notes:

> "*In circumstances where a failure in the provision of care which causes suffering is identified this is adult abuse which is a breach of the duty of care and could amount to a criminal offence being committed by the home*." (WG 2009, p. 2)

The JIMP report referred to an earlier corrective action plan (CAP) that was intended to bring the care home up to minimum standards. It was evident that there had been long standing issues concerning nursing practices and environmental care standards. A HOSG had been convened to assess the interim risks to the older residents as a result of the provider's non-compliance with minimum standards. Social workers and district nurses had been making frequent visits to the care home to reassess the residents and monitor the care at the home. A 'decant log' was used for current residents recording the status of progress towards moves to alternative care homes in the event of immediate closure. The care provider worked with the HOSG on the CAP to attempt to address highlighted concerns that presented the greatest risks to the residents, such as the correct administration of medication and provision of adequate nursing care.

Several deadlines had been imposed on the provider to provide evidence of improvements. However, it was clear from the JIMP minutes that these deadlines had not been met. The JIMP resorted to 'considering' further action including cancellation of the provider's registration if the final deadline was not complied with. The way in which this action is recorded in the minutes implies a concern amongst the group of the implications that cancelling the registration of the care home would have upon the provider's future practice and operation. However, it was clear that the care provider intended to close the home before the ninety days usually required for terminating contractual arrangements with commissioners and processing an application for closure with the CSSIW.

The provider voluntarily closed the home quickly, avoiding enforced closure and the subsequent impact on their reputation. The JIMP report noted that the statutory support services encountered difficulties in responding to the tight deadline, for instance noting difficulties in arranging transport for residents from one home to another (some of whom were confined to bed). There were also issues with communication between agencies regarding individual residents' needs. For example, the JIMP report noted that some older residents were relocated to facilities without the necessary equipment to meet their needs, for example profiling beds. This deviates quite dramatically from WG guidance which states:

> *"Local agencies must ensure that 'assessed need' is a key determinant in selecting and/or funding a care placement. The care setting must be able to meet the assessed needs of service users. Service users should not be placed in a setting, even if this is the home of choice, merely because there is a vacancy if the assessed needs can't be met."* (WG 2009, p. 5)

The main lessons learned from this care home closure, and highlighted in the report to the CSSIW, were in relation to the speed with which the care home closed and the ability of statutory support services to respond in a timely fashion. It was suggested that the Local Authority protocol should be amended so that it was clear how future home closures should be conducted in order to avoid these issues. The JIMP suggested that the amended protocol could include options for emergency nursing placements where residents with high care needs could be temporarily placed until assessments could be made and permanent accommodation sourced. The JIMP report also suggested that HOSGs should include key staff who would be in a better position to expedite the outcomes of assessments (e.g. nurse assessors instead of GPs or district nurses). Furthermore, it was clear that the lead agency/person for each action should have been clearly specified, and a time-scale for action agreed. For instance, the CSSIW has the power to cancel the care provider's registration and the Local Authority has the power to terminate the care provider's contract. Delays occur when both agencies feel the other should act first. Within the WG guidance there are no clear stipulations regarding over what period of time certain actions should take place.

Summary

Wales is the first, and remains the only country in the United Kingdom to have developed statutory guidance on care home closure and the Welsh Government must be commended for this. The WG guidance contains useful information on care home closures in relation to proactive and preventative action via quality control and monitoring systems, managing escalating concerns as well as the home closure process. It also encourages and reinforces the need for multi-agency working.

The WG guidance requires Local Authorities to prepare local protocols and to consider the processes to be followed in dealing with home closures and escalating concerns. However, it is clear that not all local authorities have undertaken this task, for which there seems to be no sanctions or consequences for the Authorities concerned. The lack of consistency across Local Authorities in the preparation of locally appropriate protocols is

reflected in the different pathways leading to the care homes closure or saving care homes from closure.

Our examples of the Local Authority protocols in practice highlight four major issues. Firstly, the WG guidance does not provide enough information on the process of closure for Local Authorities who are planning to close homes for strategic reasons. Secondly, where the WG guidance has **not** been extensively adapted for use in the local context there is confusion over roles, responsibilities and time scales for action, resulting in difficulty in responding to speedy care home closure. In particular, in the example provided in this chapter, we noted serious deviances from WG guidance with respect to the relocation of older residents into facilities that did not meet their care needs. This suggests that the WG guidance requires some additional material on what constitutes good practice. Thirdly, where a Local Authority had developed a protocol that we considered to be an example of 'good practice' there were still problems with communication between CSSIW and HOSG. This resulted in a degree of uncertainty about the future of the care home, and directly impacted on residents who were unsure about their future. The Local Authority was keen to address these shortcomings by making amendments to the local protocol. However, this brings us to our fourth and final point, which is that although JIMPs and HOSGs are required to report to CSSIW on care home closures regarding lessons learned, there is currently no mechanism by which the information in these reports is relayed to other statutory agencies across Wales to inform improvements in local practice.

7

THE LIMITATIONS OF THE WELSH GOVERNMENT STATUTORY GUIDANCE AND LOCAL AUTHORITY PROTOCOLS

Introduction

Chapter 6 examined the efficacy of the escalating concerns statutory guidance and how this has been interpreted, or developed in Local Authority protocols. This chapter adopts a different approach and focuses on the limitations of the WG guidance and assesses whether these limitations are reflected at a local level in the Local Authority protocols. In particular, we address four main issues. Firstly, the WG guidance appears to cause confusion in terms of its applicability to all types (voluntary and enforced) of care home closure. Secondly, the way in which the guidance is written suggests that it is directed towards independent sector homes rather than the public sector. Thirdly, the WG guidance seems to be inappropriate for Local Authority homes closing for policy reasons. Fourthly, the WG guidance does not cover all of the issues associated with home closures and does not provide specific and detailed examples of good practice.

Confusion of Applicability: Type of Closure

The WG guidance is the only statutory guidance in Wales on home closure and on this basis it would be expected to be appropriate to use in all types of care home closures. Indeed the guidance states that there are two categories of care home closure: voluntary where the home chooses to close and enforced where it is forced to do so. The document **does not** state that it will be limited to either one or the other of these. Indeed some sections of the protocol can apply and are useful in all types of home closure. For example, the emphasis placed upon monitoring and review of the care management process and the requirement that *"home closure plans are in place to run alongside individual service user and resident resettlement plans"* (WG 2009, p. 7) should apply to all types of care homes. Furthermore much of the operational arrangements included in the Example of Closure Arrangements (Annexe 1) are applicable in all types of home closure e.g. ensuring all service users and families receive as much information as possible, that service users are re-assessed and are involved in the choice of new homes.

Although some sections of the WG guidance encompass all types of closure, certain sections of the document are not applicable in all cases. The principal reason for this is that escalating concerns and home closure are combined into one protocol. The purpose of the

WG guidance is clearly stated as being *"the management of escalating concerns with, and closures of, care homes"* (WG 2009, p. 1). Making a connection between these two issues has seemingly had the effect of limiting the applicability of the home closure protocol to homes which are or have been subject to the escalating concerns process. Escalating concerns refer to instances where care home experience accumulating issues around the quality or operation of the care provided, consequently the guidance is difficult to apply where this has not been the case. This is most notable in the case of voluntary closures such as Local Authority care homes closing on policy grounds (see below) or independent sector homes closing because of financial reasons.

Local Authority protocols have all adopted the same definition as the WG guidance and do not offer any alternatives for care homes closing for reasons other than those relating to escalating concerns. However, as with the WG guidance, they also lack clarity and can cause confusion as they include sections which would be appropriate and good practice for all home closures. For example at the beginning of Powys' Home Closure protocol it claims to be all encompassing stating that it covers all types of closures: *"This includes both care homes and other services, whether provided by statutory, voluntary or private providers. It covers both voluntary and enforced closure"* (Powys 2010b, p. 1). However an analysis of the actual processes to be followed suggests otherwise as the processes relate to the role of the JIMP and HOSG which, under the WG guidance and Powys' own protocol, are initiated in instances of escalating concern. If the document is to be considered as guidance in relation to home closures then it needs to be disentangled from the escalating concerns process. Home closures may need speedy action and responses. Although escalating concerns may not be brought into play there is still a need for clear and precise definitions in terms of processes, roles and responsibilities. The current WG guidance or Local Authority protocols may not be helpful in these situations (see the example of rapid home closure in Chapter 7).

Focus on Independent Care Homes

Although not explicitly stated, the WG guidance is very much geared towards the independent care home sector and this is evident from the way it is written. Within the document the Local Authority is clearly regarded as holding a monitoring, or investigative, role. This is clear from the relationship between CSSIW and Local Authorities and the requirements for alerting concerns: *"Where the local authority has serious concerns about a care home it has a duty to share information about concerns affecting vulnerable adults with CSSIW, an LHB and any other involved statutory body"* (WG 2009, p. 6). Likewise, the

guidance notes *"If CSSIW becomes aware of a planned voluntary closure or has concerns about the welfare or safety of service users, especially those concerns that might lead to an enforced closure, it will inform the local authority in whose area the home is situated"* (WG 2009, pp. 5-6). Requiring the Local Authority to report such issues, or CSSIW to report to the Local Authority implies that the concerns would relate to an independent sector provider. Furthermore the guidance states that clear arrangements need to be in place for contract monitoring and review which would be the role of the Local Authority as it is they who commission independent sector care homes.

Presumably concerns in Local Authority homes would be reported to CSSIW, but the WG guidance does not provide sufficient information on how Local Authority homes would be monitored, either routinely or in the case where escalating concerns have arisen. Given the role assigned to the Local Authority within the WG guidance it could be argued, that it is not appropriate to apply it to Local Authority homes. The Local Authority protocols are also focussed on issues or concerns within independent sector care homes. Indeed Wrexham makes this explicit by stating that the protocol should be followed where there are issues relating to external providers only: *"On-going, serious concerns with an externally commissioned service"* (Wrexham CBC 2010, p. 1). The role given to the Local Authority in the local protocols also confirms its position as a monitoring one and one which takes a key role in responding to and managing escalating concerns and home closures.

Local Authority Homes Closing for Policy Reasons

The focus of the WG guidance on care homes where escalating concerns have arisen makes it very difficult to apply to care homes closing on a voluntary basis, in particular Local Authority homes closing for policy reasons e.g. a decision to remodel residential care into Extracare sheltered housing. The guidance is strongly rooted in the situation where there would be concerns about the welfare of residents of the home in question and that these concerns are 'escalating'.

The WG guidance can be broken down into the following stages; in the first instance local agencies are encouraged to use existing quality control and monitoring systems to identify any issues of concern which would, where possible, be addressed via existing processes, hence preventing escalating concerns arising. However where escalating concerns exist the WG guidance outlines structural arrangements that should be put in place to tackle these. It proposes, "*a proactive and reactive framework to secure immediate improvements in care provision and also to respond to intermediate or longer term issues or concerns"* (WG

2009, p. 9). As outlined elsewhere, these take the form of the JIMP which is responsible for leading the escalating concerns process and to manage the Development Action Plans (DAPs) and the Corrective Action Plans (CAPs). The intention is that this process would be successful in addressing the issues of concern and thus save the home from closure.

Where Local Authorities are closing care homes voluntarily on policy grounds it is unclear how the WG guidance should be applied. Not only are there unlikely to be any issues of concern but, more importantly, there would be no purpose in following these procedures given that there is no intention to keep the care home(s) open. Indeed, having made a decision to close a home, the escalating concerns procedure would be meaningless. Moreover, with regards the closure arrangements contained in the WG guidance, the requirement that the JIMP *"will immediately appoint a Chairperson who will establish a home Operational Support Group (HOSG)"* (WG 2009, p. 12) also poses difficulties in applying these to Local Authority homes closing on a policy basis. As a JIMP would not have been necessary for care homes closing for policy reasons a HOSG would not be convened. In this respect the guidance provides contrary advice. Whereas the main document stipulates that a JIMP would be convened to lead the escalating concerns process, Annex 1 (an example of closure process) suggests that a JIMP should be convened "Once it is evident that a care home is going to close, whatever the circumstances". This suggests that the wording in the WG guidance needs to be amended so that is abundantly clear that when a care home has been identified as under threat of closure (for any reason) a JIMP will immediately appoint a Chairperson who will establish a Home Operations Support Group (HOSG). In these circumstances, we suggest that the Chair should be independent of the Local Authority.

As the WG guidance is linked to escalating concerns it is of limited benefit for service users and relatives, or staff within care homes that are voluntarily closing (especially Local Authority homes closing for policy reasons). Regardless of the reasons for closure, families and service users will have concerns. For example, when a Local Authority plans the closure of a care home, relatives and often the community at large and will question the reasons for such closure, often doubting the reasons provided by the Local Authority (e.g. reduction in demand for placements, a policy decision to develop other forms of care provision to replace the residential care home pattern). Such situations are often fraught with suspicion, and press involvement can add to the tensions around the event. Examination of the WG guidance may reinforce those tensions and suspicions of a local authorities' true purpose and intentions, as the guidance excludes them from following the same processes as the independent sector, and

does not include provision for independent oversight of the process to protect the interests of the residents involved.

These same difficulties exist with the Local Authority protocols which have followed the WG guidance. Some (Rhondda Cynon Taff, Neath Port Talbot, Caerphilly, Powys, Torfaen) have tried to make a clear distinction between the escalating concerns and home closure process by having separate protocol documents for these but they still cross reference each other and give the responsibility to the JIMP to establish the HOSG resulting in the same issues outlined above in cases of voluntary home closure on policy grounds. One local protocol (Powys) does make reference to policy based closures but states that these would be covered by other processes and not the home closure protocol:

> *"This protocol does not cover the reconfiguration of services where it is expected that the responsible organisation adheres to its obligations for notification and consultation and any consequent details"* (Powys 2010b, p. 1).

Judicial guidance on consultation for Local Authorities was developed during the 1990s and is set out in *R v North and East Devon HA exp Coughlan* [2001] QB 213. However, the legal obligation to consult does not cover the 'subsequent details' (Powys 2010b, p. 1), which presumably relate to the co-ordination and management of the care home closure. Without a formally convened HOSG there is no process whereby a 'Closure Plan' and 'Individual Relocation Plans' would be developed. In Neath Port Talbot one of the appendices to the local protocol does include arrangements for a Strategic Group to meet on a six monthly basis the purpose of which is: "*to share and discuss strategic developments, (and) consider the practical implications of Social Care/Health/Regulatory policy developments on the provision of long term care in this sector"* (Neath Port Talbot CBC 2011d, p. 2). However, there is no reference to this in the main protocol document or any explanation as to how this fits into the escalating concerns and home closure processes. It is important to reiterate that sections of the home closure protocol would be applicable and useful to use in situations of reconfiguration e.g. closure plan and the individual relocation plan.

Summary

A number of limitations have been identified within the WG guidance which can be largely attributable to (i) the 'dual purpose' of the guidance connecting escalating concerns with home closure as well as (ii) the lack of clarity around independent sector/Local Authority closures and responsibilities when home closures are voluntary (not enforced). In

Chapter 8 we suggest that it would be beneficial and timely for the existing WG guidance to be reviewed and updated to address the limitations and include the good practice identified, thus making the document the most comprehensive best practice guidance available.

8
DISCUSSION

In this report we have identified the rate of closure of care homes for older people from 1 June 2009 to 31 May 2010, the types of homes closing and the reasons for closure. We have examined the process surrounding the closure of care homes, and the process leading to saving care homes from closure in 2010/11, especially with regard to adherence to, and deviance from the guidance issued by the Welsh Assembly Government in the public and private sector. Furthermore, we have explored the experiences of providers and key stakeholders in care homes under the threat of closure, and during and after the closure of a care home procedures. In the section we address some of the issues that have been raised in the previous chapters and discuss these in more detail. In particular, we examine the 'reporting' role of CSSIW and indicate how this may be improved by including analysis of the pathways to care home closure (or saved from closure).

With regard to the pathways to care home closure, we discuss the power wielded by key stakeholders and agencies, specifically the Local Authority, CSSIW and the financial sector in 'making or breaking' the independent care home provider. We also examine the power of the provider in terms of a geographic monopoly on care provision, and look at the implications of this for registration and regulation.

Before we address the limitations of the WG and Local Authority guidance on *Escalating Concerns With, and Closures of, Care Homes Providing Services for Adults,* we consider the first-hand experiences of the stakeholders who have directly witnessed a care home closing, or being saved from closure. These accounts help inform our understanding of the guidance in practice, and provide us with information on how the process of closure can be improved. Following this, we re-examine the limitations that have been identified within the WG guidance. These are largely attributable to (i) the 'dual purpose' of the guidance connecting escalating concerns with home closure as well as (ii) the lack of clarity around independent sector/Local Authority closures and responsibilities when home closures are voluntary (not enforced).

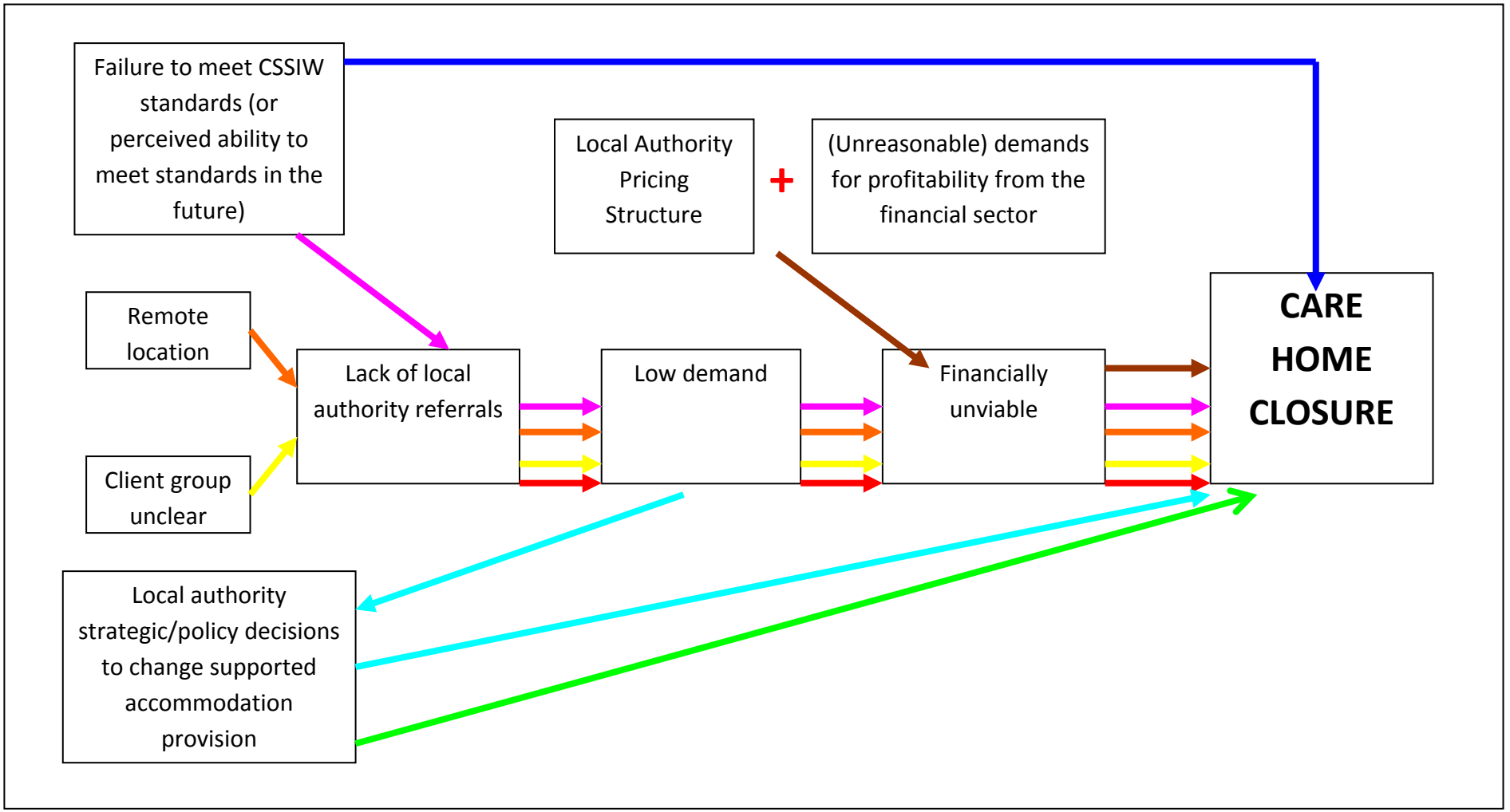
Turning firstly to the role of CSSIW in reporting data from care home closures. In Chapter 3 we recounted the prevalence of care home closure in Wales. We found that 16 care homes closed during a 12 month period. However, our investigations highlighted a discrepancy between the number of closed care homes identified by the research team and

those identified by the CSSIW which suggests that there are problems with CSSIW reporting mechanisms. Currently, CSSIW report annually on the prevalence of care home closure. Using deregistration data, CSSIW are able to establish the number of care homes that have closed voluntarily and those for which closure has been enforced. However, in Chapter 4 we identified seven key pathways to closure. Furthermore, in Chapter 5 and Chapter 6 we identified two additional pathways that could lead to closure (see Figure 4) demonstrating that the reasons for closure are more complex than 'voluntary' or 'enforced'.

Identifying the pathways to closure is important, because if we can identify where care home closures could be avoided, in the future we may be able to eliminate unnecessary duress to residents and other key stakeholders involved in relocation. Likewise, it is equally important to record information on the methods of saving care homes from closure. In order for the WG (and Local Authorities) to benefit from this type of information, we think that the CSSIW should undertake more in-depth analysis of the data that they have to hand. The CSSIW hold information on deregistration of care homes, but they are also the recipients of JIMP and HOSG reports on lessons learned from care home closures, that are submitted from Local Authorities. Given the small number of care home closures in Wales, the analysis of these reports should not be too arduous a task, but may require additional resources (person hours) to achieve.

At the moment JIMPs and HOSGs are required to meet following the closure of a care home to prepare a report on the process. However, due to lack of clarity in the guidance and variations in how it has been interpreted, currently JIMPs and HOSGs tend to be instigated when there are escalating concerns about the operation of a care home. This means that reports are not produced for voluntary closures in either the independent or public sector when escalating concerns have not been instigated. Furthermore, there is no requirement for JIMPs and HOSGs to submit reports on care homes that have been saved from closure (without instigating escalating concerns). Consequently, CSSIW receive reports on 'lessons learned' about the process of home closure only when escalating concerns have been instigated. We believe that the WG guidelines should be amended to broaden the remit of JIMPs and HOSGs. The amended guidelines should ensure that when a JIMP has been made aware of the threat of closure (resulting in escalating concerns, enforced home closure, voluntary care home closure, or a care home saved from closure), the JIMP and HOSG should meet to evaluate the closure process and to identify lessons learned. The Chair of the JIMP should prepare a report on the home closure or the methods by which a care home was saved from closure. A copy of the report must be provided to CSSIW.

Figure 4. Pathways (indicated by different colour arrows) to care home closure



Currently, CSSIW compiles deregistration information on the prevalence and reasons (enforced or voluntary) for care home closure. We think CSSIW should triangulate this basic information on deregistration with the JIMP/HOSG reports to provide more detailed information on pathways to closure (or saving homes from closure). Furthermore, CSSIW should analyse JIMP/HOSG reports to identify lessons learned from care home closure process (and for those care homes saved from closure), and distribute this information to statutory organisations annually so that (where necessary) amendments can be made to WG guidance and/or local protocols to improve practice.

Although there are improvements that could be made to WG guidance around lessons learned from care home closures there are some issues identified in some of the pathways to closure some of which are outside the remit of guidance, but nonetheless warrant our attention. These relate to the power of various agencies to 'make or break' independent care homes. Firstly, the Local Authority has a powerful role in both determining the fee levels for publicly funded residential care places, but also in providing referrals to care homes. Whilst one Local Authority has been successfully challenged by a care provider and required to adjust the fees to ensure the continuing viability of the independent provider, in other cases in the provider has fallen foul of a drop in referral rates. In four care homes financial viability was primarily linked to demand issues. In each case reductions in referrals from the local authority compromised the financial viability of the facility. The evidence from our interviews suggests that the decreasing referrals were not due to official embargos on care placements. The WG guidance states that "*There must be a clearly evidenced rationale for usage of embargos. Application of an embargo would be open to challenge through Judicial Review"* (WG 2009, p. 11). We have evidence of 'unofficial' embargos, with reasons such as 'unclear client group' leading to a drop in referrals. This does not warrant sufficient justification to financially ruin a care home. We believe that the WG guidance should state that Local Authorities should not enforce informal embargos through decreasing referrals to a care home. In order for this to be properly enacted, independent providers should be able to challenge Local Authorities about the justification for decreases in referrals.

Although the Local Authority has a certain level of power over the independent section with regard to fees and referral rates, the independent provider (with multiple sites) also holds a certain amount of power over the Local Authority. Where an independent provider runs more than one facility, the threat of closure puts the Local Authority in a tenuous position. Two examples of the threat of closure in Wales illustrate this. Firstly, the notification that Southern Cross were looking for new operators in 33 care homes in South

Wales (see the methods section) raised serious concerns. Had new operators not been found, alternative placements would be required for residents in all facilities at the same time. This would have stretched existing supported living facilities beyond their capacity. A similar situation was demonstrated in Chapter 5, when the threatened closure of one private provider (of four care homes) would have entailed the relocation of residents beyond the boundary of the county. Relocation of residents over such distances is likely to abrogate their local social relationships, rendering them socially isolated. This raises concerns about regional regulation of the independent sector without due consideration given to the impact that closure may have on residents (i.e. are there enough places locally to accommodate displaced residents from one provider?). This problem has also been raised in England by the National Audit Office, and the Public Accounts Committee which oversees its work. Margaret Hodge MP (Chair of the Public Accounts Committee) has noted "*No-one, Government or local authorities, really knows what is going on locally or whether one provider is becoming too dominant"* (BBC News Health 2011). This is one area where there may be a reasonable expectation for state intervention or regulation of the free market to ensure that the spatial distribution of the independent sector does not have the potential to seriously jeopardise the wellbeing of residents.

The example of the threat of closure in the independent sector (see Chapter 5) also highlights a further concern regarding businesses which apparently operate within narrow margins between success and failure. The Public Accounts Committee have also reported rising levels of debt in the independent care home sector, the Chair person has commented that one company *"carries nearly £1bn of debt - yet the department [Department of Health] is not monitoring their financial health"* (BBC New Health 2011). These businesses are financially fragile and as such the residents are vulnerable to the impact of unpredictable market fluctuations on the viability of their home (and the consequences of closure and relocation). The case study highlighted the pressures faced by independent care home providers, particularly within a recession, where banks and lending institutions are prone to impose significant financial penalties without regard to the nature of the business and in the case of care homes, the impact that actual or threatened closure would have on older residents. The power in such situations lie with banks and lending institutions, who have the authority to decide whether a care home remains opens or is forced to close. Currently these decisions go unchecked and unchallenged. In this situation older people are viewed as commodities within a business model where profit is placed above welfare.

There are two possible course of action to deal with voluntary closures due to financial demands, firstly a requirement for independent care homes to have more robust business cases before they are allowed to register as care providers, or secondly regulation of the financial sector to ensure that in unreasonable profit margins are not demanded for business (fully or partially) contracted to the public sector. Probably the former solution would be easier to achieve. However, whilst profitability is not addressed, this would still leave the independent providers free to set the fees for fee-paying private clients. In the example in Chapter 5, we were informed that a contingency plan (should the Local Authority not be legally required to increase fees) was to raise the fees paid by the privately funded residents to cover the short-fall in income that would be accrued form the publicly funded resident. This is morally and ethically questionable and suggests that the Welsh Government should consider financial regulation of the sector.

The financial regulation of profitability in commodities that are essential to the British public is not without precedent. The profitability of telecommunications, public utilities (electricity, gas and water) and transport are all regulated. The Littlechild Report was published in February 1983 and has become the blueprint for the regulation of the privatisation of utilities (Stern 2003). Similarly an argument could be made for profit regulation of care home fees (for self-funders). The rise in the provision of care homes by the independent sector has parallels with the increase in independent providers of public utilities. Furthermore, we have highlighted where protection against regional monopoly (see Chapter 5) is also important – another feature of the Littlechild Report (1983). We are not suggesting that the Littlechild formula should be used for care home pricing as this incentivises efficiency improvements and cost savings (Stern 2003) which we do not think are entirely appropriate for supported living environments. Ultimately, an economic regulator needs to consider what the best formula would be to set a ceiling (possibly the calculation for fees set by Laing (2008) plus X%) to ensure that self-funders in independent care homes are not excessively charged for their care. A recommendation regarding the appropriate formula is beyond the scope of this report.

As well as examining the data collected about the prevalence, reasons for and pathways to care home closure in this report, we have also considered the experiences of stakeholders who have witnessed the closure of a care home, or have been located in a care home under the threat of closure. We found that some of the data illustrated shortfalls in WG guidance or local practice. In particular, we identified four main areas that could be improved to benefit service-users. The first concerns residents' low expectations of service and general

lack of knowledge regarding the types of services provided in supported living environments (residential care, nursing homes, extracare sheltered housing). Our second area of discussion focuses on residents' sense of powerlessness during the relocation process. The third topic we address concerns the absence (or at least visibility) of social workers and advocates in supporting the process of relocation, especially for residents without relatives or those with cognitive impairment. The fourth topic we discuss is concerned with the time frame for closure, in particular how both long and drawn out process of closure and a speedy closure can be detrimental to the welfare of residents and staff.

Firstly, we consider residents' low expectations of services which is closely allied to the residents' and relatives' lack of knowledge regarding the types of services that are provided in the range of supported living environments. In Chapter 3 we showed that older people have low expectations of services and treatment within a care setting and we illustrated this with statements that highlighted their gratitude for personal care services that should be fundamental aspects of care provision in residential and nursing homes. Furthermore, both residents and relatives were unsure about the suitability of alternative care facilities in terms of the level of services they could expect (or demand) to receive. We noted that the inability for residents and relatives to discern between the different living environments in terms of their appropriateness to meet needs "is not surprising given that there has been a consistent failure within policy to define the objectives of residential care, sheltered housing or extra care sheltered housing" (Burholt & Windle 2007). A recent study in Wales, comparing residential care, community care and extracare sheltered housing also found that the public had a lack of understanding about the services that they could expect to receive in each care environments. This was particularly applicable to extracare sheltered housing settings. The study concluded that,

> *"Extracare should be defined clearly by the Welsh Assembly Government (sic) – there should be a gold standard so that it is clear to older people what they can demand/expect from these facilities either in the public or private sector."*
>
> (Burholt et al. 2011).

It is clear that this recommendation needs to be extended to encompass all supported care environments, and for the WG to define the role, function and service provision in each.

With regards to the WG guidance on care home closure, it would beneficial if it clearly indicated to service providers the sort of help they should provide to residents and

relatives in order for them to make informed choices about alternative accommodation. Whilst the WG guidance currently notes that "*local agencies must identify and arrange placement in the home of choice as a first option… where possible*" (WG 2009, p. 4) and that "*local agencies should agree to a placement of choice when the registered care setting can meet the individual's assessed needs and can provide a placement"* (WG 2009, p.4), without information about the range of accommodation plus the care it provides, residents will be ill-equipped to make a choice. Therefore, we suggest that the WG guidance should stipulate that residents (or advocates working on behalf of the resident), and relatives should be told of the range of accommodation available (including extracare sheltered housing, residential care homes and nursing homes, both in the public and independent sector). The types, levels (ceilings), and costs of care and support that each facility provides should be explained fully. Residents (or advocates working on behalf of the resident) should be offered the opportunity to visit alternative accommodation in order for a properly informed choice to be made. The report on extracare shelter housing in Wales noted that older people should be fully informed when making a decision to move to a care environment, this equally applies to older service-users who are relocating between care environments, thus:

> *"During the process of making a decision to move, an explanation should be given to potential clients regarding what is available on-site and around the clock (clearly distinguishing between housing support services, personal care provision, and heath care), who organises personal care and health care. […] Furthermore, the upper limits on care provision (i.e. when a resident would be required to move out of the facility) should be clearly specified."* (Burholt et al. 2011)

Our second concern focuses on residents' sense of powerlessness over the process of relocation. We noted in Chapter 4 that some older people in closing homes viewed themselves as objects to be placed elsewhere, and that there had been an erosion of the older person's sense of worth whilst in the care system. Disempowered elders may be particularly vulnerable when care homes close, and may agree to decisions that are not in their best interests. In the examples we presented in Chapters 4 and 5, there was evidence that some residents felt that they did not fit the 'ideal' of a care home resident. Elsewhere it has been suggested that "competent behaviour could be described as inappropriate, atypical and therefore detrimental in an environment that specifically caters for the least capable" (Burholt 1998; Posner 1975). Residents that are labelled independent, self-opinionated, or unsociable

may feel that they are likely to receive less support, or be relocated more quickly than others, as suggested by some of our interviews with older residents. Elsewhere research has found that low participation in organised activities were associated with negative outcomes for residents (Spector & Takada 1999) suggesting that being labelled 'unsociable' may impact on the way that a client is treated. It is imperative that all residents are treated fairly with regard to the support provided during relocation or whilst under the threat of care home closure.

The evidence that we collected from stakeholders indicates that little attention was paid to some of the fundamental social and psychological needs of the residents during the process of relocation. Furthermore, these issues are not addressed in the WG guidance. In particular, there is a lack of attention given to residents' attachment to place, or attachment to other residents. It is not inconceivable that some residents will enter a care facility as a couple, whilst in other cases residents will form new relationships with other residents in the facility. For example, in Chapter 4 we noted that insufficient attention had been paid to the co-relocation of Tom and his wife, or two males residents who had become close friends. We suggest that this was 'insufficient' because neither Tom (and his wife) nor the two friends knew whether they could be relocated together. This sense of uncertainty would undoubtedly lead to a feeling of disempowerment and lack of control over the process of relocation.

Allied to the social relationships that residents may form between each other, is the relationship that may develop between people and the place in which they live – that is, an attachment to place. Place attachment is a set of feelings about a geographic location that emotionally binds a person to that place (Shumaker & Taylor 1983). Research has identified different spheres of place attachment (Burholt 2006, 2012; Relph 1976; Canter 1977; Sixsmith 1986; Gustafson 2001) and an attachment that is developed because of the appropriateness of the environment to meet a person's needs could be applied some of the residents in this study (Burholt 2006, 2012).

Lawton (1988) has argued that there are three functions of the environment: maintenance, stimulation and support. The maintenance function of the care home is to provide an environment in which people may perform everyday tasks within a familiar setting. This reduces the amount of energy expended in each routine, because the spatial location of each element is well known and the function of each is customary. In this role the care home may provides a place of equilibrium where competence[3] and the resulting

[3] Lawton (1982, p. 350) defines competence as 'the theoretical upper limit of capacity of the individual to function in the areas of biological health, sensation and perception, motor behaviour, and cognition'.

behaviour of the person are in harmony with the environment. The correspondence between functional ability and environmental press (or the demands placed on them by the environment) is also called person-environment fit (Kahana et al. 2003). Familiarity with the environment and its importance in reducing the amount of effort expended in everyday tasks along with the desire to retain autonomy in familiar surroundings have been cited as explanations for attachment to place (Kahana et al. 2003). In the present study, older residents (and their relatives) talked about the security and safety that the care home provided and were doubtful if this would be found elsewhere. In this respect residents may become attached to care homes by virtue of the appropriateness of the resources and environment therein, because they acknowledge that certain facets of the environment have optimised their functioning (Burholt 2012).

It is important to consider older residents' social attachment and place attachment in care settings, because subsequent relocation may induce separation anxiety. The notion that older people may experience separation anxiety following relocation from their home is based on attachment theory. Attachment theory states that anxiety and grief might be experienced by children after separation from 'social' attachments to significant others (Bowlby 1969). The theory has been extended to encompass adult relationships (e.g. Hazan & Shaver 1994) and relationships between people and the environment (Burholt 2012). The separation anxiety or grief following the disconnection from people or places may be the reason that a range of negative psychological and physical transformations occur in older adults after forced or unplanned relocation, such as depression, social withdrawal, changes in life satisfaction with life, pain, mental and physical functioning (Gallagher & Walker 1990; Grant et al. 1992; Thomasma et al. 1990). Therefore, we recommend that the WG guidance should be amended and require that individual service user relocation plans take into account social and psychological needs of the resident (such as the maintenance of social relationships formed in the care home), as well as the need for any physical personal and nursing care.

A lack of attention to social or place attachment may lead to an erosion of a sense of worth, and disempowerment for residents in care homes, but this is also likely to be reinforced by the non-disclosure of certain information. We acknowledge that the reasons for making decisions about disclosure are complex and the outcomes not always straightforward. Whilst key staff in care homes under threat of closure noted that they were uncomfortable giving impartial information about prospective accommodation, the alternative course of action (providing subjective opinions on prospective accommodation) may be equally

problematic. This was demonstrated in the study conducted in England: during the closure process care home staff readily shared with residents and their relatives their opinions on alternative accommodation. This was not always welcomed, and relatives did not always find the subjective advice helpful. For example one relative commented, *'She [a care worker] eliminated three of them [prospective care homes] immediately. I suspect because she had been sacked [from one of the care homes], I don't know, obviously'* (Williams et al. 2003, p. 37) . On reflection, it seems that the decision to require staff to be impartial when providing information on prospective care homes is preferable. However withholding other information regarding the threat of closure or about closing care homes may not be justified.

Withholding information about care home closure or the threat of closure may contravene the intentions of the WG guidance which states: *"In instances where accumulating issues are being identified there should already be interaction between key agencies including, […] service users and their families"* (WG 2009, p. 2). This point is included in a section sub-headed 'escalating concerns' and thus 'accumulating issues' will interpreted in terms of problems that leading to the instigation of escalating concerns and the threat of closure, rather than issues leading to voluntary closure. In this case the guidance needs to be more explicit and we suggest a similar statement is included in the WG guidance under the sub-heading that relates to home closure noting that: *"In instances where issues are identified that may be leading toward voluntary closure (e.g. drop in referrals, financial difficulties, or strategic changes in the provision of care) there should be interaction between key agencies including, as appropriate, commissioners, the service provider, service users and their families."* Furthermore, we think that the best interest of residents (with regard to the disclosure/non-disclosure of information) could be usefully judged by a multidisciplinary team. This brings us to our fourth point that was identified in our analysis of the experiences of stakeholders during the closure process, and this relates to the absence (or at least visibility) of social workers and advocates in supporting the process of relocation.

The role of social workers (or care managers) in care home closures is outlined in the Escalating concerns guidance and states:

> *"…agencies will owe a duty of care to service users, in particular relating to their duties to assess the needs of service users and for providing or securing care and accommodation.*

11. *When home closures occur, working with service-users and their families or other representatives to identify, prepare for and make the transition to a new home requires that key information is provided and constantly updated. Other factors for successful transfer include ready access to support staff with excellent one-to-one communication skills and a genuine opportunity for service users and their families to contribute to the design of new or revised care plans and service specifications."* (WG 2009)

In research undertaken in England, "the average amount of time spent on each resident ranged from about four and-a-half hours to almost five times that much" (Williams et al., 2007). It appears that in Wales, care managers do not spend as much time with residents. For older residents, relatives and many care home staff, social work appeared indistinct in the overall process. The role of advocates or advocacy services were equally absent during the process of care home closure. The Mental Capacity Act (MCA) (2005), suggests that advocacy is only required for older residents in closing care homes if there are no relatives. The WG (2009) guidance notes:

> "*The Act emphasises the importance of supporting incapacitated service users to make decisions and has created a statutory entitlement to advocacy through specialist Independent Mental Capacity Advocates (IMCAs). In specified circumstances IMCAs will support and represent people who lack capacity and have no family and friends to speak for them."*

However, the MCA enshrines the principle that people have capacity unless otherwise proven. Furthermore, even when capacity is limited there is an expectation that older people should be supported to make choices or decisions, not as in the case of many of the residents in the two case studies, be kept in the dark about the possibility of care home closure. Our observations of care home closures suggest that the imperative to 'manage' the process of closure and relocation of older residents has resulted in a failure to properly engage with older residents and their relatives in a meaningful way. The case study of one provider with four residential care homes and one nursing home situated in a single Local Authority, provides a useful insight into the complexity surrounding the management of the threat of care home closure. The care home provider in this case study went to great pains to ensure that they put in place processes to ensure that clear communication and support was available

to staff and relatives. Perhaps those who were least supported were the older residents who were largely shielded from the reality of the situation.

In a majority of the case studies, there was a tendency to view older residents (especially those with some degree of cognitive impairment) as a homogenous group, shielded from the truth and infantilised, regardless of their individual strengths and needs. There was also an implicit assumption that relatives were best equipped to provide all the necessary emotional support whilst the relatives we spoke to struggled with the process and felt unsupported practically and emotionally. Although this approach may have been underpinned by what is believed to be the best interests of the individual, it is clear that more work needs to be done to assist care providers and staff in both independent and public sector in making better decisions with regard to how to support older residents in situations where care homes are either in the process or under threat of closure. We suggest that the WG guidance should be amended to include the following clause:

> *When the threat of closure has been recognised by a JIMP (or equivalent), a decision regarding the mental capacity of each resident should be made by a multidisciplinary team, including the care home owner/manager, care manager, relatives and with specialist input from a clinical psychologist and/or psychiatrist with specialist expertise in the care of older people. Subsequently, and based on the level of mental capacity, a plan should be developed for each resident on whether/how to inform them of the threat of closure and to prepare for relocation. It is not acceptable to assume a policy of non-disclosure to all residents within a care home.*

We think that the 'disclosure plan' should be developed before the individual service user relocation plan. The decision of the multidisciplinary team assessment of mental capacity will decide with whom the individual service user relocation plan should developed, that is with the resident, Independent Mental Capacity Advocate (IMCA), and/or relative. We recommend that if the multidisciplinary team decides that the resident has mental capacity, then they should still be offered the help of an advocate (e.g. from an independent advocacy service but not necessarily an IMCA) especially with regard to developing the service user relocation plan.

Whilst a multidisciplinary team assessment may ensure that residents are properly informed about closure according to the level of their mental capacity, this would do little to

counter the fourth issue that was raised in the stakeholder interviews, that is the impact of a lengthy closure. We acknowledge later in this chapter that a speedy closure creates problems for service providers, however, in our interviews with residents, relatives and staff we found that a drawn out closure process also had a detrimental impact. The lengthy process adopted in the closure of Local Authority care homes had the opposite affect than intended: rather than quashing worries (that were anticipated if a quick closure had been undertaken), the uncertainty about a final closure date increased the levels of anxiety of residents and relatives.

The long period for closures of public sector care homes were due to two factors: (i) public consultation and (ii) the decision to keep operating the home until all residents had relocated to the accommodation of their choice. Currently the WG guidance lacks any reference to public consultation on the closure of care homes. We suggest that this is amended to include the following clause under the sub-heading legal duties:

> *Voluntary public sector closures require consultation with the public. Judicial guidance on public consultation process is set out in R v North and East Devon HA exp Coughlan [2001] QB 213. To comply with the rules of consultation, the process must be undertaken at a time when proposals are still in the formative stages. It must include sufficient reasons for particular proposals to allow those consulted to give informed consideration and an intelligent response (for example a range of costed options, a preferred option, and a reason for this). Furthermore, adequate time must be given for consultees to formulate a viewpoint. The product of the consultation must be conscientiously taken into account when the ultimate decision is taken. When considering the closure of a care home, it would be good practice to relay the decision to the residents and relatives of residents in the care home explaining how the consultation evidence was taken into account and on what grounds the final decision was made*[4].

What constitutes an adequate time for a consultation process has been discussed elsewhere (Welsh Language Board 2010). Eight weeks is generally considered adequate time for consultees to formulate a viewpoint. In the case of voluntary closures within the public sector, in addition to the period of time set aside for consultation, the Local Authority also has to determine how long the process of closure will take. In the case of Local Authority

[4] Some of this wording has been adapted from localgovernmentlawyer.co.uk

care home closure for strategic reasons, we recommend that the consultation process should take 8 weeks (2 months), analysis of responses should take 4 weeks (1 month), and if closure is the outcome of the consultation then this should be undertaken within 3 months. In total the voluntary closure of a public sector care home should take no more than 6 months. However, in the example provided in Chapter 4, no final closure date had been set. Although it was clear that the Local Authority were trying to comply with WG guidance with regard to the following clause *"Where a service user requests a specific choice of accommodation local agencies should, where ever possible and reasonable to do so, accede to such requests"* (WG 2009, p. 4) further thought should have been given what is considered 'reasonable'. Where acceding to requests for placement entails continuing to run a care home on minimum staff with a decreasing number of residents and without a closure date in mind, this may be to the detriment of all concerned. We suggest that the WG gives some guidance to Local Authorities on the maximum time that a voluntary closure should span. This would take the onus off of the Local Authorities to determine what this may be. Furthermore, it would ensure that HOSGs could manage the operational closure of the home within a stipulated time frame, and that individual relocation plans would have a definite end point.

As well as providing evidence on the impact of a long drawn out home closure process, this report has also highlighted outcomes where home closure has been swift. In Chapter 6 we reported on a speedy voluntary home closure that presented significant challenges to statutory agencies to assess and relocate residents. To a certain extent this problem could be overcome if planning for relocation had happened as soon as the JIMP were aware of the threat of closure. We have already suggested that when the threat of closure has been identified, a 'Home Operations Support Group' (HOSG) or similar support mechanism should be established where they do not currently exist, for managing possible care home closures (either voluntary or enforced). One of the first tasks of the HOSG group should be to ensure that a multidisciplinary team meeting is held to assess the capacity of residents and to develop 'disclosure plans' for each older person in the facility (see above). This should be followed by the development of an individual service user relocation plan where the likelihood of closure is high. It should be made clear to the resident whether this is a precautionary measure (i.e. the home is only under threat of closure) or that closure is imminent. Furthermore, should the speed of closure change (that is move from escalating concerns and either a CAP or DAP, to a swift voluntary closure instigated by the provider), mechanisms will be in place to ensure that statutory agencies are well-prepared to support resident in the relocation process.

The change in designation of the type of closure (from one under escalating concerns, to a voluntary closure) raises other issues regarding the leadership of CSSIW and Local Authorities in decision making. For instance, in one of the examples in Chapter 6, the CSSIW had the power to cancel the care provider's registration and the LA had the power to terminate the care provider's contract as minimum standards had not been met, and deadlines for the CAP had been missed. In the event, neither agency acted, preferring instead to leave the provider to dictate the timescale of closure. This had two potentially negative outcomes: (i) a swift closure process that statutory agencies found challenging to deal with, and (ii) the negligent provider would be able to register as a care provider in the future (as deregistration was voluntary not enforced). Whilst a CAP or DAP may be required to ensure the safety of residents, the JIMP and HOSG should be mindful of the intentions of the provider. Where it is clear that the provider is threatening closure (regardless of escalating concerns), then all statutory agencies should be prepared for closure. This could have been foreseen if a risk assessment of the threat of closure had been undertaken (see examples of good practice in Chapter 6).

Throughout this report and in particular in this discussion, a number of limitations have been identified within the WG guidance. In the introduction to the discussion we noted that these limitations could be largely attributable to (i) the 'dual purpose' of the guidance connecting escalating concerns with home closure as well as (ii) the lack of clarity around independent sector/Local Authority closures and responsibilities when home closures are voluntary (not enforced). We suggest that it would be beneficial and timely for the existing WG guidance to be reviewed and updated to address the limitations and include the good practice identified, thus making the document the most comprehensive best practice guidance available. Here, we revisit some of the gaps and good practice omissions, and in Chapter 9 we use this evidence to formulate some key recommendations which are included in a redraft of the guidance in Appendix 10.

While the WG guidance contains many useful suggestions and recommendations on care home closure, a detailed analysis of its content has highlighted a number of gaps. Thus, in its current format there is lack of clarity around how to use WG guidance except in instances of care home closure where there have been escalating concerns. The most obvious example is the lack of applicability to Local Authority homes that are closing for policy reasons. Similarly the WG guidance does not adequately cover other types of voluntary closure such as private care home closure to liquidate capital assets or the retirement of an owner. In order to address this gap the WG guidance not only needs to make a clear

distinction between escalating concerns and home closures but must be more comprehensive and offer tailored guidance for home closures in general.

The fact that only 12 Local Authorities supplied local protocols and, more importantly, that only 9 of these had been written since the introduction of the WG guidance suggests that Local Authorities may be experiencing difficulty in interpreting the guidance and producing local protocols that are applicable to all types of home closure. This is reinforced by the fact that there was significant variation in the content and detail provided in the local protocols as Local Authorities attempted (or not) to adapt the guidance for the particular local circumstances and instances where the guidance is relevant, with differing success. Whilst Local Authorities, LHBs and NHS Trusts are asked to "*ensure that they have appropriate local arrangements in place to handle escalating concerns over care homes or home closures which discharge their statutory responsibilities highlighted in this guidance"* (WG 2009, p. 12), we think that the WG guidance should go further and require local action in developing appropriate 'detailed and comprehensive' local protocols in order to protect the interests of older care home residents within their jurisdiction.

The WG guidance lacks the detail required in certain areas. For example, it provides little assistance in identifying how and when to involve other agencies. Furthermore, the current guidance lacks clarity around the assessment of capacity of residents and access to independent advocacy, or the timing concerning either instructing an Independent Mental Capacity Advocate (IMCA) for those that need one, or the involvement of social workers to discuss options for moving to an alternative home. It is encouraging that some of the local protocols do attempt to address these gaps by providing more detailed guidance (e.g. Powys' Closure Plan and Individual Support Plan; the HOSG and home closure checklists in Caerphilly, Monmouth, Torfaen, Newport). However, at a local level there is clearly a lack of consistency and a wide variation in the content and detail of the local protocols which can, to a large extent, be attributed to the shortcomings of the national guidance. Above, we make some suggestions as to how these shortfalls can be addressed. In particular, we suggest that the 'threat of closure' should be the trigger for the JIMP to meet (regardless of the nature of the closure, or the sector of the care home), and that this occasion would activate a cascade of events within a specified timescale. These would need to be attuned to the needs of residents and as well as the type and location of the care home. For instance, finding alternative accommodation for residents of an EMI home that is closing may be difficult and more time consuming due to the shortage of these types of homes in Wales and, likewise, the closure of

a rural or remote care home may require a different approach to finding suitable and accessible alternative accommodation.

The gaps in the WG guidance discussed so far confirm that the document falls short of comprehensive best practice. A useful resource on good practice in this area is the recently published guide by the Directors of Adult Social Services (ADASS) and the University of Birmingham entitled 'Achieving Closure: good practice in supporting older people during residential care closures'. The document provides a summary of the best practice that exists on care home closure and "seeks to make a modest contribution to overcoming the current gap in evidence" (Glasby et al. 2011, p. 4). Six key themes were identified via in depth interviews with Directors of Social Services in England as being essential to any best practice home closure process: the importance of established policies and procedures; the importance of time; the role of assessment; the impact of closures; communication and information; barriers and success factors (Glasby et al. 2011). The report's authors concluded that it is essential that Local Authorities have the time and space to undertake a planned and best practice home closure process. Furthermore, they recommend that care home closure process must include the following key components (Glasby et al. 2011, p. 19):

- *Put in place well organised, dedicated and skilled assessment teams.*
- *Involve all relevant parties (especially older people themselves) in decisions about future services.*
- *Get to know people well and carry out holistic assessments of their needs.*
- *Support older people, families and care staff through potentially distressing and unsettling changes.*
- *Work at the pace of the individual and give as much time and space to explore future arrangements as possible.*
- *Help residents and key members of care staff to stay together if possible.*
- *Ensure independent advocacy is available.*
- *Plan the practicalities of any moves and ensure as much continuity as possible after the move has taken place.*
- *Stay in touch with people and assess the longer-term impact of resettlement.*
- *Work in partnership with a range of external agencies and key stakeholders, managing information and communication well.*

The Social Care Association (SCA 2011) has also published a useful online toolkit on care home closure. This provides guidance on a number of key issues including communication, continuity of care, assessment and choice, capacity, information sharing and legal issues and also includes good practice examples of templates, procedures and checklists from various organisations in Britain. While it is aimed at commissioners and other statutory agencies it can also be useful for staff, residents and carers. Encouragingly, the topics and the key components of best practice in care home closures identified by both Glasby et al. (2011) and SCA (2011) overlap with the themes identified in this report. In Chapter 9, we use the evidence that we have collected (that is supported by research elsewhere) to make several recommendations and to draft an amended set of guidelines.

Limitations of the study

We were hampered in the conduct of this study by independent providers, Local Authorities and care home managers acting as gatekeepers and deciding whether or not the research team could access residents in closing care homes and those under threat of closure. This is not a new phenomenon and elsewhere (for example, in Canada) researchers have indicated that difficulties in recruitment have "necessitated changes in research design, disrupted study progress or rendered samples unrepresentative" (Miller et al. 2003, p. 111). Following refusals from care homes to participate in this study, we took steps to change the study design (i.e. recruiting in care homes under threat of closure, and those that were saved from closure) to ensure that we had a large enough sample to examine a range of experiences.

A systematic review of recruitment issues in health services research found that a number of key factors influenced the recruitment process. Those that were identified in the health services literature included: the recruiter; strategies or methods of recruitment; participant preferences; and gatekeepers (Miller et al. 2003). Whilst most of these factors are applicable to methods adopted in randomised controlled trials and intervention studies, the difficulties encountered with recruitment through gatekeepers were relevant to care home settings. In particular, the systematic review found that, "the abilities and interests of clinical and study nurses to promote or to inform patients about research were found to be negatively influenced by heavy workload (Hawranik & Pangman 2002)." (Miller et al. 2003, p. 114). Broadhead and Rist (1975-6) also suggest that gatekeepers consider two factors when determining whether or not to allow access to social researchers. These are the public image of the organization and the administrative redistribution of human resources required to undertake the research. In the context of care home closure, one could envisage that the

workload of care home managers and key workers would have increased whilst they are supporting residents and relatives during the closure process. However, we suggest that the gatekeepers may also be operating on an additional principle (other than the protection of the image of the care home, or stretching human resources). In this respect, the gatekeepers may believe they are working in the best interests of (vulnerable) residents.

In addition to having an impact on the recruitment to the study, acting in the 'best interests' of residents has wider implications, in particular for service user outcomes. For example, elsewhere it has been found that rights of access to specialist mental health services are determined by gatekeepers. In this respect the caveat 'if they require it', demands that staff make the judgement whether or not to introduce specific services (McEvoy 2000). Likewise, in this study we found that care home staff decide who 'requires' the support of independent advocacy services (evidenced in the lack of visibility of these services in any of the homes visited), or determine whether or not residents should be informed of care home closure. For this reason we have suggested that independent advocates should be offered to all residents in care homes under threat of closure (whilst IMCAs are still required for those that lack mental capacity), and that disclosure plans should be developed by multidisciplinary teams (with specialist input) for all residents. This takes the onus off of staff to act as gatekeepers by determining that the eligibility criteria for these services is residency in a care home under the threat of closure.

Although the gatekeeping encountered in the project has resulted in a restricted sample, we believe that we have captured a reasonable breadth of experience of stakeholders during the threat and closure of care homes. This is reinforced by the similarities between the key topics that we have identified and those highlighted in the English study that we sought to replicate (Netten et al. 2002; Williams et al. 2002), and the more recent finding of Glasby et al. (2011) and the SCA (2011). However, we cannot ignore that gatekeeping practices undermine residents' rights to make decisions about whether or not to participate in research for themselves. Ultimately, it seems that the care home resident waivers their right to determine participation in research and the provider/manager assumes governance and determines this decision on their behalf (see for example Southern Cross's decision to exclude the research team from all facilities). Whilst we acknowledge that participants have an ethical right to decline to participate, it seems unjust that even when the resident has the mental capacity to make their own decisions this is option is removed from them. Within the public sector care homes, these decisions may contravene Human Rights with regard to exercising one's rights to freedom of thought, freedom of expression and the right not be

discriminated against in respect of these rights and freedoms. Furthermore, in both the public and independent sector, gatekeeping on behalf of older people (especially those who have capacity to make their own decisions) contravenes several UN Principles for Older People (1991). In particular the following principles are not upheld:

- Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations;
- Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs needs and privacy and for the right to make decisions about their care and the quality of their lives (UN, 1991).

Restricting the access of social researchers to organizations is not a recent phenomenon and some 35 years ago Broadhead and Rist (1975-6) noted that a managers and administrators within formal organizations have control over screening prospective researchers, and ultimately,*" this small group of 'gatekeepers' has a central role in deciding the fate of those who desire to conduct social research with someone else's money, data, or organization"* (p. 326). In this respect, we think that it is vitally important that the Older People's Commissioner in Wales exercises her legal powers (section 5 of the Commission for Older People (Wales) Act 2006) to conduct a Review into advocacy arrangements for older people in care homes in Wales. Under section 13 of the Commissioner for Older People (Wales) Act 2006 the Commissioner or a person authorised by her may, for the purpose of a review, enter any premise, other than a private dwelling, for the purpose of interviewing an older person accommodated or cared for there, and may interview the older person with their consent. Where this study may have failed to access some older people (e.g. those accommodated in closing independent care homes), the findings may be usefully supplemented by the Older People's Commissioner exercising her legal powers and ensuring that the views of older people in a range of residential care settings are heard.

9
CONCLUSIONS

Since the introduction of the WG guidance on escalating concerns and home closure in 2009 there has been further research and guidance, albeit limited, on the home closure process (see Chapter 8). In this chapter we draw together the conclusions from our report and combine these with the other findings in the field to make several recommendations. Some of our recommendations are directed at various statutory agencies involved in escalating concerns and home closure, but a majority relate to Local Authority protocols and the need to ensure that these are fit for purpose. Given that the Local Authority protocols have been developed in response to the guidelines on *Escalating Concerns With, and Closures of, Care Homes Providing Services for Adults* (WG 2009), we have attempted to redraft these guidelines by weaving together the best practice from the Local Authority protocols from within Wales and evidence from other research on care home closures (Glasby et al. 2011; SCA 2011). We hope that the Welsh Government will draw upon this document to amend the WG guidance. In order to facilitate this we have amended the existing guidance to include extra clauses, and to clearly distinguish which elements of the policy apply to escalating concerns, enforced closure and voluntary closures (see Appendix 10). We have also made sure that the policy is relevant to closure in the independent and public sector.

To facilitate a clear understanding of the 'best practice' pathway to home closure (or pathway to saving a care home from closure) we have developed several flow charts. These emphasise proactive action (prior to the threat of closure, of closures taking place) to avoid closure where possible, but in the case of the threat of care home closure, the flowcharts help practitioners identify the process in the case of escalating concerns, the threat of voluntary closure in different sectors (i.e. public or private) and the process of closure.

Before making our recommendation with regard to amending the WG guidance, there are other recommendations that have arisen that are specific to the WG legislation and the role of CSSIW. These relate to their roles monitoring and reporting on care home closures in Wales, providing independent oversight in the case of care home closures, and tightening procedures concerning care home registration in Wales. In terms of monitoring and reporting we recommend that:

1. CSSIW should undertake more in-depth analysis of the data on care home closures (or saving care homes from closure). Specifically we recommend that CSSIW should:
    a. triangulate deregistration data with the JIMP/HOSG reports to provide more detailed information on pathways to closure (or saving homes from closure),
    b. analyse JIMP/HOSG reports to identify lessons learned from care home closure process (and for those care homes saved from closure),
    c. distribute this information to statutory organisations annually so that (where necessary) amendments can be made to WG guidance and/or local protocols to improve practice.

We have found that the spatial distribution of care homes in the independent sector is problematic when one care provider has several care homes within a fairly small areas (e.g. within one Local Authority), or has many care homes within a region. Essentially in both scenarios, the total percentage of care homes owned by one provider within a defined geography is great enough that closure would result in a crises of accommodation in the area. Currently care home providers can be registered if they meet minimum standards of care, health and safety regulations, employment and training concerns. There is currently no state intervention with regard to the number of care homes that can be registered in any given area. Although restricting the number of licenses for care homes may seem contrary to 'free-market' principles the state does intervene in other areas where the control of certain premises is considered to be in the best interest of the public, for example with regard to licensing place for gambling and entertainment. We think that there is a very good argument that similarly, the number of licenses/registrations for care homes to a single provider within a particular location (market share) should be controlled. As of March 2011, the Welsh Government were granted law-making powers in relation to health and social care provision (amongst other devolved areas). We recommend that:

2. WG legislates for the maximum proportion of care homes that a single independent provider can supply within a single local authority (or other geographically defined region).

3. Should WG legislate for the maximum proportion of care homes that a single independent provider can supply within a single local authority (or other geographically defined

region), then CSSIW should enact the legislation through the controlled registration of independent providers.

The vulnerability of the independent sector is further aggravated, in some circumstances, by a lack of financial stability. In other sectors that provide public services, (e.g. the education and skills), systems and checks are in place to monitor the financial health of providers. For example, in England a system has been proposed for monitoring NHS providers in England (Monitor 2011). We recommend that:

4. WG legislates that the financial health of an independent provider should become a factor that is taken into consideration before registration as a care home provider: financial health should be a *National Minimum Standard for Care Homes for Older People* (WG 2004).

5. CSSIW assesses the financial health of independent providers before registration to understand the degree of risk they may represent to the WG or Local Authority/LHB if they do not have the financial resources to continue operation.

6. CSSIW[5] monitors the financial health of providers and as part of their duty, keep the level of balances under review. If the financial health of an independent care provider deteriorates and the risk of closure increases, the CSSIW should report this to the JIMP within a Local Authority who will take action necessary when a care home is under 'threat of closure'.

Furthermore, we think that pricing of care homes should be regulated in a similar manner to the regulation of profitability in public utilities. This should protect self-funders from being overcharged, and impendent providers setting self-funding fee levels in order to supplement the fees paid to the care home by the Local Authority for publicly funded residents. We recommend:

[5] Although Local Authorities could monitor independent providers that are commissioned/contracted to provide care, there may be cases when the independent sector is contracted to several Local Authorities and a broader oversight is required. Therefore we suggest that monitoring of is a role for the CSSIW, but that the organization would need increase resources to do this.

7. WG should commission an economist to consider a formula for a ceiling on self-funding fees (possibly the calculation of fees set by Laing (2008) plus X%) to ensure that self-funders in independent care homes are not excessively charged for their care.

Moving on to consider the WG guidelines for Escalating Concerns with and Closure of, Care Homes Providing Services for Adults, we have tried to keep the amendments to the main document to a minimum (see Appendix 10). In the main section of the document we recommend that the following amendments are included:

8. The document should be amended to make it clear that it applies to voluntary and enforced closure, and that action should be instigated when the threat of either type of closure is detected.

9. The JIMP is required to meet when the threat of closure is detected. This is not confined to the threat of closure because of poor care, or the potential for escalating concerns, but in all instances which may result in the closure of a care home.

10. The HOSG should be independent from the care home for which it is managing change or closure, thus, in the case of the threat of closure in the independent sector the HOSG will be chaired by the Local Authority, in case of the threat of closure in the public sector the HOSG will be chaired by someone independent of the public sector.

11. Legal duties in relation to closures should specify the requirements placed on the Local Authority concerning the proper conduct of public consultation.

12. We recommend that the threat of closure (i.e. duration of escalating concerns, CAPs and DAPs or consultation in the public sector) and the process of closure should not exceed six months, thus limiting the period that residents, relatives and other stakeholders are placed under duress.

13. Local Authorities should not enforce informal embargos through decreasing referrals to a care home. Independent providers should be able to challenge Local Authorities to justify decreases in referrals

14. With regard to ‘Minimum Requirements’ the WG guidance should clearly guide the Statutory Agencies to the relevant Annexes that describe how their functions should be discharged.

15. The development and use of disclosure plans for individual residents should be included in the guidance. Plans should be developed with input from specialists (clinical psychologist/psychiatrist with expertise in the care of older people) who can help decide how and when residents with cognitive impairment should be informed about the threat of, or closure of the care home. It not acceptable to assume a policy of non-disclosure to all residents within a care home.

16. The guidance should stipulate in the ‘Minimum Requirements’ that **all** residents should have access to independent advocacy services (not confined to statutory Independent Mental Capacity Advocacy service), and other such services to support service users as appropriate. The registered provider must support and enable approved advocacy services to meet with service users to identify their wishes and offer appropriate support.

17. The development and content of individual relocation plans should be clearly specified. In particular, the individual service user relocation plan should be developed with the resident (or advocate working on behalf of the resident), and relatives, taking into account the decision of the multidisciplinary team assessment of mental capacity. Furthermore, the plans should take into account social and psychological needs of the resident (such as the maintenance of social relationships formed in the care home), as well as the need for any physical personal and nursing care.

18. Individual relocation plans should reflect (where possible) the wishes of the resident concerning the choice of alternative accommodation. Thus, all residents (or advocates working in behalf of the resident) and relatives should be told of the range of accommodation available (including extracare sheltered housing, residential care homes and nursing homes, both in the public and independent sector). The types, levels (ceilings), and costs of care and support that each facility provides should be explained fully. Residents (or advocates working on behalf of the resident) should be offered the opportunity to visit alternative accommodation in order for a properly informed choice to be made.

19. Where a JIMP has been made aware of the threat of closure, at the end of the process (whether this results in the or continued operation of the care home), the JIMP and HOSG will meet to evaluate the whole closure process and to identify lessons learned. The Chair of the JIMP will prepare a report on the home closure or the methods by which a care home was saved from closure. A copy of the report must be provided to CSSIW.

20. The role of the CSSIW should be redefined, especially concerning the actions that are required with regard to in-depth analysis of the data on care home closures (or saving care homes from closure) (see 1 above), and where independent oversight is required (chairing HOSG) in the closure of homes in the public sector.

Although the recommendations constitute fairly minor changes to the main document, we have made major changes to the Annexes of the document which were designed to provide some examples of how the statutory agencies should discharge their responsibilities (see Appendix 10). In particular, we have taken care to ensure that the several stages of the process are separated from each other. Thus we have a section describing monitoring and proactive actions to prevent escalating concerns and home closure (Appendix 10, Annex 1). We have described when a Joint Interagency Monitoring Panel (JIMP) should be either established or take action during the 'threat of closure' (Appendix 10, Annex 2). Annex 3 in Appendix 10 provides an example of the process that should be adopted during escalating concerns, whilst Annex 4 describes the arrangements during the threat of Voluntary Closure of care homes. Finally Annex 5 describes the process of care home closure for all sectors. Annexes 2-4 are supplemented by flow charts which describe the actions and outcomes of the process. These together should provide much clearer guidance to the statutory agencies. Therefore, finally we recommend that:

21. The WG seriously considers adopting the amendments to the guidance, and issuing the Annexes to aid all statutory organisations in discharging their duties during the threat or closure, or closure of care homes in the independent and public sectors (see Appendix 10).

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APPENDIX 1

ETHICAL APPROVALS

GIG CYMRU NHS WALES
Canolfan Gwasanaethae Busnes
Business Services Centre

Research Ethics Committee for Wales

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22 October 2010

Professor Vanessa Burholt
School of Human Sciences
Swansea University
Singleton Park
Swansea SA2 8PP

Dear Professor Burholt

Study Title: **The Closure of Care Homes for Older People in Wales: Prevalence, Process and Impact**
REC reference number: **10/MRE09/24**

Thank you for your letter of 12 October 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chairman.

Confirmation of ethical opinion
On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites
The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion
The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study

and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents
The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Investigator CV	1 dated 29 July 2010 (- page 22 of protocol)	29 July 2010
Investigator CV	Christian Beech; dated September 2010	
Protocol	1	29 July 2010
Letter confirming funding	signed Andy Privett, WORD	02 March 2010
Protocol for the disclosure or witness of abuse whilst undertaking research with vulnerable adults - A guide for researchers	3 dated September 2010	
REC application	signed Professor Burholt	26 July 2010
Covering Letter	signed Professor Burholt, dated August 2010	
Letter from Sponsor	signed Ceri Jones, Swansea University	12 August 2010
Interview Schedules/Topic Guides	Interview / Manager / Closing; version 3 dated July 2010	
Interview Schedules/Topic Guides	Interview / Manager / Closed; version 3 dated July 2010	
Interview Schedules/Topic Guides	Interview / Relatives / Before; version 3 dated July 2010	
Interview Schedules/Topic Guides	Interview / Relatives / After; version 3 dated July 2010	
Interview Schedules/Topic Guides	Interview / Relatives / After; version 3 dated July 2010	
Interview Schedules/Topic Guides	Interview / CareStaff / Before; version 3 dated July 2010	
Interview Schedules/Topic Guides	Interview / CareStaff / After; version 3 dated July 2010	
Interview Schedules/Topic Guides	Interview / Residents / Before; version 3 dated July 2010	
Interview Schedules/Topic Guides	Interview / Residents / After; version 3 dated July 2010	
Interview Schedules/Topic Guides	Telephone / Managers / Closed; version 3 dated August 2010	
Interview Schedules/Topic Guides	Interviews / Telephones / CSSIW; version 3 dated August 2010	
Letter of invitation to participant	Invite Care Staff, 2 dated July 2010	
Letter of invitation to participant	Invite Manager / Closed, 1	

	dated August 2010	
Letter of invitation to participant	Invite Letter Residents, version 2 dated July 2010	
Letter of invitation to participant	Invite Letter Relatives, version 2 dated July 2010	
Letter of invitation to participant	Invite / CSSIW, version 1 dated August 2010	
Participant Information Sheet: Keyworker / carestaff / Closing	4 dated September 2010	
Participant Consent Form: CSSIW	2 dated July 2010	
Response to Request for Further Information	signed Professor Burholt	12 October 2010
Participant Information Sheet: PIF - CSSIW Inspector	3 dated July 2010	
Participant Information Sheet: Resident	4, dated September 2010	
Participant Information Sheet: Relative	4, dated September 2010	
Evidence of insurance or indemnity	UM Association Certificate of Insurance; expires 31 July 2011	06 July 2010
Referees or other scientific critique report	WORD Research Funding Scheme Peer Review Assessment Form x 2	
Gantt Chart - Closures Project	1 dated August 2010	
Participant Information Sheet: Manager / Closing	4, dated September 2010	
Participant Information Sheet: Manager / Closed	4, dated September 2010	
Participant Consent Form: Standard	3 dated September 2010	

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review
Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If

you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/MRE09/24	Please quote this number on all correspondence

Yours sincerely

pp **Dr Gordon Taylor**
Chairman

Email: corinne.scott@wales.nhs.uk

Enclosures: "After ethical review – guidance for researchers"
Copy to: Mr Christian Beech

GIG CYMRU NHS WALES
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18 January 2011

Professor Vanessa Burholt
School of Human Sciences
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Singleton Park
Swansea SA2 8PP

Dear Professor Burholt

Study title:	**The Closure of Care Homes for Older People in Wales: Prevalence, Process and Impact**
REC reference:	**10/MRE09/24**
Amendment number:	**Amendment 2**
Amendment date:	**24 November 2010**

The above amendment was reviewed at the meeting of the Committee held on 13 January 2011.

Favourable opinion
The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents
The documents reviewed and approved at the meeting were:

Document	Version	Date
Letter of invitation to participant	Relatives - Under Threat; version 2 dated November 2010	
Participant Consent Form: Standard	version 3 dated September 2010	
Participant Information Sheet: Resident - Under Threat	1 dated November 2010	
Participant Information Sheet: Keyworker / Carestaff - Under Threat	1 dated November 2010	
Participant Information Sheet: Keyworker / Carestaff - Under Threat	1 dated November 2010	
Participant Information Sheet: Manager - Under Threat	1 dated November 2010	
Participant Information Sheet: Relative - Under Threat	1 dated November 2010	
Protocol	version 2 dated November 2010	
Notice of Substantial Amendment (non-	Amendment 2	24 November 2010

Please note the new address for the REC for Wales at the header of this letter

CTIMPs)		
Covering Letter	signed Professor Burholt	16 December 2010
Letter of invitation to participant	Manager - Under Threat; version 2 dated November 2010	
Letter of invitation to participant	Residents - Under Threat; version 2 dated November 2010	
Letter of invitation to participant	Care Staff - Under Threat; version 2 dated November 2010	
Interview Schedules/Topic Guides	Manager - Under Threat; 2 dated November 2010	
Interview Schedules/Topic Guides	Care Staff - Under Threat; version 2 dated November 2010	
Interview Schedules/Topic Guides	Relatives - Under Threat; version 2 dated November 2010	
Interview Schedules/Topic Guides	Residents - Under Threat; version 2 dated November 2010	

Membership of the Committee
The members of the Committee who took part in the review are listed on the attached sheet.

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/MRE09/24:	**Please quote this number on all correspondence**

Yours sincerely

Dr. Corinne Scott
Committee Co-ordinator

E-mail: corinne.scott@wales.nhs.uk

Enclosures: List of names and professions of members who took part in the review
Copy to: Mr Christian Beech

Ethical Approval

Ethics Committee Use Only

Principal Investigator	Prof. V. Burholt + Christian Beech
Title of Proposed Research	The Closure of Care Homes for Older People in Wales.

Application approved	Yes	✓	No	
Date	26th November 2010			
Name	Dr Tracey Maegusuku-Hewett			
Signature				
Position (please state if a member or Chair of ethics committee and name of committee)	Member of ethics committee. Lecturer social work and social care.			

This application has not been granted ethical approval in its current form. Please ensure that you take account of the comments and feedback provided below and prepare a revised submission:

APPENDIX 2

LOCAL AUTHORITY PROTOCOLS FOR ESCALATING CONCERNS AND CARE HOME CLOSURE

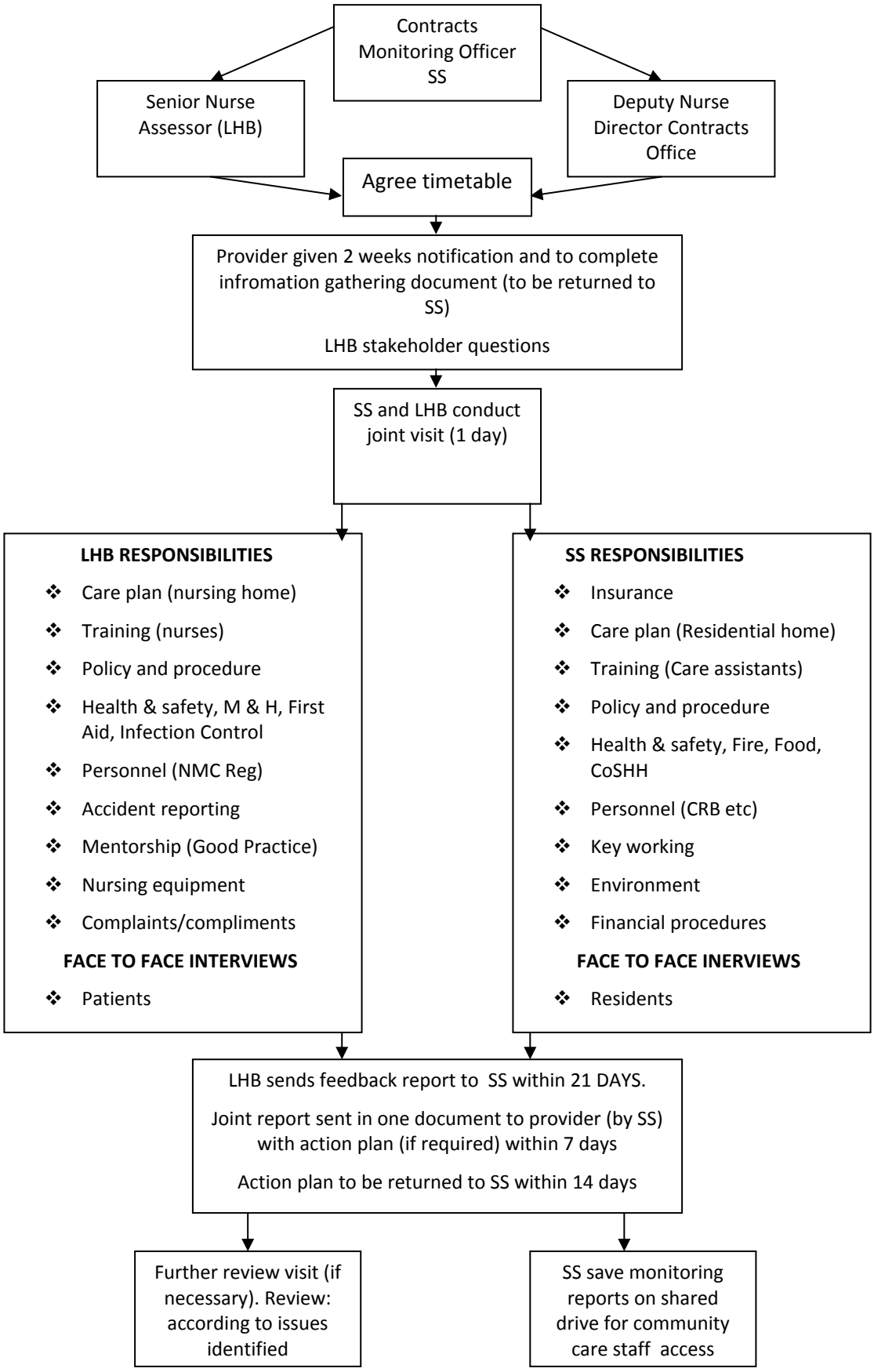
LOCAL HEALTH BOARD AREA	PROTOCOL YES/NO	DOCUMENTS SUPPLIED
(1) **ANEIRIN BEVAN HEALTH BOARD**		
Blaenau Gwent Local Authority	Yes *(pre dates WG guidance)*	• Inter Agency Policy and Procedures for Responding to the Closure or Impending Closure of a Care Home (2002)
Caerphilly Local Authority	Yes	• Caerphilly Area Adult Protection Committee – Provider Performance Monitoring Protocol (November 2010) • Caerphilly County Borough Council Draft Home Closure Protocol – Version 3 (May 2010)
Torfaen Local Authority	Yes	• Torfaen County Borough Council Escalating Concerns Policy • Torfaen County Borough Council and Aneurin Bevan Local Health Board Home Closure Protocol (draft August 2010)
Monmouthshire Local Authority	Yes	• Monmouthshire County Council Draft Home Closure Protocol (February 2010)
Newport Local Authority	Yes	• Newport County Council Home Closure Protocol (January 2010)

(2) **ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD**		
Bridgend Local Authority	No	
Neath Port Talbot Local Authority	Yes	• Neath Port Talbot Joint Interagency Policy for Managing Escalating Concerns in Accordance with Assembly Government Statutory Guidance • Protocol for the Sharing of Information Between the Care Standards Inspectorate for Wales and Local Authorities
Swansea Local Authority	Checklist only	• Care Home Closure/Enforced Removal of Residents checklist • Template for Minutes of Home Operational Support Group Meeting • Template for Care Home Closure Report
(3) **CARDIFF AND VALE UNIVERSITY HEALTH BOARD**		
Cardiff Local Authority	Yes *(but pre dates WG guidance)*	• Procedures for the Transfer of Residents from Council Care Homes (June 2007)
Vale of Glamorgan	No	

(4) **HYWEL DDA HEALTH BOARD**		
Carmarthenshire Local Authority	No	
Ceredigion Local Authority	Not known *(no response)*	
Pembrokeshire Local Authority	No	
(5) **CWM TAF HEALTH BOARD**		
Merthyr Tydfil Local Authority	Yes *(but pre dates WG guidance)*	• Joint Protocol: Procedures to be Followed in the Event of a Home Closure (draft July 2006)
Rhondda Cynon Taff Local Authority	Yes	• Escalating Concerns: Protocol for Contract Monitoring, Patient Assessment and Residents Reviews at Independent Sector Care Home Settings in Rhondda Cynon Taff (March 2010) • Escalating Concerns: Memorandum of Understanding- Arrangements for the Local Management of Escalating Concerns in Care Home Settings in Rhondda Cynon Taff (March 2010) • Escalating Concerns: Protocol for the closure of a care home in Rhondda Cynon Taff (June 2010) • Escalating Concerns: Policy and Procedures for the Application and Lifting of Placement Embargoes at Independent Sector Care Home Settings in RCT (March ’10)

(6) **BETSI CADWALADR UNIVERSITY HEALTH BOARD**		
Conwy Local Authority	Yes	• Protocol to Manage Escalating Concerns in Care Homes or Home Closures Agreed Locally with Statutory Agencies(draft)
Denbighshire Local Authority	No	
Flintshire Local Authority	Checklist only	• Checklist of Action in Respect of An Emergency Closure of a Nursing/Dual Registered Home
Wrexham Local Authority	Yes	• Escalating Concerns Process (Including Home Closure) (June 2010)
Anglesey Local Authority	No	
Gwynedd Local Authority	Not known (no response)	
(7) **POWYS TEACHING HEALTH BOARD**		
Powys Local Authority	Yes	• Powys County Council Provider Performance Monitoring Protocol (2010) • Powys Joint Inter-Agency Monitoring Panel (JIMP): Terms of Reference (June 2010) • Protocol for managing closures of care homes and services for adults (July 2010)

APPENDIX 3
NEATH PORT TALBOT
JOINT PURCHASER MONITORING PROCEDURES



APPENDIX 4
NEATH PORT TALBOT
JOINT INTERAGENCY MONITORING PANEL JIMP
RISK RATING MATRIX

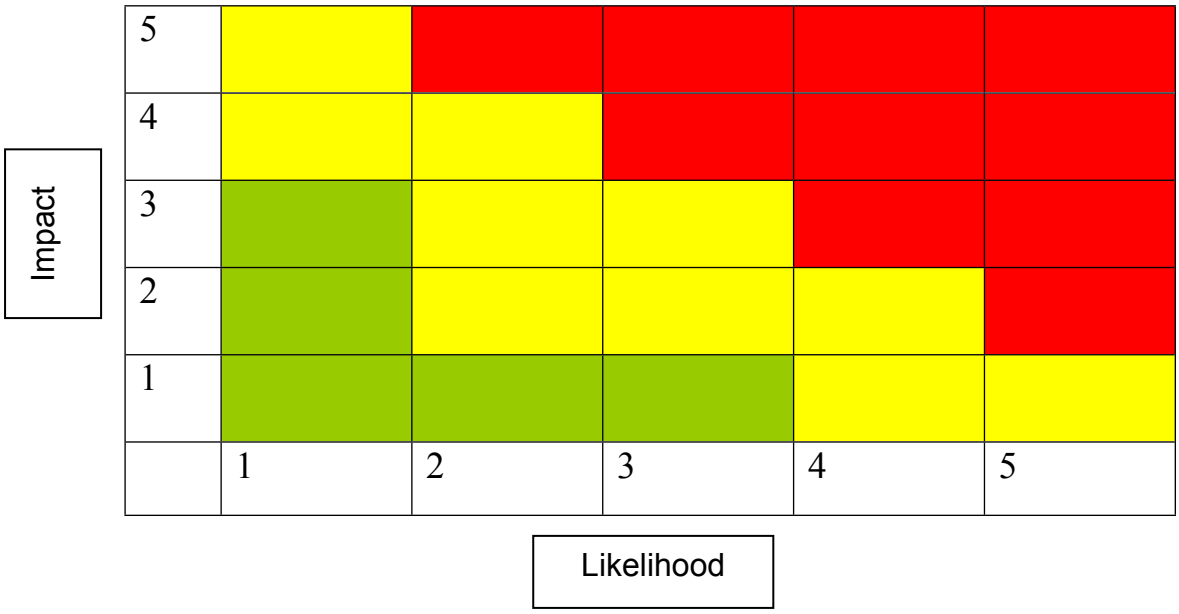
To be used to determine if Service Provider is at Escalating Concern Status

Impact Criteria

Description	***Rating***
Overall service will not be materially affected. Client perception and experience would remain intact. Provider would recover quickly	1
Slight difficulty in operational performance of the provider. Client level of service and experience would not be disrupted significantly. Recovery would not require diversion of significant resources.	2
Operational performance of the provider would be compromised to extent will require revised ways of working. Client perception and experience would be significant due to unsatisfactory level of service. Recovery would be more gradual and require significant input and resources.	3
Operational performance of the provider would be severely affected and maybe unable to meet a large proportion of its obligations and liabilities. Client experience would be majorly disrupted and poor. Recovery would be complicated and time consuming.	4
Operational performance of the provider would be compromised to the extent it would not be able to meet core obligations and liabilities. Major adverse repercussions for clients making care unsustainable or unsafe. Provider maybe unable to recover or continue to be viable.	5

Likelihood Criteria

Description	***Rating***
Unlikely to occur	1
Low chance of occurrence	2
Even chance of occurrence	3
High chance of occurrence	4
Expected to occur	5



Red – There are significant problems which will impact the service and or safety of service users and or staff if not resolved - CAP required

Amber – Could affect the service and or safety of service users and or staff if not addressed developmentally – DAP required

Green – Being addressed or of less significant concern but will require monitoring to ensure intended improvement sustained – Routine monitoring and review

(Source: Neath Port Talbot CBC 2011c)

APPENDIX 5
CAERPHILLY AREA ADULT PROTECTION COMMITTEE
GUIDANCE FOR USING ACTION PLANS

This guidance should be used where an action plan is required as part of the provider performance monitoring process.

The action plan should be developed using the standard template.

The provider (where in attendance) and other agencies will contribute to the development of the action plan and the risks will be rated and managed through a multi agency process owned by the agencies involved. Stakeholders must attend or ensure continuity of attendance is provided for through nomination of a representative thus ensuring that previously requested actions and results are made available to the meeting.

When identifying improvements required the meeting should determine whether the required improvement actions are either development actions (DA) where they are good practice requirements to assist overall improvement or corrective actions (CA) where the improvements are related to a contractual or regulatory breach in line with the Escalating Concerns with, and closures of, Care Homes providing services for Adults (WAG May 2009).

The action plan should be reviewed by during the provider performance meeting. Monitoring must be evidenced and contingencies required for repeated lack of adequate progress or further deterioration with robust challenge and rationale recorded. Contingencies may include mandatory suspension of placements i.e. embargo.

The action plan is given an overall start date and target dates for improvements to be made are recorded alongside the person responsible. Dates and sources of evidence of improvement are recorded on the action plan. The date the action was completed should be recorded.

Failure to progress the improvement actions must be considered at the Provider performance meeting alongside an assessment of the level of risk i.e. is it increasing decreasing or remaining the same in relation to the specific actions not completed and the overall concerns. Agreement should be reached as to whether target dates will be extended or sanctions applied. Where target dates are extended the rationale will be recorded in the minutes and the date upon which the target date was extended and the new target date will be recorded in the 'by when' box of the action plan.

Immediate focus must be given to protective issues for individual and others within care setting who may also be at risk, thus the issues for improvement should be prioritised around risks to service users.

The concerns will be scored by their likelihood and impact. The colours red, amber and green will be used to signify the level of risk rather than the outcomes.

The provider performance process may be closed where the action plan has not been completed however the likelihood of the risk occurring must have significantly reduced and the partners agree that the issues are suitable for single agency monitoring. The impact of the risk will not change. Therefore if the issue remains a high score and is coloured red the action plan cannot be closed. Feedback must be provided at the monthly quality assurance meeting.

CCBC will take responsibility for storing information relating to Provider Performance. Individuals chairing the provider performance meetings are responsible for advising Commissioning Team administrative staff of information to be recorded on the monitoring spreadsheet and providing copies of minutes/agenda/action plans used.

Risk assessment process

Risks will be assessed and reviewed during the provider performance Meeting.

The risk will be rated using the matrix below.

An overall risk rating will be determined by multiplying the likelihood of the risk (scale of 1 to 4) by the consequence of the risk (scale of 1 to 4).

The colour coding represents the current level of risk rather than the progress made against the required improvements.

Likelihood	**Impact**			
	1. Insignificant	2. Minor	3. Moderate	4.Major
4. Almost certain	**4**	**8**	**12**	**16**
3. Likely	**3**	6	9	12
2. Possible	**2**	**4**	**6**	**8**
1. Unlikely	**1**	**2**	**3**	**4**

Action plan template

Name of provider/organisation:
Name of setting or service:
Date action plan started on:
Version number:
Last updated on:

If business is suspended during the PP process please list date of start and finish of embargo

Issue of concern	**Improvement required (development action / corrective action)**	**By When (Note when dates extended)**	**Person Responsible**	**Likelihood** **(1 – 4)**	**Impact** **(1-4)**	**Overall Risk** **Rating**	**Evidence of improvement or failure to improve and date noted**	**Progress:** Completed Ongoing Not started

Likelihood	**Impact**			
	1. Insignificant	2. Minor	3. Moderate	4.Major
4. Almost certain	**4**	**8**	**12**	**16**
3. Likely	**3**	6	9	12
2. Possible	**2**	**4**	**6**	**8**
1. Unlikely	**1**	**2**	**3**	**4**

APPENDIX 6
CAERPHILLY AREA ADULT PROTECTION COMMITTEE
PROVIDER PERFORMANCE CHECKLIST

Name of Service: …… Name of Provider: ……	(✓)	Date Completed	Signature
Inform other Local Authorities & other commissioners that the Provider Performance Process has commenced.			
Write letter to the Provider explaining that the service has been placed under the Provider Performance Monitoring Protocol.			
Inform other Local Authorities & other commissioners that the Provider Performance Process has ended.			
Write letter to the Provider explaining that the service is no longer being considered under the Provider Performance Monitoring Protocol.			
Inform other Local Authorities & other commissioners that an embargo has been placed on the service.			
Write letter to the Provider explaining that an embargo has been placed on the service.			
Write letter to service user/representative explaining that due to lengthy concerns an embargo has been placed.			
Inform other Local Authorities & other commissioners that an embargo has been lifted at the home.			
Write letter to the Provider explaining that an embargo has been lifted.			
Write letter to service user/representative explaining that the embargo has been lifted and monitoring continues.			

(Source: Caerphilly AAPC 2010c)

APPENDIX 7
CONWY CBC, BETSI CADWALADR UNIVERSITY HEALTH BOARD AND CSSIW REFFERRAL TO HOME ORGANISATIONAL SUPPORT GROUP (HOSG)

	Date of Referral to JIMP:
	Date discussed at JIMP:
Name of Service User:	**Alerter:**
Address:	**Status of Home Registration: RH ☐ NH ☐**
	Qualify:
D.O.B:	**General: ☐**
Joint Funding: YES ☐ NO ☐	**Specialist: ☐**
Self Funding: YES ☐ NO ☐	**EMI: ☐**
	OTHERS: ☐

Summary of Findings from JIMP	
Evidence list and send copy to HOSG	
Key risk factors details of individual and others	
Recommendation **Clear guidance from JIMP**	
Provide TOR for closures including time table	
Any other action by HOSG	

Source: Conwy CBC et al. (nd)

APPENDIX 8
MONMOUTHSHIRE COUNTY COUNCIL
HOME OPERATIONS SUPPORT GROUP (HOSG) KEY RESPONSIBILITIES AND HOME CLOSURE CHECKLIST

Home Operations Support Group Key Responsibilities

	Action Description	MCC SC&H	ABHB	Home	CSSIW
1	Obtain list of all current residents at the care home (including self funders, CHC and other LA placements)	✓	✓	✓	
2	Obtain a list of next of kin and contact details	✓	✓		
3	Consider the role of advocates	✓	✓		
4	Compile and share list of contact numbers	✓	✓		
5	Determine who is financially responsible for each resident. Inform the appropriate local authority	✓			
6	Clarify who is responsible for care management support for each resident	✓			
7	Involve Legal Section	✓	✓		✓
8	Prepare press statement / release with the Press Office	✓	✓		
9	Determine where alternative staff can be found - agencies, MCC, ABHB	✓	✓		
10	Inform elected members	✓	✓		
11	Ensure feedback to indicate each task has been completed (outcomes).	✓	✓		
12	Appoint lead officer to coordinate all assessment information including other LA's	✓	✓		
13	Maintain contact with other LA's	✓	✓		
14	Arrange weekly meetings	✓	✓		
415	Review all residents - Social Care, nursing, FNC, O.T., etc.	✓	✓		
16	Undertake risk assessment on each resident regarding moving	✓	✓		
17	Lead officer informs all families via letter	✓	✓(CHC)	✓	
18	Family meetings arranged and held	✓	✓(CHC)		
19	Request GP's to undertake medical risk assessment, where appropriate		✓		
20	Establish what equipment does each resident need and can it move with them?		✓	✓	
21	Clarify what legal rights families have regarding decision making for residents (e.g. power of attorney)	✓	✓		
22	Produce information for families regarding choice, procedures etc.	✓	✓		
23	Choice leaflets taken to the care home and family meetings	✓			
24	Develop communication strategy (weekends, bank holidays, etc)	✓	✓		
25	Inform out of hours service, other HB's and Local Authorities	✓	✓		

	Action Description	MCC SC&H	ABHB	Home	CSSIW
26	Establish what alternative beds are available and where	✓	✓		
27	Freeze vacancies	✓	✓		
28	Arrangements made to hold placement meetings - DTOC meetings and CHC panels	✓	✓		
29	Contact other local authorities for places	✓	✓		
30	Check Health Board beds - Gwent and other Health Boards		✓		
31	Check availability of other nursing staff (RMN and RGN)		✓		
32	Ask manager if there is a natural grouping of residents that could move together	✓	✓	✓	
33	Provide care managers with an information pack including complaints, alternative providers	✓	✓		
34	If unable to move equipment, determine where alternative equipment may be found	✓	✓		
35	Arrange suitable medical transport (e.g. ambulance)	✓	✓		
36	Arrange suitable non medical transport (e.g. taxi, mini bus)	✓			
37	Develop strategy to support residents, families, staff after the move (care planning process)	✓	✓		
38	Debrief meeting	✓	✓		
39	Review residents following the move (settling in, have to move again?)	✓	✓		
40	Cancel existing contracts immediately (overarching)	✓	✓		
41	Cancel existing contracts immediately (individual)	✓	✓		
42	Contractual financial arrangements to be coordinated	✓	✓		
43	Scope of family involvement e.g. packing, transport (including self funders), (contact other LA's)	✓	✓		

Source: Monmouthshire CC 2010a

Home closure checklist

It is essential to name who is going to be responsible for arranging/undertaking each action.

	TASK	LEAD PERSON	ACTION BY DATE
1	Undertake a risk assessment on each resident re moving.	Care Manager / OT / Nurse Assessor	
2	Consider alternative heating, hot water, food etc. if faced with emergency closure.	HOSG Chair	
3	Review all residents – nursing, FNC, O.T. etc.	Care Manager / Nurse Assessor	
4	Obtain a list of all residents at the care home.	C&C Team	
5	Clarify who is responsible for care management support for each resident?	HOSG Chair	
6	Establish what alternative beds are available and where?	Commissioning Team / ABHB	
7	Obtain a list of next of kin	Care Manager / Nurse Assessor	
8	Inform families/carers of what is happening and alternative placement	HOSG Chair	
9	Determine what involvement will families have e.g. packing, transport	Care Manager	
10	Clarify legal rights families have regarding decision making for the residents.	Care Manager	
11	Consider the role of advocates	Care Manager	
12	Develop a communication strategy – week ends, bank holidays etc.	HOSG Chair	
13	Compile and share list of contact numbers – mobile, out of hours etc.	HOSG Chair	
14	Determine who is financially responsible for each resident. Inform the LA etc.	HOSG Chair	
15	Inform Out-of-Hours service.	HOSG Chair	
16	Provide information for families re choice procedures etc.	Care Manager	
17	Establish what equipment does each resident need and can it move with them?	Care Manager / OT / ABHB	
18	If unable to move equipment, determine where can alternative equipment be sourced?	Care Manager /OT / ABHB	
19	Arrange suitable transport e.g. ambulance	ABHB	
20	Involve legal section on issues of registration and/ or regulations	CSSIW	
21	Liaise with Press Officers regarding press statement/release.	HOSG Chair	
22	Ask matron/manager if there is a natural grouping of residents that could move together?	HOSG Chair	
23	To ensure safety and good care, prior to closure, determine where alternative staff be found (with owner's permission) – agencies. L.A.'s	ABHB / HOSG Chair	
24	Develop strategy to support residents, families, staff following the move.	HOSG Chair	
25	Review residents following the move – settling in, move again?	Care Manager / Nurse Assessor	
26	Cancel existing contracts immediately – both individual and overarching.	Care Manager / Commissioning Team / ABHB	
27	Inform politicians – both local and national (WAG)	HOSG Chair	
28	Ensure feedback to indicate each task completed/outcomes.	HOSG Chair	
29	Keep Director of Social Services and Heads of Service informed of progress	HOSG Chair	

Source: Monmouthshire CC 2010b

APPENDIX 9
NEATH PORT TALBOT
VOLUNTARY/ENFORCED CARE HOME CLOSURE
SERVICE USER RELOCATION CHECKLIST

Procedure

CSSIW to determine deadline for closure and liaise with Service Purchasers

Home Operational Support Group (HOSG) to Coordinate

- Care Home management
- Social Work management
- Contracting/Commissioning
- Identified social workers from Area Teams (to case manage individual moves
- EDT to be aware of plan and contacts in case out of hours.
- LHB representative if appropriate (nursing care)
- Representative from community nursing services
- (CSSIW liaison).

Process (based on standard home closure plan for planned closure)

- **List of all residents and funding arrangements**
  LHB to take lead with relocating CHC residents.
  LA to take lead in relocating all others residential/self funding.
- **Establish responsibility -** allocation of cases/re-location-lead persons (see above re: social work involvement in team)
  LHB to allocate a nurse assessor to CHC residents for case management .
  LA and LHB to inform Care Home of names of allocated workers.
- **Families and relatives to be consulted** to view the new care homes / to confirm acceptance of new arrangements/costs. Social Workers to phone and confirm in letter. Social workers and new Provider to discuss third party costs. LA to meet third party if families unable or unwilling.
- **IMCA-mental incapacity** –to identify resident potentially requiring IMCA input-individual care managers to take this issue forward. Social work to advise and arrange.
- **Re-assessments -** Check if current assessments or arrange re assessment/review. Need to ensure up to date assessment prior to move. Care Management CM/LHB to take appropriate action.
- **OT support** –identify any residents requiring -assessment /equipment . Social Workers to check if current equipment to transfer with residents. All residents moving to alternative homes usual arrangements will apply regarding individual requirements for equipment.

- **GP/Pharmacy** - transfer of care arrangements to be agreed. Social Worker to coordinate with GP and pharmacist for all residents moving. LHB pharmacy assistance if required?
- **Personal Property** - transfer arrangements. Social Workers to co-ordinate transfer arrangements - in consultation with families/residents. Provider to be asked to provide transport?
- **Vacancy situation** - Private and local authority sector – Contracts section to ensure a list of current local vacancies. To contact in-house care homes and check on vacancy levels and potential to prioritise these cases if emergency provision needed on temporary basis.
- **Financial concerns-**New contracts/third party agreements/3rd party issue-New pre-placement agreements /third party agreements to be signed CM to coordinate –individual social workers to liaise with new care home/s.
- **Contractual issues –** Contracting Officer in conjunction with finance to clarify with provider cessation of payments as appropriate and to confirm in writing contractual position if provider no longer able to deliver service.
- **Registration issues** – FAO CSSIW.
- **Transportation** issues/ambulance/transport-LHB to take lead on residents needing ambulance transfers. Social work to compile a list of individual residents needs as regard transport requirements (including options of family assistance, taxi/Community transport). Individual social workers to confirm transport arrangements for each allocated case/person. LA to arrange transport for non ambulance residents and escort if family cannot assist.

Home to provide information for each resident on an individual basis

- **Medication records**- to secure medication records for transfer
- **Outpatient appointments** - to provide list of all out patient appointments
- **GP/Pharmacy**-transfer of care arrangements.
- **Personal property**- inventory
- **Files**-current files to transfer to new homes to include all care plans and current assessments. Files of deceased persons to be archived.
- **Residents monies**-current provider to comply with procedures for transfer of monies between one home to another client/family to be consulted.

Source: Neath Port Talbot CBC (2011e)

APPENDIX 10
RECOMMENDED AMENDMENTS FOR
ESCALATING CONCERNS WITH, AND CLOSURES OF, CARE HOMES PROVIDING SERVICES FOR ADULTS

Purpose of Guidance

1. This statutory guidance addresses the management of (1)[6] escalating concerns with, and (2) closures of, care homes that are registered with the Care and Social Services Inspectorate Wales (CSSIW) to provide services to adults, including those providing nursing care. It is issued under section 7 of the Local Authority Social Services Act 1970 and sections 12 and 19 of the National Health Service (Wales) Act 2006. It sets out local authorities', local health boards' (LHBs) and NHS Trusts' responsibilities in this area and suggests ways in which these responsibilities can be discharged.

Background

2. Escalating concerns arise where there are accumulating issues relating to the operation of, or quality of care provided in, a registered care home providing services to adults. These concerns may have been identified through a number of routes including:

- statutory agencies involved in regulating or purchasing services;
- by visiting professionals, such as care managers and nurse assessors;
- complaints or disclosures directly from service users, their families, friends, advocates, or from current or ex-employees of care homes; and
- as a result of the seriousness of an individual adult protection referral or the concerns arising from a series of adult protection referrals in a particular home, or in a group of homes managed by a particular provider.

3. In instances where accumulating issues are being identified there should already be interaction between key agencies including, as appropriate, commissioners, the police, the service provider, service users and their families. Regulatory involvement will include CSSIW along with other regulators where indicated, such as the Health and Safety Executive. This will have led to the identification of issues and, given a failure to address and resolve them by the home, an 'escalating concern status' will have been reached.

[6] Red text indicates where wording has been changed.

4. The safety and well-being of services users is paramount. In circumstances where a failure in the provision of care which causes suffering is identified this is adult abuse which is a breach of the duty of care and could amount to a criminal offence being committed by the home.

5. Escalating concerns will warrant proactive or reactive intervention from those commissioning services, possibly from one or more commissioning agencies, designed to improve the quality of services and, where possible, prevent what might be avoidable home closures.

6. Where abuse is suspected the policy and procedures to protect vulnerable adults must take precedence. The overriding objective should be to ensure the safety of vulnerable service users. In many situations it will be in the best interest of service users to use the escalating concerns procedure alongside the adult protection procedures in an effort to keep the home open. In such situations, clear communication between staff and agencies involved in both processes is essential. However, in the most serious situations it may neither be possible nor in the services user's best interests to attempt this and closure could be unavoidable.

7. Closures of care homes fall into two main categories under the Care Standards Act 2000; 'voluntary' (where the home chooses to close) or 'enforced' (where the home is forced to close). Voluntary closures may occur in the independent sector, or in the public sector. They may be triggered by variety of reasons, and the reason for closure may have an impact on the speed of closure. Whichever the category of closure the Act sets out the legal basis governing the process.

8. In instances where issues are identified that may be leading toward voluntary closure (e.g. drop in referrals, financial difficulties, or strategic changes in the provision of care) there should be interaction between key agencies including, as appropriate, commissioners, the service provider, service users and their families.

Legal Context

General

9. The response of CSSIW, local authorities and LHBs to either escalating concerns or home closures is shaped by their statutory functions, duties and roles as regulator or service provider/commissioner/contractor. For example, section 21 of the National Assistance Act 1948 places a duty upon local authorities to make arrangements for the provision of residential

accommodation for certain persons and to have regard for the welfare of all persons for whom accommodation is arranged.

10. The Local Health Boards (Functions) (Wales) Regulations 2003 transferred functions of the former health authorities to LHBs. Each LHB is responsible for discharging these functions to persons who are usually resident in their area. They are required to meet all reasonable requirements, services for 'the care of persons suffering illness and the after-care of persons who have suffered from illness as they consider are appropriate as part of the health service'.

Legal Duties in Relation to Closures

11. There is no legislation specifically defining the powers and responsibilities of authorities or NHS bodies during care home closures. However, agencies will owe a duty of care to service users, in particular relating to their duties to assess the needs of service users and for providing or securing care and accommodation.

12. Voluntary public sector closures require consultation with the public. Judicial guidance on public consultation process is set out in *R v North and East Devon HA exp Coughlan* [2001] QB 213. To comply with the rules of consultation, the process must be undertaken at a time when proposals are still in the formative stages. It must include sufficient reasons for particular proposals to allow those consulted to give informed consideration and an intelligent response (for example a range of costed options, a preferred option, and a reason for this). Furthermore, adequate time (8 weeks) must be given for consultees to formulate a viewpoint. The product of the consultation must be conscientiously taken into account when the ultimate decision is taken. When considering the closure of a care home, it would be good practice to relay the decision to the residents and relatives of residents in the care home explaining how the consultation evidence was taken into account and on what grounds the final decision was made.

13. When home closure is threatened, working with service-users and their families or other representatives to identify, prepare for and make the transition to a new home requires that key information is provided and constantly updated. Other factors for successful transfer include ready access to support staff with excellent one-to-one communication skills and a genuine opportunity for service users and their families to contribute to the design of new or revised care plans and service specifications.

14. The reaction of service users and their families to notification that a proposed home closure may be imminent, will vary from person to person and be significantly influenced by the messages and information provided to them.

Mental Capacity

15. Enshrined in the Mental Capacity Act 2005 is the principle that people have capacity unless otherwise proven. Even when their capacity may be limited, they may still be able to make some clear choices or decisions. The Act emphasises the importance of supporting incapacitated service users to make decisions and has created a statutory entitlement to advocacy through specialist Independent Mental Capacity Advocates (IMCAs). In specified circumstances IMCAs will support and represent people who lack capacity and have no family and friends to speak for them. The legislation requires local authorities to refer individuals to the IMCAs service where decisions about a change of residence is required, and local authorities may refer where decisions are required at a care review or where there are adult protection procedures. Local authorities and NHS bodies have a duty to instruct IMCAs where accommodation arrangements are being made on behalf of a person lacking capacity without friends or family.

16. When the threat of closure has been recognised by a JIMP (or equivalent), a decision regarding the mental capacity of each resident should be made by a multidisciplinary team, including the care home owner/manager, care manager, relatives and with specialist input from a clinical psychologist and/or psychiatrist with specialist expertise in the care of older people. Subsequently, and based on the level of mental capacity, a disclosure plan should be developed for each resident on whether/how to inform them of the threat of closure and to prepare for relocation. It is not acceptable to assume a policy of non-disclosure to all residents within a care home.

Choice of Accommodation

17. Local authorities are reminded that the National Assistance Act (Choice of Accommodation) Directions 1993 will apply where individuals are moving location as a result of a home closure. Residents (or advocates working on behalf of the resident), and relatives should be told of the range of accommodation available (including extracare sheltered housing, residential care homes and nursing homes, both in the public and independent sector). The types, levels (ceilings), and costs of care and support that each facility provides should be explained fully. Residents (or advocates working on behalf of the resident) should be offered the opportunity to visit alternative accommodation in order for a properly informed choice to be made.

18. Where a service user requests a specific choice of accommodation local agencies should, where ever possible and reasonable to do so, accede to such requests. Local health services are encouraged to adopt the same approach when arranging care placements. In this context local agencies should agree to a placement of choice when the:

- registered care setting can meet the individual's assessed needs and can provide a placement;
- registered care home is willing to provide and contract for the placement; and
- cost of the placement is not more than local agencies would reasonably expect to pay to meet similar levels of assessed needs.

19. In circumstances where a service user is currently accommodated in a home whilst waiting for a placement in their home of choice, local agencies must:

- Identify and arrange placement in the home of choice as a first option, (subject to the Directions on choice), where possible;
- when undertaking a needs and risk assessment, determine the potential impact that a further temporary move may have upon the individual's health and well-being. This should include an assessment of their capacity to make decisions, following the Mental Capacity Act principles. The care setting must be able to meet the service-users assessed needs. Consideration should also be given to how the level of care provided in the new placement will impact on the services user's personal freedom.

20. Local agencies must ensure that 'assessed need' is a key determinant in selecting and/or funding a care placement. The care setting must be able to meet the assessed needs of service users. Service users should not be placed in a setting, even if this is the home of choice, merely because there is a vacancy if the assessed needs can't be met.

Accountability, Roles & Responsibilities

21. It is important that managers and their agencies understand that this guidance does not replace or interfere with existing statutory duties, functions or obligations. Additionally this guidance does not require local agencies to undertake any responsibility or functions which are currently managed by CSSIW. The following paragraphs briefly set out current agency arrangements and responsibilities.

CSSIW

22. CSSIW is the national regulatory inspection and review body for a wide range of services including registered care home settings. Its aim is to encourage the improvement of the social services and care sectors in Wales, by raising standards, improving the quality of services and promoting best practice.

22. CSSIW provides a citizen-centred regulation, inspection and review service. It is operationally independent and contributes to fulfilling the Welsh Ministers' statutory obligations and safeguards those people who use care and social services. This role includes:

- registration - deciding who can provide services;
- inspecting services and publishing reports of inspections;
- reviewing local authority performance;
- dealing with complaints in regulated services where these have not been satisfactorily resolved by services;
- supporting compliance with the regulations;
- taking, where necessary, action including enforcement to achieve compliance; and
- reporting on the quality and status of regulated services on an all Wales basis.

23. CSSIW ensures that commissioners of services are informed of the outcomes of its regulatory function and six monthly meetings are held between Regional Directors, Directors of Social Services, and Chief Executives and senior officers of LHBs with responsibility for commissioning.

24. CSSIW do not commission or undertake placement monitoring or review under either the care management or local agency contracting process. If CSSIW becomes aware of a planned voluntary closure or has concerns about the welfare or safety of service users that might lead to an enforced closure, it will inform the local authority in whose area the home is situated in line with the published protocol between CSSIW and local authorities. Local authorities will be expected to notify any others that were funding other patients or service users in the home.

25. In the case of local authority care home closures a CSSIW inspector will assume the role of Chair (or will appoint an alternative independent chair) on the HOSG to oversee the operational management of the closure.

26. CSSIW compiles deregistration information on the prevalence and reasons (enforced of voluntary) for care home closure. This information will be triangulated with the JIMP/HOSG reports (see 47) to provide detailed information on pathways to closure (or saving homes from closure). CSSIW will analyse JIMP/HOSG reports to identify lessons learned from care home closure process, and distribute this information to the WG and statutory organisations annually so that (where necessary) amendments can be made to WG guidelines and/or local protocols to improve practice.

Local Authorities

27. Section 21 of the National Assistance Act 1948 sets out a local authority's duties in respect of the provision of accommodation. It places a duty on the authority to provide residential accommodation for persons "who by reason of age, infirmity or any other circumstances are in need of care and attention." It also places a duty on the authority to have regard to the welfare of people for whom accommodation is provided and requires it to provide accommodation of different kinds for different descriptions of persons.

28. Accommodation may be provided directly by a local authority. However, the duty to provide accommodation could include arrangements made with a voluntary organisation or any other registered care home provider. The local authority is responsible for commissioning, procuring and contracting for the provision of care within a registered care setting where an individual is ordinarily resident within their area.

29. Section 47 of the National Health Service and Community Care Act 1990 places a duty on the local authority to carry out assessments of care needs where anyone appears to be in need of community care services – subject to any directions given by the Welsh Ministers. Section 47(3)(a) provides that the local authority must notify a local health board if it is apparent that the person may have needs for services which may be provided under the NHS (Wales) Act 2006.

30. The authority must decide, in the light of that assessment, whether a person's assessed needs call for the provision of any services. Guidance published in 2002 'Creating a Unified and Fair System for Assessing and Managing Care' reinforces the responsibility of local authorities to prepare an individual care plan (referred to as a "Personal Plan of Care" – PPC), devise an individualised service specification and to monitor and review the PPC service specification and commissioned placement.

31. The local authority discharges its responsibilities and duties by:

- assessing individual needs;
- constructing a PPC, service specification and commissioning a service provider or agency to meet the assessed needs;
- formulating, monitoring and reviewing service contract arrangements;
- terminating contracts and placements or taking other enforcement/corrective actions;
- responding to complaints;
- local market management and development activities; and
- working reactively and proactively with service providers.

32. Where the local authority has serious concerns about a care home it has a duty to share information about concerns affecting vulnerable adults with CSSIW, an LHB and any other involved statutory bodies – even if this means disclosing personal information about service users.

33. Any disclosure of personal information should however be considered under three legal frameworks. These are:

- the common law duty of confidentiality, which still applies where the issue is not determined by other legislation;
- the Data Protection Act 1998; and
- Article 8 of the European Convention on Human Rights, the right to respect for privacy.

34. In considering disclosure of personal information, the safest course is to always secure the consent of the service user concerned (the data subject under the 1998 Act). Alternatively, the consent of a donee could be sought where the data subject is unable to give informed consent, the donee has a lasting power of attorney and the authority clearly covers such circumstances. Where consent is not available or has been withheld, the 1998 Act still provides for disclosure to safeguard the vital interests of the person – or to safeguard the vital interests of someone else. In disclosing information the best interests test in the Mental Capacity Act 2005 would also have to be applied. Where there is any concern as to powers to disclose personal information, legal advice should be sought.

35. In the case of Local Authority care home closure for strategic reasons, we recommend that the consultation process should take 8 weeks (2 months), analysis of responses should take 4 weeks (1 month), and if closure is the outcome of the consultation then this should be undertaken within 3

months. In total the voluntary closure of a public sector care home should take no more than 6 months.

Health Services

36. LHB or NHS Trusts may commission support, patient accommodation or nursing care from voluntary or private registered providers. The local health services discharges their responsibilities and duties by:

- assessing individual health needs;
- funding nursing care and commissioning 'continuing NHS healthcare';
- constructing a plan of care, service specification and commissioning a service provider or agency to meet the individual's needs;
- formulating, monitoring and reviewing service contract arrangements;
- terminating contracts and placements or taking other enforcement/ corrective actions;
- responding to complaints; and
- local market management and development activities.

Local Authority and Health Services Working Reactively and Proactively with Service Providers

37. Health and social services need to ensure that they work towards preventing escalating concerns developing, and potentially home closures occurring, whenever possible and put in place quality control and monitoring systems. The act of commissioning and procuring individual placements within a registered care home places a duty of care upon statutory agencies to be proactive in monitoring service delivery, safety and performance of care providers and managers.

Guidance Framework

38. This guidance is designed to establish and clarify common systems and requirements which will help shape the response of local statutory bodies when confronted by (1) escalating concerns and in (2) impending home closures. The guidance also contains advisory material on good practice intended to suggest how statutory agencies can discharge their statutory responsibilities in this area[7].

39. To respond effectively and appropriately in the interest of service users and providers local agencies will need to employ a framework of practice which includes the following elements:

[7] No reference to separate guidance could be found on the WG website, therefore a section has been deleted here: "In addition, as part of the implementation of "Fulfilled Lives, Supportive Communities" separate guidance is being developed in respect of agencies' commissioning and contracting functions."

- person centred contracts which place the service user at the heart of the commissioning relationship;
- greater emphasis and importance afforded to placement monitoring and review as part of the care management process;
- senior management commitment and oversight of commissioning, contracting and review processes and of the agreed handling arrangements for escalating concerns and closures;
- effective multi-agency communication and co-ordination, with agreed protocols on information exchange and handling of escalating concerns and home closures;
- inter-agency arrangements for discussing and agreeing action in relation to escalating concerns, closures and the longer term development of residential care;
- agreed multi-agency 'corrective' and 'developmental' action planning to address escalating concerns in the short term and the development of residential care in the longer term (such plans are described later in this guidance); and
- where homes are to close, procedures and home closure plans are in place to run alongside individual service user and resident resettlement plans.

Minimum Requirements

40. Health and social care agencies will have in place systems and processes which enable registered providers, contract managers, care managers and other professionals to clearly understand what is expected and required from each setting and how such requirements will be delivered and monitored in the case of (1) avoiding escalating concerns (2) instigating escalating concerns and (3) care home closures (voluntary or enforced). These systems will frame how agencies contract and work with providers to shape quality services. This will require health and social services to take a number of key steps. These must include:

- Development of service-specifications and contracts for registered settings which cover health and social care and take into account relevant regulations and national minimum standards for care homes for adults, health care standards and other relevant central guidance
- Development and implementation of clear arrangements for contract monitoring (as distinct from care management and nurse assessment of an individual) based upon joint professional responsibility between health and social care agencies. Contracts should not be imposed; they should be agreed following consultation and agreed between health, social care and providers

- Establishment of mechanisms to link information from different sources (e.g. care managers, nurse assessors, CSSIW, complaints officers and contract monitoring officers) with agreed information exchange to maximise information about quality and safety within registered settings (see Annex 1)
- Establishment of mechanisms for information sharing with CSSIW at a regional level (see Annex 1)
- Agreement on mechanisms for the development of corrective and developmental action plans to address escalating concerns (these plans are described later) including a timeline whereby we recommend that residents are not under the threat of closure for longer than 6 months (see Annex 3)
- Agreement between local agencies on how escalating concerns will be managed if corrective action plans are not successful. This may include embargo and home closure considerations, (see Annexes 3 and 5)
- In order to strengthen joint working, local management, co-ordination and communication systems, for managing escalating concerns local authorities, NHS Trusts and LHBs are required to create a "Joint 'Inter-agency Monitoring Panel" (JIMP) or similar mechanism where they do not already exist.
- When the threat of closure has been identified, a 'Home Operations Support Group' (HOSG) or similar support mechanism should be established where they do not currently exist, for managing possible care home closures (either voluntary or enforced). In the case of the threat of closure in the independent sector the HOSG will be chaired by the Local Authority, in case of the threat of closure in the public sector the HOSG will be chaired by someone independent of the public sector (e.g. CSSIW) (see Annexes 2, 3 and 4).
- When the threat of closure has been identified for care homes in any sector, a disclosure plan should be developed for each resident on whether/how to inform them of the threat of closure and to prepare for relocation (see 16 above). A decision regarding the mental capacity of each resident should be made by a multidisciplinary team, including the care home owner/manager, care manager, relatives and with specialist input from a clinical psychologist and/or psychiatrist with specialist expertise in the care of older people.
- When the threat of closure has been identified and care homes are at a high likelihood of closing (see Annex 3 and 4) in any sector, individual service user relocation plans must be co-ordinated for everyone accommodated within the care home. The individual service user relocation plan should be developed with the resident (or advocate working on behalf of the resident), and relative, taking into account the decision of the multidisciplinary team assessment of mental capacity. The individual service user relocation plan should take into

account social and psychological needs of the resident (such as the maintenance of social relationships formed in the care home), as well as the need for any physical personal and nursing care (See Annex 5).

- All residents should have access to independent advocacy services including the statutory Independent Mental Capacity Advocacy service, and other such services to support service users as appropriate. The registered provider must support and enable approved advocacy services to meet with service users to identify their wishes and offer appropriate support.

41. Local agencies will need to:

- Communicate and work jointly with CSSIW and agree how they will manage their distinctive responsibilities in the case of escalating concerns, enforced or voluntary care home closure.
- Sharing information with CSSIW will be vital where agencies intend to put in place either a Development Action Plan (DAP) or Corrective Action Plan (CAP). These plans are described later (see also Annexes 3 and 4);
- Make other potential contracting agencies aware of the issues surrounding escalating concerns, enforced or voluntary home closure. For example, other neighbouring agencies may also have service users resident within the same care home;
- Recognise that a CAP is linked to risk assessments which inform health and social services decision making processes (see Annex 3);
- Work with registered providers to ensure they understand why a DAP or CAP has been initiated and to establish the reasons for this, what improvements are required and by when, how the plans will be monitored and by whom and what criterion will be used to suspend or remove the need or requirement for an action plan continuing to be maintained (see Annex 3).

Possible Structural Arrangements

Joint Inter-agency Monitoring Panel (JIMP) and Home Operations Support Group (HOSG)

42. Statutory bodies will need to ensure that they have arrangements in place for a joint inter-agency monitoring panel (JIMP) to lead arrangements when the home is under threat of closure.

43. In the case of escalating concerns and enforced care home closure the JIMP will be responsible for developing DAPs and CAPs.

44. The JIMP will arrange for a Home Operations Support Groups (HOSG) to be convened (unless this already exists). In the case of the threat of closure in the public sector, the Local Authority will ensure that a HOSG is convened and chaired by someone independent of the public sector (e.g. CSSIW). The HOSG will be responsible for the arrangements for direct operational management while the care home is under threat of closure, and where necessary for a care home closure.

45. There are several ways in which statutory agencies can discharge their statutory responsibilities in relation to (1) escalating concerns within homes and (2) in relation to homes that are closing. Whilst it is ultimately a matter for local authorities and local health boards to decide how they discharge these responsibilities, they are required under this statutory guidance to have jointly agreed local arrangements in place to manage escalating concerns and closures. They must also be able to demonstrate the robustness of those arrangements. These should be set out in a protocol that is publicly available and the process is transparent for members of the public.

46. An example of how such responsibilities can be discharged in a care home closure situation is provided in Annexes 1-5. Agencies should adapt these to meet their individual circumstances.

47. Where the JIMP has been made aware of the threat of closure, resulting in escalating concerns, enforced home closure, voluntary care home closure, or a care home saved from closure the JIMP and HOSG will meet to evaluate the whole closure process and to identify lessons learned. The Chair of the JIMP will prepare a report on the home closure or the methods by which a care home was saved from closure. A copy of the report must be provided to CSSIW.

Developmental & Corrective Action Plans

48. The following paragraphs describe a proactive and reactive framework to escalating concerns and to secure immediate improvements in care provision and also to respond to intermediate or longer term issues or concerns. This guidance requires local agencies to develop structures in line with the following arrangements.

49. A Development Action Plan (DAP) may be required where care management, contract monitoring, complaints monitoring and/or other sources of information indicate a short fall in the quality of service provided and statutory agencies want to see the service moving forward in specific areas of quality and practice.

50. A Corrective Action Plan (CAP) will be required where immediate action to ensure the safety of service users and/or staff is needed. This would be indicated in situations where a delay in taking preventative or remedial action could result in the need for enforcement action and cancellation of registration.

51. Corrective and Development Action Plans may also work alongside each other where preventative or remedial action is required to target critical areas of performance and other short falls that require focused or in-depth consideration and action.

52. The use of CAPs and DAPs do not replace compliance notifications instituted by CSSIW. It is critical that agencies understand their distinctive roles and responsibilities in respect of poor performance and/or breaches in regulations or standards. Local authorities and health services must act within the sphere of their own roles and responsibilities. For example they can take specific action in terms of breach of contract or poor performance where necessary.

53. CSSIW is principally concerned with compliance by registered providers and managers with national regulations and standards, and enforcement in respect of breaches of statutory provision and of national regulations by registered providers and managers. CSSIW holds a range of enforcement powers to call on through both criminal and civil routes. CSSIW will also encourage improvement in services in line with national regulation. It is not the role of CSSIW to lead on work with providers which is designed to ensure that local service specifications or contractual terms and conditions are met.

Embargos

54. Subject to the terms of the contract, where a local authority or LHB applies an embargo to a particular home, i.e. it chooses not to place new service users there for a specified reason, it should be put in place in line with the authority's of LHB's policy on embargos and applied consistently. Any variations from normal practice should be recorded. Local Authorities should not enforce informal embargos through decreasing referrals to a care home.

55. There must be a clearly evidenced rationale for usage of embargos. Application of an embargo would be open to challenge through Judicial Review. The use and removal of embargoes, or indeed

cancellation of a contract, must be linked to a thorough risk assessment which has been considered as part of the multi-agency framework.

56. If the embargo is considered to be warranted because new service users might not be safe at the home, local authorities and LHBs should make arrangements for all existing service users at the home to be reviewed individually to assure their wellbeing.

Action

57. Local authorities, LHBs and NHS Trusts are asked to:

- note this statutory guidance and the advice it contains;
- ensure that they have appropriate detailed and comprehensive local arrangements in place to handle escalating concerns over care homes or home closures which discharge their statutory responsibilities highlighted in this guidance;
- ensure that these local arrangements are in line with the content of this statutory guidance.

Annex 1

Example of monitoring and preventative arrangements [8]

The Usual Role of Statutory Agencies

1.1 Each agency has a clear role to ensure that satisfactory care is delivered to vulnerable adults and, where care is inadequate, to communicate concerns both internally and where appropriate externally. This ensures actions of advice, support and monitoring can be considered and selected to assist service improvement.

1.2 Whilst some agency partners have a key role in determining the fitness of a care provider for example a regulatory body, Commissioning agencies must take account of their own contract requirements and measure the quality received by service users as an indicator of contract compliance. Commissioners must hold an independent view of the quality they expect to receive rather than perhaps be more reliant upon inspection reports of other agencies. For example, Service Purchasers (social services and LHB) conduct joint annual contract compliance visits to homes and undertake a series of checks to ensure that the service provider meets its statutory obligations and provides an appropriate service to its residents[9]. In the case of quality visits to public sector care homes the group should include external members e.g. CSSIW, nominated private care providers, care agency forum members to ensure some level of independence. Following the visit social services and the LHB write a joint report detailing the findings and where the service provider is failing to meet standards, agree an action plan (this should be shared with the Quality Assurance Meeting – see below). The service purchasers offer support and advice to the provider in an attempt to rectify problems and prevent the instigation of escalating concerns or home closure. Further review visits, where necessary, may be carried out according to the issues identified.

1.3 Agency partners aim to work in a proactive and preventative manner, rather than wait to respond to a service that has deteriorated resulting in inadequate care, abuse or neglect.

1.4 In addition to determining the fitness of a care provider to provide quality care, each agency has a role in identifying other matters that may impact on the future operation of a care home. This includes monitoring the financial health of independent care providers, being aware of independent providers future plans (e.g. retirement), and local authority decisions to change care provision that may impact on continued operation of a care home.

[8] Large sections of this Annex have been drawn directly (word for word) from *Caerphilly Provider Performance Monitoring Protocol* (Caerphilly CBC 2010a).

[9] See Appendix 3 for a flow chart of this process.

1.5 Therefore, when a member of staff identifies concerns he/she addresses them as part of the usual role of their organisation and considers whether it is appropriate to share the issue of concern with other sections within the Directorate. This can be done in one of two ways.

- Firstly, the member of staff can bring their concerns to the attention of the member of staff from their organisation who attends the regular quality assurance meeting in order that the issue is brought to the agenda and information about the provider shared.
- Secondly, the member of staff can bring significant concerns to the attention of the Local Authority Commissioning Service Manager or POVA Service Manager in order that a decision to call an urgent meeting to discuss the provider performance can be considered.

Consent & Information Sharing

1.6 Service users are not always sure how to raise their concerns. They may be uncertain of whom to approach or may approach a number of different teams and/or agencies. It is vital that everyone involved in the provision and monitoring of services shares information received regarding service provision

1.7 Information, whether arising from a POVA referral, a complaint or a contracting issue, can be shared without the enquirer's consent where there is an allegation that:

- A criminal offence has been committed, is being committed or is likely to be committed
- A person has failed, is failing or is likely to fail to comply with any legal obligation to which s/he is subject[10]
- The health and safety of any individual has been, is being or is likely to be endangered
- There has been a breach of statutory regulations

Sharing Information regarding Provider Performance at a Quality Assurance meeting

1.8 The Local Authority holds a regular Quality Assurance Meeting; a key part of the provider performance monitoring framework. The quality assurance meeting acts as an important link between the information provided by its members and early intervention (see Figure A1.1)

1.9 The Quality Assurance meeting consists of Local Authority representatives: Assessment, Care Management and Review Teams; Customer Service (complaints); Protection of Vulnerable Adults (POVA) Team; Commissioning Team; and Supporting People Team (and any other appropriate members e.g. CSSIW regional inspector, independent care provider representative).

[10] If our recommendation that financial health becomes a National Minimum Standard, then this would include information relating to financial instability information relating to financial instability

1.10 The purpose of the meeting is to help internal teams to work together across adult services in a proactive manner and specifically to:

- Share information gained by each team
- Record escalating concerns in care services
- Recommend actions to be taken and where appropriate disseminate across each Team.
- Demonstrate the use of contract monitoring and case management review to achieve improvement rather than wait for a complaint or POVA referral to be received
- Record improvements in care services
- Share good practice and lessons learned across the service to support continuous improvement.

1.11 Service Purchasers (social services and LHB) conduct joint annual contract compliance visits to homes (in the independent and public sector) in order to undertake a series of checks to ensure that the service provider meets its statutory obligations and provides an appropriate service to its residents (Appendix 3). Following the visit social services and the LHB write a joint report detailing the findings and where the service provider is failing to meet standards, agree an action plan. The contract monitoring report should be shared with the Quality Assurance Meeting.

1.12 All participants bring any information regarding concerns, monitoring outcomes and/or improvements which have been identified and managed by their team since the previous meeting and which are thought to be relevant for other adult service departments. For example: information on complaints, POVA; issues of concern about a particular service noted by the review team; or improvements noted regarding a provider.

1.13 This discussion will facilitate early identification of patterns of concern or risk that can be addressed through the ordinary activity of adult services department before the significance of the issue or risk escalates. Concerns may be passed to the relevant Emergency Duty Team.

Figure A1.1 Example of an agenda for a Quality Assurance Meeting

Date:

Time:

Venue:

Present:

Apologies:

AGENDA ITEM	DECISIONS / ACTIONS	ACTION BY/ DATE
1	**Introductions & Apologies**	
2	**Minutes of the previous meeting**	
3	**Review of all providers who are already subject to the Provider Performance monitoring protocol meeting process**	
3	**New concerns regarding contracted services** *Update from: Commissioning Team Supporting People Team Assessment / Care Management, POVA Team Review Team and customer services.*	
4	**Positive feedback regarding contracted services** *Update from teams as above*	
5	**Any other business**	
6	**Summary of actions**	
7	**Date and time of next meeting**	

Annex 2

Example of the establishment of a Joint Interagency Monitoring Panel (JIMP)[11]

2.1 There is an expectation that staff will use their professional judgement in decision-making as to whether the concerns identified will continue to be managed through their own department, or discussed at the regular Quality Assurance Meeting or shared urgently. Local Authorities may consider using an electronic database to record issues as and when concerns arise and/or as a consequence of routine involvement/intervention with the individual care home setting during Nurse Assessor, Contract Monitoring Officer and Review Team visits and from the receipt of POVA referrals and complaints.

2.2 When the Quality Assurance Meeting are made aware of a potential threat of closure of a care home (voluntary or enforced), information will be sought from external agency partners for example CSSIW, EMI care home advisor, practice development nurse, regarding their views on their risk of closure.

2.3 Once it is evident to the Quality Assurance Meeting that there is a threat of a care home closing (albeit minimal), or where a multi-faceted approach to quality management is anticipated, the Joint Inter-agency Monitoring Panel (JIMP) will be convened to specifically discuss the issues in relation to the provider.

2.4 The identification of one of the following circumstances would lead to a JIMP being held:

Firstly issues that may lead to escalating concerns, or enforced closure:

- The Council has been notified of significant issues by partner agencies e.g. Health Trust, CSSIW or HIW
- The provider is unable to make the improvements required of them.
- The provider is unwilling to make the improvements required of them.
- A single or repeated concern is raised by a care manager or other staff, service user or their representative, highlighting a risk
- A single POVA referral identifies significant risk to other service users[12]
- The number and type of issues identified gives cause for concern

Secondly, issues that may lead to voluntary closure:

- Financial instability of a provider

[11] Large sections of this Annex have been drawn directly (word for word) from *Caerphilly Provider Performance Monitoring Protocol* (Caerphilly CBC 2010a).

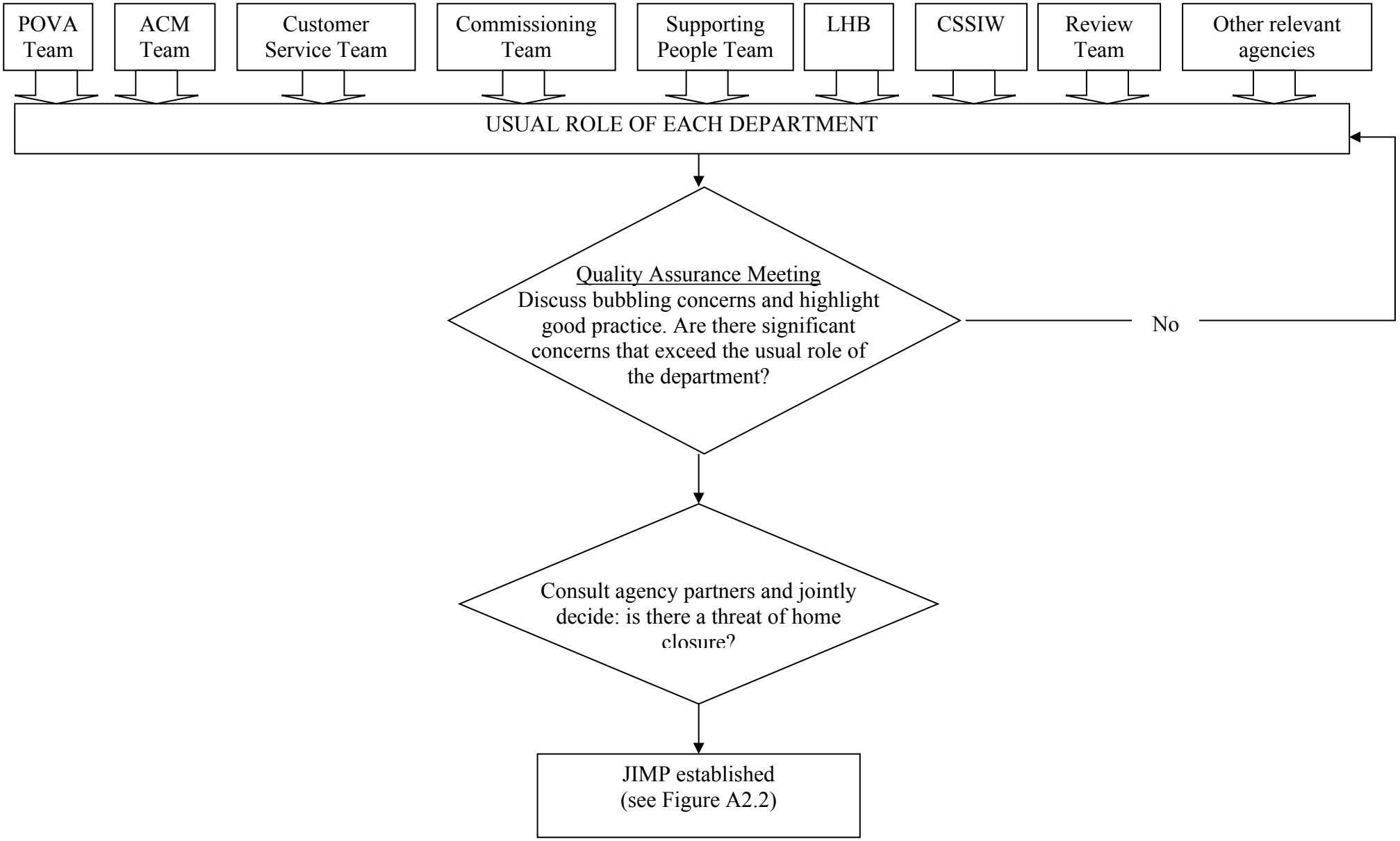
[12] Whilst the Local Government Data Unit defines large scale investigations as five or more POVA referrals for one care provider, this is not an automatic trigger to hold a provider performance meeting. Rather, the POVA referrals would be considered along with other information that had been made available to the most recent quality assurance meeting and a decision taken as to its significance and the most appropriate course of action. For example it may be decided to await the outcomes of the individual POVA investigations and seek further information from agency partners about current information to determine the level of significance and the depth and breadth of the concerns.

- Personal circumstances of a provider
- Local Authority strategic decisions to change type or amount of care provision

This is not an exhaustive list.

2.5 A flow chart is provided in Figure A2.1 illustrating the use of the regular Quality Assurance meeting and the instigation of a JIMP

Figure A2.1 Flowchart indicating how a Quality Assurance Meeting would lead to the instigation of Joint Interagency Panel Meeting



Annex 3

Example of Escalating Concerns[13]

3.1 Once it is evident that a care home is under the threat of closure **due to poor standards of care**, **or a failure to meet minimum standards** the Joint Inter-agency Monitoring Panel (JIMP) will immediately appoint a Chairperson who will establish a Home Operations Support Group (HOSG). In the case of the threat of closure in the public sector, the Local Authority will ensure that a HOSG is convened and chaired by someone independent of the public sector (e.g. CSSIW).

3.2 The HOSG will be responsible for the arrangements for direct operational management of care homes considered under escalating concerns (i.e. the implementation of CAP or DAP).

3.3 Both health and social services will nominate members of the HOSG group. Agencies must ensure that representatives have appropriate specialist skills according to the needs of service users. Nominations should include the Contract Monitoring Officer for the 'host' authority, senior nurse from both the local health board and NHS Trust, and social services locality manager or principal officer in whose area the home is located (in this context 'host' authority means the local authority area in which the home is physically located.) CSSIW will also have a key role in care home closures.

3.4 The JIMP will conduct a risk assessment to determine if the Service Provider is at Escalating Concern Status.[14] The level of concern will determine the outcome:

- Red – there are significant problems which will impact the service and or safety of service user and/or staff if not resolved – CAP required (see below)
- Amber – Could affect the service and or safety of service users and/or staff if not addressed developmentally – DAP required (see below)
- Green – Being addressed or of less significant concern but will require monitoring to ensure intended improvement sustained – Routine monitoring and review.

3.5 The JIMP will conduct a likelihood assessment to determine if the Service Provider is at High Likelihood of closing Status (see Figure A3.1). This should ensure, that where possible, individual relocation plans and home closure plans are not developed hurriedly, and will allow statutory agencies and residents time to prepare for the event of closure should it occur. This JIMP should be mindful that the timeline for closure may be subject to change (e.g. enforced

[13] Large sections of this Annex have been drawn directly (word for word) from *Caerphilly Provider Performance Monitoring Protocol* (Caerphilly CBC 2010a) and from Neath Port Talbot *Joint Interagency Policy for managing Escalating Concerns* (Neath Port Talbot 2011c)

[14] See Appendix 4 for a good example of a risk rating matrix.

closure may be planned to take place over several months, but if the provider decides to pre-empt enforced closure and close voluntarily, the period may be much shorter). Relocation plans may need to be developed earlier for care homes with a large number of residents.

- High – The likelihood of closing coupled with the anticipated closure timeline requires that a resident disclosure plans, individual relocation plans and a home closure plan is developed.
- Low – The likelihood of closing coupled with the anticipated closure timeline requires that only resident disclosure plans are developed.

Figure A3.1 Assessment of Likelihood of closing.

Anticipated closure timeline: Likelihood of closure:	3 months	2 months	1 month	Less than 1 month
Unlikely				
Low chance				*?[15]
Even chance			*	*
High chance		*	*	*
Expected to occur	*	*	*	*

Key: * denotes individual relocation plan and home closure plan required.

3.6 At a high or low likelihood of closing status the HOSG will ensure that a multidisciplinary meeting is held (including the care home owner/manager, care manager, relatives and with specialist input from a clinical psychologist and/or psychiatrist with specialist expertise in the care of older people) and that a disclosure plan is developed for each resident so that the course of action is clear should the risk of closure increase. Individual disclosure plans should state whether/how to inform the residents of the threat of closure and to prepare for relocation. It not acceptable to assume a policy of non-disclosure to all residents within a care home.

3.7 At a high likelihood of closing status the HOSG will ensure that individual relocation plans are developed for each resident and a home closure plan developed for the care home. For further

[15] Careful consideration should be given as to whether individual relocation plans should be developed. Although the chance of closure is low, the timescale suggest that should closure take place there would be insufficient time to allow residents to make informed choices about alternative accommodation, or for statutory organisations to prepare for relocation. In these cases, we suggest that the likelihood of closure is monitored and reassessed frequently.

information on the content of individual relocation plans and home closure plans see Annex 5. The reasons for preparing 'contingency' individual relocation plans should be explained to the residents.

3.8 At amber or red Escalating Concerns status, the provider (when in attendance) and JIMP will develop an action plan using a standard template.[16]

3.9 When identifying improvements required the meeting should determine whether the required improvement actions are either development actions (DA) where they are good practice requirements to assist overall improvement or corrective actions (CA) where the improvements are related to a contractual or regulatory breach in line with the Escalating Concerns with, and closures of, Care Homes providing services for Adults.

3.10 The action plan is given an overall start date and target dates for improvements to be made are recorded alongside the person responsible. Dates and sources of evidence of improvement are recorded on the action plan. The date the action was completed should be recorded.

3.11 Following the development of an action plan the the HOSG will oversee its implementation and risks will be rated and managed through the HOSG. The concerns will be scored by their likelihood and impact. The colours red, amber and green will be used to signify the level of risk rather than the outcomes.[17]

3.12 Risk reduction steps may include requiring addition expertise and advice from health professionals, considering staffing numbers and structures, supernumerary hours for key staff to target improvements and monitoring to determine whether the risks are being managed to an acceptable level.

3.13 HOSG Monitoring and risk management arrangements may include:

- A series of meetings with the provider
- Further specific service user care reviews
- Directly seeking service user feedback
- Quality assurance monitoring visits
- Contract monitoring visits
- Care manager monitoring visit
- Monitoring visits by the regulator - CSSIW/HIW
- Dialogue with Carers and family
- Expertise

3.14 The HOSG will report to the JIMP on progress with regard to progress towards the CAP or DAP and the action plan should be reviewed by the JIMP. Monitoring must be evidenced and

[16] See Appendix 5 for a good example of an action plan template.
[17] See Appendix 5 for a good example of risk rating and monitoring for use by the HOSG.

contingencies required for repeated lack of adequate progress or further deterioration with robust challenge and rationale recorded. Contingencies may include mandatory suspension of placements i.e. embargo (see below).

3.15 Failure to progress the improvement actions must be considered by the JIMP alongside an assessment of the level of risk i.e. is it increasing decreasing or remaining the same in relation to the specific actions not completed and the overall concerns. Agreement should be reached as to whether target dates will be extended or sanctions applied. We recommend that residents are not under the threat of closure for longer than 6 months. Where target dates are extended the rationale will be recorded in the minutes and the date upon which the target date was extended and the new target date will be recorded in the 'by when' box of the action plan.

3.16 Immediate focus must be given to protective issues for individual and others within care setting who may also be at risk, thus the issues for improvement should be prioritised around risks to service users. For example the JIMP may recommend suspension of any new business with the organisation, whilst maintaining existing contracts until the issue has been resolved or termination of the contract and services to be delivered by an alternative provider. If the decision is taken to suspend new placements/packages of care then CSSIW or HIW along with the other agency partners will be informed and a letter will be sent to the Provider setting out the rationale.

3.17 Whilst the new placements or packages of care may be suspended the local authority will ensure along with agency partners that service users already receiving a service from the provider are protected. It is imperative that care is monitored frequently in order that vulnerable adults are not exposed to unnecessary risk.

3.18 Where the improvements required in the action plan have been completed and the breadth/depth of the risk has significantly reduced the provider performance group will consider whether it is appropriate to lift the suspension of placements/packages of care.

3.19 The provider performance process may be closed where the action plan has been completed, or when the action plan not been completed but the likelihood of the risk occurring has significantly reduced (to green on the HOSG rating – see Appendix 5) and the partners agree that the issues are suitable for single agency monitoring. If the issue remains a high score and is coloured red the action plan cannot be closed. Feedback must be provided at the Quality Assurance Meeting (see Annex 1).

3.20 Following the agreement that issues are suitable for single agency monitoring, within one calendar month the JIMP and HOSG will meet to evaluate the whole process of saving the home from closure and to identify lessons learned. The Chair of the JIMP will prepare a report and this will be circulated to senior managers within local statutory agencies, chairman and

members of the local authority scrutiny panel and also chair and members of the LHB. A copy of the report must also be provided to CSSIW.

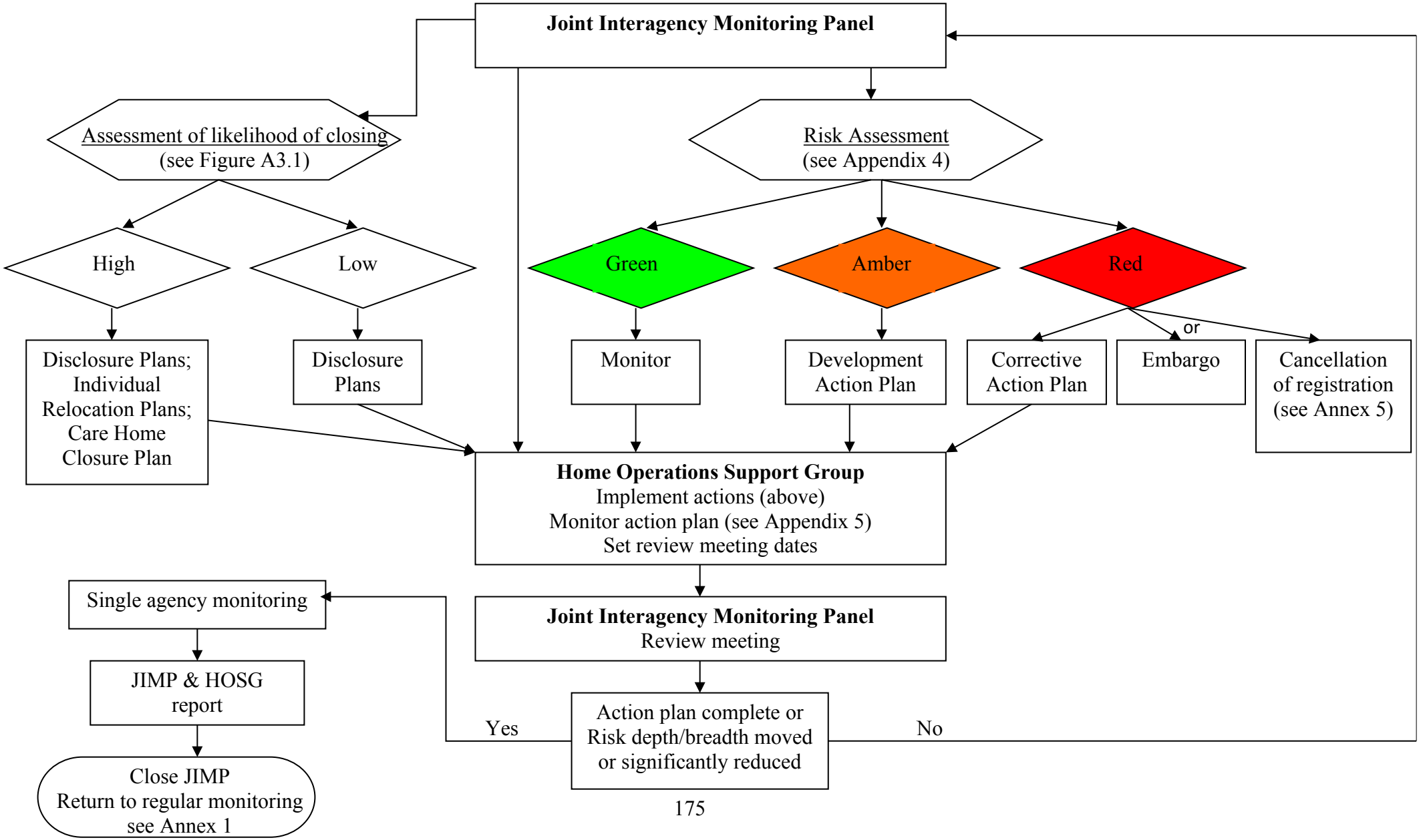
3.21 Where a provider continues to fail to improve quality or protect vulnerable adults consideration will be given to terminating the contract.

3.22 Where the contract is terminated with a care home (under sections 20 or 14 of the Care Standards Act 2000), the care home closure policy will be used to ensure a smooth transition for service users to a new service provider (see Annex 5).

3.23 The LA will take responsibility for storing information relating to provider performance (in the case of independent providers), while an independent body should store information relating to information relating to Public sector provider performance.

3.24 A flow chart is provided in Figure A3.2 illustrating the process of escalating concerns.

Figure A3.2 Flowchart indicating the process of escalating concerns



Annex 4

Example of the Threat of Voluntary Closure

This example of the threat of voluntary closure arrangements assumes that **either**:

- an independent provider has announced that they made need to close (for any reason, but has not yet provided a closure date)

or

- the Local Authority has decided to close a home because of strategic decisions to change the type or amount of care provision.

4.1 A flow chart is provided in Figure A4.1 illustrating the process of the threat of voluntary closure.

Organisation

4.2 Once it is evident that a care home is under the threat of closure **due to voluntary reasons** the Joint Inter-agency Monitoring Panel (JIMP) will immediately appoint a Chairperson who will establish a Home Operations Support Group (HOSG). In the case of the threat of closure in the public sector, the Local Authority will ensure that a HOSG is convened and chaired by someone independent of the public sector (e.g. CSSIW).

4.3 The HOSG will be responsible for the arrangements for direct operational management of care homes.

4.4 Both health and social services will nominate members of the HOSG group. Agencies must ensure that representatives have appropriate specialist skills according to the needs of service users. Nominations should include the Contract Monitoring Officer for the 'host' authority, senior nurse from both the local health board and NHS Trust, and social services locality manager or principal officer in whose area the home is located (in this context 'host' authority means the local authority area in which the home is physically located.) CSSIW will also have a key role in care home closures.

4.5 The JIMP will conduct a likelihood assessment to determine if the Service Provider is at High Likelihood of closing Status (see Figure A3.1 – Annex 3). This should ensure, that where possible, individual relocation plans and home closure plans are not developed hurriedly, and will allow statutory agencies and residents time to prepare for the event of closure should it occur. Relocation plans may need to be developed earlier for care homes with a large number of residents.

- High – The likelihood of closing coupled with the anticipated closure timeline requires that a resident disclosure plans, individual relocation plans and a home closure plan is developed.

- Low – The likelihood of closing coupled with the anticipated closure timeline requires that only resident disclosure plans are developed.

4.6 At a high or low likelihood of closing status the HOSG will ensure that a multidisciplinary meeting is held (including the care home owner/manager, care manager, relatives and with specialist input from a clinical psychologist and/or psychiatrist with specialist expertise in the care of older people) and that a disclosure plan is developed for each resident so that the course of action is clear should the risk of closure increase. Individual disclosure plans should state whether/how to inform the residents of the threat of closure and to prepare for relocation. It not acceptable to assume a policy of non-disclosure to all residents within a care home.

4.7 At a high likelihood of closing status the HOSG will ensure that individual relocation plans are developed for each resident and a home closure plan developed for the care home. For further information on the content of individual relocation plans and home closure plans see Annex 5. The reasons for preparing 'contingency' individual relocation plans should be explained to the residents.

Threat of closure in the independent sector

4.8 The JIMP will establish whether there is chance that the threat of voluntary closure can be averted (e.g. financial situation can be changed, an alternative provider can be found). When there is evidence to suggest that the risk of closure can be averted the provider (when in attendance) and JIMP will develop a corrective action plan (CAP) for risk reduction steps using a standard template.[18] This may include requiring additional expertise and advice from financial advisors, or considering alternative providers with CSSIW.[19]

4.9 Where escalating concerns have been instigated before the threat of voluntary closure the risks to residents will be rated and managed through the HOSG as outlined in Annex 3.

4.10 The HOSG will implement JIMP action plans.

4.11 The HOSG will report to the JIMP and the action plan should be reviewed by the JIMP.

4.12 Failure to progress the corrective actions must be considered by the JIMP alongside an assessment of the level of risk i.e. is it increasing decreasing or remaining the same in relation to the specific actions not completed and the overall concerns. Agreement should be reached as to whether target dates will be extended. Where target dates are extended the rationale will be recorded in the minutes and the date upon which the target date was extended and the new target date will be recorded in the 'by when' box of the action plan.

[18] See Appendix 5 for a good example of an action plan template.
[19] If our recommendation that financial health becomes a Minimum Standard then financial instability would be dealt with through escalating concerns (see Annex 3) and would probably result in the JIM issuing a CAP.

4.13 The JIMP process may be closed where the action plan has been completed and the threat of voluntary closure occurring has significantly reduced (to green on the HOSG rating – see Appendix 5). Feedback must be provided at the Quality Assurance Meeting (see Annex 1).

4.14 Where the issue is not resolved the care home closure policy will be used to ensure a smooth transition for service users to a new service provider (see Annex 5).

4.15 The Local Authority will take responsibility for storing information relating to the independent provider.

Threat of closure in the public sector[20]

4.16 Holding a public consultation regarding a strategic decision to close a public sector care home is not an optional step in the process. It has been ruled that "The very concept of administrative discretion involves a right to choose between more than one possible course of action upon which there is room for reasonable people to hold differing opinons as to which is to be preferred" (*R v North and East Devon HA exp Coughlan* [2001] QB 213).

4.17 The Local Authority has an obligation to let those who have a potential interest in the care home closure to know in clear terms what the proposal is and exactly why it is under positive consideration. The Local Authority is required to inform those with a potential interest in the care home closure enough (which may be a good deal) to enable them to make an intelligent response. This may be best operationalised through a fully costed option appraisal, providing evidence for and against the status quo, the preferred option (the reason for this), and other possible scenarios. .

4.18 The local authority will need to discuss and agree a consultation programme with the HOSG. This can be done at any time, but no consultation should be launched without first receiving the written approval of the HOSG. The contents of a consultation programme are as follows:

- a timetable noting the main methods of consultation. **Note:** as the consultation is a statutory duty, the dates noted in the timetable have the power of statute. As a result, local authorities are expected to adhere to the dates noted and to ask the HOSG for permission if they need to be changed. Authorities will need to demonstrate exceptional circumstances before the HOSG will grant permission to vary any dates.
- a copy of the report that is to be circulated
- details of any other publicity the Council intends to give to the consultation before launching it and during the consultation itself

[20] The process of consultation has been adapted from the Welsh Health Board (2010), although some is reproduced word for word.

- a list of the individuals, bodies and organisations the Council intends to consult

Length of consultation period

4.19 Adequate time must be given for consultees to formulate a viewpoint. Usually, the consultation period should last for at least 8 weeks. Such a period can improve the quality of the responses by enabling bodies who wish to do so to consult internally or locally before responding.

4.20 When planning a consultation, it is important to raise awareness of the exercise among the audience to whom it is likely to be of interest (i.e. residents, relatives, and interested organisations). Local authorities should consider ways of advertising the consultation at the time of the launch date or, if possible, beforehand so that respondents can take full advantage of the consultation period to prepare detailed and meaningful responses.

Clarity regarding the consultation process

4.21 Consultations should be clear regarding the consultation process i.e. how the consultation will work and, as far as possible, what will happen when it comes to an end.

4.22 As well as inviting responses on the closure of the care home, authorities can offer a series of open and closed questions regarding specific aspects of the closure and the expected outcomes (e.g. relocation of residents). Consideration should also be given to offering respondents the opportunity to voice their opinions on related matters that are not specifically referred to in the questions.

Accessibility

4.23 It is necessary to identify early in the process those bodies (and individuals) which will have the most interest in the closure of the care home draft and target it appropriately. When it is necessary to reach a varied audience, several methods of consultation will be needed. An explanation should be given of the ways that are available for people to take part, how to do so and, if appropriate, why there are several ways of doing so.

4.24 As far as possible, the proposal for the closure of a care home should be easy to understand, self-contained and free of jargon. That will assist in reducing the burden of consultation.

4.25 It is important, to be proactive in consultation. Careful consideration should be given to how to warn prospective respondents of the consultation and now to obtain comments from relevant sections of the community. There is not an expectation for authorities to produce the proposal for closure of a care home in a range of different versions e.g. *Braille* or community language versions (unless the authority's own policy demands it, or the care home caters for a particular

community that would benefit from these forms of communication) but consideration should be given to different ways of reaching specific audiences such as public meetings, discussions forums and focus groups etc. The proposal should be produced in Welsh and English.

4.26 If the Local Authority places a notice in the daily newspapers and the regional weeklies which circulate in the same area, it is not necessary for the notifications to appear on the same day or during the same week. The Welsh version of the notice should appear also in the Welsh-language weekly newspapers.

4.27 It is good practice to hold at least one **public meeting** as part of the consultation process. The appropriate details will need to be included in the formal notification (to the HOSG) and ways of advertising the meeting(s) will need to be found.

4.28 There are several ways in which a local authority can give **informal publicity** to a consultation on the proposal to close a care home:

- a notice on the homepage or front page of the Local Authority website. This notice should be retained in a prominent location on the website throughout the consultation period. The notice should include the following:
  - a link to both the Welsh and English versions of the proposal
  - a brief explanation of the nature and length of the consultation period
  - a name, address and e-mail address for the receipt of responses
  - an electronic response form on the website
  - details of how to get hold of a hard copy of the proposal if desired
- the Local Authority's newsletter that is distributed to all households within the catchment area
- a copy of the advertising materials together with a hard copy of the proposal in the following locations:
  - libraries (including mobile ones)
  - foyers of public buildings
  - local Citizens' Advice Bureaux
- the website of the local Family Information Service together with the Service's centres or offices, as appropriate
- the Older People Ageing Research and Development Network (OPAN Cymru) bulletin

4.29 There is a wide range of all-Wales, regional and local bodies and organisations which should be given the opportunity to take part in the consultation on the closure of a care home. By virtue of their nature, some of these bodies are relevant to all local authorities in Wales while others which operate regionally or locally will only be relevant to specific local authorities. As noted above, the list of bodies and organisations the Council intends to consult will be part of

the consultation scheme to be submitted to the HOSG.

Responsiveness to consultation exercises

4.30 Local authorities will need to interpret every response (whether written or received through other channels such as discussion forums or public meetings) carefully. The product of the consultation must be conscientiously taken into account when the ultimate decision is taken. When considering the closure of a care home, it would be good practice to relay the decision to the residents and relatives of residents in the care home explaining how the consultation evidence was taken into account and on what grounds the final decision was made

4.31 The timetable for the consultation foresees that local authorities will want to set aside two or three weeks after the closing date to analyse responses, and to draw up a post-consultation report for submission to the HOSG for an independent oversight

4.32 Local authorities are expected to attach copies of all the written responses with the report together with notes or records arising from any public meetings, discussion forums or focus groups arranged.

4.33 It is considered good practice for local authorities to disseminate the report to consultees, care home residents, relatives and other stakeholders.

4.34 The HOSG will ask authorities to consult with the public a second time if it concludes that the consultation has not followed the consultation programme agreed at the beginning of the process.

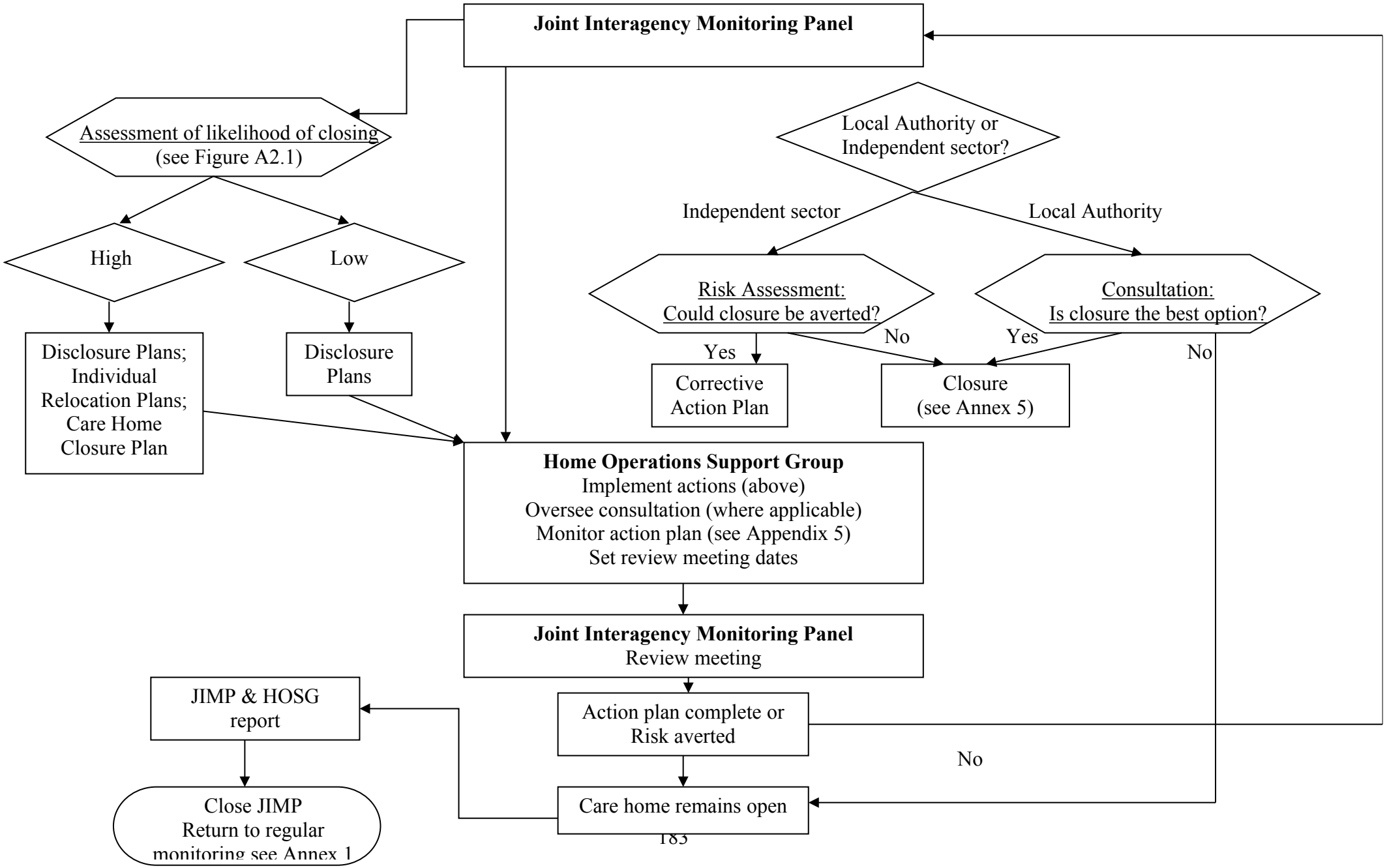
4.35 The HOSG will discuss a draft of the post-consultation report especially if there is any doubt whether the proposal to close a care home should be changed as a result of the comments received. The HOSG will need to agree with the conclusions of the local authority whether or not to close the care home.

4.36 If the HOSG and the authority reach agreement on the contents of the post-consultation report that the care home will remain open the JIMP and HOSG will meet and the provider, residents and families notified. Within one calendar month the JIMP and HOSG will meet to evaluate the whole process and to identify lessons learned. The Chair of the JIMP will prepare a report and this will be circulated to senior managers within local statutory agencies, chairman and members of the local authority scrutiny panel and also chair and members of the LHB. A copy of the report must also be provided to CSSIW.

4.37 If the HOSG and the authority reached agreement on the contents of the post-consultation report that the care home will close or the Director of Social Services (or equivalent) and LHB Director will be asked to endorse the care home closure plan (that will already have been prepared by the HOSG if the likelihood of closure had been judged as ‘high’), and the provider,

residents and families notified. The care home closure policy will be used to ensure a smooth transition for service users to a new service provider (see Annex 5).

Figure A4.1 Flowchart indicating the process during the threat of voluntary closure.



Annex 5

Example of Closure Arrangements

This example of closure arrangements assumes that **either**:

- the actions recommended by the JIMP and put into action by the HOSG have failed to address escalating concerns at the care home setting.
- the situation has deteriorated to the point where there is no possible rescue plan and the home is no longer viable and/or the risks to service users can no longer be managed at an acceptable level.
- an independent provider has decided to close (for any reason, including pre-empting enforced closure)
- an independent or public sector provide has had to close because of emergency or crisis (e.g. flood).

or

- the Local Authority has decided to close a home because of strategic decisions to change the type or amount of care provision and that they have already followed due process with regard to consultation with the public.

5.1 The timescale of the closure will affect the urgency of procedures of the Home Operations Support Group (HOSG).

- an immediate closure (e.g. cancellation of registration (under S20 of the Care Standards Act 2000), financial viability, or crisis, such as flood)
- a planned closure (e.g. cancellation of registration (under S14 of the Care Standards Act 2000), independent provider closing for personal reasons but prepared to work with the Local Authority on a planned closure, or a Local Authority strategic closure).

5.2 The HOSG will focus upon co-ordination and management of the transfer of service users from the registered care home. The Chairperson will work with local health and social services to prioritise the commissioning of 'all' new admissions to vacant places within the area until all service users from the identified care home are re-located.

5.3 Following notification of the 'Proposal' to close and before the 'Decision' to cancel registration is taken, or after the notification of the intention to voluntarily close the HOSG will need to ensure that it has:

- identified with CSSIW all potential risks to patients and service users and the contingency arrangements necessary to minimise avoidable exposure to risk;
- an agreed multi-agency policy and approach in respect of re-admissions to the home of patients or service users admitted to hospital;

- established a communication strategy designed to engage patients, service user and families and any other relevant parties in key discussions (Individual Disclosure Plans); and
- whenever possible, established a close dialogue with the registered provider who should assist in assuring the safety and welfare of patients and service users.

Closure Plan

5.4 Local agencies must define immediate priorities and core tasks. They must assign tasks and actions to key personnel and ensure that Group members are briefed on any legal issues including rights of entry, confidentiality and securing resident property. The HOSG must agree a strategy to support interim arrangements. The following areas will require immediate information gathering and consideration:

- Is closure likely to be immediate, occurring in under forty-eight hours?
- Are there any Court decisions or judgements which must be taken into account?
- What immediate, short-term and long-term risks are there to the health, safety and welfare of service users?
- Are there problems with the structure, fabric or service connected to the building which makes its continued occupation dangerous or unsafe? Is any remedial action possible?
- Can essential services such as heating, water, electricity and gas be maintained?
- Are the actions or potential omissions of the existing staff group likely to expose service users to inappropriate care, abuse or risk of harm?
- Has the number of care/nursing staff diminished to a serious or critical level and what actions need to be taken immediately or on a short term basis?
- Can the closure be planned and if so over what time scale?
- Is there capacity and the ability to work with the home owner and/or manager in planning and/or managing the transfer of service users?
- Could interim management or staffing support be provided from an external source and would this be acceptable to the registered person/s/receiver and have CSSIW registration requirements been considered?
- Has key equipment been removed or sold which further undermines the potential to keep the home open in the short-term? Could alternative equipment be found or provided?
- What actions have been/or need to be taken to prevent further admissions?
- How are vacancies in other homes/locations being prioritised?
- At a regional level should other agencies be involved in the plan?

- What actions are being planned or being taken by authorities or agencies that have placed people within the home from out-of County?
- How much is known by the staff, clients and their relatives/carers?
- Is there media interest?[21]

5.5 Once a Home Closure Plan has been agreed, the Director of Social Services (or equivalent) and LHB Director will be asked to endorse it and the provider, residents and families notified.

Individual Relocation Planning

5.6 The HOSG should ensure that prior to individual relocation planning, each resident (self-funder or publicly funded) has a Disclosure Plan, and that this is adhered to in the development of an Individual Relocation Plan.

5.7 The HOSG should ensure that all residents (self-funder or publicly funded) have access to independent advocacy services including the statutory Independent Mental Capacity Advocacy service, and other such services to support service users as appropriate. It is expected that the registered provider must support and enable approved advocacy services to meet with service users to identify their wishes and offer appropriate support. The HOSG should ensure that independent advocates are fully briefed.

5.8 The HOSG should ensure that every (publicly funded) service user is allocated to a professional care co-ordinator, or social worker, or care manager or nurse assessor and that they are all briefed fully.

5.9 The HOSG should ensure that self-funding service users are offered the support of a care manager. The self-funding service user is free to decline the support of a care manager but this facility must still be offered:

- Transport to a new home of their choice
- Support in moving or transferring personal possessions
- The same level of information on the closure process as others
- Relevant support to carers and families
- Details of vacancies within the area
- Support in contracting with an alternate provider

5.10 The HOSG should ensure that a needs assessment is obtained for all service users (including with their agreement people who are self-funding). The assessment should consider issues of mental capacity and any risk factors that may arise as a result of physically moving the person

[21] A good example of the summary of the HOSG responsibilities is provided in Appendix 8 (Monmouthshire CBC 2010a).

from the home. Additional critical information required as part of the assessment process includes:

- Details of all equipment or environmental aids used by the person
- Details of medication and pending hospital treatment or appointments
- Details of personal non-clothing items held in the home (a check form could be used, see Figure A4.1)
- Details of finances/savings etc held by the home
- Details of preferred care routine
- Details of significant relationships within their current home.

5.11 Using the Disclosure Plan as guidance, the HOSG should ensure that the relevant parties (family, friends, carers, significant others, advocate and the resident) are appropriately involved in identifying an alternate home or in preparing/facilitating the user for transfer to alternate accommodation.

5.12 The HOSG should ensure that **all** residents (or advocates working on behalf of the resident) and relatives are informed of the range of accommodation available (including extracare sheltered housing, residential care homes and nursing homes, both in the public and independent sector). The types, levels (ceilings), and costs of care and support that each facility provides should be explained fully. Residents (or advocates working on behalf of the resident) should be offered the opportunity to visit alternative accommodation in order for a properly informed choice to be made.

5.13 The HOSG should ensure that Individual Relocation Plans have taken into account services users and their family options, choices and need to ensure continued access to the individual by friends (including residents of the closing facility) and family.

5.14 The HOSG should ensure that a new care and service-delivery plan is constructed (with the resident, relative or advocate working on behalf of the resident) to meet a person's needs and agree transitional support, monitoring and review arrangements.

5.15 The HOSG should ensure that existing contracts are cancelled.

<u>Monitoring & Review</u>

5.16 Within one calendar month of all service users being moved from the home the JIMP and HOSG will meet to evaluate the whole closure process and to identify lessons learned. The Chair of the JIMP will prepare a report on the home closure and this will be circulated to senior managers within local statutory agencies, chairman and members of the local authority scrutiny panel and also chair and members of the LHB. A copy of the report must also be provided to CSSIW.

Figure A4.2 Residents' property sheet to be used during a home closure.

From: ……Care Home to: ……
Name: ……

Property Type	Description, detail and comments
Documents (including Pension Books, Wills, Bank or Building Society A/C, Insurance Certificates and any other legal documents).	
Jewellery and Valuables (including cash).	
Electrical Goods (include serial numbers).	
Furniture (give clear description)	

N.B. Please asterisk those items of property to be left at the Home for collection at a later date and identify the place where any items have been temporarily relocated for safekeeping.

Documented by …… Contact Tel No. ……

Designation ……

Service User/Representative Signature …….. Date……

Source: RCT et al. (2006a).

Figure A4.3 Resident's individual relocation plan and transfer document

From: _____ To: _____

Date Completed: _____ By: _____

Full Name and Address prior to Admission:	
Date of Birth:	
Date of Admission to Home:	
Next of Kin and/or Identified Emergency Contact Person:	Name: Address: Tel no.
Funding status:	Self / Local Authority / Continuing Health Care / NHS funded nursing care
GP	Name: Tel no: Advised: Yes/No Date:
Care Manager:	Name, Location Telephone Number Follow up: Date Time Date Time
Advocate: (state if none)	Name, Location Telephone Number
Date of Assessment for relocation	
Type of Placement required	Extracare sheltered housing Residential care home Nursing care home Mental health care home
Service User's Preferred Alternative Placement: (state name of home and address)	
Service User's Agreed Placement: (state name of home and address if different from above)	
Summary of Service User's Disclosure Plan (attach full plan)	
Name of Hospital and reason for Admission: (state if not applicable)	
Special Nursing Needs: (e.g. EMI, wheelchair dependent)	

Special Personal Care Needs:			
Notes on maintenance of social contacts (how existing friendships within and outside care home will be maintained)			
Details of existing appointments	Practitioner & location	Date	Time
	…… …… …… …… …… ……	…… …… …… …… …… ……	…… …… …… …… …… ……
Records	Tick	Handed to	Date
Care Plan Drug Sheet Medical Records Medications Medical Records Property form		…… …… …… …… ……	…… …… …… …… ……
Identified Transport Requirements:	Own arrangements / Family / Taxi / Minibus / Adapted Vehicle / Ambulance		

Completed by …….. Contact Tel. No. ……

Designation ……..

Adapted from: RCT et al. (2006b).