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Short-notice care home closures: a guide for local authority commissioners



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of Adult Social Services

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The Social Care Institute for Excellence (SCIE) was established by Government in 2001 to improve social care services for adults and children in the United Kingdom. We achieve this by identifying good practice and helping to embed it in everyday social care provision.

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About this guide

This guide brings together best available knowledge and practice based learning into a suite of practical materials to support commissioners who may be called upon to manage unplanned care home closures. The experience of commissioners as well as the regulator and bodies representing the interests of providers, residents and relatives has helped to shape the content. At this stage, drawing upon this experience and research-based evidence, the guide highlights key issues to take account of rather than to provide conclusive recommendations. Legal advice should always be sought appropriate to individual and local circumstances.

SCIE, in conjunction with ADASS, commissioned the AESOP consortium to help us bring together these materials which we hope you will draw upon to inform local plans. We are also grateful to representatives from the following organisations who contributed to shaping the guide:

- Care Quality Commission
- Gloucestershire PCT
- Hampshire County Council
- Northamptonshire County Council
- North Yorkshire PCT
- Relatives and Residents Association
- St Cecilia's Care Services Ltd.
- Social Care Association
- West Sussex County Council

We aim to build upon this initial work to support best practice. We welcome your feedback on the guide itself and your views on how we can improve it. Plus, if you have any examples from experience that you would like to share, please send them to closures@scie.org.uk

Introduction

This guide helps commissioners, particularly local authority staff, to manage care home closures at short notice in situations that may be unexpected and therefore unplanned. It should also be useful to care home staff, residents and relatives. All commissioners and providers should have procedures for managing planned closures where they have more than three months' warning that the service is being shut down.

The guide covers implications for practice, examples of what others are doing and a summary of what policy and research tells us. It also includes examples of procedures, checklists and templates from various organisations around the UK.

We want to hear about your experiences and views so that this tool can be updated to make it even more practical and helpful. Please email us on closures@scie.org.uk.

Continuity of care

Providers and commissioners should ensure that the health and the wellbeing of residents in care homes are maintained regardless of threatened or actual closure of their care home and, ideally, wherever possible, by staff who know them.

‘We're dealing with some very vulnerable people here and they need to know that we're going to look after them well during the whole process - it's scary and unsettling

(Care Manager)

Where there are safeguarding issues these need to take precedence and locally agreed safeguarding vulnerable adults procedures/policies should be followed.

The content which follows is focused on addressing potential market failure.

Avoiding closures

- The risk of market failure can be reduced through good commissioning policy and practice (see '**Intelligence and information sharing**' section).
- Local authorities (and partners) should take steps to prevent potential home closures occurring by putting in place quality control and monitoring systems.
- Local authority commissioners can help to maintain continuity of care in a home threatened by market failure in a number of ways, for example by:
 - issuing a new contract to the care home at a different price
 - retaining the existing contract, but providing financial assistance in the form of a grant or a loan
 - seconding council staff to the care home on a temporary basis.
- There is no automatic right for a local authority to put its own staff into a home; only if this is by agreement or **already in the terms of the contract**. See **examples and tips** for more information.

Reducing risk for all residents

- If a home closure is unavoidable, the care home managers, local authority and health commissioners must try to manage the pace of the closure in order to reduce the risk to the wellbeing of residents.
- Local authorities are required to safeguard the needs and welfare of **all** residents in care homes in their area, regardless of whether they are self or publicly funded and regardless of which local authority has placed them there.
- Involving existing staff as far as possible under the presenting circumstances will do much to allay anxiety in residents. See **examples and tips** for more information.

When closure is unavoidable

- The closure process needs to be handled sensitively in order to allay anxieties and protect the welfare of residents to ensure that good quality care is continued during the days and weeks of negotiations.
- Where possible, residents should not be separated from long-term friends and/or staff.
- Staff should be aware of residents' reactions to change and listen to their fears, wishes and needs throughout the process. In turn, those arranging transfer to new homes should heed the experience of existing staff.
- Residents should not be promised anything that cannot be delivered.
- Care home closure should be managed as a multi-agency project so that all organisations offering some level of care or support to residents and staff can work towards the common aim of effecting best outcomes and continuity of care.
- Key players (regulators, receivers/administrators, commissioners, NHS, residents' representatives, professional associations etc.) must therefore be engaged at the earliest possible stage.
- Closure processes should be informed by a clear purpose with values and principles that guide how the desired outcomes are to be achieved.
- Commissioning staff should identify a range of alternative services which are available and can be matched to the needs of the residents being relocated.
- Good record keeping is important to promote effective communication between staff and organisations, and to enable the transfer of information to the new home.
- Be clear about who will manage staff and who will be paying salaries and other costs.
- Support staff in the aftermath of any announcements about the future of the home.
- Staff need to be kept informed and advised of their employment rights. See [examples and tips](#) for more information.

Reassessment and care plan development (see 'Assessment and choice' section for further information)

Good quality assessment and care planning is essential to ensure that the best interests of each individual resident are met, and that, wherever possible, residents are helped to make as informed a choice as they can over where they will next live.

- reassessment and care planning must be undertaken with all publicly supported residents who are going to be moved (and must be offered as well to self-funders).
- Every resident should have an initial one-to-one meeting with a senior member of the care staff.
- A key worker should be identified for each resident for the duration of the closure and transfer process.

- Personal histories, likes and dislikes (e.g. names) should form part of the information transferred.
- Families and carers should be involved throughout the process or an independent advocate where the person is without a family who can help.
- Particular attention needs to be paid to more vulnerable residents (e.g. those with dementia or with medical conditions requiring health care interventions and/or equipment). Their individual care plans will need to be more comprehensive.
- Where the person's needs are complex, communication with other health professionals, including district nurses and GPs, will be important.
- Staff should look out for any residents who become withdrawn, depressed or anxious about the move.
- Every person should have a list of equipment and medication prepared in advance and then checked so that all items are ready to go with them.
- Contact details of GPs and relatives should be secured at an early stage.
- The requirements of the Mental Capacity Act must be fulfilled.
- Keeping friendship groups together is very important. Awareness of alternative vacancies in other establishments that would accommodate friendships is essential.
- Care staff should be encouraged to support residents at their new home for an initial settling-in period if possible as this promotes familiarity and continuity of care.
- People's new care arrangements should be reviewed three weeks, three months and six months after the point of transfer.

See [examples and tips](#) for more information.

Enable choice and control

- While continuity is hugely important, once the closure of one home and the move to another becomes inevitable, residents need to be provided with sufficient information to exercise choice and control over where they will next live and how their support is delivered.
- Families will require reassurance about continuity of care and this should be the responsibility of the key worker appointed to work with the resident.
- Commissioners should identify a range of alternative ways of securing individuals' outcomes (including other care home placements, home care packages, higher cost placements, split packages with the NHS, extending direct payments to relatives, family placement schemes or the procurement of 'extra care' capacity).

See [examples and tips](#) for more information.

Supporting staff

- The existing staff in a care home have a central role in ensuring continuity of care and it is therefore important to work with and involve them in the closure process.
- Staff should receive particular support in the immediate aftermath of any announcement. They need to be provided with timely and credible communication which enables them to make sense of what is happening and their options for the future.
- Be clear about who will manage paying salaries to retained or replacement staff.
- Managers will need to be aware of the potential for difficulties around equal opportunities when people's futures are under threat.
- The effect of administration and receivership on staff needs to be considered carefully.

See [examples and tips](#) for more information.

Examples and tips

Examples of what others are doing plus materials they have developed and useful tips.

With careful planning, residents should experience as little disruption or unevenness as possible in the quality and quantity of care that they receive before, during and after any transition that has to take place. The aim should be to minimise anxiety and promote reassurance. The following are examples of what others are doing plus materials they have developed and useful tips.

Changes to services – policy statement

Northamptonshire County Council Health and Adult Social Services (HASS) Directorate are committed to the following principles:

- Ensure that the dignity and welfare of HASS customers is considered at all times.
- Embed a culture of engagement by promoting the involvement of HASS staff, customers and other stakeholders in decision making about the future of services.
- Communicate decision making in a timely, effective and transparent manner to all stakeholders.
- Minimise disruption and distress to customers, promoting familiarity and consistency of care wherever possible.
- Where relocation of residents is required, assess the needs of all care home residents irrespective of funding arrangements.
- Where decision making results in the need to close a home, ensure timescales are appropriate to residents.
- Work collaboratively with other organisations and partners to promote effective communication, timely processes and effective use of shared resources.

- Ensure that any individual assessments or decision making meet the requirements of the **Mental Capacity Act 2005**; particularly the need to assess mental capacity during the closure process and to make decisions on behalf of those lacking mental capacity in their best interests.
- Consider equality and diversity issues throughout the closure process, respecting the cultural needs of customers and using advocates and interpreters wherever necessary.
- Develop good practice by monitoring and reviewing the processes used as part of the organisation's governance structure.
- Staff will work in accordance with the principles of the Data Protection Act 1998.

(Source: Northamptonshire County Council - Changes to Services Procedure and Practice Guidance)

Good record keeping

Good record keeping is important during the closure and relocation process to promote effective communication between staff and organisations, to promote transparency of decision making and to promote the transfer of information to the new home. For a care home closure, staff will need to:

- Ensure any care plans are photocopied and information relevant to the resident moves to the new home with the resident. Robust care plans should be in place to ensure continuity of care and to encourage the maintenance of residents' preferred lifestyles.
- Keep a record of all assessments, decision making and movements of residents.
- Keep a log of medicines and ensure these are moved with the residents.
- Keep a log of change of GP if this is necessary.
- Keep a log of residents finances and ensure these are moved with the resident.
- Keep an inventory of residents' belongings, to be signed by the resident.
- Information should be available for each resident on the following:
 - registration category of residents and identify any change of category
 - details of relatives
 - medical history
 - whether there is a requirement for advocacy to support the resident
 - details of residents' needs including those that may require exceptional arrangements or health care provision. Also identify if there are any relatives of residents who may have factors to consider such as own health, whether they are out of county, etc.
 - The resident's life history book is particularly important for people with dementia.

Not all of this information may be essential for a care home closure.

(Source: Northamptonshire County Council - 'Changes to services procedure and practice guidance')

Involve existing staff

- Existing care staff should be utilised during the closure and relocation process to pass on knowledge of customers to new services, handover care plans and summaries, etc. and verbally discuss residents' care needs.
- Wherever possible, and with the agreement of the person themselves, details of the person's likes, dislikes, routines, aspirations, diet, abilities, risks, preferred lifestyle and support needs etc. should be passed on. This will promote continuity of care and support.
- Care staff should be encouraged to support residents at their new home or services for an initial settling-in period if possible. This promotes familiarity and consistency of care.
- Care staff should be consulted and encouraged to be involved in the closure and relocation process.
- Care staff should be kept informed of progress and customers' moving dates as well as how residents are settling in to new homes when this applies.
- It is acknowledged that closures can be distressing for existing care staff as well as residents and that they may need support.

(Source: Northamptonshire County Council - 'Changes to services procedure and practice guidance')

Tools and checklists

We've included Word files so you can take away and adapt to your local needs.

Considerations when moving residents from care homes with nursing

- Is the resident fit to travel or do they need a GP to review them prior to moving e.g. somebody who is unwell with an infection or is dying?
- What type of transport is needed? Does the resident need to be moved in a chair or on a stretcher? If they need oxygen a paramedic crew will be required
- If the resident is using oxygen a temporary prescription for cylinders will need to be obtained and be in place at the new home prior to transfer. British Oxygen Company (BOC) will then need to be contacted to move concentrator to the new home.
- The new home needs to know about any pressure relieving equipment that is in use prior to transfer.
- Dressings and catheters need to be sent with the patient as well as medication they are taking.

- If the resident has a PEG the equipment must go with the resident and the dietician informed to ensure further supplies sent to new home.
- Other equipment such as nebulisers, walking aids, wheelchairs may need to go with the resident and needs to be communicated to transport when arranging the transfer. Remember to check if they belong to the resident or the home, if they belong to the home alternatives will need to be identified.
- If the patient is on Warfarin the new home needs details of when the next blood test is due.
- A detailed and comprehensive nursing transfer letter needs to accompany the resident.
- A list of other professionals involved with the resident needs to accompany them so they can be notified of change of address and maintain continuity or care.

(Source: West Sussex County Council)

Individual relocation planning

- Ensure that every 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. Where necessary ensure that an Independent Mental Capacity Advocate has also been briefed.
- 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:
 - o Transport to a new home of their choice
 - o Support in moving or transferring personal possessions
 - o The same level of information on the closure process as others
 - o Relevant support to carers and families
 - o Details of vacancies within the area
 - o Details of local advocacy services
 - o Support in contracting with an alternate provider
- Obtain a needs assessment 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 from the home. Additional critical information required as part of the assessment process includes:
 - o Details of all equipment or environmental aids used by the person
 - o Details of medication and pending hospital treatment or appointments

- o Details of personal non-clothing items held in the home
 - o Details of finances/savings etc held by the home
 - o Details of preferred care routine
 - o Details of significant relationships within their current home.
- Establish the extent of continued contact with family, friends or carers and agree with significant others and the service user the degree of their involvement in identifying an alternate home or in preparing/facilitating the user for transfer to alternate accommodation.
 - Explore with services users and their family options, choices and need to ensure continued access to the individual by friends and family.
 - Construct a new care and service-delivery plan to meet a person's needs and agree transitional support, monitoring and review arrangements. Cancel existing contracts.

[Source: Statutory Guidance on Escalating Concerns with, and Closures of, Care Homes Providing Services for Adults, Welsh Assembly Government, 2009]

Transfer checklist

Name:	
DOB:	Category:
GP name and contact:	
Relatives:	Relatives:
Name:	Name:
Address:	Address:
Telephone/email:	Telephone/email:
Medical history:	
Funding: (NCC/CHC/Other LA/Self-funding)	Advocate required?
	Advocate name and contact:
Date customer information:	Date relative informed:
	Name of relative informed:
Possible homes:	
Confirmed placement:	Confirmed moving date:

Transfer checklist:

Relative informed of moving date:

Medication arranged for transfer:

Finances arranged:

Inventory of belongings signed:

Belongings packed:

Transport arranged:

Care plan copied for new home:

[Source: Northamptonshire County Council – “Changes to Services Procedure and Practice Guidance”]

Preventative framework for proactively addressing potential home closure risks

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:

- 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 coordination, 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)
- where homes are to close, procedures and home closure plans are in place to run alongside individual service user and resident resettlement plans.

(Source: Statutory Guidance on Escalating Concerns with, and Closures of, Care Homes Providing Services for Adults, Welsh Assembly Government, 2009)

Adopting a project management approach

Effective management is essential to any successful project. Ideally, those delivering a closure project should be accountable to a Project Board where there are representatives from all interested parties and it may include representatives from the residents, families and the workforce. The Project Sponsor/Champion who may be the owner, Nominated Individual or relevant senior executive, or a Head of Service if it is a local authority home, should chair the board. It should:

- receive and consider the feedback from consultations and dialogue with interested parties
- set out the closure timetable
- agree the communications plan
- undertake organisational risk assessments (in the case of the local authority also in respect of the wider market for social care)
- consider local risk assessments
- receive progress reports
- monitor progress against agreed milestones
- monitor performance of the project team against agreed quality standards
- ensure rights of residents and staff are protected
- coordinate work of key partners.

The project manager may be the Registered Manager or a person selected to work with them for the specific assignment. The project manager will need to:

- develop the project plan
- undertake local risk assessments
- consider individual risk assessments undertaken by social workers and key workers
- review individual support plans
- co-ordinate activity for work streams
- ensure project meets milestones
- prepare progress reports
- review implementation of communication strategy
- act as 'information hub'
- ensure compliance with legislation
- ensure people can exercise rights
- involve advocates as necessary and in liaison with social workers
- arrange for an Approved Mental Health Practitioner (AMHP) to undertake mental capacity assessment as necessary
- arrange with the AMHP 'best interest' meetings as necessary
- ensure involvement of key partners
- review needs of workforce
- support re-settlement/relocation of workforce
- recognise and respond to the emotional needs of workforce

- meet with the relevant social work manager to ensure all residents are allocated a social worker
- ensure decisions are taken about who will act as the lead professional
- make sure an updated assessment is completed so that the new provider has up to date information
- take steps to inform the local GPs and health workers of the decision and the timetable for closure

The key worker designated lead professional for each individual will need to:

- contribute to the risk assessment for each individual with whom they work
- liaise with the social work manager or care coordinator of the funding agency where appropriate
- contribute to revising the care/support plan
- maintain contact with family/friends
- arrange medical /nursing assessments where necessary
- review equipment for moving
- ensure dietary needs are fully recorded
- support people to work through the loss of their home
- support people to visit potential new homes

Where the resident is publically funded there will be a care co-ordinator/social worker/reviewing officer involved in reviewing and restructuring the care and support plans for each individual. Self-funders are likely to require a key worker from the home to take a lead. If the organisation has specialist Human Resources personnel, they will be involved in carrying out individual interviews with employees and identifying options for future employment either inside or alternatives outside the organisation.

[Source: Managing Care Home Closure, Social Care Association, 2011]

Care home urgent closure checklist

This is a list of things to consider when you are involved with a home that has reached crisis point and likely decision to close the home at short notice.

	Area/task	Comments
1	How to manage the process	
	The safeguarding adults policy sets out the framework for this	
	Arrange regular joint meetings of the key organisations involved to agree actions and responsibilities	
	Consider using one or two support staff to co-ordinate all written communication	
	Use a core group of practitioners to work with the residents and their families	
	Identify one manager (Group Manager or Assistant Area Manager) to be the lead throughout the process	
2	Residents	
	Tell them what is happening	
	Assess their care needs	
	Prepare up-to-date SAP for new placement	
	Identify new placements	
	Check if home provides other services i.e. day care, meals etc	
	Inform new placements of urgency and CQC involvement	
	Ensure new placement understands what documentation is required/what the standards are with an urgent move. With CQC support and agreement, urgent moves can be made with the minimum of paperwork, can cause problems in the receiving home	
	Where possible try to ensure ASC/SPT/PCT staff are involved in 'transfer' assessment between the homes	
	Make sure that medication is up-to-date	
	Arrange transport	

	Area/task	Comments
	Follow up review as soon as possible after moving in	
	Standard review in 4 – 6 weeks	
3	Relatives	
	Tell them what is happening	
	Arrange face-to-face meeting – SCC and CQC and others as appropriate	
4	Public/press	
	Inform press office	
	Prepare statement	
5	Managing the home	
	Insurance cover needed for SCC staff, provider staff and residents	
	Organise a provider to provide care and direct home management	
	Meet with home owner to agree terms and who is responsible for costs/charges – follow up in writing	
	Set up rota of SCC managers to be available at the home	
	Communications book for SCC managers to share information. Retain this after the closure.	
	Contact details of all relevant staff – could be SCC, PCT and provider, as appropriate for situation	
	On final day of closure consider if two people are needed on site to secure the building and protect property	
6	Staff employed by the home	
	Arrange to meet with them to explain what is happening	
	Look at following support <ul style="list-style-type: none"> • Finding new job • Employee rights – use CAB • Any counselling support needed 	
7	Interim provider (put in by SCC)	
	Set up good lines of communication	
	Confirm staffing cover needed	

	Area/task	Comments
	Confirm costs and invoicing arrangements	
8	CQC	
	Set up good lines of communication	
	Consider need for an inspector on site with SCC manager	
	Agree what information needs to be shared about why the home has closed	
9	Health	
	Liaise with PCT	
	Joint assessments to be completed with DNs	
	Make sure GPs know about the closure	
	Consider transfer of notes to new GPs	
10	SCC communications	
	EDT – do they need to know, what do they need to know	
	Somerset Direct – need to have ‘script’ for any enquiries	
	ASC staff – ensure they are regularly updated	
11	Politicians	
	MPs – brief	
	Councillors - brief	
12	SCC staff	
	Provide support as the work can be emotionally challenging – particularly at time of actual move of residents	
	Debrief staff afterwards	
13	Others	
	Are there other people who have links to home? Consider what information/ support they might need. For example, informal	

	Area/task	Comments
	volunteers or a home based in a village with close community links.	

[Source: Somerset County Council, July 2009]

Assessment and choice

Assessing people's individual needs, preferences and aspirations and enabling them to make informed choices about their place of residence are just as important as in situations of planned change.

‘Enabling people to have choices is important, even when the closure of the home is inevitable. We have to make sure we honour this and don't rush people into decisions just because it's neat and tidy for us when we're working under pressure’

(Commissioner)

Underlying principles

- Local authorities have a duty to assess the needs of **all** residents irrespective of the arrangements for paying for their care.
- If a person is facing a major decision about where to live and lacks the mental capacity to make that decision for him/herself and has no family or friends willing and able to be consulted as part of making that decision, then it is mandatory that the local authority or NHS body commissioning the care must instruct an IMCA (independent mental capacity advocate) to be part of the decision-making process. The IMCA does not become the decision maker, but the identified decision-maker (generally a care management professional from the local authority) must take account of the views of the IMCA
- The **Directions on choice** still apply.
- The **Mental Capacity Act** clearly applies.
- Relevant agencies should work together in the best interests of the residents.

See **examples and tips** and **checklists** for more information.

Organisational arrangements

- Where the number of people requesting a particular home exceeds the number of places, there will need to be a robust and defensible allocation process in place to manage competing priorities.
- Where a person's first choice is not immediately available, interim placements can be offered - though choice elsewhere may be constrained by availability and the willingness of a new provider to accept the placing authority's terms and conditions (see **Directions on choice**).
- The needs of groups with protected characteristics must be addressed - i.e. age, ethnicity, religion, disability, mental capacity, sexuality.
- After a transfer to a new home has occurred, residents must be routinely reviewed to ensure that their new homes are meeting their needs and that their wellbeing is maintained.

- Resources will need to be found in order to deliver the required assessment and case reviews.
- Formal and recorded meetings need to be held with the home owner/manager and other senior officers on managing the transfer.
- Formal and recorded meetings need to be held with nominated care managers and assessing staff on detailing information on each resident.

See [examples and tips](#) and [checklists](#) for more information.

Care and transfer planning

- Ensure that **every** resident has access to a professional key worker who is qualified to undertake their assessment and care planning.
- Agree and develop a care plan for every resident, in conjunction with them.
- Establish the extent of involvement with the resident of their family, friends and/or carers and work with them to effect the best outcome for the resident.
- Agree with the resident the degree that family, friends or carers are involved in identifying an alternative home and associated arrangements.
- Stress the importance of protecting friendship groups in the decision making.
- Ensure that self-funding service users are offered the support of a care manager and all of the above considerations - though they are free to decline support.
- Obtain the resident's consent to transfer of information and records.
- Review care plans as their quality will vary considerably, particularly where closure has been enforced because of poor care practices.

See [examples and tips](#) and [checklists](#) for more information.

Transport

- Consider transport arrangements, which may involve liaison with local ambulance services.
- Consider how people's luggage and personal furnishings and equipment are going to be moved with them.

See [examples and tips](#) and [checklists](#) for more information.

Capacity

- The assessment should consider issues of mental capacity and any risk factors and relevant information associated with the actual move from the home.
- For residents who lack mental capacity or who are not in contact with family or friends, consider an [independent mental capacity advocate \(IMCA\)](#)

See [examples and tips](#) and [checklists](#) for more information.

Nursing and medical assessment

- Local authorities will need to be proactive in their dialogue with NHS partners.
- Some residents may require a higher level of care such as residential care with nursing or NHS continuing health care.
- Where nursing care is involved, medical assessment and management must be part of the planning.
- Check the accuracy of medication records and prescriptions rigorously.
- Make arrangements for appropriate quantities of the right drugs to accompany the resident to their new setting.

See [examples and tips](#) and [checklists](#) for more information.

Contractual issues

- Cancel existing contracts - this may seem obvious but as each resident is moved, the formality of cancelling existing contracts remains necessary, even if the move is forced by circumstances not of the resident's or commissioner's making.

See [examples and tips](#) and [checklists](#) for more information.

Examples and tips

Examples of what others are doing plus materials they have developed and useful tips.

In this section we provide you with more detailed information about the various elements of assessment and choice that you will need to consider. It includes excerpts from local authority protocols, policy documents from the assemblies and governments of the UK and feedback captured during the development of the website.

Family carer story

This story from a daughter-in-law has been anonymised and illustrates the negative impact of a compulsory move when choices are limited.

'Who is to determine what good practice is? The resulting outcome can only be the best indicator.

In my experience the closure of a housing complex that was warden-aided led to the rehoming of its elderly occupants, one of whom was my father-in-law.

He did not get the move of his choice (to live nearer to me) because that was barred by the city boundary restrictions. He looked at several places in the permitted area and then plumped for one which he thought would be comfortable. The staff there were only available during the day. He had a fall in the night, lay unable to summon help for many hours and ended up in hospital for over a month. His health rapidly declined while there

and he was deemed to have dementia. This meant he was not allowed back where he had been living and had to be placed in a home for those with dementia with tragic consequences as he soon died.

The place he had lived happily for many years is still boarded up with none of the promised developments made.

What can be learnt from such outcomes is the need to listen more to the views of those affected. There had been opposition all along. Any move an elderly person has to make should be in accordance with their true and positive choice with minimal disruption.'

Supporting people to make choices

People's fears about moving, changes in care staff and increased charges will be very real and some will need intensive support. There must be sufficient, competent care practitioners to respond to residents' social and personal needs and choices, such as existing friendships with other residents, preferred geographical location and an ability of family and friends to visit. This period will also provide the opportunity for people to review the model of support they have chosen and consider alternatives. Some people may prefer to move to a different model of care such as extra care housing that may not have been an option when original decisions were made about residential care. Where people are considering alternatives to residential care, support services could include reablement.

It is possible that reassessment will reveal the need for people in residential care homes to have nursing care. This could have financial implications and increase the cost for the funding agency or for self-funders. In this latter case the lead professional will need to consider the financial arrangements on merit for each person so affected. (It should be noted that this problem should not arise if the needs of self-funders have been regularly reviewed during their stay.)

It is important that families are supported as they may feel anxious and worried. These concerns can range from seeking assurances about continuity of care, maintaining standards in the home and a concern for staff. It is likely that they will be concerned about personal aspects such as financial implications and a fear that their relative may be 'returned' to their care.

(Source: Social Care Association 2011)

Life story work

The aim of life story work is to enable people to affirm and maintain their identity and personhood through the creation of their own life story. This can be in any format that suits the individual best - photos, tapes, film clips, writing down their words - and is a way of capturing the things that have been and remain important to them in their life. As well as helping the person reminisce about their life, a life story book is a powerful way of bringing the person to life for staff working with them who have not known them

previously. The model of using life stories is in line with policy initiatives to develop more person-centred care and enabling individuals to exercise choice and control. Knowing people better as individuals enables staff to provide more sensitive and appropriate care that can reduce frustration and agitation and therefore minimise the need for more intrusive forms of physical or pharmacological constraints.

Further information can be found at www.lifestorynetwork.org.uk

Alternative accommodation

Local authorities will need up-to-date information about accredited providers, the availability of vacancies and agreed fee levels in formats appropriate to share with residents and relatives. Depending on local circumstances it may be necessary to seek information beyond the local authority boundary, for example in a small unitary London borough or where the home is located on the border of a neighbouring authority. Some residents may also want to move nearer to their relatives or friends which may mean finding alternative accommodation in a different part of the country. In these circumstances commissioners should liaise with their colleagues elsewhere on matters such as agreed fee levels. A local authority must arrange residential accommodation for an individual in accordance with their preferred wishes, provided that:

- the accommodation is suitable in relation to their assessed needs
- to do so would not cost the council more than it would usually expect to pay
- the accommodation is available
- the provider is willing to meet the council's terms and conditions. (Department of Health 2004)

Principles and rights

The wellbeing, needs and rights of vulnerable adults are paramount. This cannot be assured without appropriate communication and consultation with next of kin, and other formal and informal representatives of people who use our services.

Appropriate communication must take into account the language and communication mode appropriate to the individuals involved. Where possible, information should also be made available in a way such that individuals can reflect upon it after verbal communication is used.

Consistent and timely communication with all involved parties is necessary, as are secured and archived comprehensive written records.

Consultation with others is subject to obtaining informed consent from service users. Where an adult is unable to consent or make important decisions because of mental incapacity, the **Mental Capacity Act 2005**'s code of practice and regulations will apply to financial, serious health treatment and accommodation decisions. Best interest decision making until then is subject to common law and case law.

Self-funders will be entitled to the same advice and assistance as others who are funded by statutory and voluntary organisations.

Agencies will need to work together and take account of the following principles when relocating vulnerable adults (bearing in mind this is more difficult in a crisis or in a situation where there is pressure and stress to make decisions and take action):

- safety
- safeguarding
- minimising distress and disruption of services, including strategies for dealing with agitation, aggression or other forms of challenging behaviour
- dignity
- choice
- least restrictive options
- respect for family life
- equality and diversity
- privacy
- realising potential.

Interim moves can be disruptive for individuals and their families and these will therefore be avoided unless there are extenuating circumstances that make them unavoidable.

The importance of protecting friendship groups when planning and actioning new placements for residents will be recognised and individual and group preferences accommodated wherever practical.

All agencies operate within the boundaries of resource constraints. Realistic expectations and planning should be engendered that makes the best use of available agency and pooled resources.

(Source: Sandwell MBC August 2009)

Assessment and care planning

The assessment is the opportunity to ascertain and document whether and how needs have changed since the resident's admission to the home. It also enables them and their relatives to express their wishes about where they want to move to and to be involved throughout the decision making process. An assessment should be obtained for all residents, including self-funders with their agreement. It should consider issues of mental capacity and any risk factors associated with the actual move from the home. Assessments of need are particularly important in situations of enforced closure because of poor care, when the quality and accuracy of care records cannot be relied upon.

Areas to be covered by the assessment process

- Communication

- Cultural and spiritual needs
- Clients' views
- Circumstances of admission/changes since last review
- Health needs
- Mobility/transfers
- Mental health, emotional needs
- Diet
- Personal care
- Social needs, personal relationships
- Environment
- Finance
- Relatives/carers views
- Home's' views
- Other issues
- Needs identified

(Source: Hertfordshire County Council, June 2010)

Self-funding residents

Residents who are funding their own care must be offered the same level of advice and support as those who are publicly funded. The duty to assess rests with the local authority of ordinary residence, although there might be scope to negotiate with the local authority where the home is located for them to carry out the assessment.

- 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
- accessing the same level of information on the closure process
- relevant support to carers and families
- details of vacancies within the area
- details of local advocacy services
- support in contracting with an alternate provider.

(Source: Welsh Assembly Government, 2009)

Choice and the Mental Capacity Act

The **Mental Capacity Act** requires everyone in the first instance to assume that the individual has the mental capacity to make decisions; a person must also be supported to make their own decisions, as far as it is practicable to do so. The Act requires 'all practicable steps' to be taken to help the person. It is a key principle of the Act that all steps and decisions taken for someone who lacks mental capacity must be taken in the person's best interests. The best interests principle is an essential aspect of the Act and builds on the common law while offering further guidance.

Residents who lack mental capacity and are 'un-befriended' in a home which is under threat of closure, or is being closed, may require an independent mental capacity advocate (IMCA). It is compulsory for the local authority and/or the NHS body to consider whether an IMCA should be instructed, so it is therefore advisable to give the IMCA service early warning that their service may be required. In respect of adult protection concerns, instructing an IMCA must be considered irrespective of whether that resident is 'un-befriended' or not.

Where the home closure is undertaken as an emergency and there is not enough time to commission an IMCA to support decision making, an IMCA should be used after the move to audit the decision making process and ensure decisions were made in the best interests of the individual.

(Source: Kent Adult Social Services, March 2010)

Mental capacity and advocacy

Enshrined in the **Mental Capacity Act** is the principle that people have mental capacity unless otherwise proven. Even when their mental 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 mental capacity and have no family and friends to speak for them.

The legislation requires local authorities to refer individuals to the IMCA service where decisions about a change of residence are 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 mental capacity without friends or family.

(Source: Welsh Assembly Government 2009)

Working with families

'Priority must be given for holding an early meeting with relatives and representatives - build this into formal processes involved in assessment and care planning. In Northamptonshire, when we have any significant issues with a provider that cause us to place them in default we now insist on calling a meeting with relatives and their representatives so that they are clear as to the action we are taking and why. Whilst some resistance should be expected (some people see us as bureaucrats unnecessarily "sticking our noses in"), from experience I have gained following numerous closures and subsequent moves to better care homes, these relatives and representatives were simply ill-informed and had no idea of what they could reasonably expect - either from the care home itself or from the local authority.

Whilst it's more difficult to call a meeting when an immediate closure is required, there is a need to effectively communicate with all service users and their relatives/representatives effectively on a one-to-one basis using whatever means time constraints permit.'

(Source Phil Jones, Service Manager Contracting and Contract Management, Northamptonshire Social Services)

Tools and checklists

This section includes letters, forms, templates and checklists devised by various bodies which you can download and adapt for your local use.

Checklist for meeting between provider and council to discuss intended closure

Location, date and time

Agenda

- 1) **Closure timetable**
- 2) **Notice Requirements**
- 3) **Consultation**
(Residents/Relatives/Advocate)
- 4) **Potential staffing implications**
- 5) **Maintenance of care standards and continuity of care**
- 6) **Identification of residents**
Residents Profile (*Names, Previous addresses, Date of birth, Date of admission, Sharing arrangements/Friendship groupings, Next of Kin and Relative contact details, Appointeeship details, GP details, Medication records, Copy of care plan etc.*).
- 7) **Phasing of assessments**
Resident need and choice
- 8) **Staff briefing**
Allocation of care manager/key worker
- 9) **Phasing of discharges**
Medical assessment, supervision
Inventory of residents' belongings [and please ensure these are in appropriate packaging – no black bin bags!]
Transfer of care plans (Including Medication)
- 10) **Registration/Regulator issues**
- 11) **Contract issues**
- 12) **Financial issues**
Transfer of appointee function
Benefits Office/benefits advice
Notice requirement
- 13) **Assessments**
Identification of residents
Publicly funded / Preserved rights / Privately funded / Other local authority residents

Any suitable alternative vacancies?

14) Further meeting/s with provider

15) Any other care planning and care continuity business

[Source: Good practice guidance on the closure of a care home, CoSLA]

Medications management

Confirmation of arrangements needed to ensure that residents' medication records and medical supplies are in place prior to transfer

To : <<Proprietor/Manager/Matron as Appropriate/Agreed>>

Dear

MEDICAL ASSESSMENTS FOR RESIDENTS TRANSFERRING

As per our telephone discussion/meeting on xx-xx-xx, I attach copies of the medical assessment and consent form, which we have agreed that in the interests of speed and efficiency you would arrange to complete and forward to each resident's GP for completion.

The form attempts to capture information on people who may deteriorate and thus require a higher level of care within the next 6 months, with the intention of minimising the number of moves required. We are also asking GP's to highlight any medical issues with regard to the actual transfer.

It would be best if you ask the GP to return the form to yourself to be kept for the nominated care management staff assessing each resident.

If you have any queries on this or any other matter to do with the closure of the Home, particularly any that has a direct or indirect impact on the welfare of the residents, please do not hesitate to contact me etc etc.

Thank you for your assistance in this important matter.

Yours sincerely

<<Name>>

<<Designation>>

<<Contact details etc>>

[Source: Good practice guidance on the closure of a care home, CoSLA]

**MEDICAL REFERRAL/REPORT FORM
PRIVATE AND CONFIDENTIAL**

Dear

I should be grateful if you could arrange for an assessment/provide medical information on this patient and in particular highlight any issues about their fitness to move and any recommendations to address these.

Signed: _____

Designation:

Date:

Patient Details

NAME: DoB:

ADDRESS: < insert name/details of care home >

TEL NO:

NEXT OF KIN: RELATIONSHIP:

ADDRESS:

TEL NO:

Reason for Referral/Assessment

Assessment for onward placement following decision to close XXXXX Residential/Nursing Home

URGENCY HIGH/MEDIUM/ROUTINE (Delete as appropriate)

CARE HOME FORM ENCLOSED YES/NO (Delete as appropriate)

Which health professionals attend the patient regularly?

GP Practice Nurse District Nurse Other (specify)
HV CPN Consultant

Who is most involved?

NAME: DESIGNATION:

ADDRESS:

[Source: Good practice guidance on the closure of a care home, CoSLA]

Check List for Senior Officer –
Residential Services

TASK	DATE ACTIONED	DETAILS
Co-ordinate the closure programme and notify social work teams of residents who were placed either directly by the team or by the hospital team and had home addresses in the respective catchment area.		
Convene briefing meetings regarding the implementation of the closure programme with key personnel.		
Liaise with Care Commission staff		
Liaise with home owner regarding closure timetable taking account of requisite notice requirements, potential staffing implications, need for phasing of assessments and the phasing of discharges.		
Identify funding status of residents e.g. <host authority>publicly funded; other Local Authority funded; privately funded, or other arrangements.		
Liaise with Senior Officer (Welfare Rights) regarding benefits issues and to discuss the merits of involving welfare rights staff in an operational capacity		
Notify other placing Local Authorities as appropriate and all local authorities of the actual closure.		
Advise Finance section and Legal Services accordingly.		
Co-ordinate transfers of residents, taking account of client need and choice		
Co-ordinate production of periodic updates (at least weekly) on closure process and monitoring meetings as necessary.		
Prepare report for social work SMT on conclusion of closure programme		

Check List for Care Managers Residential Services

Relating to

- Provision of information
- Needs led assessment
- Full involvement of users and carers
- Active participation of other agencies
- Clear and effective communication to all in
- Minimum intervention (user/carer involvement avoid duplication)

TASK	DATE ACTIONED	DETAILS
Ensure that a medical report has been obtained from GP confirming the client is fit to be transferred or, where there is no choice but to transfer, indicating what medical supervision of the transfer may be required.		
Ascertain client preferences in terms of choice, including preference to move with friend/s in their current unit and liaise with other appropriate Care Managers on this.		
Advise client/carer of choices available and potential limitations on this due to timescales.		
Assist families/carers to identify and secure alternative care placement for residents.		
In the absence of carers, - identify if an advocate is required and if so involve them in securing an alternative care placement for the resident.		
Obtain resident background history; care plans; medication records; from closing home for onward transmission to new placement		
In the absence of carers - obtain bank books/statements, receipted personal monies/valuables and arrange for personal belongings to be forwarded to new home in a dignified manner.		

Check that closing home arranges with Benefits Agency for transfer of appointee function to new home as appropriate.		
Complete all relevant paperwork including financial assessments as appropriate and to liaise with welfare rights officers as required.		
Ensure Benefits Agency is informed of move of client, that claims submitted where required and that papers submitted to new Benefit Office where appropriate.		
Convene the initial review after the four week trial period or sooner if required and timely notes to all concerned with the care of the resident, including the link Senior Officer, Nursing & Residential Services.		
Alert the Care Commission / Nursing and Residential Services of any concerns during the closure process		

The Care Home Regulations 2001

The Care Home Regulations 2001 advise home owners that the retention of information set out in the Regulations (Schedules 3 and 4) 'should be retained for not less

than three years from the date of the last entry'. The information to be retained includes:

- Assessments
- Plans
- Contact details
- Medication records and notes about specialist equipment
- Medical and nursing notes
- All other records that the Regulations require a care home to keep.

Consent 02

At even the most basic level, individual's agreement must be sought and recorded that information held about their support and care can be shared with others who may be involved in their care. Please note that this must be completed or an explanation given if the individual's agreement was not possible.

Name: [insert resident's name]

I am happy for information about me to be shared with others who are involved in my care and support including my GP, my care worker, the manager of the Home

Signed:

Name:

If signed by a Representative, please give name and relationship and reason why they have signed.

Relationship:

Date:

Reason:

Transfer forms

A record needs to be kept on each resident providing detail on

- **Their full name..... and d.o.b.**
- **Address of Home moving from**
- **Address of Home moving to**
- **Next of kin contact details**
- **Date and detail of any contact made with next of kin or other close family members**
- **Name of Care Manager assigned to this resident**
- **Assessment/Risk assessment by nominated care manager**
- **Care plan, including date it was updated**
- **Date on which new Home will undertake its own pre-assessment**
- **Medication/sheet**
- **Equipment/special aids etc**
- **Personal items and anything else that needs to be transferred with the resident**
- **Any other information which needs to be recorded to provide to the new Home prior to arrival**

Communication

The announcement of a home closure can be traumatic for residents, families and the workforce. Timely and well planned communication is extremely important in reducing distress and enhancing choice.

‘We need to build up trust and report with residents and families quickly - they'll hear all sorts of things in the press or from other sources and they won't necessarily want to believe what we're telling them’

(Commissioner)

Overview

- Communication in general is the key to:
 - avoiding misunderstandings and **establishing trust with residents and their families**
 - enabling residents and families to exercise choice and control with regard to making alternative arrangements
 - allaying fears and maintaining confidence in care arrangements
 - protecting organisational reputation and demonstrating transparency.
- There is a balance to be struck between providing information that is essential at the time and that which will raise anxieties
- It is important to act in a timely fashion in order to minimise the incidence of rumour or speculation.
- Communication should be both proactive (sharing information and keeping people informed) and responsive (dealing with queries and allaying people's anxieties)
- Partners in the system need to agree a policy on information sharing between themselves, and what to communicate more widely.
- The person managing the closure project needs to develop a communications plan.
- Specific communication relating to individuals must be timely and sensitive. Once the proposal to close is confirmed, all residents, families and the workforce should have an individual letter that gives an outline of what will happen. Make sure that instructions about when and how external mail is to go out are clear
- Information needs to be shared with the Care Quality Commission (CQC) or **other national equivalents** throughout the process, particularly about the maintenance of standards of quality and safety during the closure, and future plans for residents.
- **Communication plans** will need to address the what, when, how and with whom of communication.
 - A list of frequently asked questions and answers should be devised early on in the process as a way of reducing the number of individual queries that have to be answered.

See **examples and tips** for more information.

Working with residents and families

- Trust and rapport will be established by listening to concerns and providing honest answers to questions.
- Every resident (together with families if possible) should have an initial one-to-one meeting with a senior member of the care team to explain exactly what will happen and **how their personal needs will be met**.
- Depending on the circumstances of the closure, be ready for disbelief and or anger from some residents or carers.
- Careful consideration should be given to how and when residents with cognitive impairments are informed.
- Special attention should be given to seeking out those relatives who are not in touch with the resident and/or who do not respond to initial contacts.

See **examples and tips** for more information.

Managing the media

- Agree a media handling plan with key partners to ensure factual reporting and positive media coverage wherever possible.
- Include the home owner in the media handling plan to enlist their co-operation in avoiding negative messages
- Agree consistent messages with colleagues about concern for primacy of quality and continuity of care, and the health and wellbeing of residents.
- Use local radio and newspapers for disseminating information.
- Make sure there is the capacity to respond to enquiries triggered by news bulletins or other forms of mass communication.

Communicating with staff

- The role of existing staff in providing continuity of care to residents is crucial, so minimising their stress levels will enable them to be more effective at work. Harnessing their commitment at an early stage is vital.
- Ensure regular and open communication with staff affected by the potential closure.
- Agree early on the approach to communication with staff - for example face to face meetings, e-bulletins, individual letters or through nominated representatives - depending on the size of the home and whether it is part of a larger company
- Involve the trade unions from the start; communication plans should say who will do this and timescales drawn up.
- It is vital that information to staff is coordinated and that the same facts are being provided from management, trade unions and professional bodies.

- Staff need to be given clear information about their options during and following the closure period.
- Consultation with trade unions should include arrangements for identifying jobs that will be under threat and/or arrangements for transfer to a new employer.
- Devise a list of FAQs for staff with information about where they can get further help and advice, e.g. external organisations such as Citizens Advice Bureaux.
- Commissioners have no automatic access to the staff in a care home that they do not employ. To engage with staff requires the cooperation of their employer, their unions and the staff themselves. **Provision in contracts to allow commissioners to 'step in' when there is an emergency may facilitate this.**

See **examples and tips** for more information.

Key points from policy and research

- Direct communication with residents (particularly those with high support needs) is very important as their voices are often subdued and their views represented through staff, relatives or friends (Joseph Rowntree Foundation, Older People's Vision for Long Term Care, 2009).
- Attention to communication and information dissemination has been identified as a priority by senior managers surveyed to elicit good practice on home closures (Glasby et al (2011))
- Engagement with a variety of stakeholders at an early stage is essential - including service users themselves, their families, care staff, partner agencies and external advocacy agencies. (Glasby et al (2011))
- In unplanned closures there was a greater need to work closely with the adult safeguarding team than in planned closures, because the closures often happen suddenly as a result of concerns about the quality of care (Glasby et al (2011))
- The nature and quality of communication with residents, relatives and carers about proposed home closure varies considerably (Williams and Netten 2003). The way in which residents were informed varied, some being told by their families and others by formal letter. Some first heard of imminent closure by rumour. A substantial number said that the responsibility to inform residents was left to family members.
- Relatives value openness and good communication from council staff prior to and during the closure.
- In the worst instances of practice researched, residents learned about the impending closure by gossip and rumour or from articles in the local press. (Glasby et al (2011))
- The differences in practice between councils do not generally appear to be affected by whether the individual was publicly or privately funded. (Glasby et al (2011))

What the regulator says

In the event of threatened or imminent emergency closure, commissioners should make contact with the Care Quality Commission (CQC) at the earliest opportunity. **CQC will provide information under its information-sharing protocols indicating any action which it is taking**

Examples and tips

Examples of what others are doing plus materials they have developed and useful tips.

In this section we provide you with more detailed information about the various elements of communication that you will need to consider. It includes excerpts from local authority protocols, policy documents from the assemblies and governments of the UK and feedback captured during the development of the website.

How providers can help communication

To stem rumour, speculation and distress, home owners have a responsibility to provide factual information that sets out the options for all their stakeholders. Whilst there may be times when information is commercially sensitive to be shared widely, providers need to gauge the point at which it is counter-productive to staff morale and quality of care to continue to withhold information. And when it is provided, information needs to be as simple, explicit and unemotional as possible. Providers use internal teams and networks, bulletins, news-sheets, notice-board, staff meetings etc to regularly communicate with staff; they need to ensure that all staff have access to information as soon as it is available.

Commissioners may be able to provide their own networks and routes of releasing information. In the case of high-profile closure, providers also need to have a media-handling plan and be aware of the level and quality of information others may be posting on their websites.

For instance in a recent case that attracted national media interest, Age Concern made fact sheets and advice available for anyone searching their website for guidance - **[Advice on closure of Southern Cross](#)**

Managing enquiries

It is important to agree key messages and how they are communicated at the earliest opportunity.

Kent County Council recommends that a briefing note is agreed by the designated operational manager, to include the contracting, health and media impacts of the closure. This should be used as the basis for giving out information to the public. The media and press offices for the local authority and PCTs/clinical commissioning

consortia should be provided with the briefing note and should handle all media enquiries.

(Source: Kent Adult Social Services: Protocols for managing the closure of a care home (post decision) March 2010)

Developing a communications plan for the home

Residents, relatives and staff must be kept informed about what is happening and when, so a specific communications plan for the home, as part of the broader communications strategy, should be developed.

A communications plan needs to be developed that includes consideration of appropriate methods, frequency and content of communications. Effective plans are likely to include a mix of approaches such as:

- homes newsletter produced as regular intervals
- large meetings
- small group meetings
- individual one-to-one discussions
- electronic communications including using social networking such as Facebook and Twitter
- registered manager and/or nominated individual to publicise their availability for personal questions and discussions. This could be 'open door' or planned and bookable times
- notice boards giving updates, timescales, photos of new options for moves, information about planned moves for people, notice of meetings and contact details of significant people and organisations like CQC.
- A media strategy, including clear protocols for responses to queries and use of media during consultation and subsequently

(Source: Managing Care Home Closures, Social Care Association, 2011)

Communication with individual residents and families

Typical letters supplied by a number of commissioners commonly include the following basis information:

- reasons for the decision
- decisions that remain to be taken (about how and when the closure will take place) and what further consultations will take place
- process for decision making (this will need to reflect the type of owner and how they make decisions)
- timescales involved
- people's rights and how they can be exercised
- (in the case of the local authority owner) options for appeals or representations
- complaints process

- proposed arrangements for managing the closure
- clear detail of when specific information will be available
- support that residents and families will be provided with.

Informing relatives

- The resident should be consulted on who they wish to be informed
- The resident and relative should agree on a single contact person
- Notice should not be less than two months and there must be flexibility if possible where the closure is planned
- Information provided should include:
 - Reasons for the closure
 - Reassurances places will be available elsewhere
 - Information about vacancies
 - Steps relatives will be expected to take
 - Who will provide assistance
 - The contact person/point
 - Messaging should be consistent, open and honest
 - Regular updates are advisable

(Source: Protocols for managing the closure of a care home - post decision, Kent Adult Social Services)

External mail

Some people (for example residents, families and care staff) may need hard copies of letters and other information to be sent through the post rather than by e-mail. One thing I would have done differently a commissioner stated that she learnt a lesson with information going out to residents and their relatives on a Thursday but mistakenly by second-class rather than first class post, arriving at the weekend when there was no-one available in the office to field queries and provide further information.

Rumours and speculation

Staff may be very acute about picking up that their employer is in difficulties and sometimes this feeds a rumour mill. Whilst uncertainty is very disruptive and anxiety provoking, managers should not leap to making hasty emphatic denials. Rumours that are ultimately found to be with foundation can damage trust if they have previously been categorically denied. Managers therefore need to be clear that, if there is no definite information one way or the other about a potential closure, then they should not contribute to the speculation or make emphatic denials. Where there is uncertainty it is important that commissioners press organisations for decisive information as early as possible. Cogent and timely information is the best way to stop speculation and managers need to be clear about agreements for when and where to divulge information so that any questions from residents, families or employees can be answered accurately and honestly.

(Source: Managing Care Home Closures, Social Care Association, 2011)

Communications - roles and responsibilities

Designating clear roles and responsibilities will minimise the possibility of duplication or inappropriate messages being disseminated.

- The **Head of the Directors Office** and the **Customer Care and Communications Manager** need to be contacted as soon as possible and need to have sufficient information for a first level briefing.
- The **Customer Care and Communications Manager** will keep the Press Office and in particular the Head of Press through the media alerts process
- The **Executive Member** will fully briefed and kept informed of developments by the relevant Assistant Director
- The **Project Lead** will ensure that the local Hampshire Action Team is notified and kept fully informed of developments
- The **Contracts Section** will notify the Department of Works and Pensions of the change in each resident's circumstances.

(Source: Care Home Closure - Contingency Guidelines, Hampshire County Council)

Communication in situations of institutional abuse Close

Closing a home in the context of allegations of abuse brings additional requirements around communication. The whole scenario may be more complex because of police investigations and emotions will be heightened.

Where a Safeguards issue concerns a service user's care that is managed by a health care trust the consultants for safeguarding for that trust must be informed. This will ensure that a senior professional from that health trust is involved in the strategy meetings, so that any urgent physical or mental health assessments required are facilitated. Cross border representatives should be informed of any action that may relate to service users funded by them.

Service users, carers and relatives

The full and appropriate engagement of service users, their families and representatives at all stages is fundamental. Service users must be informed of any decision that impacts them in a professional, timely and supportive manner.

Consideration must be given to a variety of forms of communication that can be utilised to liaise with and inform service users and their families including email, phone and in person. Practical considerations must be given to any meetings including location, access, timing and the amount of information that can be shared. An information pack including a brief statement of the situation, leaflets relating to advocacy services, the Residents and Relatives Association and complaints procedures for all partner organisations should be provided. This is not an exhaustive list and additional documents / information may be helpful e.g. CQC report and full contact details.

Communication must be clear and transparent and contact details (24/7) for all key personnel should be provided. Regular meetings for residents and relatives should be arranged throughout the process and newsletters/information from providers/ECC to residents and relatives can help during a closure process. Views of service users and relatives must be captured for the lessons learnt exercise at the end of the operation.

Safe and effective communication

It is imperative that staff members are aware that all records (e.g. emails, notes, diaries, minutes) may be evidence (for the prosecution) or subject to disclosure (to the defence) where a criminal case is pursued. Detailed contemporaneous notes should be made of any discussions with the owners of the home or service users. Ideally any discussions should be undertaken with a colleague present who can witness the conversation and countersign notes of the discussion as a true and accurate record.

Where it is necessary to communicate via email under no circumstances should the name of individuals or the home be disclosed in the title or body of an email. If it is necessary to communicate this information it should be in a password protected attachment. The password should only be disclosed verbally to the recipient i.e. it should not be transmitted in a subsequent email or sent for general use at the inception of the project; in this circumstance it should only be released to project members. The project will be allocated a code name and all documents must have password protection. Face to face and telephone conversation may sometimes be more appropriate than emails

Staff should be cautious when information is requested over the telephone and should always verify who they are speaking to e.g. if it is a previously unknown switchboard.

The Freedom of Information Act and access to records procedures must be considered when recording information and ECC protocols must be used.

(Source: Essex Safeguarding Adults Board)

Communication plans will need to address the what, when, how and with whom of communication

- **Who** to communicate with : There are three key groups of stakeholders to be addressed in any communication plan:-
 1. Residents and their relatives,
 2. Those involved in 'the care system' - e.g. staff, other commissioners, health professionals such as GPs and district nurses; regulators; other providers; Administrators if a company is put into liquidation;
 3. Those with an interest in holding public services to account - i.e. Elected members, the Press, the general public, advocacy groups

The intended audience will affect all the other dimensions of communication (see below)

- **What** to communicate: factual and unemotional information which is clear on detail and spare on unnecessary narrative. For residents and family it will be very important that messages are sensitive to their likely concerns.
- **When** to communicate: immediately a decision is taken on closure or as soon as definite information is known that a closure or significant management change is imminent. There should be a hierarchy of timescales, tailored to the requirements of the various stakeholder groups (see above). As well as the initial dissemination of information, consideration will need to be given to the requirements along throughout the whole process - i.e. information that might need to be communicated at regular intervals, or at key decision points, or upon request
- **How** to communicate: this is needs to be tailored to each stakeholder. For residents and family, individual arrangements should be considered involving anything from face to face meetings, telephone (including dedicated phone lines), e-mail, post or in some cases, public meetings. For other stakeholders some of these means will be appropriate (e.g. email and phone) but could also include press briefings, meetings for targeted groups, web-sites etc.

(Source: Care Home Closure - Contingency Guidelines, Hampshire County Council)

Communicating with people with cognitive impairments

Careful consideration should be given to how and when people with cognitive impairments are informed about the closure of their home, as this may increase their confusion or agitation. However, whilst receiving such information in advance of the event may be distressing for some, discovery at a later date by other means could be more so. It is important to involve staff who know the individual resident well and seek specialist advice if necessary, so that the right decisions are made with the best outcomes. Such decisions should be made on an individual resident by resident basis. It is also important to work with and support any relatives who are involved in such situations.

Residents of homes or people who use our service have a right to be consulted about proposals which affect the service even where it may cause them distress. This is relevant particularly for people with learning disabilities where carers have argued that residents should not be informed about options because it would 'upset them considerably'. The argument has also been made about the residents of homes for older people.

What is important to consider is the timing of the consultation, how it is presented and how the process is handled so that distress is minimised and support is given to residents and people who use our services.

(Source: Protocol for care home closure and transfer of frail/vulnerable adults, Sandwell MBC , 2009)

Intelligence and information sharing

Information gathering and information sharing are essential components of commissioning activity. They should be both **proactive** - to help anticipate and ideally prevent closure or discontinuity of service provision; and **reactive** - to share concerns and ensure a coordinated and coherent response to difficulties.

- Economic and environmental pressures may cause market failure resulting in closure, or service disruption, and may be outside of the control of the commissioner.
- Enforcement action by the regulator may be the consequence of **system failure or enforcement** reflecting concerns about the quality of care and/or the need to **safeguard vulnerable adults**.

In both cases, the **processes of gathering information and disseminating it effectively** should lead to more satisfactory outcomes for the individuals affected by service cessation; for the care workers and owners of facilities providing service; and for the diversity and choice of the marketplace.

‘You've got to understand the local market - its strength and weaknesses, where gaps are - act on information received and alert each other to potential problems’

(Commissioner)

Market failure

- Commissioning processes should be addressing a number of key questions to ensure a robust understanding of the market and its potential weaknesses, and enable appropriate action to be taken.
- Commissioners and their contracts department should hold information sought from a basic questionnaire on the legal status of an organisation, its capacity and contact data on the owner etc.
- Commissioners should maintain a list of organisations and the roles in which they should be collaborating, including receivers and HMRC
- Reciprocal arrangements and cross-boundary agreements need to be in place.
- Commissioners need to understand the local market and RAG-rating for risk based on:
 - safeguarding alerts
 - occupancy levels
 - risky contract models - e.g. single purchaser, monopoly provider
 - building viability
 - fitness for purpose of the business
 - age profiles
 - hospital admissions
 - strength of competition

- financial viability/financial data
- validating the data (i.e. in cases of suspected under-reporting)
- using the market itself to add to intelligence
- allowing the market to develop based on shared intelligence
- Commissioners should develop (and regularly update) multi-agency Escalation Plans and Resilience Plans
- Protocols for extra resources need to be agreed and regularly adjusted, particularly if the scale of market retraction is considerable and will have a commensurate impact on the commissioner's budget.
- Analysis of complaints data and reports on what is done with it need to be used to continually monitor the ability of providers to meet standards and contractual requirements.
- Commissioners need an understanding of plans for the development of new build and the data upon which speculative development is based.
- Commissioners must feel able to establish whether care homes have their own continuity plans

See [examples and tips](#) for more information.

Acting on intelligence

It is important to **act** on intelligence gathering and information sharing if they are to contribute to preventing service failure from either systemic abuse or market failure.

Communication with CQC

Clear lines of **communication with the Care Quality Commission (CQC)** (at a regional as well as local level) need to be maintained in order to ensure it is able to fulfil its requirement to inform local authorities of providers in breach of regulation at the point an appeal has been exhausted.

System failure and enforcement

Closure due to **enforcement action** because of poor quality of care which has been subject to scrutiny by the regulator may also be related to the economic pressures that can cause market failure - for example, when a local authority's policy to reduce price or the number of placements contributes to a fall in occupancy levels below what is viable. Reduction in the number of referrals and the reputation for poor quality are often interrelated.

Institutional abuse is often a different matter altogether. The regime in a home where abuse is occurring may 'go under the radar' until such time as clear evidence emerges or a whistle-blower alerts the authorities. Commissioners may well be in ignorance of concerns about the standards of care until notified at an advanced stage by CQC.

Institutional abuse

- Concerns about institutional abuse may come to light in a number of ways:
 - adult safeguarding units may note patterns of abuse from reporting data
 - staff undertaking placement reviews
 - contract monitoring arrangements
 - health care professionals attending to residents
 - family or friends
 - complaints
 - NHS Serious Untoward Incident reviews concerning people receiving NHS funded care.
- Agreements between key agencies on information sharing and communication must be in place in order to deal effectively with accumulating concerns relating to the operation of, or quality of care provided in, a registered care home.
- In all instances where abuse is suspected, following initial enquiries, safeguarding protocols and the relevant information sharing arrangements should be followed.
- Commissioning arrangements should be used to reduce the risk of abuse - for example, use of person-centred contracts, placement monitoring and review.
- Mechanisms need to be established to link information from different sources (e.g. care managers, CQC, complaints officers, contract monitoring functions, primary and secondary care staff) with agreed information exchange protocols.

See **examples and tips** for more information.

Safeguarding

Adult safeguarding procedures should include procedures for detecting and responding to suspected abuse within care home settings.

Key points from policy and research

A 2006 report by Age Concern - 'Rights for real - older people and human rights' shows how the Human Rights Act (HRA) 1998 provides the principles, practice and policy to safeguard older people and ensure they have good quality services from a range of providers. The report also highlights risk areas where older people may not be covered under human rights legislation, such as privately self-funded clients and people managing their own care arrangements.

Exploration of the changes needed by public services to meet the independence and wellbeing of older people and support to carers, considering the various strategic alliances that need to be formed across health and social care (Audit Commission 2004).

Research into the protection of service users who are receiving care from non-public organisations offers guidance on contracting for services in light of the HRA 1998 (Department for Communities and Local Government 2005).

For those in local government involved in asset transfer to the community sector, a practical guide on how risk can be managed and minimised, drawing on successful case studies and examples, is available. Whilst concentrating on cashable and tangible resources, there is evidence that a smooth transfer can be facilitated for the benefit of all affected (Department for Communities and Local Government 2008).

The personalisation agenda set out by the Department of Health in 'Putting people first' defines the market and consequent contractual relationships in a more personalised approach to care provision (Department of Health, 2008).

The work of the My Home Life team sets out those elements of care that are the cornerstone of quality of life for residents and maps out service specifications for both providers and commissioners www.myhomelifemovement.org

Where market failure is due to lowered income streams through lower occupancy levels or low prices, providers and commissioners may consider using a toolkit designed for professionals involved in negotiating care home fees (Joseph Rowntree Foundation 2008).

Earlier work on a similar theme was issued as 'Guidance on unfair terms in care home contracts', Office of Fair Trading 2003.

What the regulator says

In the event of threatened or imminent emergency closure, commissioners should make contact with the Care Quality Commission (CQC) at the earliest opportunity. **CQC will provide information under its information-sharing protocols indicating any action which it is taking**

Examples and tips

Examples of what others are doing plus materials they have developed and useful tips.

Market failure

Market failure occurs when the current supply is no longer able to meet demand and can be caused by a variety of economic and environmental factors. Chief amongst these relate to occupancy levels and the price paid for care. All providers operate within certain margins and if occupancy levels fall below a level, and therefore when income is insufficient to meet outgoing expenditure, those businesses are vulnerable to collapse. It is not unknown for banks, for example, to give only two hours notice of foreclosure, in extreme cases. Many providers do not share this risk with their commissioner in case

lost confidence leads to even fewer placements, so the news of the business failing becomes a high-priority crisis.

The commissioner has a responsibility to try to understand these pressures and to ensure that no behaviour of a major purchaser such as the local commissioning authority, jeopardises the stability and viability of local business. Where necessary, however, and especially in the case of poor quality of care, or the wrong type of provision, a commissioner may need to make intervention.

Other changes in market provision can be stimulated by proactive structuring by using the intelligence gained from market and joint strategic needs analysis.

Definitions

Market intelligence - the development of a common and shared perspective of supply and demand (including any gaps in provision) leading to an evidenced, published, market position statement for a given market. This involves commissioners having an understanding of their market place by routinely updating their knowledge of the provider market in accordance with the data gathered for example in a market intelligence checklist

Market structuring - the actions commissioners take in order to deliver the kind of market considered necessary to meet the needs of any given community; this will include stimulating new providers into the area, or encouraging existing providers to diversify. It covers the activities of commissioners designed to give any market shape and structure, where commissioner and provider share data to formulate business development plans for the future and would additionally impact on the behavioural relationships between commissioners and providers, for instance to be one of more mutual reliance than an adversarial stance.

Market intervention - related to market structuring, but where commissioners may need to take specific and direct action to stimulate new provision to meet identified needs, or to disinvest in provision that no longer meets those needs. It calls upon the commissioner to exercise negotiation powers to encourage new provision and decommissioning and disinvestment strategies to discourage forms of provision that are no longer needed.

Home closures: Some key questions

1. Q: Where Care and Social Services Inspectorate Wales (CSSIW) is aware of welfare concerns about service users or a planned voluntary closure or is itself anticipating an enforced closure, does it have any legal power to inform a local authority? Does it have a legal duty to do so?

A: If CSSIW is aware of a planned voluntary closure or has concerns that might lead to an enforced closure, it would inform the local authority in which the home was situated in line with its published protocol. It is expected that that authority would notify any

others that were sponsoring service users in the home. As with any other decision by any public body, this decision - if for example it were to threaten the financial viability of the home - would be open to challenge through Judicial Review. CSSIW could, if need be, point to its general duties under Section 8 of the Care Standards Act 2000 and section 92 of the Health and Social Care (Community Health and Standards) Act 2003 to encourage improvement in the quality of social care services and the provision of Welsh local authority social services, taken with its general wellbeing powers under section 60 of the Government of Wales Act 2006. CSSIW would need to be prepared to demonstrate, if required to do so, that it has exercised its functions reasonably.

2. Q: Where the local authority has serious concerns about a care home, does it have any legal power to disclose its concerns to CSSIW or to a local health board (LHB) - even if it means disclosing personal information about service users?

A: 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 or to an LHB and any other involved statutory bodies - even if this means disclosing personal information about service users. Any disclosure of personal information to CSSIW or to an LHB would need to be considered against the authority's duties 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
- Article 8 of the European Convention on Human Rights, the right to respect for privacy.

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. Next of kin should of course be consulted.

The ECHR Article 8 right to privacy is qualified. In a case involving the death of a resident in a nursing home, the courts accepted that sometimes disclosure was necessary in a democratic society for the protection of health or morals or for the protection and rights of freedoms of others.

(Source: Older People and Long Term Care Policy Directorate, Welsh Assembly Government)

Possible structural arrangements

Joint Inter-agency Monitoring Panel (JIMP) and Home Operations Support Group (HOSG) Statutory bodies will need to ensure that they have arrangements in place for a joint inter-agency monitoring panel (JIMP) to lead the escalating concerns process and arrangements for direct operational management for a care home closure (HOSG). The JIMP will be responsible for DAPs and CAPs.

There are several ways in which statutory agencies can discharge their statutory responsibilities in relation to escalating concerns within homes and 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.

Where there has been a home 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. A copy of the report must also be provided to CSSIW.

Developmental & Corrective Action Plans

The following paragraphs describe a proactive and reactive framework 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.

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.

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.

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.

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.

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.

(Source: Older People and Long Term Care Policy Directorate, Welsh Assembly Government)

Tools and checklists

We've included Word files so you can take away and adapt to your local needs.

Prompts to alert practitioners

The following set of prompts can be used by practitioners to clarify whether abuse is taking place:

<p>Identification and response to individual care</p> <p>Are the care plans of a good quality and do they reflect current need? Is there evidence that a life history has been undertaken? Have service users been involved in the care planning process? Have families been involved in the care plan? When was the last review undertaken? Is risk assessment for individuals and risk management obvious in the organisation? Is MCA (Mental Capacity Act) and DOL (Deprivation of Liberty) part of routine practice?</p>
<p>Dignity/privacy choice</p> <p>Are people treated with respect? Are they able to make choices and decisions? What is the attitude of management/carers towards:</p> <ul style="list-style-type: none"> • Bedtimes • Mealtimes • Visitors i.e. are they encouraged to visit at any time/have access to all areas? • Privacy i.e. knocking before entering rooms • Laundry • Communication with service users i.e. are staff abrupt, friendly, patronising? <p>Are there privacy and dignity champions?</p>
<p>Support systems</p> <p>Are residents aware of the complaints system? Do the residents have access to information on how to raise concerns outside of the organisation, i.e. ASK SAL, Social Care Direct, Care Quality Commission etc. Do residents have access to an advocate?</p>
<p>Staff morale</p> <p>What is staff morale like? Is there a key worker that can communicate with the individual? How long has the key worker been working with the individual? Does the organisation have external quality awards e.g. Investors in People? Is there any system to recognise and value staff i.e. employee of the month</p>
<p>Finances</p> <p>Do they receive their personal allowance? Who manages their finances – do they know? Are service users finances clearly documented? Are there processes in place to audit these?</p>
<p>Environment</p> <p>What is the level of hygiene like both in the individual bedrooms and communal areas? Is there evidence of personalisation in the resident's room? Is the room warm, clean, adequately furnished?</p>

<p>Are personal and private possessions in evidence? Is there individual equipment available for residents, i.e. hoists, wheelchairs, bathing equipment, lifts? Is the equipment in good working order? How does the call bell system work, are staff responsive? Does it work?</p>
<p>Residents well being</p> <p>Are residents subdued? Are there obvious opportunities for individualism? Are there opportunities to participate in other activities? Is there an atmosphere of wellbeing promoted for individuals within the organisation? Are people's ethnicity, culture and religious needs identified and respected? Does the organisation promote individuals lifestyle choices/beliefs? Are the choices and decisions made by the resident respected by the care staff and management (even if they are deemed as unwise)? Do they appear to be happy? Are they appropriately dressed? Do they talk enthusiastically about activities within the home? Are there activities in the home?</p>
<p>Medical</p> <p>Do residents have access to health services and are supported to access these services e.g. G.P, dentist, chiropodists? Is there a good relationship with health care professionals? Are medications (incl. benefits and side effects) properly reviewed and monitored? What are medication administration records like i.e. are there gaps in MAR sheets? Are codes used appropriately and accurately when medication is not given? Are there incident and accident books in evidence? Is PRN medication prescribed? / Are there protocols for usage in place? Are other interventions in place before PRN medication is used (if appropriate)? (PRN - medication that should be taken only as needed).</p>

Please note that the above are indicators of institutional abuse, they are not exhaustive and not all issues will be relevant to every individual. Staff should not use the list of prompts as a tick box exercise, but nevertheless if shortfalls are noticed in some of the areas it may be necessary to report your concerns. Be aware, that if you have concerns your colleagues may also have concerns. Discuss these, and ask if they are indicators of abuse or an unhappy resident.

[Source: Essex Safeguarding Adults Board]

**‘ANYTOWNSHIRE’
OLDER PEOPLE’S CARE HOME BASIC QUESTIONNAIRE
Dated #.**

1. Name of Care Home.....
2. Name of Owner
3. Name of Ownership Company.....
4. District / Borough of Northamptonshire.....
5. Total of Registered Placements Available in this Care Home.....
6. Can / Do you take Nursing Placements
7. If yes to Question 6, then what is your capacity
8. Through which different streams are your Customers funded
NCC CHC RNCC Private Other.....
9. Do you charge Third Party Contributions if so - From To
10. What is your average level of vacancies
11. Do you operate a waiting list if so, how many are on it
12. What is your Care Home’s approximate annual turnover.....
13. Are you part of a larger ownership group of Care Homes.....
14. If so, what is the ownership company’s name.....
15. Do you or your Company own this Care Home outright
16. Do you have an outstanding mortgage
17. Do you own the Freehold or Leasehold on which the Care Home is built
.....
18. If not, please tell us who owns the land on which the Care Home
operates.....

Thank you for taking the time to complete this questionnaire.

[Source: Northamptonshire Social Services]

Market intelligence checklist

The following questions could be helpful for commissioners to be asking themselves about their knowledge of local markets:

- Do you know how stable your market place is?
- Do you risk assess private sector provision on the basis of information gained from the market place, or from regulators?
- Do you know who owns the businesses with whom you contract and on what financial models their businesses are built?
- In the event of market failure, have you contingency arrangements for the safe transfer of residents/service users to alternative accommodation, including alternative living arrangements, for instance extra-care?
- Do you regularly take snapshots of occupancy levels and available capacity?
- Do you know enough about the residents/service users for whom you have a duty of care to make alternative arrangements that best meets individuals' needs?
- Could you involve them in discussing alternative arrangement?
- Do you have regular resident forums where such scenarios are discussed and planned?
- Do you know the balance of residential care home residents and continuing health care (NHS funded) residents, and self-funders?
- Given how long it takes to develop alternative accommodation solutions, for instance it may take up to two years to get design/plan/build in place for extra-care accommodation, do you have contingency arrangements for short-term placements?
- Is the market large enough to sustain the current or projected number of providers?
- Is the market dominated or likely to be dominated by a small number of providers?
- Will commissioners be able to assess quality and make informed choices?
- Is there a level playing field in terms of client costs?

Legal issues

Local authorities have clear legal duties when undertaking a home closure and it is important to get the process right for residents, families, staff, the owner and the public.

‘We wanted to make sure that the way we are doing it (is set out) clearly, minimising risk for people. We wanted to make sure primarily that we were protecting individuals, but also that we wouldn't fall foul of the law’

(Local authority DASS)

Underpinning legal responsibilities

- There is no legislation specifically defining the powers and responsibilities of local authorities or NHS bodies during care home closures but there are many legal frameworks (see below) that need to be adhered to.
- Commissioning authorities need to comply with the statutory duty to safeguard the needs and welfare of **all** residents in care homes affected by circumstances that may interrupt their **continuity of care**.
- Local authorities need to recognise that their statutory duties apply equally to all residents whether they are self-funded or publicly-funded and regardless of which local authority has placed them there in accordance with Ordinary Residence Criteria.
- When working with people who might lack mental capacity to decide for themselves where and how to live the **Mental Capacity Act 2005** applies.
- Local authorities should consider their powers under the Local Government Act 1972 (and subsequently updated in 1999, 2000 and 2003) to incur expenditure to resolve a crisis situation.
- Local authorities need to abide by the National Assistance Act 1948 and the NHS and Community Care Act 1990 which set out the key statutory duties in respect of the provision of accommodation and the **assessment responsibilities**.
- Local authorities need to ensure that they work towards preventing escalating concerns developing (and home closures potentially occurring) by putting in place quality control and monitoring systems as part of their approach to commissioning.

See **examples and tips** for more information.

Commissioning authority requirements

- Local authorities are required by the duty of care invoked when they commission placements to be proactive in monitoring service delivery, safety and performance of care providers and managers.
- Commissioning authorities owe a duty of care to **all** residents regardless of whether their placement is funded privately or publicly, and all must comply with

- human rights legislation, particularly in regard to safeguarding someone's privacy and dignity.
- Local authorities need to ensure the safety and wellbeing of residents as where there is a failure in the provision of care which causes suffering, this can constitute a breach in duty of care and could amount to a criminal offence being committed by the home.
 - Local authorities must undertake the transfer of residents to alternative accommodation in accordance with **safeguarding procedures**, good practice and due diligence within the law.
 - Where people do not have the mental capacity to make decisions without support, local authorities must pay particular attention to the requirements of the **Mental Capacity Act (2005)** in situations which involve the transfer of residents.
 - Local authorities have a duty to instruct independent mental capacity advocates (IMCAs) where accommodation arrangements are being made on behalf of a person lacking mental capacity and without friends or family.
 - In the case of insolvency, and where an administrator has been appointed, the council must engage with the administrator under provisions of administration and/or receivership (see 'Administrative receivership' under '**Legal issues - examples and tips**'). The administrator's principal objectives to stabilise the business and optimise attempts to sell it may, however, differ from the commissioner's primary requirements to ensure continuity of care and the best outcomes for residents.
 - Local authorities need to adhere to the choice directions where individuals are moving location as a result of a **home closure** and where choice is constrained by availability, suitability and the provider's willingness to accept contract terms.

See **examples and tips** for more information

Legal responsibilities in practice

- Local authorities need to be able to draw on basic guidance on what can and can't be done, and the legal basis for it.
- Local authorities need to identify and consult immediately with the lead people within the commissioning authority who have expert knowledge of legal parameters and, ideally, previous experience of dealing with 'unsteady state' situations.
- Local authorities need to be familiar with the relevant clauses and sections of the legislation that govern a commissioner's activity.
- Local authorities need to cascade the knowledge of the legislation and ensure that staff involved in emergency transfers (such as the local response team) understands the requirements, and the sequence of activities that need to occur.
- Local authorities need to understand the roles and responsibilities of each of the partners in the area and what governs their activity, including the role of the regulator.

- Local authorities need to appreciate the legal rights of some agencies - for example, police, UK Border Agency, Care Quality Commission (CQC), to enforce, deal with 'breach of the peace', and - in cases where a commissioner's staff face hostility and antagonism in carrying out their statutory duties - provide police protection in volatile situations.
- Local authorities need to try to ensure that their contracts make suitable provision to 'step in' where necessary to have access to the premises for the purpose of continuity of care and, furthermore, lay a requirement upon care providers to cooperate.
- Local authorities will need to ascertain the legal status of residents and their financial circumstances as part of the assessment and care planning process.

See [examples and tips](#) for more information

Key points from policy and research

Whilst there is little specific research on this topic, all legal advisers point commissioners to key policy documents and the legal frameworks that underpin them, for example:

- 'No secrets' (DH 2000) sets out the policy framework and requirements for safeguarding vulnerable adults. A major consultation exercise on whether and how policy and legislation should be updated was undertaken in 2007, but no major changes have yet taken place.
- The Office of the Public Guardian published various booklets to explain the provisions of the [Mental Capacity Act 2005](#) and the responsibilities of people taking on the roles under [Lasting Power of Attorney](#) and the [Justice Department](#)
- [Data Protection Act 1998](#)
- [Freedom of Information Act 2000](#)

What the regulator says

- Commissioners should make contact with the Care Quality Commission (CQC) at the earliest opportunity. The Commission will provide information about the compliance status of the provider and any action it is taking under its information sharing protocols, in line with the requirements of the legislation.
- CQC will work with the service provider, commissioners and other stakeholders to promote and protect continuity of care (although the provision of care is not directly CQC's responsibility). This will include consideration of the requirements of the legislation, regulatory requirements and any specific response which is required during a crisis period.
- During any transition period the focus of CQC will be on ensuring that the essential standards of quality and safety continue to be met and people using services continue to be safe. The Commission has a range of powers which are applicable to different scenarios so early engagement with and involvement by CQC are essential.

Examples and tips

The following key issues were identified through the feedback exercise which helped to shape the production of this guide. Legal advice should always be sought appropriate to individual and local circumstances.

Statutory duty

The local authority's mandatory statutory duty to eligible people already resident in the home is to meet their assessed eligible needs appropriately and safely (to do otherwise would be a breach of statutory duty, potentially enforceable by injunction). Leaving a person in an inadequate home on the brink of failure or closure could lead to a breach of their rights under the Human Rights Act HRA. It is part of the duty to re-assess someone's needs before attempting to move them (if circumstances permit this to be a planned part of the re-provisioning - that is, it may not be possible in extreme circumstances such as fire or flood, to undertake this duty, but a review would then be conducted at the first opportunity). In reassessment, the law requires best interests of the residents and their families are considered, in compliance with the Choice Rights outlined in Choice Directions and that appropriate consents are observed in accordance with the [Mental Capacity Act](#).

Because of their additional vulnerability at a time of crisis, the transfer must be effected as carefully as possible to avoid causing harm and their human rights must be seen to be taken into account, in accordance with the extent the scale of the crisis allows time to do so.

Choice directions

The Choice Direction and Guidance

When someone is moved from one residential home to another the four provisions of the Choice Directions still apply - re-accommodating is therefore subject to:

1. **availability** of suitable alternative accommodation (including, of course, the home that is closed down. This is an obvious point, but it is not a reasonable choice for a resident to choose to remain where they are when the administrator has made the legally enforceable decision to close down the property or has abandoned the local authority's contract for the resident's place in it
2. **suitability** of alternative accommodation to meet the person's assessed need
3. **the usual rate** paid for such accommodation is acceptable to the new residential care provider. If it is not, and there is no other alternative accommodation for the person, meeting their assessed needs, the commissioning authority has no choice but to pay whatever rate is necessary to get them satisfactorily placed.
4. **choice** has been offered where it is possible and feasible to offer options that enable the resident to make a positive choice based on their preferences and all other conditions in 1, 2 and 3 above can be met.

Residence

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 wellbeing. This should include an assessment of their mental capacity to make decisions.

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.

Mental Capacity Act

The **Mental Capacity Act** is crucial to decision-making by health and social care professionals, which must always be made in the light of the five Statutory Principles of the MCA:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Following the Statutory Principles of the MCA, and working within a human rights based framework, all efforts must be made to enable people to make decisions concerning themselves.

- If a resident has capacity to understand the options for provision of future care, then that person makes the decision, with their decision-making capacity enriched by appropriately-presented information about the alternatives.
- If a person might be able to make the decision for themselves, all concerned professionals must maximise that person's capacity (Principle 2), by careful and person-centred explanation (e.g. delivered in appropriate language, using

appropriate aids, ensuring that the person is presented with the information at the time of day when they are most alert).

(See MCA s.1; MCA Code of Practice, Chapter 2).

Mental capacity must be assessed in a decision-specific and time-specific way - can the person make a certain decision at the time it needs to be made. To work this out, you need to think about the two-stage test of capacity: firstly, is there any impairment of, or disturbance in, the functioning of the mind or brain? (note that this can be temporary or permanent; you do not need a diagnosis; a person's capacity can be impaired by, for example, an infection or flu, or by bereavement). The second question is, does this impairment mean that the person cannot make this decision when it needs to be made? A person has capacity to make a decision only if they can carry out all four of these steps in relation to that decision:

- Understand appropriately-presented information about that decision
- Retain the information, just for long enough to
- Use and weigh it to reach a decision, and
- Communicate that decision by any recognisable means

(See MCA s.2; MCA Code of Practice Chapter 4)

If a person lacks capacity to make the decision about where to live following a care home closure, then professionals (social workers/care managers) or family members (if they hold a Personal Welfare Lasting Power of Attorney which has been registered with the Office of the Public Guardian) must make that decision in the **best interests** of the person. If time allows (or, if a decision is made in an emergency, then at the first opportunity) the following **best interests checklist** must be considered:

- Consider whether the person is likely to regain capacity and, if so, whether the decision can wait
- Involve the person in the decision as much as possible
- Explore the person's past and present views, culture, religion and attitudes
- Do not make assumptions based on a person's age, appearance, condition or behaviour
- Consult interested family and friends
- Search for the least restrictive option that meets the need.

(See MCA s.4; MCA Code of Practice Chapter 5)

Note that if a person is facing a big decision about where to live, and lacks capacity to make that decision, and has no family or friends able and willing to be involved and consulted as part of the decision-making, then the relevant local authority **MUST** involve an independent mental capacity advocate (IMCA) as part of the decision-making process. The IMCA does not become the decision-maker, but the decision-maker must be able to demonstrate, whether they agree with any proposals suggested by the IMCA or not, that they have taken the views of the IMCA into account in reaching their decision.

(See MCA ss. 35-41; MCA Code of Practice Chapter 10)

(Source: Advice from Provider Development Manager, Mental Capacity Act | English Community Care Association/ Social Care Institute for Excellence)

Administrative receivership

Administrative receivership differs from simple receivership in that an administrative receiver is appointed over all of the assets and undertakings of the company owning the home. Insolvency legislation usually grants wider powers to administrative receivers, but also controls the exercise of those powers to try to mitigate potential prejudice to unsecured creditors. The administrative receiver's first responsibility may be to the creditors - a commissioner must engage early to ensure that the administrative receiver is aware of the plans to minimise harmful disruption to existing residents. An administrator has the power to close down a business with immediate effect, or choose to continue trading, or to sell the business. An administrator may also abandon contracts (but this will be in accordance with the provisions for termination within the commissioner's contract with the care provider).

The administrator's principal role is to stabilise the situation and to attend to matters of principal concern** relating to continued and viable trading and they will ensure involvement of all operational, regulatory or financial stakeholders***.

Principal Role of the Administrator*

- Rescue the company so that it can remain a going concern.
- Achieve a sale that enables it to continue as a going concern.
- Realise a better outcome than winding-up or liquidation.
- Provide shareholders with options to vote on.

Matters of principal concern to Administrator**

- Getting stability and control over activity
- Stay trading
- Clear communications to everyone that it's 'business as usual'. This includes residents/relatives, other 'customers', employees, unions, banks and other financial creditors, trade creditors and suppliers, landlords, government and regulators, pension funds.
- Managing media coverage.
- Achieving a cash positive business, which might involve securing funding to trade BUT also to ensure that creditors aren't disadvantaged by trading.
- Exercising tight control so that the fiscal position doesn't worsen.
- Reducing liabilities.

- Developing a realisable exit strategy. Where properties are concerned, this may involve keeping/selling good sites, restructuring underperforming sites to keep/sell, closing bad sites.

Governmental/regulatory or operational stakeholders of care sector***

Regulatory

- Care Quality Commission (CQC) in England); - Social Care and Social Work Improvement (CSWIS) in Scotland; Care Standards Inspectorate for Wales (CSIW); Regulation and Quality Improvement Authority (RQIA) in Northern Ireland.
- Office for Standards in Education, Children's Services and Skills (OFSTED)
- Association of Directors of Adult Social Services (ADASS)
- Office for Budget Responsibility
- Office for Disability Issues
- Parliament/Devolved governments
- Monitor

Financial

- HM Revenue and Customs (HMRC)
- HM Treasuring
- Insolvency Services
- Redundancy Payment Services

Operational

- Individual local authorities (according to contracts)
- NHS - PCT or other healthcare commissioners including GP consortia
- Local Government Association
- Department for Work and Pensions
- Department for Business, Innovation and Skills

Human Rights Act

The Human Rights Act came into force on 2 October 2000 and incorporates into UK law certain rights and freedoms set out in the European Convention on Human Rights such as:

- right to life (Article 2)
- protection from torture and inhuman or degrading treatment or punishment (Article 3)
- protection from slavery and forced or compulsory labour (Article 4)
- right to liberty and security of person (Article 5)
- right to a fair trial (Article 6)
- protection from retrospective criminal offences (Article 7)
- **The protection of private and family life** (Article 8)

- freedom of thought, conscience and religion (Article 9)
- freedom of expression (Article 10)
- freedom of association and assembly (Article 11)
- right to marry and found a family (Article 12)
- freedom from discrimination (Article 13)
- right to property (Article 1 of the first protocol)
- right to education (Article 2 of the first protocol)
- right to free and fair elections (Article 3 of the first protocol)
- abolition of the death penalty in peacetime (Articles 1 and 2 of the sixth protocol).

Of these, articles 3 and 8 are particularly relevant

Local Government Act 2000 amended

s2 gives a local authority power to incur expenditure (including the provision of staff, goods, services or accommodation to any person), to give financial assistance to any person and to enter into arrangements, agreements or to facilitate or coordinate the activities of any person in order to promote or improve the social wellbeing of anyone affected by home closure. This power does not allow a local authority to do anything which they are not legally able to do, for instance, buying registered nurse nursing care, nor raising money (by precepts, borrowing or otherwise) to fund extra costs that responding to emergency homes closures might incur. Under s76, however, a local authority may be able to make payments to a local NHS provider towards expenditure it may incur in the connection with arrangements they have made for emergency provision of accommodation (for instance, the re-opening of a ward so that people displaced in an emergency can be accommodated). Further information can be obtained from the National Health Service (Payments by Local Authorities to NHS Bodies) Regulations 2000, under s2, s3(1) of the 1977 Act, and s25A-25H and s117 of the Mental Health Act 1983.

Basic guidance

Responsibility to assess, the legal framework

The overarching duty on local authorities is set out in the **NHS and Community Care Act 1990. NHS and Community Care Act 1990 Section 47(1)** imposes a duty on local authorities to carry out an assessment of need for community care services with people who appear to them to need such services and then, having regard to that assessment, decide whether those needs call for the provision by them of services.

NHS and Community Care Act 1990 Section 47(2) states that if, during the Section 47(1) assessment the person is identified as being 'disabled', that person has additional rights as set out in Section 47(2). This requires local authorities to make a decision as to the services required under Section 4 of the Disabled Persons (Services and Consultation and Representation) Act 1986.

The **Chronically Sick and Disabled Persons (CSDP) Act 1970 Section 2** places a duty on local Authorities to assess the individual needs of everyone who falls within Section 29 of the National Assistance Act 1948 above.

Duty to arrange/provide services for people with Eligible Needs:

The **National Assistance Act 1948 Section 21(1)** concerns the provision of residential accommodation to certain groups of people over 18 years who through age, illness, disability or any other circumstances are in need of care and attention which would otherwise be unavailable to them. The duty is owed to people 'ordinarily resident' in the Local Authority's area.

It is made clear in **National Assistance Act 1948 Section 29** that the local council has a **duty** to exercise its powers for people 'ordinarily resident' in its area and must provide:

- a social work advice and support service
- facilities for rehabilitation and adjustment to disability
- facilities for occupational, social, cultural and recreational activities.

Under the provisions of the **Chronically Sick and Disabled Person's Act 1970 Section 1**, a **duty** is imposed on local authorities to provide information about relevant services.

The **NHS and Community Care Act 1990 Section 47, para 1**, states that an individual's 'financial circumstances should have no bearing on whether a council carries out a community care assessment' (Department of Health 2002b, p.14). In general, therefore, local authorities have a duty to carry out needs assessments for any person for whom it appears the council might provide or arrange community care services, including residential care, or who might be in need of such services.

The National Minimum Standards, Care Homes for Older People (DoH 2002) Standard 3 para 3.3 places a responsibility on the registered manager of the home to assess individuals who are self funding and do not have a care management assessment. The only duty for local authorities is to assess publicly-funded residents, however good practice would require assessment of both funded and self-funded residents subject to a home closure.

The **Mental Capacity Act 2005**, sets out key principles applying to decisions and actions taken under the Act. The starting point is a presumption of mental capacity. A person must be assumed to have mental capacity until it is proved otherwise. A person must also be supported to make his/ her own decision, as far it is practicable to do so. The Act's definition of a person who lacks mental capacity focuses on the particular time when a decision has to be made and on the particular matter to which the decision relates, not on any theoretical ability to make decisions generally. It follows that a person can lack mental capacity for the purposes of the Act even if the loss of mental capacity is partial or temporary or if his mental capacity fluctuates.

The **NHS and Community Care Act 1990 Section 47, para 3-6**, allows local authorities to relocate residents without assessment where services are needed urgently.

National Health Service Act 2006 / Local Authority Social Services Act 1970
The NHS Continuing Healthcare (Responsibilities) Directions 2007 sets out the responsibilities of the NHS to fully fund individuals who have a primary health need and who meet the eligibility criteria for NHS funding.

National Assistance Act 1948

In general terms the National Assistance Act 1948 and the NHS and Community Care Act 1990 stipulate that local authorities discharge their responsibilities by:-

- assessing individual needs
- constructing a 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
 - working reactively and proactively with service providers.

Capacity and resources

Dealing with care home closures has implications for staff capacity and other resources.

'We certainly couldn't afford to bring in agency staff. We had some people working round the clock - the remaining staff certainly went 'above and beyond the call of duty' out of loyalty to us and concern for the residents

(A care home provider)

Overview

- Local authorities are required to prioritise the health and wellbeing of residents.
- Given that a failure in the provision of care which causes suffering is a breach of the **duty of care**, local authorities will need to find the resources to rectify any actual or potential situation.
- Local authorities need to consider the likely resource elements that will need to be addressed and plan how they might meet them.
- Protocols should be established to govern decision making about extra resources in an emergency.
- Staff training should address the whole issue of planning for home closures.

Resources required

Managing a closure process will require resources to:

- lead and direct the process
- carry out reassessment and care planning
- undertake the communications and **information sharing** with all stakeholders
- pay for alternative placements
- pay for additional staffing, or to backfill staff seconded to manage the closure
- transport people to new homes
- supporting existing staff
- mitigate impacts on other parts of the system
- facilitate media activity in terms of communications and press.

Find out more about Resources required in **Further information**

Key points from policy and research

A local authority must arrange residential accommodation for an individual in accordance with their preferred wishes, provided that:

- the accommodation is suitable in relation to their assessed needs;
- to do so would not cost the council more than it would usually expect to pay;
- the accommodation is available;
- the provider is willing to meet the council's terms and conditions.

(Department of Health, 2004)

- Research indicates that that the role of care managers is crucial in the process of re-provision and that they therefore need adequate support and guidance. Demands placed upon them are likely to be complex and stressful, and as their primary responsibility is to the residents, they may have to make decisions that are in conflict with the wishes of families (Le Mesurier and Littlechild 2011).
- Reassessment of needs can result in some residents requiring higher levels of support following deterioration in their health or abilities, for example - people whose dementia has advanced significantly since their last care review or those who may be nearing the end of life (Williams et al. 2005). Care managers therefore had to argue for additional resources to meet higher fee levels.
- 'The Vision for adult social care (DH, 2011)' states that the provision of information and advice is a universal service, and that people funding their own care have a particular need for information and guidance to help plan how their care needs are met.
- Research on staff experience of organisational change suggests it is critical to maintain their organisational commitment. A before and after study of hospital employees during a reorganisation involving closures, reduced budgets and a hiring freeze showed that employees with higher levels of organisational commitment were better able to withstand the effects of increased pressure during this period (Begley and Czajka 1993).
- Managers can enhance commitment by using 'high performance working practices', particularly a participatory style of management, and systems for recognising and rewarding performance (Huselid 1995).

What the regulator says

In the event of threatened or imminent emergency closure, commissioners should make contact with the Care Quality Commission (CQC) at the earliest opportunity. **CQC will provide information under its information-sharing protocols indicating any action which it is taking.**

Further information

Stepping-in rights

In negotiation with providers, contract clauses can allow for 'stepping-in' rights at times of crisis, for instance, when a service can no longer be run by the existing management or other circumstances arise whereby the home cannot be fully staffed. Stepping-in rights allows the commissioner to provide additional staffing capacity for an agreed duration and with explicit understanding about who bears the costs of such an arrangement.

Naturally, some providers may not welcome such a provision, particularly in geographical areas where the local authority is a minor purchaser, but agreement can and must be reached on defining the sort of crisis when this contractual provision may reasonably be invoked, for the benefit of existing residents, to support the staff and for business continuity.

Directing the process

- A project lead with responsibility for coordinating the relocation of residents should be appointed at the earliest opportunity.
- The project lead should manage a **project team** which will primarily include care managers, commissioning staff, finance and human resources (HR) from all relevant agencies.
- The head of safeguarding will need to coordinate safeguarding issues.
- All normal staff duties may have to be 'back-filled' while they are engaged in managing the closure, and this will have resource implications.

Reassessment and care planning

- Commissioning authorities must reassess all publicly funded residents before a move - **this service should also be offered to self-funding residents.**
- Where the person is funded through NHS continuing care resources, the relevant health community will need to take the lead on assessing the patients who are fully funded by NHS funds.
- All residents (and their families) should be allocated a **key worker** - this will have resource implications for assessment and care management capacity within the system.

- Where people are judged to lack mental capacity, the provision of an independent mental capacity advocate (IMCA) will be required so that a 'best interest' decision can be arrived at for the individual.

Alternative placements

- Local authorities must ensure that the person's assessed need is the key determinant in selecting and/or funding a care placement.
- Residents should not be placed in a setting which is not able to meet their assessed need, just because there is a vacancy.
- Choice of accommodation regulations still apply. This means that local authorities can limit the cost of new placements to what 'local agencies would reasonably expect to pay to meet similar levels of assessed need'.

Transport

- Helping people move to a new home will require transport, including in some cases an ambulance.

Supporting existing care staff

- Local authorities need to provide support to existing care staff in order to maintain mental capacity and continuity of care. This means being open with information about the impact that change may have for their clients but for themselves. Local authorities need to encourage the employer also to share human resources information in a timely and sensitive manner.
- Staff will have many employment queries and local authorities will need to arrange the input of people with human resources expertise as well as general people management skills.

Impacts on other parts of the system

- Acute and mental health trusts and NHS commissioners need to be kept informed about the possible 'knock on' effects of demand for staff (for assessment and care management) and alternative placements, as there may be an impact on hospital discharge flows.

Communications and press

- Councils will need to secure capacity to ensure the timely and sensitive communication of information to residents and family.
- The project lead will need to develop a communication plan, including the resources to deliver it.
- Councils will need to ensure that they have the resources to manage the message with press, and this will require the involvement of **corporate communications teams**.

Examples and tips

Establishing a response team

A project lead will be identified who will have overall responsibility for the day-to-day management of the team, and be responsible for the relocation of the residents of the home. The project lead will be appointed by the area director/head of service and will report into the Quality Outcomes and Contract Monitoring Group (QOCMG)

The project lead will identify the resources required from within existing area-based care management teams and if necessary consider the need to draw in additional capacity from other areas of the county. Identifying and agreement of additional resources will be approved at the QOCGM. It is the responsibility of the area director/head of service to specially convene an area QOCGM meeting where necessary.

The area director in consultation with the head of safeguarding will identify the safeguarding co-ordinator and/or the best interest assessors where appropriate. Where there are safeguarding issues they will act as an adviser to the project team.

The area director/head of learning disability or mental health will establish the nominated link person with the primary care trust where there are joint health-related issues. The nominated health person will be part of the project team and will work to the project lead.

(Source: Hampshire County Council)

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This guide helps commissioners, particularly local authority staff, to manage care home closures at short notice in situations that may be unexpected and therefore unplanned. It should also be useful to care home staff, residents and relatives. All commissioners and providers should have procedures for managing planned closures where they have more than three months' warning that the service is being shut down.

We aim to build upon this initial work to support best practice. We welcome your feedback on the guide itself and your views on how we can improve it. Plus, if you have any examples from experience that you would like to share, please send them to closures@scie.org.uk

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