Summary of recommendations

- The current statutory Escalating Concerns Guidance should be updated to better address situations where the closure of a local authority care home is the result of a policy decision. It is also important to recognise that policy decisions may be taken by local authorities in respect of budget resources for care provision - and commissioning and contract arrangements - which can impact upon the shape of the care sector market and closure of homes in the private sector. Local Authorities have a duty to consider the impact of decisions they are taking and to take account of their duty of care to residents placed by them in care settings.

- The statutory Guidance should include the guiding principles set out in this report.

- The guiding principles set out in this report would also be applicable to those situations and would assist local authorities when considering the impact of decisions they are taking and their duty of care to residents placed by them in care settings.

- The updated guidance should outline more explicitly the benefits of independent advocacy for older people who live in care homes that are closing and should make reference to the duties that will, in due course, be placed upon local authorities and service providers in relation to independent advocacy in the forthcoming Social Services and Well-being (Wales) Bill.

- The guidance should be clear that where a care home is designated for closure, or for consideration of closure, independent advocates should be involved at the earliest stage possible.
The guidance should re-emphasise the legal framework underpinning the role of Independent Mental Capacity Advocates (IMCAs), the duties of local authorities in relations to IMCAs, how this relates to care home closure and the need for IMCAs to be involved at as early a stage as possible.

The updated guidance should give more prominence to the need to assess capacity to make decisions at an early stage.

Background

It is the statutory duty of each local authority in Wales to assess the social care needs of its population and provide or commission services to meet those needs. Where a local authority decides to close a care home, the local authority must follow any statutory guidance laid down by the Welsh Government.

In 2008, as part of the Welsh Government’s commitment to improve the protection of adults in care homes, CSSIW was asked to lead a Stakeholder Task and Finish Group to consider the issues faced by a local authority and/or a local health board in situations where there were concerns about the operation of a care home. As a result of this work ‘Escalating Concerns With, and Closures of, Care Homes Providing Services for Adults’ was issued in May 2009 after full public consultation. It was issued as statutory guidance under s.7 of the Local Authorities Act 1970 and ss 12&19 of the National Health Service (Wales) Act 2006.

‘Escalating Concerns’ was drafted to help statutory bodies deal with situations where there is an accumulation of issues relating to the operation of, and/or the quality of care and conduct in, a care home and advise them on the discharge of their functions where there is the risk of an enforced closure or where the operator has decided to close their facility. It was not intended to provide detailed advice when a home is closed as a result of a local authority’s change of policy, e.g. as part of the reconfiguration of social services. Since its publication, care home closures have become more numerous and will continue to increase in number, often on a planned basis and often as a result of new models of social care provision. The effect of this
is that the current s.7 Guidance no longer fully meets the needs of the sector or of older people.

In October 2012, the Welsh Government asked the Older People’s Commissioner to develop and lead a working group which will consult with key stakeholders and advise on revised guidance.

Terms of Reference and Membership

Terms of Reference

The working group will:

1. Hear and consider evidence about the principles on which new guidance regarding Local Authority Closure of Care Homes should be built.

2. Identify good practice in dealing with care home closure from the UK or elsewhere.

3. Clearly outline the statutory duty of Local Authorities and Local Health Boards in relation to instructing Independent Mental Capacity Advocates.

4. Identify the role, and means of providing, independent advocacy when a care home is closing.

5. Produce findings and recommendations that could be utilised to draft statutory guidance for Ministers’ consideration.

Membership

The following were invited to be members of the group:

- Social Services Improvement Agency
- Care and Social Services Inspectorate for Wales
- Healthcare Inspectorate Wales
• Care Forum Wales
• National Partnership Forum
• Association of Directors of Social Services Cymru
• Welsh Senate of Older People
• The Improvement Unit – Public Health Wales
• Welsh Government

The Advisory Group was chaired by the Older People’s Commissioner for Wales. The Commissioner's office also provided secretariat for the group.

The Advisory Group met on:

• Friday 26 April, 3 – 5pm
• Tuesday 25 June, 2 – 4pm
• Monday 8 July, 2 – 4pm

All meetings were held at the offices of the Older People’s Commissioner for Wales, Cambrian Buildings, Mount Stuart Square, Butetown, Cardiff, CF10 5FL

Findings, Principles and Good Practice

All members of the Advisory Group brought a good level of knowledge and expertise about care homes and the issues that are important when considering any closure. At an early stage it was decided that to write separate guidance for local authorities only would be to miss an opportunity to renew the principles which should underpin all care home closures, whether due to escalating concerns or otherwise. Therefore, the Advisory Group is strongly of the opinion that it would be preferable to update the current s.7 statutory ‘Escalating Concerns with, and closures of, Care Homes Providing Service for Adults’ Guidance rather than produce a separate piece of guidance for care home closure as the result of a policy decision, e.g. social care reconfiguration or a decision to provide more care in the home or through ‘extra care’ schemes.
Evidence

There are not many publications or research papers that deal with the matter of care home closure as the result of a policy decision. However, some useful resources and links are listed at the end of this report and by piecing together learning from these various sources, as well as hearing evidence from those who have considered this in more practical terms, the group can paint a picture of principles and good practice.

We heard evidence from John Moore of ‘My Home Life Cymru’ who gave a compelling presentation on the need to see the care home closure process for what it is for the older person: moving to a new home. With that comes uncertainty, concerns, change and a real need for information about what is happening. We all know that moving home can be stressful and unsettling, particularly if we are not sure of what is going on round about us. This is no less the case for older people whose home is the care home. John Moore emphasised that a crucial element when moving anyone from one place to another is to recognize the importance of relationships – relationships between the older person and their family, the older person and their friends, the older person and care staff, staff and the families, and many other valuable relationships. It is important to remember that older people who are ‘moving home’ will have fewer opportunities to make new friends and acquaintances; if existing relationships can be enhanced and maintained, a move will be easier for all concerned. At the root of all good relationships is two-way communication and information about the move needs to be conveyed in numerous ways. Older people must be allowed to ask questions, to be consulted with and – most importantly – to have their thoughts, fears and opinions listened to and taken into consideration. Of course, if this has been the culture of the home already it will be easier to continue this into any closure process; if not, greater efforts will need to be made.

Reflecting on the principles on which ‘My Home Life Cymru’ operates, the Advisory Group discussed several issues that are particularly pertinent when considering care home closure:

- **Managing transitions** – it is vital that older people and their families have as much information as possible about moving into a care home, but they also need to be as informed about a transition from one care home to a new care home. For many older people, the move to a new care home may feel like a loss of control yet it may actually open up more choices; perhaps the new home is less restrictive or may have greater scope for
making friends or taking part in activities. Good practice will provide real support to older people to help them process what is happening to them, to have time to gather and pack their belongings, to say goodbye to their current home and to be supported to begin a new phase of life.

- **Maintaining identity** – in many care homes, collective living will have allowed staff to really get to know the older people they work with, to look beyond the dementia, beneath the frailty, seeing them as human beings, knowing what is important to them and what the care home can do to respond to this. It is important that this identity is not undermined as the result of a move to a new care home and this is why it is important that as much information about the older person accompanies them when they move. It is also vital that personal possessions that say something about them and their lives (photos, ornaments, books, keepsakes and documents are kept safely and not lost in transit).

- **Creating community** – the move to a new care home may involve a move from the community in which a person has lived all their life. Some care homes are very effective in helping older people to get out and engage in external community activities, and invite others to come into the care homes to engage in meaningful activities. There may be volunteers who come into the home on a regular basis and who also form part of that wider community. Their importance in helping with the transition must not be forgotten and local authorities should think very carefully about how these relationships will continue to exist and how a member of the ‘old’ community could be pivotal in introducing the older person to the ‘new’ community.

- **Sharing decision making** - many different approaches exist to support older people to get more involved in decision-making. Informal approaches (e.g. shared meal times) have particular value in eliciting views and engaging older people. During times of transition, as with any family, it is important that there is a sense of ‘togetherness’. It is important that older people, their families and front-line staff are genuinely included in as many decisions as possible – especially those that affect their day to day living and working.

- **Supporting the workforce** – managers, staff and volunteers must be supported throughout the process of closure and must be able to talk about what is happening freely amongst themselves and with residents
and families. Since relationship is at the heart of a good care home, anything that hinders the interaction and conversation that fosters good relationships must be addressed as soon as possible, for example, information ‘leaked’ to the press that might be worrying.

Professor Vanessa Burholt from the Centre for Innovative Ageing at Swansea University gave a presentation of findings from research that she and others had done on ‘The Closures of Care Homes For Older People in Wales: Prevalence, Process and Impact’. This piece of research, which has already been shared with the Health and Social Care Committee during its Inquiry into residential care for older people in Wales, aimed to examine the process surrounding the closure of care homes especially with regard to adherence to/deviance from the Escalating Concerns guidance, and to explore the consequences for, and the experiences of providers, key workers, older people, their relatives and carers during and after relocation because of the closure of a care home and where care homes avoided closure.

The research pinpointed some areas of the statutory guidance that could be improved upon, particularly in light of closures which are made as a matter of policy and which might take a great length of time to come to fruition. A copy of the improvements suggested by Burholt et al, with some additions from the Advisory Group, can be found in Appendix 1. A copy of the full research report is available online – see web link at the end of this report.

Burholt et al identified four primary areas that could be improved to benefit service-users. The first concerns residents’ need for information about the types of services provided in supported living environments (residential care, nursing homes, extra-care sheltered housing). Secondly, they found that residents had a sense of powerlessness during the relocation process. The third area of concern was the absence (or at least visibility) of social workers and advocates in supporting the process of relocation, especially for residents without relatives or those with cognitive impairment. Lastly, they found that the process of moving is not helped if the time frame for closure is particularly long and drawn out or if it is too speedy a closure and can be detrimental to the welfare of residents and staff. The research found that older people may live with the threat of their home being closed for several years – consultation processes may have to be repeated because they were not sufficiently robust the first time round (there is an example of this in Gwynedd at present). Some
Older people move home more than once or twice because the new home to which they relocate are also earmarked for closure.

Older people have on several occasions complained to the Older People’s Commissioner that local authorities do not place new residents in the homes which are subject to consultation for closure, or use them for respite care only. They (older people) describe this a ‘closing homes by stealth’. Regardless of the reason for not commissioning further places in these homes, it is demoralizing for all concerned – the residents who remain and the staff who may be uncertain of when their employment will be terminated.

**Guiding principles**

Several guiding principles can be drawn from the presentation by John Moore and the research by Professor Burholt, as well as from literature available on the matter of care home closure (listed below):

1. We need to talk less about the process of ‘closure’ and more about the ‘moving home’, recognizing that this can be a stressful and uncertain time for all involved – residents, staff, families and friends.

2. The **welfare of the residents** must be the paramount consideration.

3. People must be given **information** about the relocation and options open to them as early as possible and every effort must be made to involve them at each stage along the way – before, during and after the move.

4. It must be recognised that the care home is part of a **wider community** that is also affected by any decisions to close the home. The closer the community, the greater the impact.

5. People must be supported to **have their voice heard** and they must be listened to. Public bodies have a duty to engage, consult, listen and respond. Principles for engagement and consultation are clearly set out in R v North and East Devon HA ex parte Coughlan [2001] QB 213 and must be adhered to. Every effort must be made to involve and assist those with **limited capacity** to have their voice heard and to support them in making those decisions for which they do have capacity.
6. Independent **advocates** and Independent Mental Capacity Advocates (see below) must be both visible and active in the process of closure and moving to a new home.

7. The **timing** of the process needs to be carefully thought through so as to avoid lengthy closure processes or very sudden closures (unless there is an emergency which requires that there is a very swift closure).

8. The process should **avoid periods of delay** unless this is in the best interests of the residents.

9. **Open communication** between agencies and individuals is vital to a smooth transition.

10. There should be more focus on the **new place of residence** and how it is being prepared to receive the new resident than on the home which is closing. Agencies should work together to make sure that the older person’s new home and community is ready to welcome them.

**This Advisory Group recommends that the statutory Guidance should include the 10 Guiding Principles set out above.**

**Independent Advocacy**

In 2012, the Older People’s Commissioner for Wales published a report entitled ‘Voice, choice and control: Recommendations relating to the provision of independent advocacy in Wales’. Where older people are facing care home closure, and have no family or friends to support them, their opportunity to exercise voice, choice and control is frequently limited because they feel unable to express wishes and concerns.

Although the current s.7 ‘Escalating Concerns’ guidance emphasises the importance of service users having access to independent advocacy services - as well as the statutory Independent Mental Capacity Advocacy service - throughout the closure process, the research carried out by the Centre for Innovative Ageing (Swansea University) in 2011 into local authority care home closures, found that the use of independent advocacy was sporadic and the role of the advocate was misunderstood by many managers. None of the older people interviewed in care homes designated for closure were able
to say whether or not they had spoken with an advocate or had been offered an advocacy service. Whilst it is true that the majority of service users may have friends or family to advocate for them when necessary, there was no evidence of any systematic check being undertaken to find out whether the older person (with mental capacity) would prefer an independent advocate to family or friends. Neither was there any evidence of family and friends being asked if they were happy to take on an advocacy role. The researchers made the recommendation that any updated guidance on care home closure should stipulate that all residents should have access to independent advocacy services (not confined to the statutory Independent Mental Capacity Advocacy service – see below), and other such services to support service users as appropriate. The registered provider should support and enable approved advocacy services to meet with service users in order to identify their wishes and offer appropriate support.

At the time when a care home is closing, or the local authority is considering closure, independent advocacy can:

- Play a vital role in providing support to individuals who are unable or struggling to speak up for themselves
- Help residents to make clear their views and wishes, express these views effectively and gain respect for their preferences and choices
- Help negotiate and resolve conflict
- Ensure improved support services for people during times of major decision making to prevent problems or crises and reduce the need for services to address those problems
- Add to the valuable support family, friends, carers and professionals provide.
- Help staff to support the resident to resolve issues and balance needs, wishes and risks
- Support higher standards and practices in care
- Create more informed providers of services who are better able to meet older people’s needs themselves or to make more appropriate referrals to other agencies if necessary
- Help create an open culture that welcomes in others and where safety, respect and dignity can flourish

Without independent advocacy, we risk a situation where some older people in Wales have no voice - or the person who claims to speak on their behalf
may simply be expressing what they think is best for the older person rather than seeking that person’s views.

In 2012, the National Assembly’s Health and Social Care Committee conducted an Inquiry into residential care for older people in Wales. The first of its key recommendations was that the Welsh Government should take action to ensure that older people in Wales have access to effective advocacy. The Committee said that this was particularly important for those older people who are in hospital and likely to require on-going social care and those residing in a care home that is at risk of closure. Since the publication of that report, the Welsh Government has been clear (statement by the Deputy Minister for Social Services on 12 June 2013) that it intends to include provisions in the forthcoming Social Services and Well-being (Wales) Bill that will require local authorities to promote and inform people of their right to advocacy, including self-funders and will also require registered care home providers to inform people in their care about the availability of advocacy services by the local authority.

This Advisory Group recommends that the updated Guidance should outline more explicitly the benefits of independent advocacy for older people who live in care homes that are closing and should make reference to the duties that will, in due course, be placed upon local authorities and service providers in relation to independent advocacy in the forthcoming Social Services and Well-being (Wales) Bill. The guidance should be clear that where a care home is designated for closure, or for consideration of closure, independent advocates should be involved at the earliest stage possible.

Independent Mental Capacity Advocacy

The Mental Capacity Act 2005 (MCA 2005) states that there is a duty on local authorities or NHS bodies to instruct IMCAs for the following accommodation decisions where a person lacks capacity to make the decision themselves, and they are without family or friends who can represent them:

- admissions to any hospital that are likely to last for over 28 days
- a move to a care home for a period that is longer than eight weeks and
- a move to any other accommodation for more than eight weeks and that is funded by the local authority or LHB.
IMCAs are not required for short-term or urgent moves, for example, a planned respite stay lasting two weeks. However, where it appears that a short-term or urgent move could last for more than four weeks in hospital, or eight weeks for any other setting, an IMCA must be instructed. The IMCA's role here is to represent the person for the decision as to whether staying in the current accommodation represents their best interests.

The MCA 2005 Code of Practice says that IMCAs should be instructed where a person may remain living in accommodation which is deregistering as a care home (10.54). Similarly there should be IMCA instruction if the place where the person is living is registering as a care home.

The Social Care Institute for Excellence states that it is good practice to instruct IMCAs for accommodation decisions in the following situations:

- The local authority is making or changing support arrangements which may allow a person to remain in their own home or **when a move to a care home is a serious consideration**.
- Moving a person **to a different service on the same site**. For example, a different building on an NHS site or a different unit within an older people's care service. This is because such a move could have a similar impact for the person as a move to a different locations. A move from Wing A of a care home to Wing B may seem trivial to most people but could have immense impact on a person who has dementia or a similar illness.
- The Mental Capacity Act (MCA 2005), suggests that advocacy is only required for older residents in closing care homes if there are no relatives.

The current s.7 Escalating Concerns guidance notes at paragraph 13: “Enshrined in the Mental Capacity Act 2005 is the principle that people have capacity unless otherwise proven. Even when their capacity may be limited, they may still be able to make some clear choices or decisions. The Act emphasises the importance of supporting incapacitated service users to make decisions and has created a statutory entitlement to advocacy through specialist Independent Mental Capacity Advocates (IMCAs). In specified circumstances IMCAs will support and represent people who lack capacity and have no family and friends to speak for them. The legislation requires local authorities to refer individuals to the IMCA service where decisions about a change of residence is required, and local authorities may refer where decisions are required at a care review or where there are adult protection procedures. Local authorities and NHS bodies have a duty to
instruct IMCAs where accommodation arrangements are being made on behalf of a person lacking capacity without friends or family.” The Guidance says little else about IMCAs other than to say that a person who lacks capacity may have the support of an IMCA to make a complaint where they have been moved to a new home against their will as a result of an enforced closure of a home.

During discussions, members of the Advisory Group were able to pinpoint, from their own experiences, situations where a local authority care home was closing but there seemed to be no involvement of an IMCA. One example was provided from the Older People’s Commissioner’s Office and involved a couple who were resident in a care home that was earmarked for closure. The closure process had been ongoing for around a year when a member of the Commissioner’s staff visited to talk with residents. She spotted the couple sitting in a side room; the husband was crying and looked like he had been for some time. When she asked the manager why this was, she replied that he and his wife were to be sent to different care homes when the care home closed because his wife had dementia. When further asked whether an independent advocate for the husband or an IMCA for the wife had been involved at all, the answer given was that they had a son in England and the husband could advocate for the wife. The husband was clearly in no position to advocate for the wife and the son did not appear to be involved. The Commissioner’s office intervened and the couple were placed together in a home that could meet the needs of both. Had an IMCA been involved, considerable distress may have been avoided.

Local authorities and LHBs are accountable for compliance with the law with regard to IMCA instruction for accommodation decisions and care reviews. During care home closure, the responsibility sits with the local authority unless the NHS is funding accommodation as part of NHS Continuing Health Care.

It is a legal requirement that IMCAs check that the instruction has come from an authorised person. Local authorities and NHS organisations may authorise a wide range of people to instruct IMCAs which helps to ensure that the legal duty to instruct an IMCA in accommodation decisions is met for all eligible individuals. Various professionally qualified people can be authorised to instruct IMCAs, e.g. social workers, community nurses, care managers, occupational therapists, commissioners. It is possible for local authorities and LHBs to authorise people other than their own employees to
instruct IMCAs. This may be particularly appropriate where there are joint health and social care working arrangements. The commissioning document of the IMCA service and/or local engagement protocol should specify who is authorised to give instruction. This information should be made available to all those people who can and should instruct.

It is vital that a proper mental capacity assessment, in line with the MCA 2005 principles, is undertaken before appointing an IMCA. There should also be robust record-keeping in relation to these assessments.

The current Escalating Concerns guidance lacks clarity around the assessment of capacity of residents and the timing concerning the instruction of an Independent Mental Capacity Advocate (IMCA) for those that need one. It is encouraging that some of the local protocols do attempt to address these gaps by providing more detailed guidance (e.g. Powys County Council’s Closure Plan and Individual Support Plan and the home closure checklists in Caerphilly, Monmouth, Torfaen, Newport). However, at a local level there is clearly a lack of consistency and a wide variation in the content and detail of the local protocols which could point to the need for more detailed guidance at the national level.

The 2011-12 ‘Deprivation of Liberty Safeguards Annual Monitoring Report for Health and Social Care’ by CSSIW and HIW comments that “We remain concerned that the wider Mental Capacity Act continues to be poorly understood by staff providing direct care in health and social care. CSSIW inspectors continue to come across care workers who do not recognise that residents may lack capacity to make some decisions, but can still make everyday choices. The provision of support to assist communication and improve understanding as required by the Act can also be lacking” (p.36).

This ongoing lack of understanding also points to a need for any updated guidance to be more explicit, possibly through an Appendix, about the requirements of the MCA 2005 and the circumstances in which an IMCA must be appointed.

A further problem that can arise where there is misunderstanding of the MCA 2005 is that care home managers, and local authorities, can fail to understand that even when capacity is limited older people should be supported to make choices or decisions. The research carried out by the
Centre for Innovative Ageing at Swansea University found that many residents were kept in the dark about the possibility of care home closure. In an attempt to manage the process of closure, and possibly any adverse publicity in the local press, residents with limited capacity had not been properly engaged with or provided with any information. For example, one care home provider went to great pains to put in place processes for clear communication with, and support for, staff and relatives but there was no support for the residents who were largely shielded from the reality of the situation. The researchers found there was a tendency to view older residents (especially those with some degree of cognitive impairment) as a homogenous group, shielded from the truth and infantilised, regardless of their individual strengths and needs.

There was also an implicit assumption that relatives were best equipped to provide all the necessary emotional support whilst the relatives the researchers spoke to struggled with the process and felt unsupported practically and emotionally. Although this approach may have been underpinned by what was believed to be in the best interests of the individual, it is clear that more work needs to be done to assist care providers and staff to support older residents, particularly those with limited or no capacity, in situations where care homes are either in the process of, or under threat of, closure.

**Therefore, the Advisory Group recommends that the guidance should re-emphasise the legal framework underpinning the role of Independent Mental Capacity Advocates (IMCAs), the duties of local authorities in relations to IMCAs, how this relates to care home closure and the need for IMCAs to be involved at as early a stage as possible.**

The updated guidance should also give more prominence to the need to assess capacity to make decisions at an early stage.

**Conclusion**

The Advisory Group fully recognises that the work it has undertaken over the past few months is but one element of the greater changes being made to service provision through the Social Services and Well-being (Wales) Bill and the forthcoming Regulation and Inspection Bill. However, much reconfiguration of social care, particularly in relation to care homes is underway at this present time and therefore there should be no delay in updating the statutory Guidance.
The Guiding Principles that we have outlined point towards a greater need to take a human rights based approach to the way in which we provide social care. It would be our expectation that the work currently underway on a Declaration of Rights for Older People would provide a different lens through which we can view the way in which we provide services not just to older people but to all people.

“Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.”

(UN Principles for Older Persons, Principle 14)

Independent Advisory Group on Local Authority Closure of Care Homes
August 2013
Relevant publications and internet links


Jolley, D., 2003, ‘The Jolley Report: Court Report, Lancashire Care Association report to the High Court of Justice, Queen’s Bench Division, Administrative Court’, Penn Hospital, Wolverhampton
Joseph Rowntree Foundation, 2012 ‘My Home Life: Promoting Quality Of Life In Care Homes’

My Home Life Cymru

Netten, A., Darton, R. and Williams, J., 2003, ‘Nursing home closures; effects on capacity and reasons for closure’ Age and Ageing, 32, 332-37
http://ageing.oxfordjournals.org/

http://journals.cambridge.org/action/displayJournal?jid=ASO


Older People’s Commissioner for Wales, 2012, ‘Voice, choice and control: Recommendations relating to the provision of independent advocacy in Wales’


Scottish Human Rights Commission, ‘Care About Rights Project’
http://www.scottishhumanrights.com/careaboutrights/
Social Care Institute for Excellence, ‘Independent Mental Capacity Advocate involvement in accommodation decisions and care reviews’

http://www.journals.elsevier.com/journal-of-environmental-psychology/

http://www.healio.com/journals/jgn

Williams, J. and Netten, A., 2003, ‘Guidelines for the closure of care homes for older people: prevalence and content of local government protocols’ Personal Social Services Research Unit, Canterbury, Kent
http://www.pssru.ac.uk/pdf/dp1861_2.pdf


http://bjsw.oxfordjournals.org/

Woolham, J (2001). Good practice in the involuntary relocation of people living in social care. 'Practice, '13(4), 49-60
Appendix 1

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

(Swansea University Research Report)

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

Background
2. Escalating concerns arise where there are accumulating issues relating to the operation of, or quality of care provided in, a registered care home providing services to adults. These concerns may have been identified through a number of routes including:
   - statutory agencies involved in regulating or purchasing services;
   - by visiting professionals, such as care managers and nurse assessors;
   - complaints or disclosures directly from service users, their families, friends, advocates, or from current or ex-employees of care homes; and
   - as a result of the seriousness of an individual adult protection referral or the concerns arising from a series of adult protection referrals in a particular home, or in a group of homes managed by a particular provider.

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

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

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

6. Where abuse is suspected the policy and procedures to protect vulnerable adults must take precedence. The overriding objective should be to ensure the safety of vulnerable service users. In many situations it will be in the best interest of service users to use the escalating concerns procedure alongside the adult protection procedures in an effort to keep the home open. In such situations, clear communication between staff and agencies involved in both processes is essential. However, in the most serious situations it may neither be possible nor in the services user’s best interests to attempt this and closure could be unavoidable.
7. **Closures** of care homes fall into two main categories under the Care Standards Act 2000; ‘voluntary’ (where the home chooses to close) or ‘enforced’ (where the home is forced to close). Voluntary closures may occur in the independent sector, or in the public sector. They may be triggered by variety of reasons, and the reason for closure may have an impact on the speed of closure. Whichever the category of closure the Act sets out the legal basis governing the process.

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

**Legal Context**

**General**

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

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

Legal Duties in Relation to Closures

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

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

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

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

Mental Capacity

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

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

Choice of Accommodation

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

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

- registered care setting can meet the individual’s assessed needs and can provide a placement;
- registered care home is willing to provide and contract for the placement; and
- cost of the placement is not more than local agencies would reasonably expect to pay to meet similar levels of assessed needs.
19. In circumstances where a service user is currently accommodated in a home whilst waiting for a placement in their home of choice, local agencies must:

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

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

**Accountability, Roles & Responsibilities**

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

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

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

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

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

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

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

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

Local Authorities

27. Section 21 of the National Assistance Act 1948 sets out a local authority’s duties in respect of the provision of accommodation. It places a duty on the authority to provide residential accommodation for persons “who by reason of age, infirmity or any other circumstances are in need of care and attention.” It also places a duty on the authority to have regard to the welfare of people for whom accommodation is provided and requires it to provide accommodation of different kinds for different descriptions of persons.
28. Accommodation may be provided directly by a local authority. However, the duty to provide accommodation could include arrangements made with a voluntary organisation or any other registered care home provider. The local authority is responsible for commissioning, procuring and contracting for the provision of care within a registered care setting where an individual is ordinarily resident within their area.

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

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

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

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

33. Any disclosure of personal information should however be considered under three legal frameworks. These are:
• the common law duty of confidentiality, which still applies where the issue is not determined by other legislation;
• the Data Protection Act 1998; and
• Article 8 of the European Convention on Human Rights, the right to respect for privacy.

34. In considering disclosure of personal information, the safest course is to always secure the consent of the service user concerned (the data subject under the 1998 Act). Alternatively, the consent of a donee could be sought where the data subject is unable to give informed consent, the donee has a lasting power of attorney and the authority clearly covers such circumstances. Where consent is not available or has been withheld, the 1998 Act still provides for disclosure to safeguard the vital interests of the person – or to safeguard the vital interests of someone else. In disclosing information the best interests test in the Mental Capacity Act 2005 would also have to be applied. Where there is any concern as to powers to disclose personal information, legal advice should be sought.
35. In the case of Local Authority care home closure for strategic reasons, we recommend that the consultation process should take 8 weeks (2 months), analysis of responses should take 4 weeks (1 month), and if closure is the outcome of the consultation then this should be undertaken within 3 months. In total the voluntary closure of a public sector care home should take no more than 6 months.

Health Services

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

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

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

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

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

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

- person centred contracts which place the service user at the heart of the commissioning relationship;
- greater emphasis and importance afforded to placement monitoring and review as part of the care management process;
- senior management commitment and oversight of commissioning, contracting and review processes and of the agreed handling arrangements for escalating concerns and closures;
- effective multi-agency communication and co-ordination, with agreed protocols on information exchange and handling of escalating concerns and home closures;
- inter-agency arrangements for discussing and agreeing action in relation to escalating concerns, closures and the longer term development of residential care;

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2 No reference to separate guidance could be found on the WG website, therefore a section has been deleted here: “In addition, as part of the implementation of “Fulfilled Lives, Supportive Communities” separate guidance is being developed in respect of agencies’ commissioning and contracting functions.”
agreed multi-agency ‘corrective’ and ‘developmental’ action planning to address escalating concerns in the short term and the development of residential care in the longer term (such plans are described later in this guidance); and

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

**Minimum Requirements**

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

- Development of service-specifications and contracts for registered settings which cover health and social care and take into account relevant regulations and national minimum standards for care homes for adults, health care standards and other relevant central guidance
- Development and implementation of clear arrangements for contract monitoring (as distinct from care management and nurse assessment of an individual) based upon joint professional responsibility between health and social care agencies. Contracts should not be imposed; they should be agreed following consultation and agreed between health, social care and providers
- Establishment of mechanisms to link information from different sources (e.g. care managers, nurse assessors, CSSIW, complaints officers and
contract monitoring officers) with agreed information exchange to maximise information about quality and safety within registered settings (see Annex 1)

- Establishment of mechanisms for information sharing with CSSIW at a regional level (see Annex 1)
- Agreement on mechanisms for the development of corrective and developmental action plans to address escalating concerns (these plans are described later) including a timeline whereby we recommend that residents are not under the threat of closure for longer than 6 months (see Annex 3)
- Agreement between local agencies on how escalating concerns will be managed if corrective action plans are not successful. This may include embargo and home closure considerations, (see Annexes 3 and 5)
- In order to strengthen joint working, local management, co-ordination and communication systems, for managing escalating concerns local authorities, NHS Trusts and LHBs are required to create a “Joint ‘Inter-agency Monitoring Panel’” (JIMP) or similar mechanism where they do not already exist.
- When the threat of closure has been identified, a ‘Home Operations Support Group’ (HOSG) or similar support mechanism should be established where they do not currently exist, for managing possible care home closures (either voluntary or enforced). In the case of the threat of closure in the independent sector the HOSG will be chaired by the Local Authority, in case of the threat of closure in the public sector the HOSG will be chaired by someone independent of the public sector (e.g. CSSIW) (see Annexes 2, 3 and 4).
- When the threat of closure has been identified for care homes in any sector, a disclosure plan should be developed for each resident on whether/how to inform them of the threat of closure and to prepare for relocation (see 16 above). A decision regarding the mental capacity of
each resident should be made by a multidisciplinary team, including the
care home owner/manager, care manager, relatives and with specialist
input from a clinical psychologist and/or psychiatrist with specialist
expertise in the care of older people.

- When the threat of closure has been identified and care homes are at a
high likelihood of closing (see Annex 3 and 4) in any sector, individual
service user relocation plans must be co-ordinated for everyone
accommodated within the care home. The individual service user
relocation plan should be developed with the resident (or advocate working
on behalf of the resident), and relative, taking into account the decision of
the multidisciplinary team assessment of mental capacity. The individual
service user relocation plan should take into account social and
psychological needs of the resident (such as the maintenance of social
relationships formed in the care home), as well as the need for any
physical personal and nursing care (See Annex 5).

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

41. Local agencies will need to:

- Communicate and work jointly with CSSIW and agree how they will
manage their distinctive responsibilities in the case of escalating concerns,
enforced or voluntary care home closure.

- Sharing information with CSSIW will be vital where agencies intend to put
in place either a Development Action Plan (DAP) or Corrective Action Plan
(CAP). These plans are described later (see also Annexes 3 and 4);
• Make other potential contracting agencies aware of the issues surrounding escalating concerns, enforced or voluntary home closure. For example, other neighbouring agencies may also have service users resident within the same care home;

• Recognise that a CAP is linked to risk assessments which inform health and social services decision making processes (see Annex 3);

• Work with registered providers to ensure they understand why a DAP or CAP has been initiated and to establish the reasons for this, what improvements are required and by when, how the plans will be monitored and by whom and what criterion will be used to suspend or remove the need or requirement for an action plan continuing to be maintained (see Annex 3).

**Possible Structural Arrangements**

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

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

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

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

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

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

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

**Developmental & Corrective Action Plans**

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

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

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

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

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

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

**Emargos**

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

55. There must be a clearly evidenced rationale for usage of embargos. Application of an embargo would be open to challenge through Judicial Review. The use and removal of embargoes, or indeed cancellation of a contract, must be linked to a thorough risk assessment which has been considered as part of the multi-agency framework.

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

**Action**

57. Local authorities, LHBs and NHS Trusts are asked to:
- note this statutory guidance and the advice it contains;
• ensure that they have appropriate detailed and comprehensive local arrangements in place to handle escalating concerns over care homes or home closures which discharge their statutory responsibilities highlighted in this guidance;
• ensure that these local arrangements are in line with the content of this statutory guidance.
Example of monitoring and preventative arrangements

The Usual Role of Statutory Agencies

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

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

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

4 See Appendix 3 for a flow chart of this process.
escalating concerns or home closure. Further review visits, where necessary, may be carried out according to the issues identified.

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

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

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

- Firstly, the member of staff can bring their concerns to the attention of the member of staff from their organisation who attends the regular quality assurance meeting in order that the issue is brought to the agenda and information about the provider shared.

- Secondly, the member of staff can bring significant concerns to the attention of the Local Authority Commissioning Service Manager or POVA Service Manager in order that a decision to call an urgent meeting to discuss the provider performance can be considered.

**Consent & Information Sharing**

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

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

- A criminal offence has been committed, is being committed or is likely to be committed
- A person has failed, is failing or is likely to fail to comply with any legal obligation to which s/he is subject\(^5\)
- The health and safety of any individual has been, is being or is likely to be endangered
- There has been a breach of statutory regulations

**Sharing Information regarding Provider Performance at a Quality Assurance meeting**

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

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

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

\(^5\) If our recommendation that financial health becomes a National Minimum Standard, then this would include information relating to financial instability information relating to financial instability
• Share information gained by each team
• Record escalating concerns in care services
• Recommend actions to be taken and where appropriate disseminate across each Team.
• Demonstrate the use of contract monitoring and case management review to achieve improvement rather than wait for a complaint or POVA referral to be received
• Record improvements in care services
• Share good practice and lessons learned across the service to support continuous improvement.

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

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

1.13 This discussion will facilitate early identification of patterns of concern or risk that can be addressed through the ordinary activity of adult services department before the significance of the issue or risk escalates. Concerns may be passed to the relevant Emergency Duty Team.
**Figure A1.1** Example of an agenda for a Quality Assurance Meeting

Date:  
Time:  
Venue:  
Present:  
Apologies:  

<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>DECISIONS / ACTIONS</th>
<th>ACTION BY/ DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introductions &amp; Apologies</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Minutes of the previous meeting</td>
<td></td>
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<tr>
<td>3</td>
<td>Review of all providers who are already subject to the Provider Performance monitoring protocol meeting process</td>
<td></td>
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<tr>
<td></td>
<td>New concerns regarding contracted services</td>
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<tr>
<td></td>
<td>Update from Commissioning Team Supporting People Team Assessment / Care Management, POVA Team Review Team and customer services</td>
<td></td>
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<tr>
<td>4</td>
<td>Positive feedback regarding contracted services</td>
<td></td>
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<tr>
<td></td>
<td>Update from teams as above</td>
<td></td>
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<tr>
<td>5</td>
<td>Any other business</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Summary of actions</td>
<td></td>
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<tr>
<td>7</td>
<td>Date and time of next meeting</td>
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</table>
Example of the establishment of a Joint Interagency Monitoring Panel (JIMP)\textsuperscript{6}

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

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

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

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

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

- The Council has been notified of significant issues by partner agencies e.g. Health Trust, CSSIW or HIW
- The provider is unable to make the improvements required of them.

\textsuperscript{6} Large sections of this Annex have been drawn directly (word for word) from \textit{Caerphilly Provider Performance Monitoring Protocol} (Caerphilly CBC 2010a).
- The provider is unwilling to make the improvements required of them.
- A single or repeated concern is raised by a care manager or other staff, service user or their representative, highlighting a risk
- A single POVA referral identifies significant risk to other service users
- The number and type of issues identified gives cause for concern

Secondly, issues that may lead to voluntary closure:
- Financial instability of a provider
- Personal circumstances of a provider
- Local Authority strategic decisions to change type or amount of care provision

This is not an exhaustive list.

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

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7 Whilst the Local Government Data Unit defines large scale investigations as five or more POVA referrals for one care provider, this is not an automatic trigger to hold a provider performance meeting. Rather, the POVA referrals would be considered along with other information that had been made available to the most recent quality assurance meeting and a decision taken as to its significance and the most appropriate course of action. For example it may be decided to await the outcomes of the individual POVA investigations and seek further information from agency partners about current information to determine the level of significance and the depth and breadth of the concerns.
Figure A2.1 Flowchart indicating how a Quality Assurance Meeting would lead to the instigation of Joint Interagency Panel Meeting

USUAL ROLE OF EACH DEPARTMENT

Quality Assurance Meeting
Discuss bubbling concerns and highlight good practice. Are there significant concerns that exceed the usual role of the department?

Consult agency partners and jointly decide: is there a threat of home closure?

JIMP established (see Figure A2.2)
Example of Escalating Concerns

Annex 3

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

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

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

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

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8 Large sections of this Annex have been drawn directly (word for word) from Caerphilly Provider Performance Monitoring Protocol (Caerphilly CBC 2010a) and from Neath Port Talbot Joint Interagency Policy for managing Escalating Concerns (Neath Port Talbot 2011c)
9 See Appendix 4 for a good example of a risk rating matrix.
• Red – there are significant problems which will impact the service and or safety of service user and/or staff if not resolved – CAP required (see below)
• Amber – Could affect the service and or safety of service users and/or staff if not addressed developmentally – DAP required (see below)
• Green – Being addressed or of less significant concern but will require monitoring to ensure intended improvement sustained – Routine monitoring and review.

3.5 The JIMP will conduct a likelihood assessment to determine if the Service Provider is at High Likelihood of closing Status (see Figure A3.1). This should ensure, that where possible, individual relocation plans and home closure plans are not developed hurriedly, and will allow statutory agencies and residents time to prepare for the event of closure should it occur. This JIMP should be mindful that the timeline for closure may be subject to change (e.g. enforced closure may be planned to take place over several months, but if the provider decides to pre-empt enforced closure and close voluntarily, the period may be much shorter). Relocation plans may need to be developed earlier for care homes with a large number of residents.
• High – The likelihood of closing coupled with the anticipated closure timeline requires that a resident disclosure plans, individual relocation plans and a home closure plan is developed.
• Low – The likelihood of closing coupled with the anticipated closure timeline requires that only resident disclosure plans are developed.

Figure A3.1 Assessment of Likelihood of closing.

<table>
<thead>
<tr>
<th>Anticipated closure timeline:</th>
<th>3 months</th>
<th>2 months</th>
<th>1 month</th>
<th>Less than 1 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### closure:

<table>
<thead>
<tr>
<th>Unlikely</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low chance</td>
<td>*?</td>
</tr>
<tr>
<td>Even chance</td>
<td>*</td>
</tr>
<tr>
<td>High chance</td>
<td>*</td>
</tr>
<tr>
<td>Expected to occur</td>
<td>*</td>
</tr>
</tbody>
</table>

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

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

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

3.8 At amber or red Escalating Concerns status, the provider (when in attendance) and JIMP will develop an action plan using a standard template.\(^{11}\)

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\(^{10}\) Careful consideration should be given as to whether individual relocation plans should be developed. Although the chance of closure is low, the timescale suggest that should closure take place there would be insufficient time to allow residents to make informed choices about alternative accommodation, or for statutory organisations to prepare for relocation. In these cases, we suggest that the likelihood of closure is monitored and reassessed frequently.

\(^{11}\) See Appendix 5 for a good example of an action plan template.
3.9 When identifying improvements required the meeting should determine whether the required improvement actions are either development actions (DA) where they are good practice requirements to assist overall improvement or corrective actions (CA) where the improvements are related to a contractual or regulatory breach in line with the Escalating Concerns with, and closures of, Care Homes providing services for Adults.

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

3.11 Following the development of an action plan the the HOSG will oversee its implementation and risks will be rated and managed through the HOSG. The concerns will be scored by their likelihood and impact. The colours red, amber and green will be used to signify the level of risk rather than the outcomes.⁠¹²⁠³

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

3.13 HOSG Monitoring and risk management arrangements may include:

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

¹² See Appendix 5 for a good example of risk rating and monitoring for use by the HOSG.
3.14 The HOSG will report to the JIMP on progress with regard to progress towards the CAP or DAP and the action plan should be reviewed by the JIMP. Monitoring must be evidenced and contingencies required for repeated lack of adequate progress or further deterioration with robust challenge and rationale recorded. Contingencies may include mandatory suspension of placements i.e. embargo (see below).

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

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

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

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

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

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

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

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

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

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

Joint Interagency Monitoring Panel

Assessment of likelihood of closing (see Figure A3.1)

High
- Disclosure Plans; Individual Relocation Plans; Care Home Closure Plan

Low
- Disclosure Plans

Risk Assessment (see Appendix 4)

Green
- Monitor

Amber
- Development Action Plan
- Corrective Action Plan
- Embargo
- Cancellation of registration (see Annex 5)

Red

Home Operations Support Group
- Implement actions (above)
- Monitor action plan (see Appendix 5)
- Set review meeting dates

Single agency monitoring
- JIMP & HOSG report

Joint Interagency Monitoring Panel
- Review meeting

Yes
- Action plan complete or Risk depth/breadth moved or significantly reduced

No

Close JIMP
Return to regular monitoring see Annex 1
Annex 4

Example of the Threat of Voluntary Closure

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

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

or

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

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

Organisation

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

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

4.4 Both health and social services will nominate members of the HOSG group. Agencies must ensure that representatives have appropriate specialist skills according to the needs of service users. Nominations should include the Contract Monitoring Officer for the ‘host’ authority, senior nurse from both the local health board and NHS Trust, and social services locality manager or principal officer in whose area the home is located (in this context ‘host’ authority means the local authority area in which the home is physically located.) CSSIW will also have a key role in care home closures.
4.5 The JIMP will conduct a likelihood assessment to determine if the Service Provider is at High Likelihood of closing Status (see Figure A3.1 – Annex 3). This should ensure, that where possible, individual relocation plans and home closure plans are not developed hurriedly, and will allow statutory agencies and residents time to prepare for the event of closure should it occur. Relocation plans may need to be developed earlier for care homes with a large number of residents.

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

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

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

**Threat of closure in the independent sector**
4.8 The JIMP will establish whether there is chance that the threat of voluntary closure can be averted (e.g. financial situation can be changed, an alternative provider can be found). When there is evidence to suggest that the risk of closure can be averted the provider (when in attendance) and JIMP will develop a corrective action plan (CAP) for risk reduction steps using a standard template.\(^{13}\) This may include requiring additional expertise and advice from financial advisors, or considering alternative providers with CSSIW.\(^{14}\)

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

4.10 The HOSG will implement JIMP action plans.

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

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

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

\(^{13}\) See Appendix 5 for a good example of an action plan template.

\(^{14}\) If our recommendation that financial health becomes a Minimum Standard then financial instability would be dealt with through escalating concerns (see Annex 3) and would probably result in the JIM issuing a CAP.
4.14 Where the issue is not resolved the care home closure policy will be used to ensure a smooth transition for service users to a new service provider (see Annex 5).

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

 Threat of closure in the public sector

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

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

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

- a timetable noting the main methods of consultation. **Note:** as the consultation is a statutory duty, the dates noted in the timetable have

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15 The process of consultation has been adapted from the Welsh Health Board (2010), although some is reproduced word for word.
the power of statute. As a result, local authorities are expected to adhere to the dates noted and to ask the HOSG for permission if they need to be changed. Authorities will need to demonstrate exceptional circumstances before the HOSG will grant permission to vary any dates.

- a copy of the report that is to be circulated
- details of any other publicity the Council intends to give to the consultation before launching it and during the consultation itself
- a list of the individuals, bodies and organisations the Council intends to consult

**Length of consultation period**

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

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

**Clarity regarding the consultation process**

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

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

**Accessibility**

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

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

4.25 It is important, to be proactive in consultation. Careful consideration should be given to how to warn prospective respondents of the consultation and now to obtain comments from relevant sections of the community. There is not an expectation for authorities to produce the proposal for closure of a care home in a range of different versions e.g. Braille or community language versions (unless the authority’s own policy demands it, or the care home caters for a particular community that would benefit from these forms of communication) but consideration should be given to different ways of reaching specific audiences such as public meetings, discussions forums and focus groups etc. The proposal should be produced in Welsh and English.

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

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

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

- a notice on the homepage or front page of the Local Authority website. This notice should be retained in a prominent location on the website throughout the consultation period. The notice should include the following:
  - a link to both the Welsh and English versions of the proposal
  - a brief explanation of the nature and length of the consultation period
  - a name, address and e-mail address for the receipt of responses
  - an electronic response form on the website
  - details of how to get hold of a hard copy of the proposal if desired

- the Local Authority’s newsletter that is distributed to all households within the catchment area

- a copy of the advertising materials together with a hard copy of the proposal in the following locations:
  - libraries (including mobile ones)
  - foyers of public buildings
  - local Citizens’ Advice Bureaux

- the website of the local Family Information Service together with the Service’s centres or offices, as appropriate

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

*Responsiveness to consultation exercises*

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

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

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

4.33 It is considered good practice for local authorities to disseminate the report to consultees, care home residents, relatives and other stakeholders.
4.34 The HOSG will ask authorities to consult with the public a second time if it concludes that the consultation has not followed the consultation programme agreed at the beginning of the process.

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

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

4.37 If the HOSG and the authority reached agreement on the contents of the post-consultation report that the care home will close or the Director of Social Services (or equivalent) and LHB Director will be asked to endorse the care home closure plan (that will already have been prepared by the HOSG if the likelihood of closure had been judged as ‘high’), and the provider, residents and families notified. The care home closure policy will be used to ensure a smooth transition for service users to a new service provider (see Annex 5).
Figure A4.1 Flowchart indicating the process during the threat of voluntary closure.

Joint Interagency Monitoring Panel

Assessment of likelihood of closing (see Figure A2.1)

High
- Disclosure Plans; Individual Relocation Plans; Care Home Closure Plan

Low
- Disclosure Plans

Local Authority or Independent sector?

Independent sector
- Risk Assessment: Could closure be averted?
  - Yes: Corrective Action Plan
  - No: Closure (see Annex 5)

Local Authority
- Consultation: Is closure the best option?
  - Yes
  - No: Care home remains open

Home Operations Support Group
- Implement actions (above)
- Oversee consultation (where applicable)
- Monitor action plan (see Appendix 5)
- Set review meeting dates

Joint Interagency Monitoring Panel
- Review meeting

JIMP & HOSG report
- Close JIMP
- Return to regular monitoring see Annex 1

Action plan complete or Risk averted
- Yes
- No: Care home remains open

Risk averted
- Close JIMP
- Return to regular monitoring see Annex 1

Yes
- No: Care home remains open

No
Annex 5

Example of Closure Arrangements

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

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

or

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

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

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

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

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

- identified with CSSIW all potential risks to patients and service users and the contingency arrangements necessary to minimise avoidable exposure to risk;
- an agreed multi-agency policy and approach in respect of re-admissions to the home of patients or service users admitted to hospital;
- established a communication strategy designed to engage patients, service user and families and any other relevant parties in key discussions (Individual Disclosure Plans); and
- whenever possible, established a close dialogue with the registered provider who should assist in assuring the safety and welfare of patients and service users.

Closure Plan

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

- Is closure likely to be immediate, occurring in under forty-eight hours?
- Are there any Court decisions or judgements which must be taken into account?
- What immediate, short-term and long-term risks are there to the health, safety and welfare of service users?
• Are there problems with the structure, fabric or service connected to the building which makes its continued occupation dangerous or unsafe? Is any remedial action possible?
• Can essential services such as heating, water, electricity and gas be maintained?
• Are the actions or potential omissions of the existing staff group likely to expose service users to inappropriate care, abuse or risk of harm?
• Has the number of care/nursing staff diminished to a serious or critical level and what actions need to be taken immediately or on a short term basis?
• Can the closure be planned and if so over what time scale?
• Is there capacity and the ability to work with the home owner and/or manager in planning and/or managing the transfer of service users?
• Could interim management or staffing support be provided from an external source and would this be acceptable to the registered person/s/receiver and have CSSIW registration requirements been considered?
• Has key equipment been removed or sold which further undermines the potential to keep the home open in the short-term? Could alternative equipment be found or provided?
• What actions have been/or need to be taken to prevent further admissions?
• How are vacancies in other homes/locations being prioritised?
• At a regional level should other agencies be involved in the plan?
• What actions are being planned or being taken by authorities or agencies that have placed people within the home from out-of County?
• How much is known by the staff, clients and their relatives/carers?
• Is there media interest?\(^{16}\)

\(^{16}\) A good example of the summary of the HOSG responsibilities is provided in Appendix 8 (Monmouthshire CBC 2010a).
5.5 Once a Home Closure Plan has been agreed, the Director of Social Services (or equivalent) and LHB Director will be asked to endorse it and the provider, residents and families notified.

Individual Relocation Planning

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

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

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

5.9 The HOSG should ensure that self-funding service users are offered the support of a care manager. The self-funding service user is free to decline the support of a care manager but this facility must still be offered:

- Transport to a new home of their choice
- Support in moving or transferring personal possessions
- The same level of information on the closure process as others
- Relevant support to carers and families
- Details of vacancies within the area
- Support in contracting with an alternate provider

5.10 The HOSG should ensure that a needs assessment is obtained for all service users (including with their agreement people who are self-funding).
The assessment should consider issues of mental capacity and any risk factors that may arise as a result of physically moving the person from the home. Additional critical information required as part of the assessment process includes:

- Details of all equipment or environmental aids used by the person
- Details of medication and pending hospital treatment or appointments
- Details of personal non-clothing items held in the home (a check form could be used, see Figure A4.1)
- Details of finances/savings etc held by the home
- Details of preferred care routine
- Details of significant relationships within their current home.

5.11 Using the Disclosure Plan as guidance, the HOSG should ensure that the relevant parties (family, friends, carers, significant others, advocate and the resident) are appropriately involved in identifying an alternate home or in preparing/facilitating the user for transfer to alternate accommodation.

5.12 The HOSG should ensure that all residents (or advocates working on behalf of the resident) and relatives are informed of the range of accommodation available (including extracare sheltered housing, residential care homes and nursing homes, both in the public and independent sector). The types, levels (ceilings), and costs of care and support that each facility provides should be explained fully. Residents (or advocates working on behalf of the resident) should be offered the opportunity to visit alternative accommodation in order for a properly informed choice to be made.

5.13 The HOSG should ensure that Individual Relocation Plans have taken into account services users and their family options, choices and need to ensure continued access to the individual by friends (including residents of the closing facility) and family.
5.14 The HOSG should ensure that a new care and service-delivery plan is constructed (with the resident, relative or advocate working on behalf of the resident) to meet a person’s needs and agree transitional support, monitoring and review arrangements.

5.15 The HOSG should ensure that existing contracts are cancelled.

Monitoring & Review

5.16 Within one calendar month of all service users being moved from the home the JIMP and HOSG will meet to evaluate the whole closure process and to identify lessons learned. The Chair of the JIMP will prepare a report on the home closure and this will be circulated to senior managers within local statutory agencies, chairman and members of the local authority scrutiny panel and also chair and members of the LHB. A copy of the report must also be provided to CSSIW.
Figure A4.2 Residents’ property sheet to be used during a home closure.

From: ........................................Care Home to:

........................................

Name: ........................................

<table>
<thead>
<tr>
<th>Property Type</th>
<th>Description, detail and comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Documents</strong></td>
<td></td>
</tr>
<tr>
<td>(including Pension</td>
<td></td>
</tr>
<tr>
<td>Books, Wills, Bank</td>
<td></td>
</tr>
<tr>
<td>or Building Society</td>
<td></td>
</tr>
<tr>
<td>A/C, Insurance</td>
<td></td>
</tr>
<tr>
<td>Certificates and any</td>
<td></td>
</tr>
<tr>
<td>other legal</td>
<td></td>
</tr>
<tr>
<td>documents)</td>
<td></td>
</tr>
<tr>
<td>**Jewellery and</td>
<td></td>
</tr>
<tr>
<td>Valuables**</td>
<td></td>
</tr>
<tr>
<td>(including cash)</td>
<td></td>
</tr>
<tr>
<td><strong>Electrical Goods</strong></td>
<td></td>
</tr>
<tr>
<td>(include serial</td>
<td></td>
</tr>
<tr>
<td>numbers)</td>
<td></td>
</tr>
<tr>
<td><strong>Furniture</strong></td>
<td></td>
</tr>
<tr>
<td>(give clear</td>
<td></td>
</tr>
<tr>
<td>description)</td>
<td></td>
</tr>
</tbody>
</table>

N.B. Please asterisk those items of property to be left at the Home for collection at a later date and identify the place where any items have been temporarily relocated for safekeeping.

Documented by ........................................    Contact Tel No. ............................
Designation .............................

Service User/Representative Signature .................................................. Date...........

Source: RCT et al. (2006a).

**Figure A4.3 Resident’s individual relocation plan and transfer document**

From: _______________________________   To: ______________________________

Date Completed: ______________________   By: ______________________________

<table>
<thead>
<tr>
<th>Full Name and Address prior to Admission:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Date of Admission to Home:</td>
<td></td>
</tr>
<tr>
<td>Next of Kin and/or Identified Emergency Contact Person:</td>
<td>Name: Address: Tel no.</td>
</tr>
<tr>
<td>Funding status:</td>
<td>Self / Local Authority / Continuing Health Care / NHS funded nursing care</td>
</tr>
<tr>
<td>GP</td>
<td>Name: Tel no: Advised: Yes/No Date:</td>
</tr>
<tr>
<td>Care Manager:</td>
<td>Name, Location Telephone Number Follow up: Date Date Time Time</td>
</tr>
</tbody>
</table>
| Advocate:  
(state if none) | Name, Location Telephone Number |
<p>| Date of Assessment for relocation |                        |
| Type of Placement required | Extrain care sheltered housing Residential care home Nursing care home Mental health care home |
| Service User’s Preferred Alternative Placement: | (state name of home and address) |</p>
<table>
<thead>
<tr>
<th>Service User’s Agreed Placement: (state name of home and address if different from above)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Summary of Service User’s Disclosure Plan (attach full plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Hospital and reason for Admission: (state if not applicable)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Special Nursing Needs: (e.g. EMI, wheelchair dependent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Special Personal Care Needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Notes on maintenance of social contacts (how existing friendships within and outside care home will be maintained)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Details of existing appointments</th>
<th>Practitioner &amp; location</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Records</th>
<th>Tick</th>
<th>Handed to</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Sheet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Records</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Records</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property form</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Identified Transport Requirements:</th>
<th>Own arrangements / Family / Taxi / Minibus / Adapted Vehicle / Ambulance</th>
</tr>
</thead>
</table>

Completed by .................................................. Contact Tel. No. ........................................

Designation ..................................................
Adapted from: RCT et al. (2006b).