Isle of Wight Council
Adult Social Care

Care Home & Home Support Provider Closure Protocol

March 2021

1. Introduction

1.1 Changes in the shape of the local Social Care and Health Market place are not uncommon. It is therefore not unusual for providers to take the decision to close or withdraw from the local market place. Whilst not unusual, thankfully it is rare and the purpose of this protocol is to ensure that where such circumstances do arise there is clear guidance as to how the situation should be dealt with.

1.2 Home closures 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).

1.3 Chapter 5 of the Care Act 2014 sets out the legal requirements on Local Authorities to respond to the business failure of any care and support provider in their area to ensure that adults' needs for care and support continue to be met.

1.4 The Isle of Wight Council has an important role in situations where a provider is unable to continue to supply services because of business failure.

1.5 The Local Authority has no legal powers to prevent the closure of a residential or nursing home or home support provider, nor does the Clinical Commissioning Group so where this does occur a standard approach is required.

1.6 The Isle of Wight Council has developed this protocol so that when faced with care home or home support provider closures there is clarity around expectations and process.

1.7 The possibility of interruptions to care and support services causes uncertainty and anxiety for individuals receiving services, their carers, their family and their friends, as well as for the staff of the provider. Having clear processes in is vital in an emergency situation. It is important to use this document effectively particularly if a home closes or a home support provider closes at very short notice. There needs to be an immediate understanding of the tasks that are required and who take responsibility for these.

1.6 This protocol has been written in conjunction with the following:

1.6.1. *Managing Care Home Closures: A Good Practice Guide for Local Authorities, Clinical Commissioning Groups, NHS England, CQC, providers and Partners* (developed by the Department of Health, ADASS, Local Government Association, The Care Provider Alliance, CQC and NHS England) https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/1577_QuickGuide-CareHomes_9.pdf

1.6.2. *Care and Continuity: Contingency planning for provider failure* (LGiU/ADASS/LGA/DH) https://lgiu.org/briefing/care-and-continuity-contingency-planning-for-provider-failure/

2. Directing the Process

2.1 The response required where there is to be a home closure or home support provider closure will be led by the Commissioning Team with in Adult Social Care. It is essential that the Commissioning Team are supported by other service areas. A working group will be created and may include representatives from the following:

- Care Management
- Safeguarding
- SPOC
- Finance
- Legal Services
- Media and Communications
- Clinical Commissioning Group
- NHS Trust

2.2 The Commissioning Team will be responsible for co-ordinating the process, allocation of tasks and overseeing the day to day management of the closure process. They will also be responsible for the relocation of the residents. With regards to a home support provider closure, this relates to the reallocation of care provision for individuals requiring support to one or more other agencies or for individuals to transfer to a direct payment.

2.3 The Commissioning Team will ensure that a clear action plan is developed with the provider and other stakeholders and they will oversee the action plan to ensure that the plan is implemented effectively. The action plan shall take the form identified in Appendix A of this protocol.

2.4 The Commissioning Team is accountable to the Director of Adult Social Care and the Commissioning Team will ensure that the Director of Adult Social Care is regularly updated and informed of all key phases of the closure and transfer of residents/people supported by the provider.

2.5 Alongside the action plan the Commissioning Team will also develop a risk and issues log which will be kept up to date and reviewed at regular and appropriate intervals. This will be used in the review process at the end of a closure.

2.6 The Commissioning Team will also ensure that where relevant the DOLs Team, Advocacy provider and any other relevant party are notified of the proposed closure.

3 Initial Response

3.1 Once notification of a proposed closure has been received from the Provider, a meeting will be set up to discuss the intended closure with the provider, care management, the Clinical Commissioning Group (if relevant) and SPOC. At this stage a final closure date will be agreed. The agenda for the meeting shall be as outlined in Appendix B of this protocol.

3.2 Preceding the meeting, the Provider will ensure that the Commissioning Team has an up to date list of all residents or individuals they support and a nominated carer/relative with their contact details together with details as to whether they are or are not funding their own care. A list of individuals receiving care from a home support provider will also be required with a total number of care hours being delivered. This must include people who contract directly with the provider and who pay for their own care and support.

3.3 For home closures, the Individual Resident Information Sheet (Appendix c) must also be completed by the provider and Registered Manager, this information will be shared with the Clinical Commissioning Group should they be involved

3.4 At the meeting the action plan will be populated with the relevant dates and responsibility will be allocated for the undertaking of each task. Where possible Care Management will identify a lead social worker to support the proposed closure and this person will be the lead for the carrying out of any assessments/reviews and working with SPOC to find alternative care provision.

4. Following the Initial Response

4.1 Following the initial meeting, the Provider will send the following communication:

- a letter to each resident or individual they support
- a letter to the nominated person/family member/ representative of the resident of individual they support where the person lacks capacity

The letters will advise of the intended closure and provide the closure date. The letters will also state that the Isle of Wight Council and Clinical Commissioning Group (as required) will assist in the relocation process, identifying key personnel and contact details. The letters MUST be agreed with the Commissioning Team prior to being sent.

4.2 The lead social worker will work with people who do not have capacity to explain the process.

4.3 The lead social worker identified to support the proposed closure will maintain a presence at the care home (or in the case of a home care provider will ensure that they are readily available to the provider) and will undertake all required/requested assessments and/or reviews of the persons care and support needs. Where more than one social worker is required the identified lead social worker will liaise with the Assistant Director for Integrated Service Delivery or a Service Manger nominated by him, to secure additional resource to support the closure.

4.4 The lead social worker will assist in maintaining contact with family, friends and other local authorities, arranging medical and nursing assessments and offer support with visits to potential new homes.

4.5 The Provider will be responsible for ensuring that the lead social worker has free access to the home during the relocation period or the office of the home support provider during the reallocation of individual care.

4.6 If the reason for the closure is endemic, the Commissioning Team will consider checks on other homes owned by the same organisation. This will be co-ordinated with the Integrated Quality Assurance Team.

4.7 Where notice to close is received; no further placements shall be made.

5. Key Responsibilities

Responsibility	**Action**
Commissioning Team	The Commissioning Team will oversee the closure process.
	Convene and chair initial meeting with provider and other stakeholders
	Take ownership of the action plan for closure developed at the initial meeting
	Liaise with other Local Authorities to advise them of their individuals who require care and support who have been affected by the intended closure.
	Keep a risk and issues log.
	Ensuring that DASS and AD's are full briefed and kept informed of progress
	Be key liaison with the CQC
	Work with the provider to develop agreed press statement
	Ensure the contract is terminated and new care home / home support providers already hold a contract with the Isle of Wight Council and CCG
	Provide notification to ASC Orders of the home closure date to enable the recovery of any overpaid fees
Provider	Inform staff, residents and residents' families of the intended closure.
	Ensure regularly communication with staff, the residents and families regarding the closure offering reassurance to families/carer about continuity of care to the individuals during the closure process and keep them regularly updated with a position statement at appropriate intervals.
	Ensure that the quality of care provision, staffing and management is not affected during the closure process
	Maintain appropriate and safe staffing levels at all times to ensure that the needs of all residents/clients can continue to be met
	Arranged with the benefits agency for transfer of appointee function to the new home/home support provider as appropriate and if capacity is available
	Where appointeeship is necessary to engage with the lead social worker to ensure that appropriate action is taken.
	Implement the providers own business continuity plan ensuring they remain constantly up-to-date.

	Co-operate at all times with the Commissioning Team, lead social worker and other stakeholders
	Facilitate all assessment visits from new providers
	Ensure appropriate information sharing is undertaken
	Ensure all care plans, risk assessments MAR sheets etc. are up to date
	Where appropriate to maintain the required levels of medication to meet the persons needs
	Provide support to ensure that the transfer to a new provider goes smoothly and with the least disruption to the person.
	Ensure care and support plans are sent with the person to their new care home
Lead social worker	Prioritise working with resident/people who receive care and support, their families and/or representatives
	Support all people accessing care and support from the provider regardless of how their package of care is funded.
	Undertake any required assessments and/or reviews
	Assist in maintaining contact with family and friends
	Liaise with the Clinical Commissioning Group to ensure that medical and nursing assessments are undertaken where necessary.
	Arrange for any specialist support for individuals with advocacy/ interpretation/ communication matters
	Review required equipment aids that will need to be moved with the individual and liaise with Community Occupational Therapy Service and Community Equipment Service where necessary
	Liaise with the Clinical Commissioning Group to ensure that dietary needs and special requirements are appropriately identified if applicable
	Offer support with visits to potential new homes/meetings with home support providers
	Liaise with the Clinical Commissioning Group Medicines Optimisation Team to ensure that medication is up to date and there are no outstanding hospital appointments
	Check if the care home provides any other services such as day support, meals baths etc. and advise the Project Lead to ensure any individuals who receive this are advised of the home closure
	Ensure the individual and their family are aware of the choices and options available to them
	Agree the level of support required to identify alternative accommodation and transfer to alternative accommodation, if applicable
	Liaise with SPOC to facilitate change in provider
	Liaise with SPOC to arrange transport from the current home to the new home on the day of transfer (if moving care home)
	Be available on the day of transfer or to ensure that a suitably qualified and/or experienced colleagues is available in their place
	Complete a Service Agreement Amendment on Horizon system for Isle of Wight Council funded resident/individual requiring care and support
	Complete a new service agreement for the placement within the new care home/home support provider
	Make contact with the new care provider within 48 hours of the transfer of the package of care to ensure that the person has settled in.
	Set up a follow up review as soon as the individual has moved accommodation

	Ensure the individual has an appropriate review between 4 - 8 weeks after the change I provider which involves the family, representative and if appropriate an advocate.
	Liaise with the DOLs team to ensure that the appropriate notifications are provided promptly.
	Lead social worker to develop a transition plan that is reviewed as part of the before and after process
SPOC Team	Identify which individuals are funded by Isle of Wight Council/CCG
	Identify 'out of area' individuals funded from other Local Authorities with contact details
	Identify which individuals are self-funding
	Identify which individuals are funded solely by health
	Provide up to date bed vacancy information/home support provider hours, both locally and in the South Central Region
ASC Orders	Calculate the current cost of the placement for Isle of Wight Council funded individuals/ or CCG funded individuals within the home/home support provider
	Calculate any overpayment and take action to recover the same
Financial Assessment and Charging Team	Notify the Department of Works and Pensions of the change in each individuals circumstances
Media& Communications Council and CCG	Available at all times, to draft press releases
	Deal with media queries
	Advise of the Commissioning team of any media interest – adverse or otherwise
	To maintain contact with other relevant press offices for example CQC.
Clinical Commissioning Group	Review health funded individuals.
	The CCG may be required to lead the project if Nursing Home Closure.
	Attend meetings, as required
	Identify a lead officer to work in partnership with the council where the provider also provides care and support to individuals funded by the CCG.

6. Safeguarding

6.1. It may be necessary to involve the respective statutory agencies, Integrated Quality Assurance Team and safeguarding practitioners if the closure is unplanned in response to concerns about safeguarding or issues of quality.

6.2. The **Safeguarding the welfare of all those receiving care and support is paramount in this process** and requires the co-operation of all parties involved. At any time during the process if there are any safeguarding concerns these will be escalated through the proper process immediately.

6.3. Where there are safeguarding concerns about the wellbeing of an adult arise reasonable steps to address any immediate risks shall be taken and those concerns shall be shared with the provider, registered manager or senior care worker on duty.

6.4. If there is an adult safeguarding concern (an adult with care and support needs, at risk of or experiencing abuse or neglect and due to their care and support needs is unable to protect themselves from the risk of or experiences of abuse or neglect), this shall be immediately reported to the Safeguarding Team, where possible and appropriate a conversation will also take place with the adult at risk to inform them of the concerns and ascertain their views and wishes.

7. Care Quality Commission

7.1. The Commissioning Team will make contact with the Care Quality Commission (CQC) at the earliest opportunity. The CQC will be asked to provide information

about the compliance status of the Provider and any action it is taking under its information sharing protocols, in line with the requirements of the legislation.

7.2. The CQC will work with the Provider and the Commissioning Team to promote and protect continuity of care (although the provision of care is not directly CQC's responsibility). This will include consideration of the requirements of the legislation, regulatory requirements and any specific response which is required during a crisis period.

8. Changes in Care Provider

8.1. Care Homes:

8.1.1. Every effort will be made to identify who residents would like to live with. It may be possible that they wish to continue to live with one or more of the other residents at the home which is due to close. The lead social worker will endeavour to find suitable choice of placements facilitating a move of two or more residents together. Staff from within the home should be able to assist in identifying such relationships.

8.1.2. New accommodation sought will take into consideration the residents preferences providing that the accommodation is able to safely meet the assessed eligible need and is registered to the correct category with CQC.

8.1.3. Any new placement will not cost more than the council's pre-determined contract rates and can only be made with a contracted provider.

8.1.4. The lead social worker will support residents, family and carers to visit to alternative homes. They will also establish realistic timescales for the resident's safe relocation.

8.1.5. If any of the residents wish to move earlier than the final closure date the lead social worker will ensure there is full consultation with the resident, their family (or advocate), the provider and the new provider to achieve this.

8.1.6. On the day of the transfer, the lead social worker will be available and ensure that if transport is required, that it has been arranged and is in place. The lead social worker will consider if residents need help of care staff to escort them to a new placement.

8.1.7. The lead social worker will liaise with the SPOC Team to ensure that any moves are schedules appropriately and that wherever possible:

- residents move only in daylight hours
- that the means of transport is appropriate for the persons specific needs (using hospital transport where necessary)
- that where the person is in poor health contact is made with the person GP to establish if the GP needs to review the person prior to moving
- residents have an appropriate place to wait for transport to collect them
- residents belonging are packed properly and with care in cases/boxes provided by the family
- residents possessions are treated respectfully when moved
- residents are supported to move at their own pace/convenience (as far as possible)

8.1.8. The lead social worker will liaise with the resident their family or representative to ensure any valuables held by the care home are accounted for and they have been logged and packed carefully. The provider will share with the lead social worker the resident's inventory of belongings. This may include items of furniture that belong to the resident. Any specific equipment may also require transportation.

8.1.9. The lead social worker and the Provider will ensure that the care plan, risk assessments, MAR sheets, medication, any dressings and catheters or other specialist items that might be needed are transferred with the resident. Arrangements should be made for the secure transfer and storage of records (or archive) relating to deceased former residents (if applicable).

8.1.10. The lead social worker must ensure the transfer form is completed, to accompany the individual. This will also list which professionals are involved in the residents care. (Appendix D).

8.2. Home Care

8.2.1. Every effort will be made to accommodate the preferences of the person when looking to identify a new provider to meet the persons assessed eligible needs providing that the new provider is able to safely meet that need and is registered to the correct category with CQC.

8.2.2. The person will also be supported to consider alternative to traditional care models including increased use of assistive technology and employing a Personal Assistant

8.2.3. The lead social worker will support residents, family and carers to meet with potential new providers. They will also establish realistic timescales for the resident's safe allocation to the new provider and a facilitated hand over.

8.2.4. Any new package of care will not cost more than the council's pre-determined contract rates and can only be made with a contracted provider.

8.2.5. The new provider will be sourced through the councils existing route to market

9 Administrative Receivership and Bankruptcy/Insolvency

9.1 If a provider goes into administrative receivership, an administrative receiver will be appointed by the courts over all of the assets and undertakings of the company owning the home. The administrative receiver's first responsibility is to the creditors (of which the Isle of Wight Council will usually be one). The aim of the receiver will usually be to stabilise the situation and continue viable trading to ensure involvement of all operational regulatory or financial stakeholders although this may not always be the case and immediate closure may be implemented.

9.2 Where an administrative receiver is appointed the Commissioning Team must engage with the administrative receiver to ensure that disruption is kept to a minimum for the people who are receiving care and support from the provider.

9.3 The administrative receiver has the power to close down a business with immediate effect, or choose to continue trading, or to sell the business and where possible the Commissioning Team will work with the administrative receiver to ensure that this does not happen and that a reasonable time period is provided to facilitate safe transfers of care packages to new providers.

10 Communications

10.1 The announcement of a home closure or home support provider closing can be upsetting for individuals receiving care and support, families and the workforce. The Commissioning Team will work with the Provider and the Isle of Wight Council's Media and Communication team to develop a communications plan and reactive media statement.

10.2 It is important to act in a timely fashion in order to minimise the incidence of rumour or speculation. Media and Communication will be called upon to agree and issue the relevant press releases.

10.3 The Commissioning Team will collate a list of frequently asked questions and answers; these will be devised early on in the process as a way of reducing the number of individual queries that have to be answered and will be shared with residents, families, carers, representatives and the providers staff.

11 Review and Monitoring

11.1 The action plan relating to the closure will be regularly reviewed throughout the closure process. Daily updates will be shared between the Commissioning Team, the lead social worker and SPOC to ensure that critical timeline items are met. A weekly update will be provided to:

11.1.1 the Director of Adult Social Services
11.1.2 Assistant Director for Integrated Commissioning
11.1.3 Assistant Director for Integrated Service Delivery
11.1.4 Cabinet Member for Adult Social Care and Public Health

Any issues arising from this will be resolved as a matter of urgency.

11.2 One calendar month after the providers closure a meeting will take place which will the provider, Commissioning Team, lead social worker and other identified individuals to evaluate the closure process and identify lessons learned. Outcomes and learning from the closure process will be collated in a report, produced by the Commissioning Team and will be presented to ASC Leadership Group. The report will be made available to all relevant interested parties including CQC as considered appropriate.

11.3 The Commissioning Team will, so far as is possible, ensure individuals receiving care and support and their relatives and carers views are captured for the lessons learnt meeting along with the views of care home and home support provider staff if it is felt appropriate to do so.

11.4 This protocol will be reviewed annually and updated as necessary.

Appendix A: Action plan Template
Action Plan – Managed Closure

	Task	Actions	Responsibility	Commence	Target Date	Complete
1	**Initial Response**	Set up meeting with Provider and confirm final closure date and agree how provider will inform residents and their staff and families and provider engagement with CQC.	IWC Commissioning			
		Book in meeting with provider to work through plan to work through the plan moving forward.	IWC Commissioning			
		Compile list of individuals funded by IWC, other Local Authorities, CCG & self-funding individuals. Consider health funded individuals from out of area	Provider			
		Inform CCG of their individuals who have been affected by intended closure.	IWC Commissioning			
		Understand the current bed vacancy levels at the time of closure within the current market for care home closures	SPOC			
		Identify if safeguarding practitioners are to be included	IWC Commissioning			
2	**Residents / Individuals who require care and support**	A Social Care Worker / NHS Case Manager is allocated to the home/home support provider to conduct assessments of individuals.	Care Management			

		Develop new care plans and My Independence Plans for a move to new accommodation/home support provider	Lead Social Worker			
		Ensure new service agreements are completed.	SPOC			
		Consider if there are any individuals who wish to move/transfer earlier than the final relocation date	Lead Social Worker			
3	**Continuity of care**	Keep individuals/relatives and staff informed Provider to write to each individual and inform of each stage of the process.	Provider			
		Ensure continuity of care	Provider			
4	**Contract termination**	Terminate current contract	IWC Commissioning			
		For IWC funded placements, close down purchase orders, amend relevant systems.	IWC Commissioning			
		Provide assistance where required	IWC Commissioning			
5	**Communication**	Fully brief Director of Adult Social Care/CCG Executive Chair and Clinical Lead	IWC Commissioning			

		Fully brief communications team for the Council and CCG and send out the relevant agreed press releases, once residents/ individuals requiring care and support / staff have been informed	IWC Commissioning/DASS			
		Invite relatives and residents with IWC council in attendance (if required) to a meeting to discuss home closure	Provider			
		Collate list of Frequently Asked Questions	IWC Commissioning			
		Agree Joint media statement with Provider if possible	IWC Commissioning and Provider			
		Review Communication needs weekly	IWC Commissioning and Provider			
6	**Safeguarding**	The safeguarding team will lead on any safeguarding concerns during the process	IWC Safeguarding Team and Provider			
7	**CQC**	Notify CQC of proposed Closure	Provider			
8	**Review and Monitor**	Following the closure process set up a meeting to review process and outcomes with individual's and obtain feedback from individuals and their relatives	IWC Commissioning			

		Following the closure process set up a meeting with the Provider to review the process	IWC Commissioning and Provider			
9	**Additional Matters**					
10						
11						
12						

Appendix B: <u>Agenda for Initial Meeting</u>

Name of meeting	Initial meeting between the Provider (NAME) and the Isle of Wight Council and Clinical Commissioning Group (if appropriate) to discuss intended care home closure
Date and time	[type date of meeting]
Venue	[type venue]

Item Number	**Item**
	Closure timetable and final closure date
	Notice Requirements
	Consultation with individuals and their relatives/carers
	Maintenance of care standards and continuity of care
	Identification of individuals – Provider to compile list
	Phasing of assessments –identification of individuals Isle of Wight Council funded / Self-funding / other local authority individuals / Clinical Commissioning Group funded
	Staff briefing
	Phasing of transfer to new provider
	Registration/Regulator issues
	Contract issues
	Financial issues –appointee/benefits
	Other suitable vacancies/alternative providers
	Further meeting/s with Provider
	Populate Action Plan and agree the same
	Any other care planning and care continuity business

Appendix C: Individual Information Sheet

INDIVIDUAL INFORMATION SHEET **To be completed by the provider**		
Home:		
Name of Individual:		
Care Home/Home Support Provider: If care home category of Registration (e.g. LD, older persons, nursing):	Registration details:	
Care band (if applicable):		
Home Support Provider Total Hours Provided:		
Next of kin details:		
Relationship:		
Telephone number:		
Advised:	Yes ☐	No ☐
	Date:	Time:
GP Name and address:		
GP Telephone No:		
GP advised:	Yes ☐	No ☐
	Date:	Time:
Forwarded to Allocated Social Care Worker/NHS Case manager (if appropriate)		
Date:		

TO BE COMPLETED BY THE ALLOCATED SOCIAL CARE WORKER / NHS CASE MANAGER		
Name of Social Care Worker / NHS Case Manager:		
Individual transferred to:		
Home Support Provider total hours:		
Care band (if applicable):		
	Date:	Time:
Transferred by:		
Care Plan completed by:		
Date issued:		
Copies issued to:		
Date of 1st review:		
Subsequent reviews:		

Appendix D: Transfer Form

(For use on day of move from care home – N/A home support)

Transfer Form		
For use on day of move from care home – n/a home support		
Date of move:		
Full Name:		
Date of Birth:		Category:
GP name and contact:		Funding: (LA/CHC/Other LA/Self-funding)
Allocated Social Care Worker /NHS Case Manager		Advocate required? Name and contact
Name and address of home moving from		
Name and address of home moving to		
Relatives: Name: Address: Telephone/email		Relatives: Name: Address: Telephone/email
Names and contact details of professional involved in care. Dieticians/District Nurses/OT/Physio/CPN		
Checklist (√)		Details
Care Plan –(including date last updated)		
Risk Assessments		
Medication list		
Other medical supplies. e.g. dressings, catheters		
Specialist equipment/aids		
Personal belongings (provide details, e.g. no. of bags/boxes, any furniture)		
Transport		
Additional information not covered above		