# The Rate, Causes and Consequences of Home Closures

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***Notes on Terminology and Symbols***

1. Percentages have usually been rounded to whole numbers and may not sum to 100 due to rounding.
2. The symbol '<1' denotes non-zero percentages of under one per cent.

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## Summary


1. One of the attributes of a mixed economy of care is that inevitably some homes will go out of business, with consequent costs for the individuals involved and the regulating authorities. However, the rise in home closures during recent years has given rise to concerns about the capacity of the care home sector and the effects on current residents.

2. This report describes the results of the first phase of a study on the causes, processes and consequences of home closure. A survey of registration and inspection (R&I) units was conducted to identify rates of closure, the proportion of closures that were due to business reasons, changes in registration, the consequences for supply and the views of unit managers. A follow up telephone interview was conducted with those units that covered areas included in a 1996 survey of homes. This interview was used to collect more detailed information about the two most recent closures.

3. Of the 215 registration and inspection units identified for the survey, 177 (82 per cent) responded. The overall response from health authority registration units (86 per cent) was higher than that from local authority units (81 per cent) and from joint health authority/local authority units (76 per cent).

4. In 2000–2001 there was a reduction of 5.8 per cent in local authority homes, 4.0 per cent in independent residential and dual registered homes, 4.9 per cent in small homes (defined as those with fewer than four places) and 4.8 per cent in nursing and dual registered homes. These corresponded to reductions of 8.5 per cent of places for local authority homes, 1.1 per cent of places for independent residential and dual registered homes, 7.6 per cent of places for small homes and 4.2 per cent of places for nursing and dual registered homes.

5. It was not possible to separately identify dual registered homes in all areas. Where it was possible, the relative change in the number of dual registered homes was less marked than the relative change in either the number of residential or the number of nursing homes. The number of dual registered homes reported by local authority and joint units increased by 0.7 per cent, compared with a reduction of 4.8 per cent in residential homes. From the information reported by health authority and joint units, the number of dual registered homes fell by 2.9 per cent, compared with a fall of 6.2 per cent for nursing homes.

6. Among local authority and independent residential homes, the greatest reductions were in the southern part of the country, whereas among small homes and nursing homes the reductions were distributed more evenly. However, the largest percentage reduction in

the number of places for both small homes and nursing homes was in the Trent region. In the London region the number of places in independent residential homes increased, largely because of the transfer of local authority homes to the independent sector, and the number of places in nursing homes also increased slightly.

7. The overall rate of home closure, 5 per cent, was very similar to the rate reported for 1999–2000 nationally. National figures for the two previous years suggested that the rate of closure was increasing dramatically. The evidence here suggests that the rate is levelling off, although if it continued at this rate there could be serious consequences for overall supply, as in some areas the number of new registrations is far from keeping pace.

8. Respondents were asked to classify closures occurring during 2000–2001 as whether they were due to business failure, enforcement action or for other reasons. This information was available for about 60 per cent of home closures. Overall, business failure was cited as the main reason for closure for 46 per cent of closures of independent residential homes and for 37 per cent of closures of small homes, but for 58 per cent of closures of nursing homes. The national figures conceal substantial variations between regions, and there was no consistent regional pattern across the different types of home.

9. Thirty-eight units provided information about 69 homes that had recently closed. Due to the approach to sampling, a higher proportion of the closed homes were nursing homes than in the national survey (41 per cent compared with 23 per cent). They were smaller than average (15 place residential homes, compared with 22 nationally, and 24 place nursing homes, compared with 35 nationally). The closed nursing homes were less likely and the closed residential homes more likely to belong to chains than homes nationally.

10. Unit managers were asked about the quality of care in the two most recently closed homes. The majority provided at least ‘fair’ quality of care: only 19 per cent were described as providing ‘poor’ care. In a third of cases the quality of care was described as ‘excellent’ or ‘good’. However, in two instances the R&I unit had cancelled the registration (lower than would be expected from the national proportion of cancellations of registration). A further 12 homes had compliance notices outstanding.

11. The most commonly cited main reasons for closure among the recently closed homes were a change in personal circumstances (including retirement and bereavement), financial reasons and care standards. In all three instances these accounted for about a quarter of the closures. Of the factors relating to standards, the maintenance, or lack of

maintenance of the premises, and the resulting deterioration of buildings and the implied cost of repairs, was the most frequently cited as the first reason for closure.

12. Respondents in the national survey were also asked about issues affecting home closures in their areas generally. Several respondents identified that it was usually a combination of factors that was associated with home closures, rather than any single issue. Where a single issue was selected as most important, it was usually the low level of fees paid by local authorities. Clearly, however, there are many other factors playing a part in current home closures, with the availability and cost of staff, particularly nursing staff, being a major issue (although this was not frequently cited as an issue in individual closures). There was some evidence that the market is acting to improve quality of care overall, but improvements in (or even maintaining) quality will clearly be limited while there are such problems in recruiting, retaining and meeting the cost of training all care staff, nursing staff and managers. This is all the more so in the face of increasing demands on the competency of homes.

13. It is not really surprising that homes, especially small homes, are closing in the face of current pressures. At present it does not seem that the planned introduction of the new care standards is having much of an impact on home closures, but it must add to the incentive to get out of the business. Opportunities to 'exit' are most prevalent where property prices are high and there are demands for alternative use of buildings.

14. The implication of the comments by respondents in the national survey is that the introduction of the new care standards has been more of an influence on the decision to close in the South East, where other pressures on homes were already very high. The higher the pressures on homes in the area, the less likely respondents were to identify low quality of care as leading to closure. However, issues relating to care standards were more frequently cited in relation to individual closures than might have been expected from the issues identified at an area level in the national survey.

15. The results for London were in some ways rather surprising. The high costs of property and the competitive labour market have been cited in the past as reasons for low levels of supply. While cost and price related issues were identified more frequently than any other issues in this region, concerns were not at the same level as in the wider South East region. The rates of closure were lower among independent residential homes, and the overall effect on capacity rather less than elsewhere in the south. This may be one reason for the lower levels of concern, or it may be that owners of homes in London are so used to both high prices of staff and the alternative value of buildings, that the issue is not one

to affect whether a home closes or not. Moreover, capacity tends to be defined more widely as long-term shortage of places. In London this means that people are often placed out of borough, indeed out of London.

16. There are three principal issues of concern about the consequences of the rate of home closure: effects on capacity, effects on quality, and the effects of the process on those involved. Clearly, there is a national reduction in available places as a result of more homes closing than are opening. In some areas this is not a great cause for concern, reflecting a response to historical over-supply and an increased diversion to caring for people in the community. However, this varies regionally, with some areas, especially in the south of the country, expressing great concern, particularly with respect to nursing home places.

17. Comments by respondents suggested that the biggest pressure is on places for older people with mental health problems, with concerns being expressed about the competence of existing homes to cope, in addition to concerns about the numbers of specialist places. Furthermore, the particular pressures on smaller homes means that choice for those who prefer more domestic surroundings is likely to be increasingly limited. The decline in numbers of small homes is likely to have a knock-on effect on the distribution of homes, and thus choice of location, a key factor in deciding on a home.

18. One way in which the market can potentially work to improve quality is through closures of poor quality homes and the opening of better quality homes. It is clear that in some parts of the country, at least, this is happening. However, where pressures on homes get too high it is not at all clear that the effect on quality of care is beneficial. Quality of care is being driven down in some areas through shortages of suitable staff at all levels, management, nursing and basic care. The fabric of buildings deteriorates when margins are tight. Thus standards are driven down, in some instances driving homes out of business, in others, presumably, simply resulting in lower quality care.

19. The second major consequence is the effect of the process of home closure on the residents, their relatives, the homes' staff and care managers. One, let alone multiple, unwanted moves is associated with increased mortality and, we would expect, a decline in physical, mental and emotional well-being. While policies may be put in place to reduce the rate, home closures will always be with us. While the majority of care is provided by the private sector, these closures will be for reasons of business failure rather than planned closures. There is a need for evidence about what is happening in practice now, on which to base future standards and develop policies about the home closure process.

# Chapter 1
# The Study

## 1.1. Background

One of the attributes of a mixed economy of care is that inevitably some homes will go out of business, with consequent costs for the individuals involved and for the regulating authorities. Considerable public concern has been expressed recently about the pressures on care homes for older people resulting in an increase in home closures (see, for example, Bunce, 2001). Press coverage suggests that home owners feel they are receiving inadequate fees for the services they provide at present, while the introduction of national care standards will have further cost implications for many homes (see, for example, Mitchell, 2001; Pollock, 2001; Steele, 2001). Nationally, there has been a downturn in the number of nursing home places and a levelling off in the numbers of residential care places. However, the picture seems to be mixed geographically, and much of the discussion is based on anecdotal evidence. There is a need for more systematic information about the rate of home closures, the effect of this on the supply of places and types of home available, the reasons underlying business failures and the consequences for staff and residents.

The Department of Health commissioned the Personal Social Services Research Unit to undertake a study to examine these issues. The aims of the study are to identify:

- The rates of closure of all types of homes for older people nationally, and the consequences for local supply.
- The rates of home closure that are attributable to business failure nationally and regionally, and the reasons for this.
- The types and characteristics of homes that are going out of business.
- The combinations of circumstances that lead to home closure as a result of business failure.
- The consequences for staff and residents.

The work forms part of the long-term programme of PSSRU, but also feeds into a wider Department of Health-led project on the supply of care homes. This paper reports on the results of the first phase of the study: a study from the perspective of registration and inspection units. This chapter describes the study and response rates. Chapter 2 identifies national and regional rates of closure, new and changing registrations of homes, and the characteristics of homes that are closing. Chapter 3 describes registration and inspection

(R&I) unit managers' views of the reasons behind closures, and the effects on capacity and quality of care. Chapter 4 considers the evidence available from the study about the consequences of current closures.

### 1.2 The Study

R&I units are responsible for registering and de-registering independent homes. Thus, they have a unique perspective into both the rates of home closure and factors associated with them in their locality. A national survey of units was undertaken in April 2001 to identify the rates of home closure, the primary underlying reasons for these closures, and local demand and supply issues.

We also took the opportunity to follow up a previous national survey of homes conducted in a cross-section of types of authority in England in 1996 (Netten et al., 1998). The R&I units which covered the 21 authorities in the 1996 survey were contacted, and a telephone interview was conducted with unit managers[1] between April and June 2001. This interview was used to follow up homes identified in the 1996 survey that had since closed. The results of this are reported elsewhere (Darton, 2002). Unit managers were also asked about the characteristics of the two most recent homes that had closed and the factors that lay behind closure in these particular instances. They were also invited to comment on the current situation with respect to home closures in their area. This report includes information obtained from the interviews with unit managers about recent closures.

### 1.3 Response Rates and Regional Coverage

Table 1.1 shows the response to the national survey. Of the 215 registration and inspection units identified, 177 (82 per cent) responded. The overall response from health authority registration units (86 per cent) was higher than that from local authority units (81 per cent) and from joint health authority/local authority units (76 per cent). There were regional variations in response rates. Response rates from units in the North West, Trent and London regions were below the overall response rates for both local authority and health authority units. Three returns provided insufficient information to be used in the analysis, although information from one of these returns is included in section 8, below. The remainder of the

[1] Interviews were conducted by Ipsos-Insight.

analyses contained in this report are based on returns from 174 registration and inspection units.

**Table 1.1: Response to the survey**

| *Region* | *Local authority units* | | *Health authority units* | | *Joint units* | | *All units* | |
|---|---|---|---|---|---|---|---|---|
| | *Total no.* | *No. of respondents*[2] | *Total no.* | *No. of respondents*[3] | *Total no.* | *No. of respondents*[4] | *Total no.* | *No. of respondents* |
| Northern & Yorkshire | 16 | 16 | 8 | 7 | 3 | 3 | 27 | 26 |
| North West | 20 | 13 | 16 | 12 | 1 | 1 | 37 | 26 |
| Trent | 12 | 9 | 9 | 7 | 2 | 2 | 23 | 18 |
| West Midlands | 10 | 8 | 9 | 9 | 4 | 2 | 23 | 19 |
| Eastern | 6 | 6 | 5 | 5 | 2 | 1 | 13 | 12 |
| London | 29[1] | 21 | 14 | 11 | 2 | 2 | 45 | 34 |
| South East | 12 | 10 | 12 | 12 | 1 | 1 | 25 | 23 |
| South West | 14 | 13 | 6 | 5 | 2 | 1 | 22 | 19 |
| Total | 119 | 96 | 79 | 68 | 17 | 13 | 215 | 177 |

Notes:
1. Excluding City of London.
2. Including 1 return excluded from subsequent analyses.
3. Including 1 return excluded from subsequent analyses.
4. Including 1 return excluded from subsequent analyses, except analysis reported in section 3.5.

Where there were substantial amounts of missing data in the national survey, the registration and inspection units were telephoned and asked to double-check the information provided. Approximately 15 per cent of the responding managers reported finding it difficult to provide the information requested due to the nature of record-keeping procedures. Difficulties included the lack of, or limited nature of databases. To establish the number of homes or places for older people at 31st March 2000 and 31st March 2001, for example, required some managers to conduct a manual check. Difficulties in establishing the number of homes and places for older people also included the following:

- information being recorded by availability for each client group rather than total places by home type, with the consequence that places were sometimes double-counted;
- difficulties in establishing the number of homes with fewer than four places: for example nursing homes with fewer than four places registered as residential could be classified by local authorities either as small residential homes or as dual registered homes;
- confusion over the number of places that were registered for use both as residential and nursing places;
- the use of homes by more than one client group;
- an inability to report the number of dual registered homes.

A recent study of six health authorities found considerable deficiencies in record keeping, including the identification of the current registration status of homes, which suggests that the difficulties reported to us are not uncommon and the level of missing and inconsistent data is a consequence of record-keeping and data management practices (Woods, 2001). However, in the case of dual registered homes, separate information on these homes is required in the annual returns to the Department of Health by local authorities and health authorities relating to residential homes and to nursing homes (Miller and Darton, 2000). Thus, it should have been possible for separate information on dual registered homes to have been provided.

The appendix describes the characteristics of the national sample in terms of national and regional representativeness. As may be expected from the information on responses by units, the respondent units in the North West, Trent and London regions accounted for smaller proportions of residential homes and places for respondents than nationally. The North West and London regions, but not the Trent region, also accounted for smaller proportions of nursing homes and places for respondents than nationally. Although high proportions of units responded in the South East and South West, the respondent units in the South East region accounted for smaller proportions of residential homes and places for respondents than nationally, while the respondent units in the South West region accounted for smaller proportions of nursing homes and places for respondents than nationally.

Due to the problems described above, the figures for dual registered homes could not be separated from those for nursing homes or residential homes for all respondents. As a result, most of the figures for residential and nursing homes presented in this report include figures for dual registered homes. Information on residential homes and dual registered homes has been drawn from returns from local authority and joint health authority/local authority units, and information on nursing homes and dual registered homes has been drawn from returns from health authority and joint health authority/local authority units. Thus, information on dual registered homes has been included in both the residential and the nursing home figures. In a number of cases, respondents left questions blank instead of entering zeros. Blank responses have normally been treated as zeros, and information supplied on the questionnaire was used to impute the number of homes where this information was missing. Furthermore, a number of respondents reported the main reason for home closures for both 1999–2000 and for 2000–2001, instead of just for the second period. As a result, the information on the main reason for home closures reported below includes some responses relating to both years. Additionally, although information on the number of changes in registration status was collected separately from information on the number of closures, it appears that some respondents may have recorded such changes in registration status as closures or as both

closures and changes in registration status. No adjustments have been made for such cases. Further details of data quality issues and adjustments to the data are given in the appendix.

Eighty-nine per cent of the registration and inspection units for authorities included in the 1996 survey of care homes provided information. Of the 44 units contacted, 39 provided information. Five inspection and registration units were unable/unwilling to participate due to sickness, lack of time or lack of information. Table A.7 in the appendix shows the distribution of the units across the regions. The North West is over-represented in our sample of units, with the consequence that other regions are slightly under-represented. The exception is London, which was deliberately over-sampled in the 1996 survey. The relatively large number of units in London in total means that the proportion of units from that region in the sample is only slightly higher than the national proportion.

Units were asked about their two most recent closures. Thirty-four units provided information about the two most recent home closures, three units in the North West provided information about the last most recent home closure, reporting that there had been only one recent closure, one London unit reported no closures since 1995 and another did not provide any information. Three of these 72 homes were local authority residential home closures and so have been excluded from the analysis. In total details of 69 recent closures were provided by 38 units. Table 1.2 shows the registration category of the most recent home closures for which details were given in the telephone survey by region. Primarily because of the distribution of respondent units, our sample includes a disproportionately high number of homes from London and the North West.

**Table 1.2: The two most recent home closures reported in the telephone survey, by region**

| *Region* | *Residential homes* | *Nursing homes* | *Dual registered homes* | *Total* |
|---|---|---|---|---|
| | *No.* | *No.* | *No.* | *No.* |
| Northern & Yorkshire | 4 | 2 | 0 | 6 |
| North West | 8 | 6 | 5 | 19 |
| Trent | 3 | 4 | 0 | 7 |
| West Midlands | 3 | 1 | 0 | 4 |
| Eastern | 1 | 2 | 1 | 4 |
| London | 7 | 8 | 0 | 15 |
| South East | 4 | 2 | 0 | 6 |
| South West | 4 | 3 | 1 | 8 |
| Total | 34 | 28 | 7 | 69 |

## 1.4 Conclusion

Registration and inspection units are uniquely placed to provide an overview of home closures and issues associated with them. Both the national postal survey and the follow-up telephone interviews achieved satisfactory response rates. We were particularly concerned about the regional distribution as we anticipated different pressures in different parts of the country. The national sample is reasonably representative of regions, although there was a slight under-representation of the North West, Trent and London. In contrast, the initial sampling frame of the 1996 survey resulted in an over-representation of sample homes that had closed from the North West and London. Nevertheless, closed homes were drawn from all regions so they can be expected to provide useful insights into the characteristics and causes of home closures.

# Chapter 2
# Rates of Home Closure in Context

## 2.1 Introduction

This chapter starts by examining overall levels of provision in terms of homes and places, and changes in capacity over the year prior to the survey. This provides a useful context to the description of the rate of home closure over the past two years, the degree to which new homes were opening to replace closed homes and how this varied between regions. The level of provision of each type of home and place is also affected by changes in registration status. We describe these changes before turning to the characteristics of those homes that closed most recently.

## 2.2 Changes in Numbers of Homes and Places

Tables 2.1 and 2.2 show the number of homes for older people and the number of places in homes at 31st March 2000 and at 31st March 2001, as reported by the respondent units. Missing information on the number of homes was imputed from the information supplied on the questionnaire (see the appendix), but missing information on the number of places could not be imputed, and so table 2.2 is based on fewer returns. Table 2.3 shows the percentage change in the number of homes and places between the two dates. Overall, there was a reduction of 5.8 per cent for local authority homes, 4.0 per cent for independent residential homes, 4.9 per cent for small homes, that is, those with fewer than four places, and 4.8 per cent for nursing homes. These corresponded to reductions of 8.5 per cent of places for local authority homes, 1.1 per cent of places for independent residential homes, 7.6 per cent of places for small homes and 4.2 per cent of places for nursing homes. Among local authority and independent residential homes, the greatest reductions were in the southern part of the country, whereas among small homes and nursing homes, the reductions were distributed more evenly.

**Table 2.1: Number of residential and nursing homes for older people reported in survey, by region, 31st March 2000 and 31st March 2001**

| *Region* | *Local authority homes* | | *Independent residential & dual reg homes* | | *Small homes* | | *Nursing & dual registered homes* | |
|---|---|---|---|---|---|---|---|---|
| | *2000* | *2001* | *2000* | *2001* | *2000* | *2001* | *2000* | *2001* |
| Northern & Yorkshire | 243 | 234 | 1421 | 1395 | 460 | 431 | 706 | 690 |
| North West | 188 | 183 | 1507 | 1450 | 481 | 484 | 683 | 641 |
| Trent | 132 | 128 | 1010 | 1023 | 295 | 275 | 537 | 511 |
| West Midlands | 109 | 104 | 798 | 773 | 196 | 184 | 437 | 422 |
| Eastern | 126 | 115 | 749 | 745 | 135 | 120 | 286 | 273 |
| London | 89 | 74 | 453 | 456 | 183 | 168 | 372 | 356 |
| South East | 159 | 157 | 2205 | 2084 | 639 | 629 | 889 | 839 |
| South West | 114 | 98 | 1805 | 1626 | 567 | 521 | 565 | 529 |
| Total | 1160 | 1093 | 9948 | 9552 | 2956 | 2812 | 4475 | 4261 |

**Table 2.2: Number of places in residential and nursing homes for older people reported in survey, by region, 31st March 2000 and 31st March 2001**

| *Region* | *Local authority homes*[1] | | *Independent residential & dual reg homes*[2] | | *Small homes*[3] | | *Nursing & dual registered homes*[4] | |
|---|---|---|---|---|---|---|---|---|
| | *2000* | *2001* | *2000* | *2001* | *2000* | *2001* | *2000* | *2001* |
| Northern & Yorkshire | 7560 | 6867 | 22174 | 21990 | 842 | 722 | 16210 | 15152 |
| North West | 4559 | 4322 | 24407 | 24687 | 759 | 793 | 17390 | 16750 |
| Trent | 3109 | 2982 | 14061 | 14450 | 422 | 356 | 11763 | 10589 |
| West Midlands | 3608 | 3446 | 13950 | 14078 | 524 | 487 | 12441 | 12415 |
| Eastern | 4568 | 4144 | 13176 | 13116 | 357 | 326 | 8651 | 8507 |
| London | 3186 | 2506 | 9087 | 9532 | 366 | 333 | 11258 | 11308 |
| South East | 4708 | 4665 | 24892 | 23212 | 747 | 682 | 28230 | 26926 |
| South West | 3564 | 2982 | 28859 | 27895 | 1497 | 1396 | 10200 | 9563 |
| Total | 34862 | 31914 | 150606 | 148960 | 5514 | 5095 | 116143 | 111210 |

Notes:
1. Based on returns from 95 of 107 respondent units.
2. Based on returns from 86 of 107 respondent units.
3. Based on returns from 89 of 107 respondent units.
4. Based on returns from 60 of 79 respondent units.

**Table 2.3: Percentage change in number of homes and places reported in survey, 31st March 2000 – 31st March 2001, by region**

| *Region* | *Local authority homes* | | *Independent residential & dual reg homes* | | *Small homes* | | *Nursing & dual registered homes* | |
|---|---|---|---|---|---|---|---|---|
| | *Homes* | *Places* | *Homes* | *Places* | *Homes* | *Places* | *Homes* | *Places* |
| Northern & Yorkshire | –3.7 | –9.2 | –1.8 | –0.8 | –6.3 | –14.3 | –2.3 | –6.5 |
| North West | –2.7 | –5.2 | –3.8 | +1.1 | +0.6 | +4.5 | –6.1 | –3.7 |
| Trent | –3.0 | –4.1 | +1.3 | +2.8 | –6.8 | –15.6 | –4.8 | –10.0 |
| West Midlands | –4.6 | –4.5 | –3.1 | +0.9 | –6.1 | –7.1 | –3.4 | –0.2 |
| Eastern | –8.7 | –9.3 | –0.5 | –0.5 | –11.1 | –8.7 | –4.5 | –1.7 |
| London | –16.9 | –21.3 | +0.7 | +4.9 | –8.2 | –9.0 | –4.3 | +0.4 |
| South East | –1.3 | –0.9 | –5.5 | –6.7 | –1.6 | –8.7 | –5.6 | –4.6 |
| South West | –14.0 | –16.3 | –9.9 | –3.3 | –8.1 | –6.7 | –6.4 | –6.2 |
| All regions | –5.8 | –8.5 | –4.0 | –1.1 | –4.9 | –7.6 | –4.8 | –4.2 |

The number of places in local authority homes declined in all regions between the two dates, but the number of independent residential home places increased in four of the eight regions. In two regions, the North West and the Trent regions, the increase in independent residential home places exceeded the fall in local authority places. The largest proportionate reduction in local authority places and the largest proportionate increase in places in independent residential homes occurred in London. This was largely due to the transfer of local authority homes to the independent sector in two local authorities.

With the exception of the North West region, all regions exhibited a reduction in the number of small homes and the number of places in these homes. All regions exhibited a reduction in the number of nursing homes, but the changes in the numbers of places in nursing homes were more variable than the changes in the numbers of homes. Among both small homes and nursing homes, the largest percentage reduction in the number of places was in the Trent region, while in London the number of places in nursing homes increased slightly between the two dates.

The figures shown in tables 2.2 and 2.3 for the Trent region exclude the information supplied by one unit which reported a 20 per cent reduction in the number of places between the two dates. National statistics for 31st March 2001 were published by the Department of Health in November 2001 (Department of Health, 2001b). Comparison between the figures supplied by the unit and those published by the Department of Health for 31st March 2000 and for 31st March 2001 (Department of Health, 2001a, b) suggested that the figures supplied by the unit on the number of places were unreliable. However, the change in the total number of

places in nursing homes, private hospitals and clinics between the two dates, derived from the national statistics, was also greatest for the Trent region.

As noted above, the figures for dual registered homes could not always be separated from those for nursing homes and, in a few cases, the figures for dual registered homes could not be separated from those for residential homes. Tables 2.4 and 2.5 show the number of homes at 31st March 2000 and at 31st March 2001, and the percentage change in the number of homes between the two dates, for those respondents for whom separate figures for dual registered homes were available. These accounted for 103 of the 107 local authority and joint units that responded (76 per cent of all such units) and for 69 of the 79 health authority and joint units that responded (72 per cent of all such units). Dual registered homes accounted for 16 per cent of residential and dual registered homes and for 38 per cent of nursing and dual registered homes at 31st March 2000. The corresponding figures for 31st March 2001 were 17 per cent and 39 per cent. As may be expected from the slight increase in the proportions of dual registered homes between the two dates, the relative change in the number of dual registered homes was less marked than the relative change in either the number of residential or the number of nursing homes. Whereas the number of residential homes fell by 4.8 per cent, the number of dual registered homes reported by local authority and joint units increased by 0.7 per cent. From the information reported by health authority and joint units, the number of dual registered homes fell by 2.9 per cent, compared with a fall of 6.2 per cent for nursing homes. In the case of the Trent region, the substantial reduction in the number of nursing homes shown in table 2.5 resulted from the exclusion of information for two units for which the figures for dual registered homes could not be separated from those for nursing homes. Excluding the Trent region, the number of nursing homes fell by 5.6 per cent.

**Table 2.4: Number and percentage change in number of independent residential and dual registered homes for older people reported in survey, 31st March 2000 – 31st March 2001, by region**[1]

| *Region* | *Independent residential homes* | | | *Dual registered homes* | | |
|---|---|---|---|---|---|---|
| | *2000* | *2001* | *% change* | *2000* | *2001* | *% change* |
| Northern & Yorkshire | 1122 | 1084 | –3.4 | 299 | 311 | +4.0 |
| North West | 1209 | 1171 | –3.1 | 298 | 279 | –6.4 |
| Trent | 637 | 636 | –0.2 | 269 | 284 | +5.6 |
| West Midlands | 520 | 499 | –4.0 | 105 | 117 | +11.4 |
| Eastern | 641 | 632 | –1.4 | 108 | 113 | +4.6 |
| London | 402 | 403 | +0.2 | 51 | 53 | +3.9 |
| South East | 1869 | 1765 | –5.6 | 171 | 161 | –5.8 |
| South West | 1558 | 1385 | –11.1 | 247 | 241 | –2.4 |
| Total/all regions | 7958 | 7575 | –4.8 | 1548 | 1559 | +0.7 |

Note:
1. Based on returns from 103 of 107 respondent units.

**Table 2.5: Number and percentage change in number of nursing and dual registered homes for older people reported in survey, 31st March 2000 – 31st March 2001, by region**[1]

| *Region* | *Nursing homes* | | | *Dual registered homes* | | |
|---|---|---|---|---|---|---|
| | *2000* | *2001* | *% change* | *2000* | *2001* | *% change* |
| Northern & Yorkshire | 299 | 287 | –4.0 | 194 | 197 | +1.5 |
| North West | 333 | 309 | –7.2 | 313 | 295 | –5.8 |
| Trent | 151 | 128 | –15.2 | 247 | 244 | –1.2 |
| West Midlands | 285 | 263 | –7.7 | 152 | 159 | +4.6 |
| Eastern | 140 | 131 | –6.4 | 107 | 104 | –2.8 |
| London | 227 | 223 | –1.8 | 55 | 52 | –5.5 |
| South East | 640 | 604 | –5.6 | 249 | 235 | –5.6 |
| South West | 327 | 308 | –5.8 | 174 | 162 | –6.9 |
| Total/all regions | 2402 | 2253 | –6.2 | 1491 | 1448 | –2.9 |

Note:
1. Based on returns from 69 of 79 respondent units.

Given the relative response rates (76 per cent and 72 per cent), the total numbers of dual registered homes reported by local authority and joint units and by health authority and joint units are similar. Using the response rates to produce crude overall estimates of the number of dual registered homes, assuming that the respondents form unbiased samples of the total number of units, gives estimates for 31st March 2000 of 2037 dual registered homes from local authority and joint units and 2071 dual registered homes from health authority and joint units. The corresponding figures for 31st March 2001 are 2051 and 2011.

However, as a result of different patterns of non-response and the relatively small numbers of units within regions, the numbers of dual registered homes reported by local authority and joint units and by health authority and joint units show much greater variation within regions. From information reported by local authority and joint units, the relative number of dual registered homes showed less of a decline than did the number of residential homes. However, the percentage fall was greater for dual registered homes than for residential homes in the North West region, and the percentage falls were similar in the South East region. Comparisons of changes in the number of dual registered homes with changes in the number of nursing homes show that the fall in the relative number of dual registered homes was less than for nursing homes outside the southern part of the country. In the London and the South West regions, the percentage fall in the number of dual registered homes was greater than for nursing homes and, again, the percentage falls were similar in the South East region. Despite a lower level of response from local authority units than from health authority units in the South East region, the percentage reductions in the number of dual registered homes derived

from the two sources were almost identical (5.8 per cent and 5.6 per cent). The North West region was the only other region for which similar estimated changes in the number of dual registered homes were obtained from local authority and joint units and from health authority and joint units, despite having a relatively low level of response (see table 1.1).

## 2.3 Numbers of Homes Closing and Opening

Table 2.6 shows the number of closures of homes reported in the years 31st March 1999 – 31st March 2000 and 31st March 2000 – 31st March 2001. Table 2.7 shows the number of closures in 2000–2001 as a proportion of the homes open at the beginning of the period. As noted above, some respondents appear to have recorded changes in registration status as closures, and thus the figures given in this section include such cases. However, the total number of changes in registration status was relatively small (see section 6, below). For both local authority homes and independent residential homes, the overall number of closures reported for each of the two years were similar, whereas for small homes and nursing homes the number of closures reported for the first year was greater than the number reported for the second year. Overall, approximately 5 per cent of local authority homes, independent residential homes and nursing homes were reported as having closed in 2000–2001, whereas the figure for small homes was 11 per cent. These rates are similar to national rates reported for 1999–2000, which showed an increase on the previous year (Department of Health, 1999, 2000a). Between 1998–1999 and 1999–2000 the rates of closure of independent residential homes more than doubled and for nursing homes increased by nearly 50 per cent. However, the results of our study suggest that the levels of closure may be levelling off.

**Table 2.6: Number of closures of residential and nursing homes reported in survey, 31st March 1999 – 31st March 2000 and 31st March 2000 – 31st March 2001, by region**

| *Region* | *Local authority homes* | | *Independent residential & dual reg homes* | | *Small homes* | | *Nursing & dual registered homes* | |
|---|---|---|---|---|---|---|---|---|
| | *1999–2000* | *2000–2001* | *1999–2000* | *2000–2001* | *1999–2000* | *2000–2001* | *1999–2000* | *2000–2001* |
| Northern & Yorkshire | 3 | 10 | 69 | 65 | 47 | 47 | 20 | 28 |
| North West | 7 | 6 | 69 | 72 | 40 | 50 | 38 | 34 |
| Trent | 5 | 5 | 22 | 32 | 45 | 28 | 29 | 21 |
| West Midlands | 8 | 5 | 35 | 38 | 27 | 24 | 19 | 13 |
| Eastern | 2 | 2 | 21 | 21 | 23 | 18 | 24 | 9 |
| London | 15 | 12 | 27 | 22 | 26 | 14 | 21 | 14 |
| South East | 3 | 2 | 164 | 149 | 63 | 59 | 68 | 65 |
| South West | 2 | 7 | 118 | 124 | 87 | 76 | 35 | 41 |
| Total | 45 | 49 | 525 | 523 | 358 | 316 | 254 | 225 |

**Table 2.7: Closures of residential and nursing homes during 31st March 2000 – 31st March 2001, as proportion of homes open on 31st March 2000, by region**

| *Region* | *Local authority homes* | | | *Independent residential & dual reg homes* | | | *Small homes* | | | *Nursing & dual registered homes* | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Homes 31/3/00* | *Closures 2000–01* | | *Homes 31/3/00* | *Closures 2000–01* | | *Homes 31/3/00* | *Closures 2000–01* | | *Homes 31/3/00* | *Closures 2000–01* | |
| | *No.* | *No.* | *%* | *No.* | *No.* | *%* | *No.* | *No.* | *%* | *No.* | *No.* | *%* |
| Northern & Yorkshire | 243 | 10 | 4 | 1421 | 65 | 5 | 460 | 47 | 10 | 706 | 28 | 4 |
| North West | 188 | 6 | 3 | 1507 | 72 | 5 | 481 | 50 | 10 | 683 | 34 | 5 |
| Trent | 132 | 5 | 4 | 1010 | 32 | 3 | 295 | 28 | 9 | 537 | 21 | 4 |
| West Midlands | 109 | 5 | 5 | 798 | 38 | 5 | 196 | 24 | 12 | 437 | 13 | 3 |
| Eastern | 126 | 2 | 2 | 749 | 21 | 3 | 135 | 18 | 13 | 286 | 9 | 3 |
| London | 89 | 12 | 13 | 453 | 22 | 5 | 183 | 14 | 8 | 372 | 14 | 4 |
| South East | 159 | 2 | 1 | 2205 | 149 | 7 | 639 | 59 | 9 | 889 | 65 | 7 |
| South West | 114 | 7 | 6 | 1805 | 124 | 7 | 567 | 76 | 13 | 565 | 41 | 7 |
| Total | 1160 | 49 | 4 | 9948 | 523 | 5 | 2956 | 316 | 11 | 4475 | 225 | 5 |

The rate of closure was slightly higher in the South East and South West regions than elsewhere, but closure rates in the Northern and Yorkshire and the North West regions tended to be slightly higher than in the central part of the country. Among local authority homes, rates of closure were higher in the London and the South West regions than elsewhere, as may be expected from the changes in the number of homes reported above.

Table 2.8 shows the number of new registrations of homes reported in the years 31st March 1999 – 31st March 2000 and 31st March 2000 – 31st March 2001. Table 2.9 shows the number of new registrations in 2000–2001 as a proportion of the homes open at the beginning of the period. The number of new registrations reported for the first year was greater than the number reported for the second year, for each type of home. Only two new local authority homes were opened in 2000–2001. Among independent residential homes, new registrations corresponded to 2 per cent of the stock of homes at the beginning of the year, but among nursing homes the figure was only one per cent. The new registrations of independent residential homes balanced the closures of homes in the Northern and Yorkshire and the Eastern regions, but elsewhere the number of closures exceeded the number of new registrations. As noted above, although the number of independent residential homes fell slightly in the Northern and Yorkshire and the Eastern regions in 2000–2001, the reduction was less than 2 per cent. Thus, the overall change in the number of homes was consistent with the number of closures and new registrations reported for these two regions.

**Table 2.8: Number of new registrations of residential and nursing homes for older people reported in survey, 31st March 1999 – 31st March 2000 and 31st March 2000 – 31st March 2001, by region**

| *Region* | *Local authority homes* | | *Independent residential & dual reg homes* | | *Small homes* | | *Nursing & dual registered homes* | |
|---|---|---|---|---|---|---|---|---|
| | *1999–2000* | *2000–2001* | *1999–2000* | *2000–2001* | *1999–2000* | *2000–2001* | *1999–2000* | *2000–2001* |
| Northern & Yorkshire | 0 | 0 | 75 | 66 | 42 | 41 | 16 | 12 |
| North West | 2 | 0 | 46 | 23 | 33 | 26 | 15 | 3 |
| Trent | 0 | 1 | 23 | 19 | 33 | 25 | 8 | 6 |
| West Midlands | 0 | 0 | 36 | 19 | 14 | 17 | 6 | 6 |
| Eastern | 0 | 0 | 46 | 28 | 10 | 9 | 9 | 4 |
| London | 0 | 0 | 28 | 18 | 18 | 13 | 16 | 12 |
| South East | 0 | 1 | 38 | 34 | 24 | 30 | 14 | 9 |
| South West | 1 | 0 | 42 | 33 | 57 | 36 | 7 | 7 |
| Total | 3 | 2 | 334 | 240 | 231 | 197 | 91 | 59 |

**Table 2.9: New registrations of residential and nursing homes during 31st March 2000 – 31st March 2001, as proportion of homes open on 31st March 2000, by region**

| *Region* | *Local authority homes* | | | *Independent residential & dual reg homes* | | | *Small homes* | | | *Nursing & dual registered homes* | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Homes 31/3/00* | *Registrations 2000–01* | | *Homes 31/3/00* | *Registrations 2000–01* | | *Homes 31/3/00* | *Registrations 2000–01* | | *Homes 31/3/00* | *Registrations 2000–01* | |
| | *No.* | *No.* | *%* | *No.* | *No.* | *%* | *No.* | *No.* | *%* | *No.* | *No.* | *%* |
| Northern & Yorkshire | 243 | 0 | 0 | 1421 | 66 | 5 | 460 | 41 | 9 | 706 | 12 | 2 |
| North West | 188 | 0 | 0 | 1507 | 23 | 2 | 481 | 26 | 5 | 683 | 3 | <1 |
| Trent | 132 | 1 | <1 | 1010 | 19 | 2 | 295 | 25 | 8 | 537 | 6 | 1 |
| West Midlands | 109 | 0 | 0 | 798 | 19 | 2 | 196 | 17 | 9 | 437 | 6 | 1 |
| Eastern | 126 | 0 | 0 | 749 | 28 | 4 | 135 | 9 | 7 | 286 | 4 | 1 |
| London | 89 | 0 | 0 | 453 | 18 | 4 | 183 | 13 | 7 | 372 | 12 | 3 |
| South East | 159 | 1 | <1 | 2205 | 34 | 2 | 639 | 30 | 5 | 889 | 9 | 1 |
| South West | 114 | 0 | 0 | 1805 | 33 | 2 | 567 | 36 | 6 | 565 | 7 | 1 |
| Total | 1160 | 2 | <1 | 9948 | 240 | 2 | 2956 | 197 | 7 | 4475 | 59 | 1 |

As noted above, information on dual registered homes could not always be separated from information on nursing homes and, in some cases, from information on residential homes. For those respondents for whom separate figures were available, dual registered homes accounted for 17 per cent of residential and dual registered homes and for 39 per cent of nursing and dual registered homes at 31st March 2001. However, dual registered homes accounted for relatively fewer closures and, for residential and dual registered homes, relatively more new registrations. For the year 31st March 2000 – 31st March 2001, dual registered homes accounted for 10 per cent of closures and 32 per cent of new registrations of

residential and dual registered homes, and for 30 per cent of closures and 38 per cent of new registrations of nursing and dual registered homes.

Comparisons between regions of rates of closure and of new registrations of dual registered homes are limited by the small number of closures and new registrations of dual registered homes. Rates of closures of dual registered homes reported by local authority and joint units tended to be highest in the London and the South East regions and lowest in the central part of the country. However, the pattern of rates of closure of dual registered homes reported by health authority and joint units was more variable, as was the pattern of new registrations obtained from local authority and joint units and from health authority and joint units.

Necessarily, the data provide just a snapshot of a dynamic situation, and as a result can over- or understate the problem. In the open-ended question seven units made it clear that they did not have a problem with closures, and that they felt public concern was misplaced. As would be expected, given the results reported above, these were mostly in the north of the country, apart from two units that were in London. In one case there were four new private homes due to be opened, between them increasing supply by 181 places. The health and local authority units for one London borough both identified large new providers coming into the area, potentially resulting in over-supply locally.

However, eight other units throughout the country were concerned that the current snapshot approach might underestimate the extent of the problem. They identified that, although in some cases there had not been many closures to date in their areas, several homes were on the brink of closing or due to close shortly. In one unit in the South West there was a sense of a crisis looming, with two full homes considering closure and insufficient vacancies to accommodate the residents. In another unit in the South East, a further 140 nursing places were going to be lost due to closures in the three months immediately after the survey date.

### 2.4 Changes in Registration Status

Table 2.10 shows the number of changes in registration status of homes reported in the years 31st March 1999 – 31st March 2000 and 31st March 2000 – 31st March 2001. As noted above, some respondents appear to have recorded changes in registration status as closures or as both closures and changes in registration status. The figures given in this section exclude cases where changes in registration status were recorded only as closures. The total number of changes reported was relatively small, so the information has not been disaggregated by region. As noted above, a number of respondents to the survey left questions blank instead of

entering zeros. For the question on changes in registration status, it has not been possible for this report to separate missing information from valid zero values. Among the 107 local authority and joint units, 81 reported changes in registration status in one or both years, and among the 79 health authority and joint units the corresponding figure was 62. For comparison with the numbers of homes which changed their registration status, the numbers of homes of each type shown in table 2.10 are the numbers reported by the units which reported changes in registration status in one or both years.

**Table 2.10: Changes of registration status of residential and nursing homes, 31st March 1999 – 31st March 2000 and 31st March 2000 – 31st March 2001**

| *Information* | *Local authority & joint units* | | *Health authority & joint units* | |
|---|---|---|---|---|
| | *1999–2000* | *2000–2001* | *1999–2000* | *2000–2001* |
| Number of units | | | | |
| Number of respondents | 107 | 107 | 79 | 79 |
| Number with registration status changes | 81 | 81 | 62 | 62 |
| Number of homes[1] | | | | |
| Local authority | 948 | 882 | - | - |
| Independent residential & dual registered homes | 8282 | 8047 | - | - |
| Small homes | 2281 | 2174 | - | - |
| Nursing & dual registered homes | - | - | 3755 | 3564 |
| Number of changes of registration status | | | | |
| From residential to nursing | 0 | 3 | 4 | 1 |
| From residential to dual registered | 11 | 5 | 5 | 1 |
| From nursing to residential | 12 | 23 | 42 | 51 |
| From nursing to dual registered | 43 | 58 | 50 | 54 |
| From dual registered to residential | 28 | 38 | 40 | 30 |
| From dual registered to nursing | 6 | 6 | 28 | 4 |
| From local authority to independent | 57 | 25 | 0 | 0 |
| From 4+ places to fewer than 4 places | 30 | 36 | 8 | 9 |
| From fewer than 4 places to 4+ places | 47 | 47 | 4 | 7 |
| To cater for different client group | 71 | 70 | 17 | 28 |

Note:
1. Number of homes reported by units which reported changes in registration status in either period.

The proportion of homes that changed registration status was small, particularly in the independent residential home sector. Nursing homes and dual registered homes were more likely to have changed their registration status, mainly nursing homes changing to dual registration and dual registered homes changing to residential homes. Health authority and joint units reported that similar numbers of nursing homes had changed to residential homes as had changed to dual registration, whereas the figures from local authority and joint units for changes from nursing homes to residential homes were much smaller. In addition, health

authority and joint units reported that fairly similar numbers of dual registered homes had changed to nursing homes in 1999–2000, but not in 2000–2001.

Local authority and joint units reported twice as many transfers of local authority homes to the independent sector in 1999–2000 as in 2000–2001. The number of re-registrations of small homes as homes with four or more places was unchanged, and the numbers of re-registrations of homes with four or more places as small homes were similar in the two years. Local authority and joint units reported that similar numbers of homes had changed client group in 1999–2000 as in 2000–2001, whereas the number of such changes reported by health authority and joint units was larger in 2000–2001 than in 1999–2000. However, the number of such changes reported by health authority and joint authority units was smaller than the number reported by local authority and joint units.

## 2.5 Characteristics of Recently Closed Homes

In the telephone survey, registration and inspection unit managers were asked to provide details about the two most recent closures of independent homes in their area, excluding homes with fewer than four places. Information was collected about the type and size of home; ownership; the estimated proportion of residents that were publicly- and privately-funded; their perception of the quality of care provided by the home prior to closure; and whether there were any outstanding compliance notices when the homes closed.

### *2.5.1 Type of home*

Of the two most recent closures, 41 per cent were nursing homes, 49 per cent were residential homes and 10 per cent were dual registered homes. This represents a higher proportion of nursing homes than the national picture, where about 23 per cent of homes closing were nursing, 68 per cent were residential, and about 10 per cent were dual registered. This over-sampling of closed nursing homes is due to identifying the same number of homes at the unit level, although health authority units are typically responsible for fewer homes than local authority units.

The sector of ownership was provided for all but one of the 69 recently closed homes. The majority were in the private sector (62, or 91 per cent), slightly higher than the national picture, where 88 per cent of residential homes are privately owned[2] (Department of Health,

[2] National information is not available about the proportion of nursing homes that are privately owned although the vast majority of nursing homes are in the private sector (Netten et al., 1998). Two of the homes in our sample were voluntary nursing homes.

2000b). One home had been a local authority home prior to becoming an independent residential home and a further five were in the voluntary sector.

### *2.5.2 Size of organisations and homes*

Over half of the most recently closed homes had been the only home owned by the organisation (38 of the 69 homes). Just under a third had been part of a pair of homes. Only two (3 per cent) of the closed homes had been part of a large chain of ten or more and eight (12 per cent) were part of a chain of between three and nine homes. Overall, this represents a similar picture to the national situation, where 16 per cent of homes are part of a chain (Laing and Buisson, 2001). However, nationally 25 per cent of nursing homes are part of chains of three or more, whereas in our sample this applied to just three out of 28 nursing homes. In contrast, just 7 per cent of residential homes are in such chains, compared with five out of 34, or 15 per cent of our residential sample. Two out of seven dual registered homes were in chains of ten or more homes, exactly the same proportion as prevails nationally. Four had been part of a pair of homes and one had been the single home owned by the organisation.

There was little regional variation in the size of the organisations which owned homes that closed. In each region, 50 per cent or more of the homes had been the only home owned by the organisation, with the exception of the South East and Eastern regions, where two-thirds or more of the homes had been part of a pair of homes. The eight homes that had been part of chains of three to nine homes were based in Northern and Yorkshire region, the North West, London and the South East. The two homes in chains of ten or more were based in the North West.

As we would expect from the national picture, the most recently closed homes were smaller than the national average. The size of home was provided for 66 of the 69 recent closures: the size of three residential homes was not given. The mean number of places in the residential homes that closed was 15, compared with 22 nationally (Department of Health, 2000b). The average size of the closed nursing homes was 24, compared with 35 nationally (Department of Health, 2001a). For both types of home the size varied, from six to 30 places in residential homes and from eight to 36 places in the nursing homes. Typically the residential homes were between 11 and 25 place homes (19 of the 31 residential homes). In contrast, there were as many nursing homes of 26 places or more as of 11 to 25 places (13 of the 28 nursing homes). The small number of recently closed dual registered homes (seven) typically had a higher average number of places (28 places), than either the residential or nursing homes, with sizes ranging from 18 to 40 places. The dual registered homes tended to have more nursing places than residential places (the mean number of nursing places was 19,

compared with ten residential places). The number of residential places ranged from four to 16, compared with 15 to 26 nursing places.

Size of home and size of organisation were associated, with homes in single home organisations having fewer places than homes in chains. Nearly a third of single organisation home closures (seven) had 11 places or fewer, half had 16 places or fewer and three-quarters had 22 places or fewer. On average, these homes had 17 places, compared with those closed homes that had been part of a pair of homes, which had a mean number of 23 places. The chains of three to nine homes ranged in size from ten to 31 places, with a mean number of 25 places. The two homes in chains of ten or more homes had 30 places.

### *2.5.3 Residents' funding*

Respondents did not know the sources of funding of residents in 14 (20 per cent) of the homes that had closed. The main source of residents' funding was public funding for nearly three-quarters (39) of the homes for which information was provided. Twelve of the homes (22 per cent) were reported to have a roughly equal proportion of publicly- and privately-funded residents, and only four homes (7 per cent) had mostly private residents. This suggests that these recently closed homes had been primarily reliant on local authority fees.

### *2.5.4 Inspectors' views of quality of care*

Unit managers were asked to rate the quality of care provided in the recently closed homes prior to closure on a five-point scale, ranging from excellent to poor. Only one of the units that provided information about the two most recent closures was unable to comment on the quality of care provided.

Table 2.11 shows the unit managers' opinion of the care provided prior to closure, by type of home. The units most commonly rated the quality of care provided in the recently closed homes as 'OK' or 'good'. This was the case for 26 per cent of the homes described. However, the quality of care was rated as either 'OK' (26 per cent) *or* 'good' (26 per cent) *or* 'excellent' (9 per cent) in over half of the homes. Over a third were considered to have provided merely 'fair' (19 per cent) *or* 'poor' (19 per cent) quality of care.

Views of the quality of care provided prior to closure varied by type of home. The quality of care in nursing homes was most typically rated as 'good', followed by 'fair', whereas the care in residential homes was most typically rated as 'OK' followed by 'good'. Over twice the proportion of residential homes compared to nursing homes were described as providing 'OK' quality of care prior to closure.

**Table 2.11: Unit managers' assessment of the quality of care provided prior to closure**

| *Quality of care* | *Residential homes* | | *Nursing homes* | | *Dual registered homes* | | *Total* | |
|---|---|---|---|---|---|---|---|---|
| | *No.* | *%* | *No.* | *%* | *No.* | *%* | *No.* | *%* |
| Excellent | 3 | 9 | 3 | 11 | 0 | 0 | 6 | 9 |
| Good | 8 | 23 | 9 | 32 | 1 | 14 | 18 | 26 |
| OK | 10 | 29 | 4 | 14 | 4 | 57 | 18 | 26 |
| Fair | 5 | 15 | 8 | 29 | 0 | 0 | 13 | 19 |
| Poor | 7 | 21 | 4 | 14 | 2 | 29 | 13 | 19 |
| Total | 33 | 100 | 28 | 100 | 7 | 100 | 68 | 100 |

Note:
1. The quality of care provided in one residential home was not known.

There was no regional pattern in the units managers' views of the quality of care provided in the homes prior to closure. The thirteen homes (19 per cent) rated by the units as having provided poor quality of care prior to closure were located in the North West (three homes), West Midlands (two homes), London (four homes), South East (three homes) and the South West (one home). The six homes rated as having provided excellent quality of care prior to closure were located in the North West, Trent and South West.

Two of the homes in our sample had had their registration cancelled, one residential home and one dual registered home. This represents a lower proportion of closures (about 3 per cent) than nationally, where in 1999–2000 about 7 per cent of closures were due to cancellations of registration (Department of Health, 2000a). Compliance notices were outstanding for a further 12 homes that had closed. Eight of these were residential homes and four were nursing homes. The number of outstanding compliance notices on a home ranged from one to nine. Seven of the homes that had notices outstanding had one or two such notices. The home for which nine compliance notices were specified was described as a voluntary closure, in the sense that it closed just before it was forcibly closed. Such imminent enforcement action was said to have been the case in another six of the homes with enforcement notices outstanding. However, while outstanding compliance notices may be an indicator of quality concerns, they are not always an indicator that enforcement lies behind the closure. When asked directly about the reason for closure, enforcement was only cited as the main factor in five cases and a contributory factor in a further five (see table 3.2).

When recently closed homes had one outstanding compliance notice, this most commonly concerned staffing, such as the need to appoint a manager, or inadequate staffing levels; such notices were outstanding in seven of the recently closed homes. After staffing, the most frequently cited outstanding notices related to the condition of the building, including room sizes, heating, lighting and ventilation. One home had more than three such notices. Notices concerning the health and safety of the environment, for example a lack of fire alarm testing or first aid, were the next most common type of notice, along with notices concerning health and personal care; each was reported as outstanding in four of the recently closed homes. The notices concerning health and personal care related to inadequate care plans and recording of medication. Notices relating to daily life, such as the quality of the food, were outstanding in two of the closed homes. Other notices concerning management, services, and the failure to notify the unit about an allegation of abuse by a staff member were reported to have been outstanding for individual homes.

## 2.6 Conclusion

Clearly, rates of closure are exceeding the rate at which homes are opening, resulting in an overall loss of capacity in most parts of the country. In London, where there are net gains in numbers of independent home places, there has been the largest proportional drop in local authority home places. In practice, overall capacity remains fairly static. However, in the South East and South West there have been a large number of closures leading to a substantial drop in overall capacity. Nationally, the greatest reduction is in nursing home places.

The sample of recently closed homes provides us with further insight into the types of home that are closing. As the national pattern of homes and places suggests, the homes that are closing tend to be smaller than average. With such small numbers we have to be cautious in generalising too far, but it did seem as though single or two home organisations were more highly represented among nursing homes and chains of three or more were more highly represented among residential homes. The views of the registration and inspection units reported here suggest that home closures are occurring when the quality of care provided is good or excellent, as well as when it is fair or poor. Although there were clearly quality issues for about a fifth of the homes that closed, over a third were identified as providing good or excellent quality of care. This leads us on to the next issue – the reasons that homes are closing.

# Chapter 3
# Reasons for Closure

## 3.1 Introduction

Homes close for a variety of reasons, some related to individual factors associated with particular homes and their owners, others more attributable to external pressures. Our primary focus was on understanding the pattern of factors that had led to the increase in rates of home closure. A separate paper will report on homeowners' views on this issue. Here we draw on the study of inspection units to identify their perspective.

We start by describing the various ways in which we identified information about the factors associated with home closures. We describe the national distribution of type of closure on the basis of whether it was attributed to business reasons, enforcement or other reasons, before turning to an overview of the more detailed information provided about reasons for closure in our sample homes. Many of the reasons that underlie closures had been hypothesised prior to the study. We describe the proportions of units that identified these issues as relevant in their areas before discussing in more detail the evidence at the home and unit level about each of these in turn.

## 3.2 Information about Reasons for Closure

Four approaches were taken to establishing information about the reasons that homes were closing:

- In the national survey of units, respondents were asked to classify all homes that had closed during the past year by whether the main reason for closure was business failure, enforcement action or for other reasons (for example, retirement of the owner).
- In the telephone interviews, 39 registration and inspection unit managers were asked an open-ended question about the reasons behind the two most recent closures in their area, with a view to identifying the type and range of reasons in more depth than was possible in the national survey.
- In the national survey, respondents were asked for their views about factors associated with home closures in their locality. This included identifying which of a list of issues were relevant in their areas, and a final open-ended question to identify further issues and elaborate on those identified.

- Those who participated in the telephone interviews were also asked an open-ended question about their views about factors that pertained locally.

### 3.3 Types of Closure

In order to identify the degree to which homes appeared to be being driven out of business, as opposed to being closed for enforcement-related reasons (including closing before such action was taken), respondents in the national survey were asked to classify all homes that closed during the previous year in terms of business failure, enforcement or other. In some cases, respondents reported the main reason for closure during the period 31st March 1999 – 31st March 2001. Information was available for 69 per cent of closures of local authority homes, and for 64 per cent of closures of independent residential homes. However, respondents were only able to identify the reason for 44 per cent of closures of small homes. In contrast, respondents in health authority and joint units reported the main reason for closure for 81 per cent of nursing homes. Details of the response to the relevant questions are given in the appendix.

For each type of home except local authority homes (where the majority of closures were for 'other' reasons), table 3.1 shows the proportion of closures for which the main reason was recorded. Overall, business failure was cited as the main reason for closure for 46 per cent of closures of independent residential homes and for 37 per cent of closures of small homes, but for 58 per cent of closures of nursing homes. The national figures conceal substantial variations between regions, but there was no consistent regional pattern across the different types of home.

**Table 3.1: Distribution of type of closure of independent residential homes, small homes and nursing homes, 31st March 2000 – 31st March 2001[1], by region**

| *Region* | *Independent residential & dual registered homes* | | | | *Small homes* | | | | *Nursing & dual registered homes* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *% of closures with reason given* | *Main reason for closure (%)* | | | *% of closures with reason given* | *Main reason for closure (%)* | | | *% of closures with reason given* | *Main reason for closure (%)* | | |
| | | *Business failure* | *Enforcement action* | *Other* | | *Business failure* | *Enforcement action* | *Other* | | *Business failure* | *Enforcement action* | *Other* |
| Northern & Yorkshire | 64 | 55 | 13 | 32 | 39 | 36 | 27 | 36 | 51 | 33 | 19 | 48 |
| North West | 52 | 46 | 18 | 36 | 40 | 30 | 0 | 70 | 89 | 85 | 9 | 6 |
| Trent | 76 | 39 | 11 | 50 | 25 | 71 | 0 | 29 | 94 | 48 | 3 | 48 |
| West Midlands | 68 | 35 | 8 | 58 | 64 | 11 | 0 | 89 | 95 | 79 | 11 | 11 |
| Eastern | 86 | 61 | 17 | 22 | 94 | 29 | 0 | 71 | 76 | 19 | 13 | 69 |
| London | 77 | 22 | 4 | 74 | 52 | 8 | 0 | 92 | 84 | 59 | 7 | 33 |
| South East | 73 | 55 | 14 | 31 | 60 | 64 | 11 | 25 | 87 | 55 | 7 | 38 |
| South West | 51 | 34 | 17 | 49 | 22 | 29 | 0 | 71 | 80 | 65 | 3 | 32 |
| All regions | 64 | 46 | 14 | 41 | 44 | 37 | 7 | 56 | 81 | 58 | 8 | 34 |

Note:
1. Includes closures in 1999–2000 reported by some units (see tables A.4–A.6).

For dual registered homes for which separate figures were available, the proportions of homes closing for business reasons lay between those reported for residential or for nursing homes. For cases where the main reason for closure was recorded, local authority and joint units reported that 53 per cent of dual registered homes had closed for business reasons, compared with 46 per cent of residential homes. Health authority and joint units reported that 46 per cent of dual registered homes had closed for business reasons, compared with 59 per cent of nursing homes.

### 3.4 Reasons why Sample Homes Closed

The open-ended questions about reasons for closure allowed a more in-depth description and post hoc classification of factors associated with closure in our sample homes. Responses ranged from the very specific (for example, the cost of updating the building was prohibitive) to the general (for example, financial reasons or staff problems).

All of the units specified at least one reason for all but one of the 69 home closures. Two reasons were specified for 61 per cent of the closures, three for approximately 20 per cent, four reasons for 10 per cent and five reasons for one of the closures. Table 3.2 shows the frequency with which different issues were identified, in terms of the first reason for closure offered and all of the reasons given.

The reasons for closure that were most commonly cited as the main reasons were a change in personal circumstances (including retirement and bereavement), financial reasons and factors related to care standards. In all three instances these accounted for about a quarter of the closures.

The financial reasons described ranged from the specific to the general: the bank was about to foreclose or the business ‘went bust’; a home was no longer viable (including explanations relating to the size of home); the owner was over-committed or ran out of money; or the bank refused a loan. Other reasons shown in table 3.2 were also linked with financial viability and would have been cited as business failure in the national survey of units. For example, the main reason cited for five closures was a low occupancy rate, a factor likely to reduce income, and four cited low local authority fees (not covering costs). The low proportion citing low local authority fees is somewhat surprising and is discussed further below.

Reasons associated with current and future care standards include issues related to physical environment, staff complement, quality of care, management, and the new standards. Of

these, the maintenance, or lack of maintenance of the premises, and the resulting deterioration of buildings and the implied cost of repairs was the most frequently cited as the main reason for closure.

**Table 3.2: Main reason and contributory factors for two most recent closures cited by units in the telephone survey, by type of home**

| *Reasons for closure* | *Residential homes* | | *Nursing homes* | | *Dual registered homes* | | *Total* | |
|---|---|---|---|---|---|---|---|---|
| | *Main reason* | *Factor* | *Main reason* | *Factor* | *Main reason* | *Factor* | *Main reason* | *Factor* |
| Number of homes | 34 | | 27 | | 7 | | 68 | |
| Demand | | | | | | | | |
| Lower demand for places/occupancy | 3 | 6 | 1 | 1 | 1 | 2 | 5 | 9 |
| Increasing dependency levels | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 2 |
| Pricing and contracting | | | | | | | | |
| Local authority fees low | 0 | 0 | 1 | 3 | 0 | 1 | 1 | 4 |
| Local auth contracting arrangement | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 |
| Inputs | | | | | | | | |
| Staff retention problems | 0 | 3 | 0 | 3 | 0 | 0 | 0 | 6 |
| Value of premises if sold | 1 | 4 | 0 | 2 | 2 | 2 | 3 | 8 |
| Staff costs | 0 | 0 | 1 | 2 | 1 | 1 | 2 | 3 |
| Care standards | | | | | | | | |
| Maintenance of premises | 2 | 4 | 4 | 5 | 0 | 0 | 6 | 9 |
| Management | 1 | 4 | 1 | 1 | 1 | 1 | 3 | 6 |
| Quality of care | 1 | 4 | 1 | 1 | 0 | 1 | 2 | 6 |
| Unable/unwilling to meet standards | 2 | 8 | 3 | 10 | 0 | 0 | 5 | 18 |
| Staff complement | 0 | 1 | 0 | 0 | 1 | 1 | 1 | 2 |
| Change in personal circumstances | 12 | 14 | 5 | 6 | 0 | 1 | 17 | 21 |
| Financial reasons (including size of home and excluding low occupancy) | 8 | 11 | 8 | 9 | 1 | 1 | 17 | 21 |
| Enforcement action[1] | 4 | 5 | 1 | 3 | 0 | 2 | 5 | 10 |
| Other | 0 | 1 | 0 | 3 | 0 | 0 | 0 | 4 |

Note:
1. Includes likely/threatened action. While enforcement notices were outstanding in 12 instances (see Chapter 2) these were not always cited as the reason for closure.

## 3.5 Issues underlying Home Closures identified in National Survey

As identified above, heads and senior managers of units were asked more generally for their views on factors associated with home closures in their locality. This group of people together have a unique oversight of home closures nationally as they cover all areas of the

country, and are involved on a day-to-day basis with the individual circumstances of homes closing and the effects of these closures on other homes within their area. A list of hypothesised issues was provided (see table 3.3) and respondents were asked to identify which of these was applicable to residential and to nursing homes in their area. Respondents were also asked for any other comments on the current concern about home closures. In addition to identifying reasons behind home closures, some respondents took the opportunity to comment on the effects of changes in registration, and current and anticipated effects on supply and standards.

**Table 3.3: Units identifying issues associated with closures in their area**

| *Issues associated with closures* | *Residential homes/places* | | *Nursing homes/places* | |
|---|---|---|---|---|
| | *No.* | *%* | *No.* | *%* |
| Number of units[1] | 94 | 100 | 78 | 100 |
| Supply | | | | |
| Oversupply of homes | 28 | 30 | 16 | 21 |
| Growth in alternative types of provision | 15 | 16 | 9 | 12 |
| Demand | | | | |
| Lower demand for self-funded places | 6 | 6 | 4 | 5 |
| Lower demand for publicly-funded places | 6 | 6 | 13 | 17 |
| LA use of residential places for high dependency residents | 19 | 20 | 32 | 41 |
| Pricing and contracting | | | | |
| Local authority pricing policies | 62 | 66 | 56 | 72 |
| Local authority contracting arrangements | 10 | 11 | 15 | 19 |
| Inputs | | | | |
| Problems recruiting basic care staff | 46 | 49 | 35 | 45 |
| Problems recruiting nursing care staff | 14 | 15 | 63 | 81 |
| Local wage rates | 37 | 39 | 36 | 46 |
| High property values | 34 | 36 | 26 | 33 |
| Care standards | | | | |
| Poor quality homes | 27 | 29 | 17 | 22 |
| Concerns about care standards | 43 | 46 | 37 | 47 |
| Other | 15 | 16 | 4 | 5 |

Note:
1. Including 1 return excluded from other analyses.

We divided the causal factors associated with home closures into supply-related, demand-related, prices, inputs, standards and other business-related factors. Table 3.3 shows the

proportions of respondents that identified each of the supplied factors as relevant in their areas. Responses from 81 local authority and 13 joint units are shown for residential homes and places and from 65 health authority and the 13 joint units about nursing homes and places. The table excludes 20 units that had closures but did not respond to any of the items.[3] Clearly, units do not represent equal numbers of homes or places, and so this simple headcount may give undue weight to those units regulating relatively few homes (such as London units). Table 1.1 shows the numbers of units responding by region. The responses were analysed by region and any important differences identified below. The information is not presented on a regional basis because the numbers of respondents representing any one region for any one type of home is relatively low (ranging between six and 22). This should be borne in mind in interpreting this information. Where numbers of units in the text are reported, there is no duplication of the area covered (i.e. both the health and local authority unit reporting the same issue for the same geographical area) unless specified.

The national survey showed a different pattern of response about issues relating to closures, compared with factors identified in the sample survey in relation to specific examples of recently closed homes. For example, issues relating to local authority pricing and problems related to recruiting staff dominated unit responses in terms of general factors associated with closures, whereas the issues were barely mentioned with respect to individual examples of recent closures. However, the units from which the recently closed homes were drawn showed a very similar pattern of responses to the question about issues relating to home closure as the national picture shown in table 3.3. This would suggest that, rather than the homes being drawn from atypical areas, the level of generality is affecting the types of issue being identified. In order to bring these perspectives together, we take each of the issues in turn and draw on the evidence from both sources.

### 3.6 Supply

Nationally, just under a third of unit managers identified over-supply of residential homes, and rather less (a fifth) identified over-supply of nursing homes as a reason for homes closing locally. There was considerable variation by region. Units in the North West and Trent regions were most likely to report over-supply of residential places (over half of the units responding in each region). None of the six units in the West Midlands and only one of the 22 London units reported over-supply of residential places as an issue. None of the Eastern

[3] One unit in the West Midlands was excluded from the analysis reported above because of data difficulties. However, this unit did provide information about factors associated with home closures and has been included in the following discussion.

region or London units that responded identified over-supply of nursing places as an issue. One unit in the South West identified over-supply of nursing places historically, but felt the situation now was about right. However, a greater rate of closures could start to cause problems.

Regional, and even local authority variations are relatively crude. In practice, there can be variations in levels of supply within authorities. One unit identified within its boundaries that there was an over-supply of homes and places on the coast, and a shortage of nursing places within the city.

Of course, with increasing diversity of care, over-supply of places may be a result of increases in other types of care settings, such as very sheltered housing. This effectively reduces the demand for mainstream registered places. Only a minority of units identified growth in alternative types of provision as having an impact currently on home closures. The few respondents that mentioned local authority supply explicitly usually did so in the context of the homes closing and being re-opened, usually as independent homes or sheltered housing, in one case with attached domiciliary care. One of the respondents expressed some concern at the lack of a regulatory role for sheltered housing, where care is being provided for increasingly dependent people.

One unit identified intermediate care facilities as potentially replacing some nursing home provision. This contrasted with another respondent, who identified the use of nursing homes for intermediate care as temporarily easing the pressure on homes, presumably by increasing demand for well-funded places.

Perhaps unsurprisingly, none of the unit managers cited over-supply as a reason for individual homes closing in the telephone survey. A number of managers did, however, refer to over-supply in the recent past as a reason for recent closures having had little effect on the supply of care home places in their area.

### 3.7 Demand

Only a small proportion of units (less than 10 per cent) identified a drop in demand, either for publicly or self-funded places as a relevant factor affecting residential home closures in their areas. In response to the open-ended question in the telephone survey, a similarly small proportion of the two most recent closures (13 per cent) were attributed to a decrease in demand for places.

There was rather more evidence of local authority policies affecting the nature of demand for publicly-funded nursing places. Respondents were asked about whether there were local authority policies for placing people in 'high dependency' residential places, affecting the demand for nursing places. Two-fifths of health authority and joint units identified that this was a factor locally, including seven out of eight units in the Trent region. This did not appear to be a major factor in London, however, where only one of the 13 units identified this as relevant to the demand for nursing places. Moreover, although nine of the 19 health and joint units followed up in the telephone survey identified the use of high dependency placements in residential homes as an issue affecting supply in their areas, this was only mentioned as a factor in any of the individual examples of closures in relation to one nursing home and one dual registered home.

Several respondents from health authority units highlighted this issue in their responses to the open-ended question at the end of the questionnaire. Concern was expressed at the trend, both formally in terms of contracting, and informally through 'apparent reluctance of Assessment Officers to classify individuals for nursing care'. Another respondent expressed concern that nursing assessments were either not being completed or were being undertaken by non-registered nurses. Some respondents from health authorities were concerned about whether homes (both residential and nursing) were able to meet the demands being made on them, in terms of the types of resident being placed. This tended to be focused on older people with mental health problems, particularly dementia.

One London unit described how closures are resulting from a change in demand in terms of the type of room preferred. Purchasers and clients prefer single rooms. Indeed, it was said that purchasers no longer purchase double rooms. Consequently, homes with a number of multi-occupancy rooms are likely to be experiencing a drop in demand for their places and may have to consider the viability of modernising the building now due to this market pressure, rather than solely in order to meet the new standards.

### 3.8 Pricing and Contracting

One of the key issues affecting home closures, identified by 66 per cent of respondents for residential homes and 72 per cent for nursing homes, was the level of fees paid by local authorities. This varied regionally, with all seven units in the South East and nine of the 11 units in the North West identifying this as an issue for residential homes. However, only nine of the 22 units in London identified low prices as an issue for residential homes, less than anywhere else in the country. With the exception of London, over 60 per cent of the units in

each region identified pricing policies as an important factor in the closure of nursing homes. In the South West all six units were concerned, but only six of the 13 London units identified prices paid by local authorities as a key issue for nursing homes.

The low rate of fees being paid by local authorities was also the issue that most respondents commented on, over 20 respondents identifying that this was the key factor underlying home closures. One respondent noted that it was only homes for older people that have closed. S/he attributed this to the greater flexibility homes for other client groups had for negotiating fees with the local authority. Where contingent fees were paid, relating to levels of dependency or cognitive impairment, these tended to be limited, with several respondents identifying that the difference was insufficient to meet the additional levels of staffing asked of the home. One respondent noted that the fee for people with cognitive impairment was only £1 per week extra, an amount not seen as adequate to meet the additional costs of care. One unit reported that one effect of low payments by local authorities was that many residents and families were making top-up payments. A couple of respondents identified the current budgetary constraints or deficits that the local authority was operating under as the primary reason for low fees being paid.

There was the occasional comment that, while the low level of fees was the issue that homes were most concerned about, in many cases the main causes of closure lay elsewhere: through bad management, for example. However, the overwhelming majority of respondents who made comments were of the opinion that fees were simply not high enough for homes to be able to provide the standards of care required. Many respondents linked the fee levels to rising costs faced by the homes (particularly staffing costs), and noted the differential impact on viability depending on the circumstances of the home, particularly the size of the home and the level of borrowing.

In contrast, in response to the open-ended question about reasons for the two most recent closures, low levels of fees paid by local authorities were only identified in relation to four of the closures. Unit managers may have encompassed the impact of low fee levels when they identified financial reasons as a reason for closure, but it is surprising in view of the current publicity about the issue and the national survey results that they did not mention the issue explicitly. As might be expected, a rather different picture emerges when home owners' views are sought (Williams et al., 2001). It may be that inspection unit managers do not attribute low fees paid by local authorities to the closure of particular homes as, typically, authorities pay the same or very similar fees, apart from whether the place being purchased is a residential or a nursing place.

The contractual arrangements made by local authorities were seen as influencing home closures locally by a minority of respondents (11 per cent with respect to residential homes and 19 per cent with respect to nursing homes). Another unit also identified that spot and longer-term contracts by the health authority were having an impact (presumably beneficial) on specific homes. Units were asked to specify what aspect of contracting arrangements they felt was affecting homes adversely. Several respondents referred again here to the level of fees being paid. Additional issues identified related to criteria used for identifying residents' needs – in particular 'EMI', differential treatment of homes and a move to block contracting. The implication with respect to residents' needs was that only people with very severe impairment were judged as entitled to a higher fee, again linking back to the issue of the relationship between costs and fees.

Two units identified the differential treatment of homes, in very different ways. In one authority enhanced payments were made to those homes that had quality assurance mechanisms in place, giving them a 'star rating'. It was not made clear, but presumably this was seen as acting as a deterrent to closure for the better homes. However, the other unit noted that in some instances 'embargoes' were made on homes 'unsupported by evidence'.

It appeared that the block contracts were being offered to larger homes, as some respondents commented that the contracting arrangements were seen to favour large providers, increasing the pressure on smaller homes.[4] Indeed, one respondent noted here that 'anecdotal evidence suggests that LA want "60 bed sheds"'. However, it was not necessarily seen that contracting arrangements were putting homes out of business; it was more that they were adding pressure rather than supporting homes. One respondent expressed concern that the local authority was 'manipulating' the market, attempting to get homes to move from generalist registration to specialist mental health care.

One factor related to contracting arrangements noted by a couple of respondents was a delay in payments by local authorities to homes, especially at the financial year end. Clearly, late payments can be critical when homes are experiencing business difficulties. In the telephone survey, delays in payments by a local authority were identified as the main reason for one of the recent home closures. A home was described as having had a good reputation and having provided higher than average quality of care until a point when fees ceased to be paid on time. The environment of the home declined, and concerns were raised. In the event, the

[4] Throughout this report the term 'small' home is taken to refer to homes with less than four places, as these have different regulatory arrangements than those with four or more places. The term 'smaller' homes refers to those homes that have four or more places but are smaller than average within that classification.

home closed just before it was forced to do so. The only explanation given for the decline in standards was the delays in payments by the local authority.

## 3.9 Inputs

The primary inputs to residential-based care are labour (staff) and capital (the building). The two linked aspects of inputs to the care process are their unit cost (local wage rates or property values) and their supply (availability).

### *3.9.1 Staff*

As identified above, many respondents linked the level of fees being paid by local authorities to the costs of care, primarily staff. Local wage rates were identified by about two-fifths of all respondents as a key issue, both for residential and nursing homes. This is inevitably linked to the ability to recruit suitable staff. Just under half of respondents identified the recruitment of basic care staff as an issue for both types of care home. However, problems in recruiting nursing staff for nursing homes were most acute, identified by over 80 per cent of respondents, outstripping even the level of fees paid by local authorities as a factor associated with home closure.

As would be expected, there was considerable regional variation in responses. The South East most consistently was identified as having high wage rates (seven out of nine units reported high local wages as an issue for residential homes and nine out of 12 did so for nursing homes). As with concerns about local authority fee rates, this result did not extend to London, where only about a third of the units identified wage rates as an issue.

All the units in the South East, the South West, the Eastern and the Northern and Yorkshire regions identified problems in recruiting nurses as an issue for nursing homes. The South East, South West, and West Midlands were most likely to identify problems in recruiting basic care staff for both types of home. Again, London units reported fewer problems associated with labour supply: only four of the 13 units identified nursing staff shortages and three noted problems with recruiting basic care staff as relevant issues. Trent was least likely to identify problems with recruiting basic grade staff: only two of the nine units identified this as a problem for residential homes and one of the eight units did so for nursing homes.

One issue raised in a number of instances was the minimum wage. This was seen as a factor in past closures by a number of units, with some also identifying the planned increase in October 2001 as likely to have a further impact. One respondent noted that local homes had

been paying slightly above the minimum wage before it was introduced. However, its introduction meant that rates for other low paid jobs were increased, drawing potential care workers to other occupations, which pay the same but are less physically and emotionally demanding. Linked with the minimum wage are the increased staff costs associated with changes in employment law, as homes now have to provide paid leave for staff. In the telephone survey, the minimum wage or increases in the minimum wage were not cited as reasons for any of the recent closures.

Recruitment and retention were widely cited as a key issue, although one respondent noted that some homes are more successful than others at recruiting and keeping staff, suggesting that good management has a part to play. Indeed, problems in recruiting good managers were also mentioned by several respondents. This, and the costs of training staff, was linked to the increasing demands on homes. Several respondents expressed concerns about the competency of homes to care for the type of residents that are now being placed in long-term care. Indeed, increased dependency levels among residents was identified as a factor in two of the most recent home closures in the telephone survey. One respondent cited the increase in numbers of serious complaints about care standards, Adult Protection referrals and referrals to UKCC[5] as evidence of the problem of competence among existing providers.

Some units identified that the shortage of trained nurses and inability of homes to pay the rates paid by the NHS meant that homes increasingly rely on agency nurses. This ultimately leads to higher costs and less stable staffing, with potential knock-on effects for residents.

One unit in London identified further costs being incurred as homeowners experience difficulties in getting appropriate medical inputs so 'many are having to pay retainer fees to secure the services of a GP'.

Despite the lower than expected rate of reporting problems with costs and recruitment of staff in London, two units did identify the high costs in London as an important issue. Issues such as the high cost of living and problems of parking add to the problems of recruiting staff in the capital.

Higher costs also result from requirements to increase staffing complements. This was identified by a number of respondents, especially in relation to caring for older people with dementia.

[5] United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

In the sample of recent closures, staff retention problems were identified by units as an issue in only six cases. Again, this factor may not have been regarded as a direct or primary cause of the closures, but rather an indirect contributory factor. When asked to identify issues affecting the supply of care home places in the telephone survey, however, ten of the 39 units referred to staff recruitment and retention problems. Where identified these were described as severe. Recruitment of trained staff in London, for example, was said to be 'nearly impossible'. Difficulties were attributed to a variety of reasons including rising stress levels. This was in turn linked to increased dependency levels and the availability of less stressful jobs for similar or higher pay.

### *3.9.2 Buildings and land*

As identified above, the other principal input to residential-based care is the building. The rising value of property has been cited as an important precipitating factor for closing homes, as owners can sell homes for alternative uses for a far higher rate of return than they could expect from continuing to run it as a care home. Nationally, about a third of respondents identified this as an issue.

As expected, the price of property was identified as a relevant issue more frequently in the south of the country. One respondent in the South West identified that this had been a factor in five out of eight closures. Another, in the Eastern region, reported that within the last two years property prices were such that it was more profitable to sell smaller homes as domestic dwellings, a trend confirmed by other respondents. However, none of the units in Northern and Yorkshire region identified high property values as a factor for either nursing or residential homes, and only one respondent thought the issue was relevant to residential homes in Trent. Although it was seen as important in London, where property prices are highest, less than half of the units identified this as an issue.

In the telephone survey the value of property was only cited as a factor for the closure of eight of the 68 most recent closures: in the Eastern (three cases), South East (one case), North West (three cases) and West Midlands (one case) regions. It was identified as the primary reason for closures in three instances, two in the Eastern region and one in the North West region.

For buildings, the lack of suitable land or buildings acts as a barrier to entry to the market. In the national survey, this was only identified as an issue by one unit in the South East, where the high cost of land was identified as precluding new developments. However, in the telephone survey the lack of affordable buildings was identified by seven (18 per cent) of the units as a principal issue affecting the supply of care home places. Again, this was through

restricting the number of new homes opening, in addition to providing an incentive for owners to sell the building. In the national survey, several units also identified that new entrants to the market were interested in greenfield sites rather than existing premises. However, the main effect in practice was that lack of land was encouraging alternative uses for the site or building, thus acting as an incentive to exit the market (or close the home).

### 3.10 Care Standards

Currently care standards can affect home closures in two ways. First, homes providing poor standards can close through lack of demand for places, or if they are very poor, through actual or threatened enforcement procedures. Nationally, about a fifth of units identified poor quality of nursing homes as a factor in closures, and a slightly higher proportion, 29 per cent, identified this as a factor for residential homes. Second, some owners may see the writing on the wall with the introduction of new care standards, and close on the basis that they cannot meet the cost of higher regulatory requirements. More units identified concerns about the introduction of the new care standards: just under a half for both types of home.

There was some regional variation. Between a third and two-fifths of units in most regions identified poor quality residential homes as an issue, but none of the units in the South West and only three of the 22 London units did so. This pattern was not reflected in nursing homes, where the distribution was more evenly spread. In the sample of recently closed homes, problems in meeting current standards in terms of building maintenance were identified in nine of the 68 most recent closures. Poor management and quality of care were both identified as issues in six of the closures, and were more likely to occur in residential than nursing or dual homes. Poor quality of care was referred to in terms of care practices and competency, and the general standard of staff.

With respect to the introduction of care standards, none of the units in the Eastern region felt this was influencing residential home closures, and only one in this region felt it was relevant to nursing home closures. This compared with the South East, where six out of the seven units identified concerns about care standards affecting residential home closures, and nine out of ten respondents felt they were affecting nursing home closures.

For the market to work effectively in raising standards, rather than homes going out of business for reasons unrelated to quality issues, it is essential that those purchasing care have good information about homes. As the major purchaser, local authorities are in a good position to obtain this information, but the same is not true of self-funders. A recent study of self-funded admissions identified widespread problems, and considerable distress among

relatives of people being admitted to self-funded places (Netten et al., 2001). These were, in part, related to lack of information about homes, so choice was based on visiting two or three homes in a suitable locality, and guided by general atmosphere rather than any knowledge about the home itself. As a result, those in the position of identifying suitable homes for themselves or their relatives are vulnerable to inappropriate advice. One respondent in the current study identified an organisation that offers a service to relatives to find a home, which charges 'member' homes for each placement. The respondent suggested that this was instrumental in keeping 'some of the smaller homes that need close regulation well occupied!'

Several respondents noted widespread concerns among homes that they would not be able to meet the new standards with fees at their current levels. In one instance it was felt that rumours about the likely effects of the new care standards had made some providers overreact and leave the business. Banks have been known to respond to such scares by calling in loans so that homes that have borrowed heavily become unviable. However, another respondent felt that the homes that were closing, as they were least able to meet the standards, were generally the ones that were currently providing a poor quality of service.

Several respondents felt that the introduction had not yet affected home closures in their areas, but the physical standards were of particular concern to owners of homes in converted properties. However, clearly building stock varies throughout the country. One respondent felt that while all the homes with four or more places should be able to meet the standards, there could be a serious impact on small homes. In another, the poor quality of the fabric of local authority homes was an issue likely to lead to closure.

The move to improving building standards need not result in overall reduction in capacity, but there may be associated transitional problems. One unit identified that a home had closed in order to move to new improved premises. It was not clear what had happened to the residents in this instance. Another unit identified problems with local planners as a factor affecting closures. It was not clear exactly what the issue was in this case, but this could be a major issue for homes that need to adapt their premises to meet care standards.

Respondents also noted considerable uncertainty about the introduction of the new care standards. Homeowners were not clear about how these would be interpreted locally and were concerned about possible loss of contact with inspectors with whom they had built up professional working relationships. Concern was also expressed that there were some homes that were very effective in meeting both care and cultural needs, but which would not meet the new standards. Residents in these homes have expressed a preference to remain, and the

inspection unit would wish to respect these views. It is not clear whether there would be any scope to do so. One unit noted that there were concerns among homeowners about the fee structure for registration and regulation that will be imposed on homes when the National Care Standards Commission is introduced.

In the telephone survey, standards, including issues related to current standards as well as the National Minimum Standards, were the most frequently cited reasons for the two most recent closures: standards were identified as a reason for closure for 60 per cent of the recent closures. Issues related to standards were identified as causing both residential and nursing home closures, and were typically identified as one amongst other reasons. After financial reasons and changes in personal circumstances, such as retirement or the death of a spouse, an unwillingness or inability to meet the new standards was the most frequently cited reason. This was linked to the closure of a quarter of the recently closed homes.

Some unit managers referred to the new standards causing closures without specifying the way in which they were doing so. Others highlighted aspects of the new standards, and these typically related to the environment of the home, including the prohibitive cost of updating buildings to meet the standards and inability to adapt buildings, for example, due to the high number of double occupancy rooms. Six units also identified the care standards as a principal issue affecting the supply of care home places, and again specified environmental aspects of the new standards. Examples included premises that could not be adapted to accommodate equipment such as wheelchairs, and in some instances homes could not meet the new standards, as the buildings did not meet current standards and should not have been registered in the first place.

### 3.11 Other Factors

One of the purposes of the research is to identify other relevant issues to closures, which have not been hypothesised to date. Most factors identified by units linked to issues that had already been identified. However, units identified a number of other issues.

Not all closures are involuntary responses to economic imperatives or as a result of poor quality services. In the telephone survey, changes in personal circumstances such as wanting to retire or the death of a spouse were identified as the primary reason for closure in a quarter or cases and a factor associated with the closure in about a third of instances. This type of turnover has always been a factor in the care home market. However, the difference now is that it is increasingly difficult to sell homes as going concerns, so homes that would have

changed owners and/or managers in the past are more likely to close now. In some situations this may be appropriate, if the building is not going to be able to meet care standards in the future. However, it is not clear that this is predominantly the case. What is clear is that where the value of the property exceeds the value of the business as a going concern, it is clearly in the interest of those leaving the business for whatever reason to close the home, whatever the quality of care provided.

One unit was concerned about homes operating under 'buy and lease back arrangements'. In such homes a drop in occupancy or other problem means that the homes do not have the collateral to survive and so go into receivership. This, and banks calling in loans, forces homes out of business that might have survived in more favourable circumstances. However, another source of information (not an inspection unit) identified that banks have been remarkably tolerant and supportive of homes in difficulties. Clearly, the attitude of those in a position to support failing homes or new entrants to the market, such as banks and other lending bodies, is likely to have an impact on the supply of homes. However, no consistent evidence about attitudes and practices has emerged from this study to date.

A couple of units identified the problem of poor management and unrealistic expectations of profits among homeowners. One respondent identified a lack of local research on the part of providers – setting up homes where there was already overprovision. This meant they were competing for both residents and staff, adding pressure to an already highly competitive market.

This respondent also identified that some large-scale voluntary organisations were taking a long term strategic view and reconfiguring services, resulting in the closure of large 'old-fashioned' homes. Although the introduction of new care standards may have played a part, in practice this was a response to changing demand and direction in the organisations concerned.

### 3.12 Conclusion

A number of different approaches were adopted for identifying the reasons for home closures. The national survey identified, at a relatively crude level, that about half of current closures are attributable to business-related reasons, rather than to personal or other factors. This information needs to be treated with some caution, given likely inconsistencies in definition of business failure. The more open-ended approach to establishing the reason for closure in the sample of recent closures did not facilitate a direct comparison, but did allow some insight into the deciding factors for individual homes from the R&I unit perspective. Immediate financial crises, factors associated with current and expected care standards and personal circumstances of owners appeared to be the key deciding issues for individual homes.

The key issues pertaining at a locality level were levels of fees being paid by the local authority, and factors associated with recruitment and retention of staff, particularly nursing staff. Several respondents identified that it was usually a combination of factors that was associated with home closures, rather than any single issue. Where a single issue was selected as most important locally, it was usually the low level of fees paid by local authorities. Clearly, however, there are many other factors playing a part in current home closures, with the availability and cost of staff, particularly nursing staff a major issue.

Fees paid by authorities and availability of staff can be represented as external factors affecting all homes in the area, and as such are less likely to be identified as specific factors in individual home closures. However, they play an important part in putting pressure on homes: financial pressures will at least in part be due to fees paid by local authorities and standards of care provided dependent on the quantity, quality and turnover of staff. Opportunities to 'exit' are most prevalent where property prices are high and there are demands for alternative use of buildings. However, the evidence from specific examples of recent closures suggests that concerns about the requirements of current and future physical standards are playing a more important part in current closures than had previously been appreciated.

The results for London were in some ways rather surprising. The high costs of property and the competitive labour market have been cited in the past as reasons for low levels of supply. While cost and price related issues were identified more frequently than any other issues in this region, concerns were not at the same level as the wider South East region. The rates of closure were lower among independent residential homes and the overall effect on capacity rather less than elsewhere in the south. This may be one reason for the lower levels of

concern, or it may be that owners of homes in London are so used to high prices of both staff and the alternative value of buildings, that the issue is not one to affect whether a home closes or not. Moreover, capacity tends to be defined more widely as long-term shortage of places. In London this means that people are often placed out of borough, indeed out of London.

# Chapter 4
# Consequences

## 4.1 Introduction

There are three principal issues of concern about the consequences of the rate of home closure: effects on capacity, quality and the effects of the process on those involved. We describe the evidence from this study about the effects on capacity and quality and conclude by briefly identifying some of the issues that need to be addressed in terms of the consequences of closures for individuals involved.

## 4.2 Effects of Home Closures on Capacity

Chapter 2 identified that there was a national reduction in available places as a result of more homes closing than are opening. This may simply reflect the market working as it should, responding to historical over-supply or current reductions in demand, with poorer quality homes closing. However, the evidence in Chapter 3 suggests that supply and demand factors are not the major forces at play in current closures, and that the sector may be responding to a combination of forces that could result in shortages of suitable places.

Nationally, ten units (six health authority, one joint and three local authority) identified serious shortfalls in capacity as a result of closures, six in the South East, South West or London. In one area, the phased closure of local authority provision could not proceed as planned because there was a real shortage of places. One health authority unit identified that the effect of the strain on homes and home closures was leading to an increase in the waiting list for discharge from hospitals. In the follow-up telephone interviews, shortages were described as local in the sense that closures were resulting in an uneven geographical distribution of provision. Such local shortages were said to exacerbate the difficulties of relocating residents when other homes closed in the same areas. One unit reported a total lack of nursing homes in certain areas, with the consequence that a high dependency patient had to be placed in a residential home. Units also reported anticipating shortages in the supply of care home places in the near future. This was linked to the observations such as: there is now ‘no spare capacity’; ‘vacancies are now full and no new homes are opening’.

In addition to overall capacity, several units identified a particular shortage of places for elderly people with mental health problems or of ‘EMI’ homes. It was not always clear whether these were closing disproportionately, or that there was just a general lack of

provision in the face of growing demand. Certainly one respondent identified that the growth in demand was in specialist mental health provision, which many homes were ill-equipped to meet. National statistics for 1999–2000 suggested that specialist homes were not closing at a higher rate. There was an overall closure rate of 4.4 per cent among homes registered as specialist EMI. Although this was higher than for dual registered homes (3.3 per cent), it was lower than for nursing homes (8.7 per cent) and was a similar rate to that for residential homes (4.9 per cent). In the follow-up telephone survey, seven of the 64 homes that were identified as having closed recently were specialist EMI: two residential, one dual and four nursing homes. These closures were causing considerable concern about the supply of specialist places in those areas. Nearly a quarter of the unit managers who took part in the telephone survey also identified a shortage of EMI places as a result of recent home closures. A couple of the managers described the shortages as severe. Another manager noted that nursing home owners are being discouraged from diversifying by offering EMI places by the standards required.

In the national survey, eight units identified that it was principally smaller homes (identified variously as less than 30, 17, 20 and 12 places) that were closing. In the telephone survey, a lack of viability of small homes was also identified for nursing homes of eight and 24 places and for residential homes of nine places. Smaller homes were seen as not having the necessary economies of scale, nor the ability to spread risk, that larger homes have. One unit also noted that smaller homes found it more difficult to expand and improve to meet the new standards. Growth was in fact occurring in a number of areas among large homes belonging to corporate organisations. One respondent identified that banks were not prepared to lend on smaller registrations, reinforcing the effect on the pattern of supply. In both the national and follow-up telephone surveys, units identified this development as resulting in a lack of choice for residents and their families, in terms of both size of home and geographical location, location particularly being a key factor in deciding on a home (Netten et al., 2002).

The knock-on effects of reduced capacity were identified by one unit in the North West, which reported that recent closures are having an impact in terms of nursing place blocking problems, and by another which reported that closures were increasing the pressure placed on community nurses.

### 4.3 Quality of Care

One way in which the market can potentially work to improve quality is through closures of poor quality homes and the opening of better quality homes. It is clear that, in some parts of the country at least, this was happening. However, where pressures on homes get too high it

is not at all clear that the effect on quality of care is beneficial. Particularly in the south of the country, respondents felt that quality of care was being driven down through shortages of suitable staff at all levels: management, nursing and basic care. Moreover, the fabric of buildings deteriorates when margins are tight. Thus standards are driven down, in some instances driving homes out of business, in others, presumably, simply resulting in lower quality care.

In the national survey, five units identified that the type of homes that tended to go out of business were the poor quality homes, in terms of management, staffing and environment. The implication was that the market was working effectively to raise standards. Indeed, one respondent felt the market was resulting in good services expanding and doing well, with poor services going out of business. Several units identified homes that had long-standing physical limitations (such as five levels and no lift) were now closing, presumably partly in response to the forthcoming new care standards. By contrast, another unit identified that new providers were entering the market providing en-suite facilities, with which other homes found it hard to compete.

This view of poorer quality homes going out of business and better quality homes surviving was supported by the follow-up telephone interviews when they were asked about the effect of recent home closures on supply. More units than in the national survey identified the overall improvement in quality: 11 of the health authority and joint units in the telephone survey (28 per cent of the respondents) and 17 of the local authority and joint units (43 per cent). This was attributed to over-capacity in the areas where homes were closing. Occupancy levels were described as good and as sustainable.

However, in the national survey, five units identified the detrimental effect that low fees were having on standards of care. They noted that training of staff and upkeep of the physical fabric of the homes were the first things to go. These then affected staff turnover and demand for places, resulting in further financial problems. One respondent in the South West felt strongly that closures were unrelated to quality of care: ‘We are losing good homes, specialist homes, smaller homes (with 4+ places) and those serving isolated rural areas.’

### 4.4 Consequences for Those Involved

An important consequence is the effect of the process of home closure on the residents, their relatives, the homes’ staff and care managers. One, let alone multiple, unwanted moves is associated with increased mortality (Hallewell et al., 1994; Beirne et al., 1995) and, we would

expect, physical, mental and emotional well-being. In addition to individual welfare issues for members of staff, people leaving the sector as a result of home closures may exacerbate the national shortage of care staff. Pressures on care managers, already high, are likely to be increased by the need to find new homes for residents and enable choice for residents who have to move as the result of closure.

For the most part, respondents in the national survey did not reflect on the consequences for residents or the process of closure. However, one respondent identified that some older people had had to endure multiple moves as each home to which they were relocated announced its closure. The respondent also noted that there is no requirement for proprietors to give an adequate notice of intention to close, nor is there any incentive to have a planned closure.

Although policies may be put in place to reduce the rate, home closures will always be with us. While the majority of care is provided by the private sector these closures will be for reasons of business failure rather than planned closures. There is a need for evidence about what is happening in practice now, on which to base future standards and develop policies about the home closure process. Future work will draw together information from this study and others to investigate the process and effects of home closures on individuals.

### 4.5 Conclusions

The overall rate of home closure identified in this study, 5 per cent, is very similar to the rate reported for 1999–2000 nationally. National figures for the two previous years suggested that the rate of closure was increasing dramatically. The evidence here suggests that the rate is levelling off, although if it continued at this level there could be serious reductions in overall supply as in some areas the number of new registrations is far from keeping pace.

The reasons for the increased rate of closure were not primarily supply- or demand-related factors, suggesting that the consequent reduction in capacity was resulting in a shortage of places in some parts of the country. Overall, it appeared that the pressures and thus consequences were highest in the south of the country, with local areas of particular concern scattered throughout the country.

Low fees paid by local authorities and staff supply problems dominated locality-related pressures leading to closure. Individual home closures tended to be ascribed to immediate financial pressures, factors associated with both current and planned care standards and

personal reasons. It is not really surprising that homes, especially small homes, are closing in the face of these pressures. Property prices contribute to the process by allowing home owners to exit the market, rather than acting as a direct cause of closure.

Overall capacity concerns were very localised, but there were widespread concerns about the shortage of specialist care for older people with cognitive impairment and mental health problems. The reduction in numbers of smaller homes was also leading to concerns about lack of choice both in terms of size and locality of homes.

In terms of quality, respondents in the national survey suggested that the introduction of the new care standards appears to be more of an influence on the decision to close in the South East, where other pressures on homes are already very high. The higher the pressures on homes in the area, the less likely respondents were to identify poor quality of care as leading to closure.

There was some evidence that the market is acting to improve quality of care overall, but improvements in (or even maintaining) quality will clearly be limited while there are such problems in recruiting, retaining and meeting the cost of training all care staff, nursing staff and managers. Moreover, there may be less pressure to conform to standards where there are supply problems. This is all the more so in the face of increasing demands on the competency of homes.

# Appendix
# Characteristics of Sample Data

## 1. Comparisons with National Data

Table A.1 presents information on the levels of provision of homes and places by region, drawing on national statistics (Department of Health, 2000b, 2001a), for all units and for respondent units, at 31st March 2000. The national statistics for residential care homes include homes for all client groups, and the national statistics for nursing homes include private hospitals and clinics and, again, include establishments for all client groups. However, the majority of residential and nursing homes cater for older people. Table A.1 indicates that the respondent units accounted for just under 85 per cent of residential homes and places and for around 85 per cent of nursing homes and places for all client groups.

**Table A.1: Number of residential and nursing homes and places for all units and for respondent units, by region, 31st March 2000**

| *Region* | *Local authority staffed residential homes* | | | *Independent residential & dual registered homes* | | | *Nursing homes, hospitals & clinics* | | |
|---|---|---|---|---|---|---|---|---|---|
| | *Total no.* | *Respondent units* | | *Total no.* | *Respondent units* | | *Total no.* | *Respondent units* | |
| | | *No.* | *%* | | *No.* | *%* | | *No.* | *%* |
| Homes | | | | | | | | | |
| Northern & Yorkshire | 364 | 364 | 100 | 2676 | 2676 | 100 | 806 | 737 | 91 |
| North West | 304 | 234 | 77 | 3399 | 2731 | 80 | 929 | 752 | 81 |
| Trent | 216 | 180 | 83 | 2089 | 1653 | 79 | 687 | 595 | 87 |
| West Midlands | 218 | 164 | 75 | 2203 | 1919 | 87 | 601 | 552 | 92 |
| Eastern | 199 | 174 | 87 | 1871 | 1578 | 84 | 439 | 365 | 83 |
| London | 268 | 185 | 69 | 2046 | 1359 | 66 | 548 | 411 | 75 |
| South East | 274 | 205 | 75 | 5033 | 3905 | 78 | 1036 | 1036 | 100 |
| South West | 182 | 168 | 92 | 3491 | 3037 | 87 | 836 | 593 | 71 |
| Total | 2025 | 1674 | 83 | 22808 | 18858 | 83 | 5882 | 5041 | 86 |
| Places | | | | | | | | | |
| Northern & Yorkshire | 9306 | 9306 | 100 | 36597 | 36597 | 100 | 27615 | 24620 | 89 |
| North West | 8239 | 6457 | 78 | 42058 | 34291 | 82 | 33472 | 27028 | 81 |
| Trent | 6382 | 5241 | 82 | 30579 | 24373 | 80 | 21378 | 17695 | 83 |
| West Midlands | 6398 | 4669 | 73 | 26098 | 22638 | 87 | 20419 | 18639 | 91 |
| Eastern | 5925 | 5438 | 92 | 29145 | 23471 | 81 | 15137 | 12221 | 81 |
| London | 6354 | 4379 | 69 | 23786 | 15665 | 66 | 18290 | 14184 | 78 |
| South East | 8289 | 5654 | 68 | 60754 | 49107 | 81 | 32357 | 32357 | 100 |
| South West | 4610 | 4216 | 91 | 41058 | 36159 | 88 | 24662 | 18288 | 74 |
| Total | 55503 | 45360 | 82 | 290075 | 242301 | 84 | 193330 | 165032 | 85 |

Sources: Department of Health (2000b, 2001a).

**Table A.2: Number of residential and nursing homes for all client groups for respondent units and number of homes for older people reported in survey, by region, 31st March 2000**

| *Region* | *Local authority homes* | | | *Independent residential & dual registered homes* | | | *Nursing & dual registered homes* | | |
|---|---|---|---|---|---|---|---|---|---|
| | *Respondent units* | *Survey: 2000*[1] | | *Respondent units* | *Survey: 2000*[1] | | *Respondent units* | *Survey: 2000*[2] | |
| | *No.* | *No.* | *%* | *No.* | *No.* | *%* | *No.* | *No.* | *%* |
| Northern & Yorkshire | 364 | 243 | 67 | 2676 | 1881 | 70 | 737 | 706 | 96 |
| North West | 234 | 188 | 80 | 2731 | 1988 | 73 | 752 | 683 | 91 |
| Trent | 180 | 132 | 73 | 1653 | 1305 | 79 | 595 | 537 | 90 |
| West Midlands | 164 | 109 | 66 | 1919 | 994 | 52 | 552 | 437 | 79 |
| Eastern | 174 | 126 | 72 | 1578 | 884 | 56 | 365 | 286 | 78 |
| London | 185 | 89 | 48 | 1359 | 636 | 47 | 411 | 372 | 91 |
| South East | 205 | 159 | 78 | 3905 | 2844 | 73 | 1036 | 889 | 86 |
| South West | 168 | 114 | 68 | 3037 | 2372 | 78 | 593 | 565 | 95 |
| Total | 1674 | 1160 | 69 | 18858 | 12904 | 68 | 5041 | 4475 | 89 |

Sources: Department of Health (2000b, 2001a); survey respondents.
Notes:
1. Excluding 3 returns.
2. Excluding 1 return.

Table A.2 shows the number of homes for all client groups, as recorded in national statistics, and the number of homes for older people reported by the respondent units, as at 31st March 2000. The table includes the number of homes recorded in national statistics for three units which provided insufficient information to be used in the analysis. The number of nursing homes for older people reported by the respondent health authority and joint health authority/local authority units accounted for 89 per cent of the establishments for all client groups recorded in the national statistics for the same health authorities. However, the number of independent residential homes reported by the respondent local authority and joint health authority/local authority units only accounted for 68 per cent of the homes for all client groups recorded in the national statistics for the same local authorities. In terms of places, places for older people accounted for just under 70 per cent of places in residential care homes at 31st March 2000 (Department of Health, 2000b). Since residential care homes for older people are likely to be larger than homes for members of other client groups, the figure of 68 per cent is consistent with the national figures. Residential homes in London had the smallest proportion of places for older people (62 per cent) and the largest proportion of places for members of other client groups. Thus, the proportions of establishments recorded in the national statistics that were accounted for by local authority and independent residential homes for older people, as reported by the respondent units (48 per cent and 47 per cent), are fairly consistent with the national statistics. However, for both independent

residential homes and nursing homes, the number of homes reported by the respondent units in the West Midlands and Eastern regions accounted for smaller proportions of the establishments recorded in the national statistics than the number of homes reported for the other regions, with the exception of independent residential homes in London.

## 2. Data Quality Issues

Three returns provided insufficient information to be used in the analysis, although one of these returns, from a joint unit, provided information relating to issues associated with closure. The information from the latter unit has been included in section 8, but otherwise these returns have been excluded from this report. A number of other factors have also affected the presentation of the results of the survey in this report. Firstly, a number of respondents provided incomplete data and, in particular, left questions blank instead of entering zeros. Blank responses have normally been treated as zeros, and information supplied on closures, new registrations and changes of registration has been used to impute the number of homes where this information was missing. However, missing information on the number of places available could not be imputed, and so comparisons of the relative levels of provision in the two years covered by the survey have been based on complete responses. Secondly, although information on the number of changes in registration status was collected separately from information on the number of closures, it appears that some respondents may have recorded such changes in registration status as closures or as both closures and changes in registration status. No adjustments have been made for such cases. Thirdly, a number of respondents in health authority units were unable to disaggregate information on nursing homes and dual registered homes. In some cases, information on dual registered homes was included with information on nursing homes and presented separately as well. In a small number of cases, respondents in local authority units were unable to disaggregate information on residential homes and dual registered homes. The national statistics on residential and nursing homes (Department of Health, 2000b, 2001a) were used to identify apparent double counting, and some returns were referred back to the respondent for clarification.

## 3. Supplementary Information on Reasons for Closures

Tables A.3 to A.6 show the main reason for closure for each category of home. As noted in the main text, a number of respondents to the survey reported the main reason for closure for closures during the period 31st March 1999 – 31st March 2000 as well as during the period

31st March 2000 – 31st March 2001. The total number of closures shown in each of these tables corresponds to the number for which a reason was given and thus these figures do not correspond to the figures given in table 2.6 in the main text.

**Table A.3: Main reason reported for closure of local authority homes, 31st March 2000 – 31st March 2001[1], by region**

| *Region* | *No. of units* | *No. of closures* | *Main reason for closure* | | | | |
|---|---|---|---|---|---|---|---|
| | | | *Business failure* | *Enforcement action* | *Other* | *Not known* | *Missing* |
| Northern & Yorkshire | 19 | 12 | 6 | 0 | 1 | 1 | 4 |
| North West | 14 | 6 | 0 | 0 | 5 | 1 | 0 |
| Trent | 11 | 5 | 1 | 0 | 4 | 0 | 0 |
| West Midlands | 9 | 5 | 0 | 0 | 0 | 0 | 5 |
| Eastern | 7 | 2 | 1 | 0 | 1 | 0 | 0 |
| London | 23 | 12 | 0 | 0 | 9 | 1 | 2 |
| South East | 10 | 2 | 0 | 0 | 0 | 1 | 1 |
| South West | 14 | 7 | 0 | 0 | 7 | 0 | 0 |
| Total | 107 | 51 | 8 | 0 | 27 | 4 | 12 |

Note:
1. Includes closures in 1999–2000 reported by 1 unit.

**Table A.4: Main reason reported for closure of independent residential and dual registered homes, 31st March 2000 – 31st March 2001[1], by region**

| *Region* | *No. of units* | *No. of closures* | *Main reason for closure* | | | | |
|---|---|---|---|---|---|---|---|
| | | | *Business failure* | *Enforcement action* | *Other* | *Not known* | *Missing* |
| Northern & Yorkshire | 19 | 87 | 31 | 7 | 18 | 4 | 27 |
| North West | 14 | 75 | 18 | 7 | 14 | 35 | 1 |
| Trent | 11 | 37 | 11 | 3 | 14 | 4 | 5 |
| West Midlands | 9 | 38 | 9 | 2 | 15 | 3 | 9 |
| Eastern | 7 | 21 | 11 | 3 | 4 | 3 | 0 |
| London | 23 | 30 | 5 | 1 | 17 | 4 | 3 |
| South East | 10 | 157 | 63 | 16 | 36 | 14 | 28 |
| South West | 14 | 127 | 22 | 11 | 32 | 15 | 47 |
| Total | 107 | 572 | 170 | 50 | 150 | 82 | 120 |

Note:
1. Includes closures in 1999–2000 reported by 17 units.

**Table A.5: Main reason reported for closure of small homes, 31st March 2000 – 31st March 2001[1], by region**

| *Region* | *No. of units* | *No. of closures* | *Main reason for closure* | | | | |
|---|---|---|---|---|---|---|---|
| | | | *Business failure* | *Enforcement action* | *Other* | *Not known* | *Missing* |
| Northern & Yorkshire | 19 | 57 | 8 | 6 | 8 | 16 | 19 |
| North West | 14 | 50 | 6 | 0 | 14 | 1 | 29 |
| Trent | 11 | 28 | 5 | 0 | 2 | 2 | 19 |
| West Midlands | 9 | 28 | 2 | 0 | 16 | 2 | 8 |
| Eastern | 7 | 18 | 5 | 0 | 12 | 1 | 0 |
| London | 23 | 23 | 1 | 0 | 11 | 7 | 4 |
| South East | 10 | 60 | 23 | 4 | 9 | 11 | 13 |
| South West | 14 | 76 | 5 | 0 | 12 | 7 | 52 |
| Total | 107 | 340 | 55 | 10 | 84 | 47 | 144 |

Note:
1. Includes closures in 1999–2000 reported by 7 units.

**Table A.6: Main reason reported for closure of nursing and dual registered homes, 31st March 2000 – 31st March 2001[1], by region**

| *Region* | *No. of units* | *No. of closures* | *Main reason for closure* | | | | |
|---|---|---|---|---|---|---|---|
| | | | *Business failure* | *Enforcement action* | *Other* | *Not known* | *Missing* |
| Northern & Yorkshire | 10 | 41 | 7 | 4 | 10 | 14 | 6 |
| North West | 13 | 38 | 29 | 3 | 2 | 4 | 0 |
| Trent | 9 | 31 | 14 | 1 | 14 | 0 | 2 |
| West Midlands | 10 | 20 | 15 | 2 | 2 | 0 | 1 |
| Eastern | 6 | 21 | 3 | 2 | 11 | 0 | 5 |
| London | 13 | 32 | 16 | 2 | 9 | 1 | 4 |
| South East | 12 | 67 | 32 | 4 | 22 | 1 | 8 |
| South West | 6 | 46 | 24 | 1 | 12 | 0 | 9 |
| Total | 79 | 296 | 140 | 19 | 82 | 20 | 35 |

Note:
1. Includes closures in 1999–2000 reported by 25 units.

## 4. Telephone Follow-Up of Units Covered by 1996 Survey

The 1996 survey of homes (Netten et al., 1998) was based on a sample of local authorities in England, stratified by type of authority (London borough, metropolitan district and county), geographical location, socio-economic group, population sparsity, and migration rate, in terms of the influx of people aged over 45 years. Within the 21 local authorities selected, probability sampling was used to select homes proportional to the size of the home, for each

type of home (residential homes for elderly people managed by local authority social services departments, and registered residential homes, registered nursing homes and dual registered homes run by voluntary and private organisations).

Table A.7 shows the registration and inspection units' response to the telephone survey by type of authority and region.

**Table A.7: Inspection unit response to the telephone interview, by type of authority and region**

| *Region* | *Type of authority* | | | |
|---|---|---|---|---|
| | *Local authority units* | *Health authority units* | *Joint units* | *Total* |
| Northern & Yorkshire | 2 | 1 | 0 | 3 |
| North West | 5 | 5 | 1 | 11 |
| Trent | 2 | 2 | 0 | 4 |
| West Midlands | 0 | 0 | 2 | 2 |
| Eastern | 1 | 1 | 0 | 2 |
| London | 5 | 4 | 1 | 10 |
| South East | 2 | 1 | 0 | 3 |
| South West | 2 | 2 | 0 | 4 |
| Total | 19 | 16 | 4 | 39 |

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