Care Home Closures: The Provider Perspective

Jacquetta Williams, Ann Netten, Brian Hardy, Tihana Matosevic and Patricia Ware

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Contents

Index of tables

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Summary

Introduction

1. As part of a wider investigation into supply of care homes a study was conducted investigating the factors and circumstances that lead to homes closing from the perspective of independent providers. Following five in-depth exploratory interviews structured interviews were designed and conducted with 20 owners, managers or owner/managers of homes that had closed within the previous two years or (in one case) were at the point of closure. The interviews focused on the background and motivation of providers, the characteristics and history of the home, the combinations of factors and circumstances that led to closure, and the closure process and consequences for staff and residents. The process and consequences of closure will be reported in a separate paper.

The respondents

2. The sample included providers of nursing (six), residential (11) and dual registered (three) care homes, from each sector of independent ownership (private (17) and voluntary (three)) and geographical region. A range of large and small providers was included, from sole traders or partners owning single organisations or groups of two or three homes to representatives of large national chains. Overall the size of homes was close to the national average for each type, ranging between nine and 99 places. The majority (18 of 20) of the homes had been preferred providers in the sense that they had been on a local authority approved list.

3. One factor we would hypothesise would be related to closing homes and reasons for closure is motivation for entering the business. As in previous work the most frequently cited motivation was to meet older people's needs. However, our sample of providers of closed homes was more likely to cite income or profit maximisation than those running homes in previous studies.

Timing

4. Commissioners may want to consider some form of intervention when providers of good quality services plan to close, either to preserve the existing service or to evaluate the option of developing a new service. The feasibility of such shared discussion and evaluation depends in part on the length of time providers spend thinking about closing a home. Closures can occur within four weeks of the decision to close. However, a considerable period of time (years) lapsed between when some closures were first

considered and the date of closure. The timing of closures was influenced by judgements about when losses were no longer sustainable or the home no longer financially viable. Changes in circumstances such as a sudden drop in occupancy, the loss of a key member of staff or the value of the property if sold also influenced the timing of closures.

Reasons for closure

5. All but one of the homes (which was closed due to enforcement action) closed either to avoid further losses, or due to the business earning an inadequate return now or in the future.

6. Respondents were asked to identify from a list of possible reasons for closure those factors that influenced and were decisive in their decision to close the home. The two factors most often identified as decisive or a factor in decisions to close were the cost implications of the National Minimum Standards (15) and local authority prices not covering costs (14). Over half of the respondents were influenced by past increases in running costs (11) and the expectation that local authority prices were unlikely to cover costs in the future (13).

7. The cost implications of the new minimum standards highlighted by the providers included the level of initial investment required to carry out work to meet the new minimum standards for the physical environment, a reduction in the value of the business due to a need to reduce the number of places to comply with the standards (identified by a quarter of the respondents) and anticipated increases in running costs associated with staffing. Four of the respondents said that the home could not be adapted to meet the new standards.

8. Aspects of local authority fees not covering costs highlighted by the providers included fee levels being below wage inflation, fees having been low for a long period and low fees being in conflict with, rather than supporting, attempts to provide a high quality of service provision.

9. Over a third of the providers had a good relationship with local authorities. However, an almost equal number described the relationship as poor. A lack of negotiation over the price of placements was identified by almost three quarters of the providers. Delays in payments, a lack of fee negotiation, and a general lack of communication, consultation and co-operation were also highlighted.

10. Half of the providers indicated that they regarded their local care market as organised and structured unfairly and inefficiently. This was attributed mainly to local authority provision and commissioning practices.

11. A quarter of the respondents had concerns about the increases in residents' dependency experienced over the life of the home. In some cases they felt placements were inappropriate.

12. Reduced demand for publicly-funded places was cited as decisive in the decision to close by eight providers. Occupancy in the 12 months prior to closure could range from 75 to 40 per cent and for smaller homes a relatively small drop in demand could reduce the business to break-even or below break-even point.

13. The majority of the providers did not cite the relationship with the registration and inspection unit as a factor in the decision to close, however, it was identified as decisive by six of the providers. In these cases the attitude and behaviour, often of individual inspectors, was described as 'endless' and petty 'nit-picking'. Interpretation and implementation of regulations and requirements, which may mean further investment in a home, was said to be inconsistent across homes and between inspectors.

14. Small business care home providers running single or small groups of homes of around 20 places or less, or who predicted that their home would have to be reduced in size to comply with the minimum physical environment standards, considered their businesses unviable. They predicted that average home sizes would have to increase.

15. Availability of capital or profit to re-invest is another issue related to the size of homes. The cost implications of the National Minimum Standards was frequently cited as a factor in decisions to close in part due to the small size of some of the homes. Even when operating at full occupancy profit levels and cash flow can be insufficient to support intensive re-investment or service a further loan. For businesses that had been running below capacity such investment was even less viable.

16. The current high value of property was identified as a factor in the decision to close by a quarter of the providers. For some the property was worth more than the business, which either provided an opportunity to sell, when there was no prospect of selling the home as a going concern, and/or made future capital investment uneconomic.

17. Recruiting care staff and nursing staff was more often cited as a background issue than as decisive in decisions to close. Care staff recruitment difficulties were linked to high levels of competition in local labour markets where less stressful jobs were available for higher pay. High levels of employment and nurse shortages were also cited. Several providers also highlighted recruiting and or retaining managerial staff as decisive. Problems were attributed to insufficient income to offer attractive salaries, a skill shortage and the highly demanding nature of the job. Increases in staff costs due to the National Minimum Wage and Working Time Directive were also identified as a factor in decisions to close.

18. The most frequently cited reason for closure additional to the factors listed was loss of motivation. This appeared to have been a factor in about a third of cases and was associated with this being their first care home and initial motivation for entering the business. While most had entered the business hoping for professional and creative achievement in practice they had felt swamped by bureaucracy and regulation.

Avoiding closure

19. The type of steps taken to avoid closure included trying to diversify into other service areas, to increase existing sources of income, or to cut expenditure. Just over a quarter of the providers reported not implementing any changes to the way they run their business.

20. An increase in care home fees paid by local authorities was the change that might have prevented home closure identified most often by providers (13). Nursing home providers suggested a higher rate of increase than residential home providers. On average residential care home providers suggested an increase of 20 per cent (ranging from 11 per cent to 30 per cent increase) compared with nursing home providers who suggested an average increase of 27 per cent (ranging from 12 per cent to 50 per cent increase).

21. Other changes identified as making it more likely that homes would remain operating or providers remain in the sector included:

- greater certainty about commissioners future purchasing plans;
- increased joint working to develop new services combined with increased sources of public funding for service development;
- improved relationship with registration and inspection; and
- improved recruitment of managerial and care staff.

Discussion

22. Clearly the key issue for providers was the level of fees paid by local authorities. This included previous fees, as long term low profit levels had led to a lack of reserves on which to draw, current fees not covering costs and expectation that future fees would not provide an adequate return.

23. While some providers had been considering closing for some time, the key issue in most cases was the requirements of the new National Minimum Standards. The focus was particularly on physical standards, but there were also concerns about the staff cost implications. The implication was that some closures might have been prevented by guidance about what was required (as there were clearly misunderstandings in some cases), financial support or underwriting of investments and more confidence in future returns.

24. One issue not raised by respondents but in wider discussions with providers was the saving factor of current low interest rates. Most providers have borrowed to start up or purchase their businesses. Should interest rates rise without other changes in place the rate of closure is likely to rise further.

25. Economic factors alone offered only a partial explanation of closure decisions. Other motivational, situational and relationship factors combined with expectations about future government and local commissioning policy to make providers lose enthusiasm for operating in a climate they see as characterised by constraints. Issues for providers of homes included:

    - lack of partnership with local authorities;
    - regulation that was felt to be inconsistent, irrelevant and ever increasing; and
    - level of red tape for small businesses.

    These combined with 'sheer pressure and hard work' made providers less willing to invest more time or capital in continuing services that they feel are being inadequately funded.

26. Evidence of good practice in building partnership in care on the part of local commissioners was uneven. As outlined in Department of Health (2001a) good practice in strategic planning, including consultation with providers, and building confidence and

stability is likely to have the benefit of both enabling providers to plan and feel that they are valued as professional partners in delivering services.

27. Diversification is one way which would enable homes to stay open, that otherwise would have closed. However, for developments such as intermediate care to succeed the advantages and benefits need to be made transparent and understood from the perspective of providers. The level of funding and commitment to commissioning need to be in place at the planning stage for providers to be able to judge the nature of the risk involved in investing in changing their service.

1. Introduction

The rise in the incidence of care home closures over recent years has been the subject of considerable public concern (see, for example, Bunce, 2001). During 2000-2001, 5 per cent of care homes for older people closed in England (Netten et al., 2002). Concerns focus on the consequences for both short and longer-term supply in addition to the immediate welfare issues for residents. This paper reports on a study that forms part of a programme of work into the causes and consequences of closures of care homes for older people. The results are intended to feed into a wider investigation into the supply of care homes funded by the Department of Health.

The study reported on here is linked to previous work that investigated the rate of closure, the effect on capacity and issues lying behind closures from the perspective of Registration and Inspection (R&I) units (Netten et al., 2002). In order to gain an in-depth understanding of the factors underlying individual home closures, we investigated the perspective of those responsible for closing the homes: the owners and managers.

We start by describing the methodology and the nature of the sample before providing the background to the closures in terms of the characteristics of the homes that were closed and respondents. We then provide an overview of the reasons for closure before examining in depth the nature of each of eight issues underlying closures: care standards, the commissioning environment, changes in demand, the regulatory relationship, value of property, staffing, personal factors and motivation. We describe the steps taken to avoid closure and those factors which might have changed the decision to close. We finish by outlining some of the implications of the findings.

2. Methodology and Sample

There are considerable problems associated with contacting and interviewing owners and managers of homes that have closed. By definition the natural point of contact, the home, is no longer operating and people have often moved away or may not want to revisit what, in many instances, was a very painful event. In order to identify potential contacts the R&I units who participated in a telephone survey about home closures (Netten et al., 2002) were asked to supply contact details or send a letter to people for whom they had details who had been involved in a closure during the past two years. Of the 39 units 16 were able to provide some contacts.

The survey company (Ipsos-Insight Ltd) conducting the telephone interviews with the R&I units contacted five providers for initial in-depth interviews (see below) and then forwarded the contact details for a further 18 independent providers to PSSRU. The details provided by the R&I units did not always include a telephone number or private address, but attempts were made to contact all of them.

The number of potential contacts was increased to 30 via interviewers' contacts and further enquiries to units. Of these just over a third (13) could not be contacted. Of those contacted only two providers did not wish to be interviewed. One was 'fed up with bureaucracy' and the other reported having little to highlight other than: 'Inadequate fees for a regulated service within which standards are being demanded to ever greater levels is an obvious recipe for trading failure.'

In order to ensure that we were covering the key issues from the owner/manager perspective five initial in-depth interviews were conducted by Ipsos-Insight with owners and managers. All of these were private homes, which in three instances had been part of companies that owned more than one home. Two of these homes were residential, two nursing and one a dual registered home. The results of this are described in a separate report (Ipsos-Insight, 2001) and, where relevant, have been drawn on in the discussion below.

A structured interview schedule was designed drawing on the results of this initial study, the results of the R&I surveys and previous work on motivations and perceptions of independent home owners and managers (Wistow et al., 1996; MEOC Team, 2000; Kendall, 2001). One-to-one interviews were then conducted with owners and managers of 20 further homes that had closed. The person interviewed was the proprietor, manager, owner/manager, regional manager/director or, in one case, a consultant representing the owners and shareholders. In four instances more than one person was present at the interview to talk about the particular home closure. There was at least one home in each of the R&I regions, with four in the South East and four in the West Midlands. Six of the homes were in the North-West or Yorkshire.

3. The Homes

The homes closed in the period between January 1999 and October 2001, or, as in one case, were at the point of closure. At the time of closure 17 of the homes were privately owned and three were in the voluntary sector, a very similar balance to the national picture where 88 per cent of residential homes are privately owned (Department of Health, 2000a). Seven of

the private homes were partnerships (six of them husband and wife teams), four sole proprietorships and six limited companies. One of the voluntary homes was described as a sole proprietorship. Half the homes were part of chains or the owners ran other types of care facilities. Of the nine homes that were part of chains, three were in a pair or group of three homes. One of the pairs of homes also included a day care facility. The larger chains ranged from eight other homes to over 200. One chain of 12 homes also included a sheltered housing facility. Overall this suggests a spread of ownership and organisational type broadly similar to the national picture (Laing and Buisson, 2001) and previous studies of care home ownership (MEOC Team, 2000).

Half the homes had been started from scratch and the other half acquired as going concerns. Of the nine cases where there was information about previous ownership the home had been owned by private individuals in five instances, in two cases the homes were owned by a commercial organisation and two were previously local authority homes. One of the local authority homes had become privately owned and the other part of a not-for-profit trust, which ran nearly 50 homes.

Ten of the homes that had been started from scratch had been going for at least 12 years, some for a very long time. Two homes had been going for 30 years or more and another for 54 years. Of the 16 homes where the original opening date was known, 11 opened during the 1980s.

3.1 Home type and size

Table 1 shows the registration type and size of the homes in the sample. Three homes had changed registration status during the respondent's period of ownership or management. One residential and one nursing home became dual registered, and one residential home became dual registered and then a nursing home.

By the time they closed the average size of homes in the sample was 28 (see table 1). The range was very wide – from a dual registered home of 99 places to a residential home with just nine places. As we would expect size of home was related to registration status. The average size of the 11 residential homes was 19 places and the six nursing homes had a mean size of 34 places, similar to the national average (22 and 35 respectively), (Department of Health, 2000c).

The size of home reported is based on the number of registered places. However a number of respondents identified that in practice they were running the home at a smaller size and would have had to employ more staff in order to get it up to full capacity.

Eleven providers had officially changed the number of places registered during the period of their ownership or management, in some cases on several occasions. For the most part (in nine cases) the overall result was to increase the size of the home. Where reasons were identified for increasing the home size they tended to relate to increasing income or extending the range of care provided by the home. The reductions in places were usually in order to increase the number of single rooms. Only two providers identified that they had changed the number of places in response to pressures resulting from the level of fees paid by local authorities.

Table 1: Size and registration status of homes at the time of closure

	Number of homes	*Average no. of places*
Residential	11	19
Nursing	6	34
Dual	3	52
Total	20	28

3.2 Clients

Only one of the homes catered for a particular professional or ethnic group. Another home had catered just for women in the past. This lack of specialisation was to be expected as previous studies of care homes for older people have found that most homes do not tend to target particular groups of individuals (MEOC Team, 2000).

For the most part homes that had closed were estimated to have had a higher proportion of self-funders than the national average (see table 2). The four providers that distinguished a difference in the pattern of funding in the year (or years) prior to closure all identified a drop in the proportion of self-funded residents. Two-thirds of publicly-funded residents were from the local authority in which the home was located. The four that distinguished a difference in the year prior to closure all identified an increased reliance on publicly-funded residents from their own local authority.

Table 2: Funding of residents

	Closed homes		*National Survey*[1]	
	Number of homes	*Average % self-funders*	*Number of homes*	*Average % self-funders*
Residential	10	48	270	34
Nursing	5	40	159	25
Dual	3	18	76	27
Total	20	41	505	34

Notes:
1. Netten et al. (1998).

Concerns about the supply of homes providing specialist care for people with dementia and other cognitive impairments have been expressed by R&I unit managers (Netten et al., 2002). Four of the providers of homes that closed (three residential and one nursing) identified this as a specialist service they had provided. However, only two of these and one other provider identified that they cared for people with challenging behaviour. None of the homes cared for people with learning disabilities or people sectioned under the Mental Health Act.

The majority of the homes (16 out of 18) had provided short-stay or respite care at some point. One provider had given this up in the year prior to closure and another had started to provide short-stay care during that period.

4. Provider Characteristics

How people respond to situations that could lead to home closure and their feelings about this will be dependent in part on their background and motivations. We collected information about respondents' background and experience and motivations for starting up or purchasing the home.

4.1 Background and experience

In the majority of cases (15 out of 20) the respondents had some care experience before they acquired or set up the home. Mostly this was related to nursing or other health profession (in 10 instances). Only one respondent had moved into this business after owning another type of business.

By the time of closure all of the respondents had worked in the care sector for at least six years. Seven had worked in the field for more than 20 years. All of them had been the owner or manager of a home for at least two years, although in one case had only managed the home in question for six months before it closed. Most respondents (12 out of 20) were owners or had shares in the home. Four described themselves as directors.

4.2 Motivations

From a list of possible motives respondents were asked to identify all the factors behind their decision to enter the business.

Table 3 compares the motivations identified in our sample with those identified by a larger sample of providers of residential homes in 1997. In seven instances other motivations were identified but most were extensions of or were encapsulated in categories given. For example those who identified as an additional motive that they wanted to provide a good quality service to vulnerable people also identified that they wanted 'to meet the needs of elderly people'. Similarly someone who had returned to this country without a pension identified profit maximisation (although he did not identify 'a satisfactory level of personal income' as a motivation). Exceptions were personal reasons such as wanting to work with a spouse and spiritual reasons.

As in a previous study the most frequently cited motivation was meeting the needs of elderly people (MEOC Team, 2000). However, table 3 shows that owners of the closed homes were more likely to identify income or profit maximisation and less likely to identify responsibility to society as a whole or a particular section of society as motivating factors.

Table 3: Motivations of providers

	Closed homes		*MEOC*[1] *sample (n = 52)*
	No.	*%*	*%*
Income/profit maximising	7	35	8
Satisfactory level of personal income	10	50	58
Duty/responsibility to society as a whole	4	20	38
Duty/responsibility to a particular section of society	6	30	50
Meeting elderly people's needs	14	70	85
Independence and autonomy	6	30	40
Professional accomplishment and creative achievement	13	65	76
Development skills and expertise	9	45	67
Total	20	100	100

Note:
1. Kendall, J. (2001).

Previous work has identified three main typologies of providers: empathisers, professionals and income prioritisers (Kendall, 2001). Clearly combinations of motivations are important but we can crudely identify in our sample categories in terms of the most important of the listed motivations. Income prioritisers identified profit maximisation or satisfactory levels of income as most important; Empathisers identified societal responsibilities and meeting needs; and Professionals identified professional accomplishment or development of skills. In the one instance where autonomy was the most important motivation the respondent was classified by the next most important motivation (professional development). In one other case the respondent identified both income maximisation and professional accomplishment but did not specify which was the most important so could not be classified. Table 4 shows the number in each group and distribution of motivation across home type.

Overall there was a lower proportion of Empathisers than we would expect from previous work where over half of providers were categorised in this way (Kendall, 2001). The largest single group was motivated by professional accomplishment and creative achievement. There was no association between providing sector and motivation: the three voluntary home providers fell into each of the three groups. However, there was a relationship between type of home and motivations. Residential care providers were more likely to emphasise professional accomplishment and nursing home providers were more likely to be classified as empathisers.

Table 4: Types of motivation by home type

	Empathisers	*Professional*	*Income prioritisers*	*Total*
Residential	1	7	2	10
Nursing	4	1	1	6
Dual	1	0	2	3
Total	6	8	5	19

4.3 Fees and contracts with local authority

Weekly local authority fees paid at the time of closure ranged between £304 and £343 for nursing homes (with one London home receiving £488) and between £218 and £269 for residential homes. Apart from one case fees paid at the time of closure were lower than the average regional weekly fees paid to for-profit homes at March 2000 (one residential home in the West Midlands was being paid three pounds more per week in 2001 than the average level of fees paid in the region at March 2000) (Laing and Buisson, 2000).

Sixteen of the 20 providers identified that different residents paid different fees. Variations depended on a number of factors including quality of facilities (such as room size and views). We asked whether fees varied according to dependency of residents or source of funding. In ten of the homes residents' fees were related to dependency. In twelve of the homes fees were related to source of funding. Some respondents volunteered the basis for this. Although two respondents were clear that they charged self-funders more, in one instance the home charged less to self-funders on the basis that they were drawing on their savings. In another the respondent identified that fees to self-funders were based on ability to pay as well as quality of facilities.

All of the providers had call off contracts with the local authorities. Call-off contracts are those where the local authority fixes a price or tariff in advance, which is paid once an individual has been admitted. Respondents were asked whether they felt that the contractual arrangements put excess risk on their organisations. It might be expected that all or nearly all providers of homes that had gone out of business would feel strongly on this issue, given that they have the contracts that place most risk on the provider. Eleven of the 16 that responded to this question identified some excess risk.

When asked which type of contract would have been their preferred choice six providers identified block contracts, where a guaranteed level of service is purchased. Such

predictability minimises the risk of variability in revenue, shifting the risk of under or over supply from the provider to the purchaser. Three were happy with the current, call off contract type and the remainder either did not know or expressed no preference. It should be noted that some providers appeared to be unaware of the options available and their risk implications. Previous research has found that private providers prefer block contacts and voluntary sector providers prefer call off contracts. Call off contracts may be preferred because of the greater degree of control they allow providers to exert over the composition of their residents, in terms of funding source or resident characteristics (MEOC Team, 2000).

5. Time Spent on the Decision to Close

The decision to close can take some time and a further period may lapse between when the decision to close is taken and the actual date of closure. One owner reported having thought about the possibility of closing the home for a year and another appeared to have first thought about selling four or five years before the home closed, in the owner's view it was due to the frustration experienced when trying to change the registration. In another case an owner described how he began thinking about an 'exit strategy' for one of his chain of four homes when he found out it was unsuitable for expansion or a change of registration. Six months before a voluntary home closed the organisation had been told by consultants that it was advisable. Thus for some, closure appears to have occurred quite some time after the decision. Some spent this time considering options or trying to sell the home as a going concern. Three residential home owners had tried to sell the business as a going concern – one had been on the market for two years. Another four providers had enquired about, investigated or even attempted to add or change to, new service areas. (Details of strategies adopted to try to keep homes open are discussed in more detail in section 7.)

For others, there appeared to have been little or no time spent considering alternatives. One manager, a relative of the owner, described closing a nursing home within two weeks of the decision to close and in another three cases there was no time lapse between taking the decision to close and starting the closure process, which was completed within a four to six week period.

Influences on timing

Many of the factors identified as influencing, and even decisive in, decisions to close were longstanding and consequently offer insufficient explanation as to why a decision to close was made when it was. For example, local authority fees not covering costs were described as a long-term problem by seven of the providers. Just why they decided to close when they did was not established in every case. Decisions to close can occur when the financial non-viability of a home is regarded as no longer sustainable or the level of future investment to meet the new standards is judged unfeasible given expectations about future income. For five owners financial non-viability was linked directly to low occupancy. In one case it was not that low occupancy had been a problem (the problem had been the failure to cover costs), rather that when occupancy happened to drop it 'seemed like a good time to close' in terms of there being less trauma to residents than if the home had been full. Losses, expenditure exceeding income or forecasted expenditure being greater than expected income appeared to be the main catalyst for another six homes.

In two cases the timing of the decision to close appeared to have been influenced by particular changes in circumstances. In one case a key member of staff left and in another the owner was having difficulty recruiting a part-time manager. Such circumstances were regarded as making the time a suitable one to close.

For another two respondents the timing of the closure appeared to be related to the degree to which they were 'fed up' and had 'just had enough'. Few interviewees referred to a single decisive event or moment, although one owner referred to a two year attempt to change registration and the 'trouble' with the R&I Unit as 'really … the last straw' in terms of making their mind up.

The opportunity to sell presented by high property prices was identified by four providers as a decisive factor in the decision to close. One owner highlighted it as a key facilitating factor since in the absence of high property prices he would 'have to continue'; the condition of the property market was an essential precondition to the decision to close/sell.

One owner of a chain of four homes said that the timing of his decision was influenced by the phasing out of the Capital Gains Retirement Relief Scheme, which as of April 2001 had two years remaining. The maximum possible tax saved was reduced by half in the following year, from £100,000 in 2001 to £50,000 from April 2002.

6. Factors and Circumstances that Lead to Closure

From a list of possible factors providers were asked to identify those that were relevant and decisive in the decision to close the home before being asked to discuss each factor in more detail. First we identify the necessarily particular perspective of the interview data. The aim here is to identify and better understand the variety of experiences, opinions and attitudes of a particular group. However, it is useful to put this in the context of registration and inspection unit officers' accounts of some of the recent closures. Next the factors most often identified are summarised and then the providers' experiences and views are described more fully in relation to:

- care standards;
- the commissioning environment;
- competition;
- demand;
- relationships between registration and inspection and providers;
- financial viability;
- the property market;
- staffing;
- personal circumstances and;
- motivation and the regulatory and administrative environment.

Throughout the report reference is made to providers' decisions to close. The decision was not a positive choice for any of the respondents in the sense that they did not want the home to have to close, all would have preferred to have sold the home as a going concern or to have turned the business around themselves. Even those who wanted to cease their involvement in the business would have preferred the home to have been sold as a going concern.

6.1 Differing accounts

We would expect the viewpoints of different participants to vary, reflecting their different concerns and the research aimed to identify providers' perspectives. Yet, how viewpoints differ is also of interest. Accounts of the reasons for closure of seven of the homes were available from the registration and inspection units. These were provided when they were asked to give details of two of the most recent closures in their area in a telephone interview (Netten et al., 2002). In some cases these accounts differ considerably from those offered by providers. In one case a registration and inspection unit manager described serious concerns about the quality of care in a residential home, noting that they did not employ 'good' staff.

The current manager of this home was said to have been 'laid off' by a succession of other homes. The owner indicated that an increase in referrals might have changed his mind about closing the home, suggesting that the main issue had been low occupancy due to an unexplained lack of referrals. The unit manager, however, reported that the reduction in referrals was intentional as a result of the concerns about the quality of care. It is difficult to gauge the extent to which other homes where the provider reported a drop in referrals, or described having suspicions that referrals were going to other homes, were being 'boycotted' by commissioners in this way.

In two other cases registration and inspection unit officers reported outstanding compliance notices. In one case the owner said the main reason for closure was low occupancy due to reduced demand for publicly funded places. This may be linked to the inspection officer's view that the main reason for closure was that the home needed refurbishment, as it failed to meet the existing registration requirements. In another case, while both the owner and the unit manager reported that the main reason for closure was the owners inability to get additional funding, the registration unit manager added that: staff turnover was high; quality of care was fair but standards were slipping and there had been a number of complaints from relatives; and staff were not being paid.

As we might have expected respondents were less likely than registration and inspection officers to raise issues of quality of care. Clearly in what follows we will be presenting a partial picture with respect to quality of care issues, however, the above suggests that this is primarily a question of emphasis and the accounts provide an in-depth insight into the reasons and circumstances that lead to homes closing.

6.2 Overview: decisive and relevant factors

Respondents were asked which, if any, of twenty potential reasons for closure had been relevant or decisive in the decision to close (see table 5). The two decisive factors most often identified were local authority prices not covering costs and the cost implications of the new National Minimum Standards. Other decisive factors identified by more than a quarter of the providers included: low levels of occupancy due to reduced demand for publicly-funded places; local authority prices being unlikely to cover costs in the near future; and the relationship with the registration and inspection unit.

Table 5: Factors relevant and decisive to decisions to close

	Decisive factors (n=20)	*Factors mentioned (n=20)*
Care Standards:		
Cost implications of new National Minimum Standards	10	15
Building could not be adapted to meet the new standards	3	4
Training requirements of new standards	1	5
Commissioning Environment:		
Contracting arrangements	1	4
LA prices not covering costs	10	14
LA prices unlikely to cover costs in the near future	8	13
Demand:		
Low levels of occupancy due to reduced demand for public funded placed	8	8
Low levels of occupancy due to reduced demand for self-funded places	2	4
Low levels of occupancy due to general drop in demand	3	4
Relationship with Registration and Inspection Unit	6	6
Value of premises/land if sold	4	5
Staffing:		
Increases in running costs, including staff costs	3	11
Recruiting care staff	2	8
Retaining care staff	1	5
Recruiting nursing staff	1	3
Retaining nursing staff	0	1
Recruiting/retaining managerial staff	2	4
Personal factors:		
Wanted to retire	3	5
Wanted to change direction	1	1
Other factors (including cost of modernisation)	7	13

Overall, the factor most often identified as relevant to decisions to close is the introduction of the new National Minimum Standards (Department of Health, 2001b) (cited by two-thirds of the providers). This was closely followed by local authority prices not covering costs (14 interviewees). Other relevant factors identified by over half of the providers included: the expectation that prices were unlikely to cover costs in the near future; and increases in running costs. Problems recruiting care staff were highlighted as often as reduced occupancy due to reduced demand for publicly-funded places. However, this was only said to be a decisive factor in two cases whereas all those who identified low occupancy of public places said this was decisive. Problems recruiting care staff and increases in running costs were identified by more than a quarter of the providers as relevant but were rarely said to have been decisive in decisions to close.

Providers of residential homes identified a number of factors as decisive that were rarely identified in relation to other types of home. For example, the impact of low levels of occupancy due to reduced demand for publicly-funded places was reported to be decisive by just over half of the residential home providers, compared to only one of the nursing home providers. Similarly only one nursing home respondent highlighted the relationship with the registration and inspection unit as a decisive factor, compared to just under half of the residential home respondents. Two residential home owners also highlighted difficulties recruiting care staff as decisive when none of the nursing home interviewees did. Increases in running costs were also highlighted as decisive by three residential home respondents when none of the nursing home respondents said it was a decisive factor. Four of the five providers, who identified low morale and or disillusionment with the nature of the care sector as relevant to the decision to close, were owners or managers of residential homes.

The majority of the providers identified more than one factor as decisive in the decision to close. The number of factors varied between one and nine. A combination of four or five decisive factors was most often identified (by nine of the 20 interviewees). Another five interviewees indicated that their decision had been based on only one or two decisive factors. Two decisive factors were jointly identified by about a third of the providers (7): local authority prices not covering costs *and* the cost implications of the National Minimum Standards. Low occupancy tended to be combined with one or both of these two factors (by 5 owners or managers) and/or increases in running costs, a concern that future local authority prices would be unlikely to cover costs in the near future, or wanting to retire.

None of the homes closed due to bankruptcy. However, all but two of the homes had been discontinued to avoid further losses or because the business was not succeeding in terms of earning an adequate return (the other two closed due to enforcement action and due to high refurbishment costs combined with the value of the property exceeding that of the business). Classification of whether a business has failed or not and in what way, is complicated by the different ways in which an adequate return or the break-even point can be defined. A reasonable income or a reasonable return on investment may be prioritised or understood differently.

6.3 Care standards

Of the suggested causes of closure the cost implications of the new National Minimum Standards for Care Homes for Older People is the most frequently cited factor (Department of Health, 2001b). The standards introduced to improve the quality of care in homes throughout the country will come into force in April 2002, with particular standards applying from 2005

(e.g. staff qualifications), or 2007 (e.g. single room and room sizes). Three-quarters of the providers interviewed reported that the cost implications of the National Minimum Standards were a factor in their decision to close. Of these ten stated that the cost implications were a decisive factor. In four residential homes the premises could not be adapted to meet the standards, although in one case this was not said to have been decisive in the decision to close. Five providers said that if the home had stayed open the building would have met the new standards without alteration.

The cost implications of the new National Minimum Standards described related to the level of investment required to meet the standards, on-going increases to running costs and a reduction in the value of the business. Some providers noted all of these implications, others one or two. Just over a quarter of the owners and managers commented on the purpose, relevance and value of either particular standards or an emphasis on the built environment within the standards.

When it was said that buildings could not be adapted to meet the standards such comments may have reflected the level of expenditure that would be incurred and the suitability or age of the building, rather than that the alterations to the premises would be impossible per se. Such comments are likely to reflect the degree to which investment and alterations were seen to be on such a scale that they were considered unachievable. Level access, for example, was a requirement that two respondents said was impossible to achieve due to the number of steps and different floors (Standard 22.2). One owner added that the home would have to be closed to wheelchair users if it remained open. Both premises were described as older buildings that had been converted. One was in a conservation area and the owner expected planning permission to install a shaft lift would be rejected and if allowed it would connect only two of four floors and mean losing rooms. In another home, in a Victorian house, where the respondent said the building could not be adapted about half of the rooms would fail to meet the new space requirements without alteration. In another case the building had been purpose built in the 1960s but had no en-suite facilities and adding them would have reduced the number of places by half.

Another two providers also highlighted the provision of en-suite facilities as a problem. The interviewees seemed to expect to have to install en-suite facilities for all service users, rather than in new builds or extensions (Standard 21). Other alterations highlighted as examples of the investment needed to meet the new minimum standards include the following: the widening of corridors and doorways to provide a clear opening width of 800 millimetres for wheelchair user access (Standard 22), which one owner said would also mean changing the lintels and carpets - even though the corridors and doorways were already large enough for

some wheelchairs; the standards for communal living spaces (Standard 20); the space requirements for individual accommodation (Standard 23). Single rooms in current use were not always large enough in terms of usable floor space and some providers appeared to expect to have to convert all double rooms to single rooms. It was not always clear whether this was due to a misinterpretation of Standard 23, to the size of double rooms not meeting the new space requirement for double rooms (16 square metres) or due to an expectation that service users and their relatives were likely to choose homes that offer single rooms. There did appear to be a misconception among providers that the new standards 'will outlaw shared rooms' (Caple, 2001). One interviewee also noted that their home was unlikely to attract private users in the future as the home could not offer 'hotel' style accommodation and in order to survive it would need to attract an even higher proportion of private residents.

The owner of a nursing home said that meeting the national minimum environment standards would cost an estimated £400,000. Another owner of a residential home highlighted the cumulative cost of relatively small alterations such as the fitting of anti-scolding devices to hot water taps, which were said to cost approximately £100 each (Standard 25.8). Standards relating to heating and lighting services such as power points, light sockets and radiator guards (Standard 25.5) were also highlighted.

Such investment was considered not financially viable for small businesses even if the capital were available 'unless they were prepared to pay a proper fee and you were very sure you were going to have a continuing contract at a proper price, you couldn't take on a large debt like that and service it'. Another owner reiterated that small homes do not have the cash flow to support such investment. Referring to a home facing closure in one of the in-depth interviews a contracting and marketing manager described the difficulty of borrowing money to invest in businesses that are 'cash negative':

> 'If we went to our bank and said, right, we want to borrow two hundred and fifty thousand pounds to invest in this home to meet the new standards and to continue operating, they're going to look at our balance sheet and say, sod off, you know, you're losing money.' (In-depth interview B.)

The standards relating to staff qualifications and training were also seen as prohibitive for small businesses by a quarter of the interviewees and they were highlighted as a decisive factor in the decision to close by one owner. Two people said that they would be unable to afford to spend three per cent of the gross salary bill on training and that such a proportion is unrealistic for a small business (it is unclear which standard this relates to, but it is probably an interpretation of Standard 30.4). Another owner highlighted the cost of NVQ courses,

both in terms of the course fees and the loss of staff time and the cost of cover. The owner of a residential home noted that, while the aim of having fifty per cent of care staff achieve NVQ Level 2 or equivalent by 2005 is commendable, it is unachievable as care staff are unlikely to want to take the courses as they 'dislike the degree of writing required' (Standard 28.1). The merit of higher levels of training among care staff was questioned by another provider who related qualifications to nursing staff and expressed scepticism about the worth of NVQs:

> 'The authorities want the staff now to be practically like nurses. You know, that sort of qualification, almost, these NVQs and God know's what. And again a lot of them are not worth the paper they're printed on.' (Residential home Q.)

The implications of requiring staff in residential homes to undertake assessment and monitoring tasks was emphasised by another manager:

> 'You are going to be expected to have levels of staff and skill levels to be able to cope with people who have got pressure sores, people who have problems with mobility, people who are falling, wandering, people with behavioural difficulties. So you're expected to have pressure sore monitoring, weight monitoring, bowel and urine chart monitoring, which previously were almost frowned upon because they had a nursing focus. … (it is) an open acceptance of increasing dependency levels.' (Residential home A.)

Five of the respondents said that complying with the new minimum standards would reduce the size of the home, which would reduce the value of the business. The extent to which the number of places would be reduced ranged from fifteen per cent to 50 per cent. The impact of this reduction is associated with the size of the home. A 50 per cent reduction would be uneconomic for any home, but the loss of three rooms in a home of 13 places would jeopardise financial viability. Such a decrease was expected to reduce potential revenue to the break-even point, which was considered unviable.

In general the providers said they supported the introduction of national minimum standards. A quarter of the interviewees, however, questioned the purpose, relevance and or value of particular standards or the apparent emphasis within the new minimum standards on the built environment. Owners and managers spoke of the environment standards as lacking 'common sense', and being 'not quite relevant to residents':

> ‘We feel too much pressure is put upon us from the material point of view and not enough interest in care … They never came to find out ... were they happy? Were they content with what we were giving them? It was all to do with buildings and legislation and paperwork.’ (Residential home P.)

Two owners (from a residential and a nursing home) considered en-suite facilities as ‘neither here nor there in practice’. The nursing home owner said ‘most residents are not mobile enough to use them – it makes no difference’. In the in-depth interviews another respondent emphasised her dislike of en-suite facilities on safety grounds: ‘I do not think bathrooms are the safest of places… if you have confused residents with their own bathroom you are asking for trouble’.

To the respondents the purpose of the environmental standards was unclear because the way in which they relate to and improve the quality of care was unclear: ‘The emphasis on the built environment does not necessarily transfer into the care environment.’ The practicability of the standards on a national level was also questioned: ‘The standards have not taken the national situation into account. The foundations aren’t there to support the policy.’

Only one owner commented on the care homes regulations. He reported feeling that they had been published surreptitiously at the back of the new standards for children’s homes and that they went a ‘step too far’ in terms of decreasing choice and imposing penalties ‘anything you do wrong…as I read it, is a criminal offence’. It was a condition he did not want to operate under:

> ‘Information about financing, financial resources, well that presumably will mean I’ll have to tell them what my mortgage is, what I’ve taken on. I think it’s none of their business. If I were to be bidding for council contracts and they demanded as part of their contractual decision to see a copy of my accounts. I can see that - then I have the choice whether I say ‘yes’ or ‘no’. This gives you no choice. So if I refuse to divulge my accounts to the commission they can give me three months notice to comply with that. I’m not a criminal. I’ve been in this business for ten years and although I’m in it for the money, I have given a first class service. We’ll nurse people through to death, and we’ve sat with people at all hours of the day and night. And to think that they could then turn round and say because I haven’t got my paperwork right, I’ve committed a criminal offence. Paperwork, which does nothing whatsoever in relation to the quality of care given ... It really is high-handed.’ (Residential home T.)

This owner also said the nature of the labour market is such that potential staff were likely to be put off by the need to provide proof of identity, two written references, and the delay likely to be caused by ensuring staff are registered with the General Social Care Council for England and by having to check the criminal records bureau list of people unsuitable to work with vulnerable adults (Department of Health, 2000b): 'They'll go round to the local bobby shop, or wherever it's going to be, and they'll pass Tesco's on the way where they can go to pack shelves and start tomorrow.'

In one of the in-depth interviews a contracting and marketing manager asked who would evaluate the business plan and when a home is found to be 'not viable, what are you going to do about it?'. The need to demonstrate the viability of the business to 'the Social Services and the City Treasurers office…' was highlighted by another owner in one of the in-depth interviews. They were a limited company and so had to demonstrate viability, which was said to mean showing 'not just a break-even or a small profit but a bloody good profit'. This requirement was seen as a 'catch 22' situation:

> 'Social services were against money grabbers, so although you had to show a good profit to be an acceptable organisation for their rules, they also then suspected you of money-grabbing and would try to hit you down in other ways. They'd start to look at you like bandits, robbing the old people. So you've lost either way.' (In-depth interview A.)

Many of the providers emphasised how they were unable to sell the business as a going concern. This was attributed directly to the National Minimum Standards by two providers, one of whom reported having built a purpose built extension to the standards of the time eleven years previously. In an in-depth interview one provider explained 'if you sold the business to someone it's the person who is registered, not the place, and they would be liable for all these new requirements. So of course it meant the price of businesses fell. It would affect everyone who bought and sold.' In another in-depth interview one home was said to have lost a quarter of a million pounds in value in the year before closing.

6.4 Commissioning environment

The majority (18 of 20) of the homes had been preferred providers in the sense that they had been on a local authority approved list. Seven were on just one authority's list. One home in the North West was on the approved list for 12 authorities. Four providers identified contracting arrangements as a factor in the decision to close and one owner said it was a decisive factor. However, when asked about the commissioning environment and

relationships with social services departments in more detail, specific criticism was made about:

- a lack of communication;
- a lack of fee negotiation arrangements;
- delays in payments;
- insufficient clarity of purchasing intentions;
- use of local authority provision.

There was very little evidence of the policy objective of widespread constructive co-operation, mutual trust, openness and transparency, or jointly articulated goals (Department of Health, 2001a).

Few of the owners or managers commented on the commissioning process overall. Those that did tended to be from homes that were part of chains. In one of the in-depth interviews a contracting and marketing manager described considerable variation between local authorities in terms of being 'forward thinking' and 'backward thinking'. This interviewee said the commissioning process needed to be changed to enable central government to consider and manage strategically. Ring-fenced funding was described as difficult 'politically'. Local authorities were said to put money intended for the long-term care of older people into other services, services that have a 'higher policy profile'; 'services for older people always seem to come bottom of the pile unfortunately'.

Relationships between commissioners and providers

The providers described the quality of their working relationships with local authorities in a variety of ways. Eight interviewees reported quite good or very good relationships. Features highlighted about good relationships related to co-operation, communication, strategic planning and the provision of information:

- a social services department and a charity provided information about local providers, who could subscribe to the service, to relatives and service users;
- local authorities that 'make it their business to communicate, to involve users and to involve providers … good authorities out there that are trying to consider the market and how they can best manage it and talk to the independent sector';
- a local authority that issued guidance to care management teams 'reminding them that top-ups are acceptable'.

In contrast seven providers described the relationship as poor or very poor. The relationships regarded as poor were described as:

- lacking in co-operation;
- a 'nightmare';
- 'frustrating' as the authorities were uninterested in examples of good practice or dialogue with providers;
- 'They're (the NHS Trust and Social Services) trying to protect their own little pots and there's lots of arguments between them and we get caught out between the two'.

Another provider noted that there had been a 'huge reorganisation and the structures are now very complicated'.

Consultation and communication

Several providers reported a lack of consultation, reporting that their views, knowledge and expertise were not sought either on issues relating to national or local capacity or to negotiate fees. One respondent with experience of working in other sectors commented: 'Co-operation with providers to find a way ahead and to plan is staggeringly absent in the long-term care sector.' Another owner described being disappointed that the local authority had not suggested new service areas or identified possible options for a change of registration.

Five of the providers said commissioners' purchasing intentions were insufficiently clear. One owner said purchasing intentions were 'made it up as they went along'. That local authorities were not taking responsibility for their role in managing the market or the importance of their long-term purchasing plans to providers was emphasised by an operations director:

> 'We've got a monopoly purchaser. They (local authorities) purchase 80 per cent. … We're discussing with another local authority the future of the homes in their area and they are saying to us, before we can have a discussion with them we want to see your business plan for the next five years. And our answer is, well, we can't value the business plan until you tell us what your purchasing plan is. Because what we're going to have to do is, to provide to that. We are now at stalemate. If they purchase at 80 per cent then they have to accept responsibility for the market. They say they're managing the market. Well if they are they have to accept responsibility for what's happening.' (Dual registered home I.)

On reflection one interviewee commented that although there was nothing dramatically wrong with the relationship 'I wouldn't say it was a partnership. They would tell you as much as they wanted you to know.' Lack of communication and co-operation was highlighted by one contracting and marketing manager in an in-depth interview as hindering the ability of independent providers to restructure or develop new services as an alternative to closing homes: 'Half the time you're guessing what people want… what their purchasing plans are'.

Fees

Nearly three-quarters (14) of the 20 providers reported that local authority prices not covering costs influenced their decision to close. Of these ten said this was a decisive factor. The level of fees was emphasised as having been a long term problem by seven of the providers. One owner had written to his Member of Parliament, the local authority and the local press on numerous occasions since 1995 to campaign for higher increases in fees. Another owner again emphasised that it was the fee level that is the problem when asked about preferred contract types – she did not mind what type of contract they had. Only one owner said she would have preferred a block contract even if it had incorporated fees at a lower rate.

When asked about fee levels a number of interviewees commented on rates of fee increases. They were said to have been small and introduced inconsistently:

- the fee for a nursing place was said to be £400 in 1992 and in 2001 it was £370 and yet owners have to provide more facilities;
- there is no recognition that health care inflation has outstripped other inflation by funding authorities;
- the local authority fee increase was 7 per cent compared to the minimum wage increase of 10.8 per cent;
- they have increased their fee rates by just over 13 per cent in the last seven years, which is on average less than 2 per cent a year.

A number of the owners compared the level of fees received for a local authority placement with the amount people pay for bed and breakfast accommodation, for example:

> 'The problem is with the way they treat everybody! There is a contradiction in wanting a quality market and then paying bottom price. In no other environment would you do this. If you can stay in a Travelodge for £40 per night you can't expect

to get expert nursing care for less than this, but this is what the government expects'. (Nursing home S.)

One respondent said that a new local authority contract no longer guaranteed that fee increases would be kept in line with retail inflation: 'there's nothing that guarantees that the fee levels would increase and they're expecting you to sign for three years'. Low fees was also said to be a factor more generally in the lack of lending to the sector.

Almost three-quarters of the providers said that no scope for negotiation about the price of individual local authority placements existed. One owner described the stance of the local authority as 'uncompromising'. Those that said there was scope for negotiation qualified this with comments such as 'technically' or there was a little 'but not much'. One provider reported not knowing if there were any fee negotiation arrangements and another that the scope varied by local authority. Another said that local providers felt that any attempts to negotiate could lead to reprisals:

'You could try and argue the case with the authorities but there is a big fear that this will not go down well and you may spoil your chances of contracting again.' (Nursing home J.)

Budget crises

When discussing fee levels about four providers spoke of local authority budget crises. This was linked to a fall in demand for publicly-funded places leading to low occupancy in care homes and in two cases to 'bed blocking'. One provider said that during one three month period there were no local authority funded admissions because of a budget crisis. The inefficiency of delaying the discharge of older people from hospital who would be better placed in nursing or residential care, which also cost considerably less than remaining in hospital was highlighted by a dual registered home provider. One owner described having been asked by a local authority to accept local authority residents for free because of a budget crisis and because the authority had closed all of its own homes.

Delays

Delays in payment, delays from assessment to admission and delays in the time taken to assess clients can be frustrating, increase levels of uncertainty and reduce income. It is good business practice to ensure bills are paid on time. In recognition of the serious cash flow problems and potential reduction in profit that can be caused by late payment small businesses have a statutory right to claim interest on late paid debts from other small

businesses, large businesses or the public sector (The Late Payment of Commercial Debts (Interest) Act 1998). A quarter of the providers reported having experienced delays in payments from authorities. Delays of up to four months were reported by one residential home owner. A nursing home manager who reported not having had any problems with delayed payments, added that payment six weeks in arrears was the norm in the industry and so was expected. In one case delays in payment occurred when dealing with other local authorities and was presumed to be due to the need to set up new contracts and the lack of standard systems across authorities. A general manager of a dual registered home highlighted good practice. The authority was said to pay on a two weekly basis, one week in arrears.

Income can also be reduced and risk increased by delays from assessment to admission. Such delays may reflect user preferences, however, there is some evidence to suggest that the cause of delays was linked to budget crises in local authorities. A social worker was said to have told one of the respondents that delays between assessment and admission were due to a lack of funding. Delays were also said to vary depending on where people are referred from: 'If they are waiting at home they bring them in as an emergency admission but if they are in a hospital they don't take them out, they keep them.' Two providers asserted that some service users died while waiting to be admitted.

Length of time to assess clients was also reported to be problematic and progressively so. This was particularly said to be the case in relation to assessment of residents to see if their needs had changed and required nursing care. Length of time taken to assess the clients was said by one regional director to vary seasonally.

Local care markets

Respondents were asked if their local care market was organised and structured efficiently and fairly by the local public bodies. Several respondents felt unable to respond to either or both of these questions. Three felt their local authorities were both efficient and fair. One of the managers said that the local authority had 'used market forces very efficiently to deal with supply. They had been a net exporter of residents to neighbouring areas and that has now been re-engineered.' This assistant regional director also described the local care market as fair; the local authority was said to be 'scrupulously fair in making sure that no individual provider gets any benefit that other providers don't get. I don't believe they favour their own homes. They are consistent.'

In contrast to this positive view, about half of the respondents were concerned with either efficiency and/or fairness. Among these respondents the fairness and efficiency of local care

markets appeared to be judged in terms of policies related to commissioning places in local authority homes, local authorities continued participation in provision and the referral of new admissions with high dependency levels assessed as having low dependency needs. Just over a quarter of the owners and managers said local authority homes receive preferential treatment. One provider described an 'unwritten' purchasing policy 'to push clients into local authority beds first'. Providers also said referrals were managed unfairly as care managers gave service users a restricted rather than comprehensive choice of providers in the area, such as a choice of only three local homes.

Other criticisms of commissioning in local authority homes relate to funding arrangements - block contracts, higher fees, and economies of scale – which were said to give an unfair advantage in terms of affording 'better wages and maintenance, repairs etc.'. The higher fees being paid for local authority placements was the reason given by a quarter of the providers for their view that local authority provision is inefficient. Examples of the price differential between independent and local authority provision ranged from £60 to £200 a week more than in the independent sector. The discrepancy in fees was said to contravene the principle of Best Value and the Fair Competition Acts by one owner in the in-depth interviews who requested that money be spent more fairly.

One manager also said that local authorities 'keep the best services in-house'. These services were said to be the 'specialist and higher value work'. Another owner said that the local authority was 'getting all the respite care'.

Dependency levels

In previous work where homes owners and managers have been asked whether they see themselves as catering primarily for high or low level dependency clients, about a third saw themselves as catering for high dependency clients (MEOC Team, 2000). Among the closed homes, however, the majority (12 out of 18) identified that they were catering for high dependency clients in the year preceding closure. However, when asked about their policy since the home started, only four respondents identified high dependency clients as their primary focus. About a third of the owners and managers indicated that the proportion of high dependency residents had increased (five of the 15 who gave details of client mix in both the year up to closure and over the life of the home). This group included nursing (2) and residential homes (3). Comments made by them, however, emphasised that either new admissions tended to have higher dependency needs than those identified in assessment or higher dependency levels than admissions in the past. New referrals were described as

'invariably wrong', having 'been in nursing homes', 'borderline nursing almost', or 'what used to be considered nursing about ten years ago'.

Some linked the higher proportion of high dependency admissions to the implementation of the Community Care policy. The manager of a dual registered home said that since 1993/4 social services started referring people who needed nursing care to residential homes because residential placements were cheaper. Residential home residents were also said to be older, less accepting of residential care, and to have a shorter life expectancy than in the past, as well as having higher dependency levels. In contrast, one residential home owner noted that in her area the type of resident they were permitted to accept had become more restricted; residents who developed 'some confusion' used to be allowed to stay in their residential home, now they would have to go to a home 'registered for EMI (Elderly Mentally Infirm)'.

In an in-depth interview one owner reported being pressured by the authority to change the registration category of the home from nursing to dual registered. Doing so was said to have resulted in the referral of high dependency residents inappropriately assessed as needing residential care and the home being paid the lower fee by the authority: 'We were told outright by social services that they would never have put them in a residential home which had not got nursing staff in it - that wasn't dual registered. So we were being abused.'

Relationships between providers and care managers

When asked about their relationship with the local authority several providers commented on their relationship with care managers. Relationships appear to have varied, with some providers describing the partnership or liaison as good and others describing a relationship that involved the possibility of reprisals. A nursing home regional manager said gaining a block contract with a health authority, for example, was 'perceived as potentially leading to bad relationships with social workers, which would need to be re-built if the block contract was not renewed'. Similarly, refusing to accept a local authority referral at a particular fee level was said by the manager of a dual registered home to involve the risk of being 'punished' by social workers, who might deliberately refer future clients to other homes. The manager also noted that self-funded referrals appear to be subject to the influence of care managers more than in the past, as 'most people are routed through social services, even private payers, when enquiries used to come from accountants and solicitors'. Two reported an apparently deliberate boycott of their homes. In one case a care manager was reported to have told the owner that this was so, due to their ceiling price being too high.

Two owners, who had both worked in the care sector for over 16 years, described the approach of care managers as different to that of the past. In the past care managers were said to have 'hands on experience'. The current approach appeared to them to be at odds with their own view of service need. To these owners 'newer' care managers appeared to be excessively concerned with procedures and regulations. Their comments suggest that this focus appears to have displaced that of the needs of the service user, with care managers adopting a more distanced position, and having less understanding and concern. For example, care managers were described as 'more formal', less focused on the person than in the past, as having less hands on experience and working 'by the rule-book'. The resident appeared to one provider to have 'become a case'.

If interviewees said their relationship with a local authority had changed over time they were briefly asked if this applied to care reviews. Less than half of the providers indicated that things had changed. Of these several noted that they rarely saw care managers. For example:

> 'The local authority did a care review six weeks after admission and then you wouldn't see anybody. There was nothing in the way of follow-up.' (Residential home A.)

Another provider added that the only care managers they saw were psychiatric care managers.

One respondent went on to say that he took the lack of follow-up as a compliment, interpreting it as a sign of confidence in the quality of care provided. Another owner noted that in the past the infrequency of care reviews had been noticed and the providers themselves were criticised for not chasing the care managers.

6.5 Competition

There was little evidence that increasing levels of competition had led to closure. The proportion that felt they faced an extremely competitive market was higher than in the previous study of providers, but we would expect this in a sample of proprietors of homes that had closed. It was interesting that the only respondent in the South West identified the market as extremely competitive, while the R&I unit manager suggested that there was a shortage of homes in the region. A couple of the owners and managers said that they did not know how to describe the level of competition. Only two providers indicated that levels of competition in the year prior to closure differed from levels of competition in the past. One indicated that competition had decreased and another that it had increased.

Table 6: Providers' perceptions of competitiveness

	Closed homes		*MEOC sample*[1]	
	No.	*%*	*No.*	*%*
Not at all competitive	1	6	6	12
Quite uncompetitive	6	33	17	33
Quite competitive	6	33	22	43
Extremely competitive	5	28	6	12
Total	18	100	51	100

Note:
1. MEOC Team (2000).

A quarter of the providers described the degree of competition they faced in the twelve months prior to closure as extremely competitive. As a factor influencing decisions to close the level of competition may have been under-reported due to the indirect ways in which it can influence other factors and circumstances that affect providers' decisions to close. The lack of negotiation about fees and in turn the low level of fees paid, was attributed by one owner in the Trent region to the local oversupply of places. In another case the opening of a number of purpose-built homes was said to have reduced the number of people who looked at their non-purpose-built residential home and it was at this point that the owner started to consider changing to another type of service provision, before later closing the home. This supply side factor also coincided with a budget crisis in the local authority. In one of the in-depth interviews a provider commented directly on supply side issues, reporting an over-capacity of approximately 600 places in the authority, which he attributed to the continuing provision of local authority homes.

6.7 Demand

In every case where low levels of occupancy due to reduced demand for publicly-funded places was cited as relevant it was said to have been decisive. It was identified as such by eight providers. Half of these were from the South East. The remaining four were from the South West, West Midlands, North Yorkshire and the Trent region. Six of these eight respondents were providers of residential homes; low levels of occupancy due to reduced demand for public funded places was said to have been relevant to the closure of one nursing home and one dual registered home. Low levels of occupancy due to a reduced demand for self-funded places was also identified as relevant to four of the closures (all residential homes), and of these it was decisive in two.

Three of the providers said low occupancy due to reduced demand for publicly-funded places had been a long-term problem, one since the mid 1990s and the others for two to two-and-a-half years before closure. Two providers reported not having received any referrals for publicly-funded residents in the year prior to closing. In a small residential home, in the South West, as well as being low, occupancy levels were described as erratic over the past two and a half years; the home was said to have been full for only five, non-consecutive, months in this period. Another owner of a residential home of less than 20 places, in the North Yorkshire region, emphasised the unpredictability of demand, which was said to have been variable over the life of the home: 'Once you had a vacancy you never knew how long it would take to fill it'. For others the problem was one of a more sudden fall in occupancy. Three providers reported consistently full occupancy in the past. Some had even had 'full' waiting lists.

The average occupancy rate in the 12 months prior to closure in the eight homes ranged from as little as 40 per cent to 75 per cent. Like the impact of predicted reductions in the number of places due to alterations to meet the new minimum standards, the impact of empty places is related to the size of a home (and the presence of other factors). Six of the eight homes where low occupancy due to reduced demand for publicly-funded places was said to be decisive had 23 places or less; the size ranged from nine to 23 places, with an average of 16. One residential home had 42 places and occupancy fell to 75 per cent and a dual registered home of 30 places experienced a fall in occupancy to 40 per cent.

The location of a home was identified as an indirect factor in the decision to close by one manager. The rural location was seen to make expansion unviable.

6.8 Relationships between Registration and Inspection Unit officers and providers

The providers' reports of their relationship with the registration and inspection unit and whether it played a part in their decision to close a home varied. Most (14) did not identify the attitude of the registration and inspection unit as a factor. Several of these highlighted their relationship with units as excellent or very good. Two providers valued the support received from registration and inspection units. A degree of informality was also emphasised as positive. An officer, for example, was described as 'approachable and there for us' by one owner and another recalled:

> 'We got some fantastic support from them … you could ring up and the head of Registration would come to see us. He'd drop in if he was passing. I was on first name terms with everyone in Registration.' (In-depth interview A.)

However, nearly a third (six) identified the attitude of the registration and inspection unit as a factor and for each of these interviewees it was considered to have been decisive in the decision to close. It was said to have been *the* decisive factor, 'last straw', by one owner who had tried to change the registration status of a home but reported giving up trying to meet all the requirements. The strength of feelings reported about relationships with registration and inspection units ranged from slight frustration at a 'mild irritant', to feelings of having been let down or unsupported, to a sense of having been subjected to taking part in an adversarial relationship. Comments about the poor quality of the relationship with registration and inspection units include: It was 'dictatorial' and policing rather than assisting; and 'What relationship? It was "Us and Them"'. An account from the registration and inspection unit is available for only one of the closures where the respondent reported a negative relationship and quality of care was considered to have been excellent. The registration officer reported expecting the home to close for months, as the owners had been disillusioned for a long time.

The professionalism or competence of staff was criticised by four providers. One interviewee described a unit officer's attitude and behaviour, concerning the new minimum standards, as inappropriately 'flippant', 'horrible' and 'less than honest'. To another manager officers were said to have been 'indiscreet' and described as 'personality driven in the way they manage things'. One inspector was said to fail to 'grasp what dual registration is. ... For example, it says "a single multi-disciplinary team" but she wants things differently, in little slots that are nursing or residential'. In another case an owner reported feeling let down by the unit as they had approved the appointment of a manager who proved incapable of doing her job without supervision. A unit was also said to be pre-empting the implementation of the National Minimum Standards by requesting that changes be carried out now in order to 'set up a good track record'.

There was considerable agreement among those who reported a poor relationship with the registration and inspection unit. Inconsistency and excessive faultfinding were common complaints. Specific criticism was made about:

- nitpicking;
- inconsistency in officers' interpretation of regulations;
- inconsistency in the implementation of regulations across homes;
- inconsistency in the requirements of the registration and inspection unit and other regulatory bodies such as health and safety;
- lack of communication.

Examples of 'petty' and 'endless nit-picking' were given by four providers who objected to being criticised for 'stupid things' like 'the stitching being undone on a net curtain'. Such criticism was described as following the 'rule book to a ridiculous level' and without purpose or apparent gain.

Many of the respondents referred to particular registration and inspection officers when describing their relationship with the unit. Disagreements could be associated closely with individual officers. For example, the owner who described having difficulties changing registration to include other services described how the difficulty was largely due to a change in personnel:

> 'The person who was in charge … was fully in agreement with everything. Then she left … The person acting up obviously wasn't going to take responsibility for this change so we were fobbed off. And every time we met the agreed requirements, the goal posts changed.' (Residential home D.)

Inconsistent interpretation of regulations and recommendations was identified as a problem by just under a quarter of the providers (and in several of the in-depth interviews). Implementing recommendations invariably involves additional cost and so their necessity needs to be transparent; inconsistency may lead to recommendations being viewed as needless. Inconsistency in interpretations of recommendations was attributed to either a change in personnel, and in turn their attitude or the ill-defined nature of the standards being implemented by the unit. One provider gave an example of their admissions book being found acceptable by one officer and unacceptable by another when the book had not changed. The inconsistent implementation of regulations across care homes was another issue raised by a couple of providers.

A lack of communication was also noted by a couple of respondents who would have liked to have been informed of changes and developments. Not being told 'of a change in personnel or even given a new inspectors name', for example, was felt to be discourteous.

6.9 Financial viability

Factors related to financial viability highlighted by the providers as contributing to the decision to close include the size of the home and the related issue of insufficient capital. The independent for-profit care home sector is still dominated by small businesses rather than major providers, with residential care homes being on average smaller than nursing homes, thereby restricting the opportunity for taking advantage of economies of scale (Laing and

Buisson, 2001). Some providers view smaller residential homes as no longer viable and by their nature small businesses were said to have insufficient capital to support the major investment required to adapt properties to meet the new standards. In some cases capital was insufficient to support routine upkeep or the maintenance required to meet the current standards. Two managers predicted the policy of introducing increasingly demanding standards for the physical environment will result in the elimination of smaller residential homes.

Size of home

A couple of the smaller homes were said to no longer be financially viable, a residential home of 16 places and a nursing home of 17 places. Financial viability appeared to be defined in terms of earning more than the break-even amount. In the relatively smaller homes the break-even point was often described in terms of the number of occupied places and just two or three vacancies could reduce income to the break-even point. For example, occupancy levels of less than seven out of nine places, 18 out of 20 places or ten out of 13 places, all in residential homes, were said to be below the break-even point. In relation to a larger home the break-even point was discussed in terms of the local authority fee being approximately £40 below the break-even point and a manager of a 20 place residential home attributed the high break-even point of 18 occupied places to the low level of fees. This interviewee explained that economies of scale are now needed in order to 'make things work in the care industry' and homes of less than 20 places cannot provide economies of scale. In the case of several homes, that were currently considered large enough to be viable, it was predicted that alterations to meet the National Minimum Standards would reduce the number of places to below the break-even point.

Capital investment

Loans were required to purchase or set up all of the privately run homes, with the exception of two that were part of large chains. Two of the voluntary homes also had to take out a loan. The only home that had not required any financing was a charitable home set up over 50 years ago. The majority (13) had mortgage loans, with only one operating under a buy and lease back arrangement. The loans were guaranteed against assets in all but one instance. The guarantees were against assets owned by the firm in six or half of these cases. In just one of the cases was the bank or other lending institution instrumental in the closure. A loan was needed to fund refurbishments to meet current physical standards and refused on the grounds that the level of borrowing was unsustainable. None of the providers reported loans having been called in. The most negative comment about lenders was that they were neutral, indifferent or unconcerned (in three cases). In five instances they were prepared to lend more

money and another instance allow the owner more time. One case described the bank's attitude as 'delightful'.

Inadequate profit to re-invest was raised as an issue by one owner of a 25 place nursing home who reported that even at full occupancy profit was too small to reinvest in the business. In another case the level of past investment appeared to have been critical. On taking over the home a considerable amount had been invested on refurbishment, an amount that appears to have been unsustainable from the start since the home was reported to have always failed to cover costs. The earlier section on Care Standards highlights the extent to which the cost implications of the new minimum standards were a factor in decisions to close homes. Such intensive capital investment was said to be either unavailable or impracticable, as the value of the business would not support the interest accrued on such a loan.

6.10 Property market

A quarter of the providers identified the value of the premises or site as a factor in the decision to close. Four of the five reported it to be a decisive factor in the closure. For one provider it was identified as the single decisive factor. Factors that coincided with the value of the premises/property being decisive varied across the four closures for which it was identified. As discussed in relation to influences on the timing of decisions, for a couple of the owners high property prices offered an opportunity to sell when there was little prospect of selling the business as a going concern. The business was failing and it was a chance to exit: 'it was worth more as an empty building'. In some cases property developers had approached owners with offers.

For others the value of the site was so high that continuing with a business that would never be worth as much as the property or site could not be justified. One home was reported to need investment of millions when the property alone was worth an estimated £10-£12 million. In another home the building was leased from a company that had not invested in the upkeep of the property. The home was closed due to the building being unsafe and the owners of the building were said to have sold the property for £5.5 million.

6.11 Staffing

Care staff recruitment and retention

Recruiting care staff was identified as a factor in decisions to close by eight providers, however, it was only said to have been a decisive factor by two, both providers of residential

homes. Of these five identified retaining care staff as a problem. There did not appear to be any regional pattern in concerns about recruitment or retention.

Problems recruiting and retaining care staff were generally attributed to a high level of competition for staff in local labour markets. One of the owners of a residential home noted a national labour shortage. Views on the sources of local competition varied. In the South West a provider described the local labour market as seasonal as positions could not be filled in the summer months due to better paid opportunities in the tourist industry. An attempt to establish a shift rota and a 'float' of care staff to provide cover had to be abandoned, as they could not recruit enough staff. Another provider noted competition from supermarkets where the pay is higher for less stressful and demanding work. Opportunities for similar care work in 'Care in the Community' for better rates of pay were highlighted by another owner. The unsociable hours was identified as the cause of the recruitment problem experienced by a residential home.

Nursing staff recruitment and retention

Recruiting nursing staff was reported to be a factor leading to closure by two of the six nursing home providers. In a dual registered home, however, staffing appeared to have been a general problem. The operations director identified recruiting and retaining care staff *and* recruiting and retaining nursing staff as factors in the decision to close, with the issue of nurse recruitment being decisive. These staffing problems were in part attributed to the rural location of the home. People preferred to work at other, more accessible, care homes in the area. The home was also part of a group that consisted predominantly of residential homes, so less attention was focused on nurse recruitment compared to the recruitment of care staff.

Few of the providers who reported difficulties recruiting nursing staff elaborated on the causes or nature of the difficulties. In one of the in-depth interviews, however, NHS pay awards and high employment levels were identified as causes of the recruitment problem. One of the nursing home providers described the nature of the problem in terms of a general lack of nurses *and* a skill shortage in terms of difficulty recruiting particular types of nurses, namely 'nurses who can manage'. She noted disappointment at the removal of the SEN role. Another interviewee discussing the closure of a residential home who also had experience of nursing homes noted both the national nursing shortage and the loss of cadet and enrolled nurses. The other nursing home provider who reported problems recruiting nursing staff described loss of staff due to long-term sickness and retirement, which led to the problem, rather than examples of why it is difficult to recruit staff. One assistant regional director, who did not identify staffing as a factor in the decision to close, reported having had past

problems recruiting nurses. This had been resolved by recruiting from overseas. The nurse recruitment problem was said to date from when nurse education came 'under local control'.

Managerial staff

Recruiting and or retaining managerial staff was identified as a factor in the decision to close by four providers. Two of these said that it had been a decisive factor. Two residential home owners said their staffing budget was the cause of their recruitment problem. Both said that they could not afford to offer a salary high enough to attract suitable candidates. One of these providers added that they could not afford to advertise a vacant post. A nursing home assistant regional director reported a problem with managerial staff turnover due to managers 'burning out'.

A couple of respondents highlighted national staff shortages or the high employment level in relation to labour shortages. When identifying recruitment problems other interviewees may have assumed that their comments were indicative of the wider employment situation.

Staffing costs

Staff costs dominate the total costs of care homes. Seven of the nine providers who identified increases in running costs as a factor in the decision to close highlighted staff costs or the impact of the National Minimum Wage. Some providers emphasised the extent to which National Minimum Wage increases were greater than increases in fee levels. Others noted the additional increase to labour costs stemming from the Working Time Directive staff entitlement to four weeks paid leave. One owner, in the North West, took the impending increase in the National Minimum Wage in October into consideration when he was thinking about whether to close and concluded that, combined with the cost of the refurbishment, the home would have to increase capacity in order to be financially viable. In one instance a provider from a national chain said the National Minimum Wage had little impact on staff costs (and the closure), as wages were relatively high already in order to recruit and retain suitable staff. The National Minimum Wage was instead viewed as having eroded their previous position as an employer who was 'ahead of the game'.

6.12 Personal circumstances

A quarter of the providers identified wanting to retire as a factor in their decision to close. Of these, three said that it was a decisive factor. They had worked in the care sector for between 13 and 30 years. The interviewee who had owned/managed the home for 30 years, and was

in her seventies when it closed, said that wanting to retire had been a factor but not a decisive one. When retirement was identified as a decisive factor it tended to be in combination with other factors like being unable to adapt the building to meet the new minimum standards, the provider's relationship with the registration and inspection unit or a fall in occupancy levels.

One of the owner referred to ill-health as a factor in the decision to close. It had also been a factor for one of the owners in one of the in-depth interviews.

6.13 Motivation and the regulatory and administrative environment

While some accounts of care home closures are based solely on economic criteria, relating to a lack of financial viability in the present or near future, others also draw on perceived changes in and reactions to the nature of the care sector and the way in which owners can operate. Previous work has suggested that owners may cease to want to continue working in an environment that no longer allows them to operate in the way that first motivated them to join the sector (Kendall, 2001). Some of the owners' accounts suggest that decisions to close a home can combine such considerations with economic criteria - although none of the closures were based alone on providers regarding their professionalism or autonomy as having been restricted. One implication of this demoralization amongst providers may be that they will leave the care sector altogether when they close a home and be unwilling to consider future service development; a change in local authority pricing, contracting or strategic planning might not be incentive enough to pursued such providers to preserve existing services or establish new ones.

A loss of motivation appeared to have been a factor in just under a third of the decisions to close (six of the 20 structured interviews, and two of the open ended interviews). Of these, the majority (five out of six) had not owned a care home before. Several of these owners, and a couple of providers in the in-depth interviews, spoke of having wanted to own a care home for 'years and years'. It had been a 'dream' or a 'life's ambition'. Four of those who reported feeling disillusioned or discouraged had indicated that their most important or second motivation for becoming a care home owner was professional accomplishment and creative achievement. In one of the in-depth interviews another owner linked her wish to be creative with that of wanting independence and autonomy:

> 'I'd worked in the health service for fifteen years or so and I just had the feeling that I'd had enough of working for someone else - that I 'know what I'm doing now'. We wanted to produce something of our own – it's what every business person must feel, it's a creative thing.' (In-depth interview C.)

The high level of bureaucracy in general was highlighted by four of these providers. The 'red tape' was described as horrendous and crazy for small employers. Examples given included the tax credit system, the National Minimum Wage and Working Time Directive. One pair of residential home owners described feeling that they had become 'glorified pen-pushers'. Another interviewee spoke of how the level of paperwork 'is absorbing so much time that they're (owners and managers) not available for the actual client'. Another owner described not wanting to continue running the home as she felt that to do so would mean compromising the standards the partnership had developed and set for themselves.

Frustration about the level of regulation and administration was sometimes linked to no longer wanting to work in the sector - although for others leaving was attributed more generally to the experience having been 'sheer pressure and hard work from day one'. One owner spoke of the home ceasing to be 'a home', due to the shift in emphasis from people to paperwork and concluded that she had to ask herself 'Why am I doing this?' since 'there is no life for you in the care industry - if you actually care as opposed to just look at it as a business'.

For a third organisation, continuing to provide in the sector was regarded as a moral and social justice issue.

Moral and social justice issues

The representatives and manager of a voluntary charitable organisation identified moral and social justice issues as decisive in the decision to close a residential home. The voluntary organisation had invested capital and subsidised the running of the home for some time and came to the conclusion that that they could no longer:

> 'Uphold something where the government funding doesn't meet the costs of it's care for the elderly… Would it be right for us as a charitable organisation to continue to support such huge sums of money in a country that is not properly funding public spending for its elderly population? … There's just no way we can meet that gap.' (Residential home P.)

7. Steps Taken to Avoid Closure

Respondents were asked if the situation of fees not covering costs prompted them to do anything to try to reduce their costs, or increase their income, in the period leading up to closure and, if so, if they had implemented any of a number of possible suggested changes. Just over half (11) of the providers reported implementing changes (six residential homes, three nursing homes and two dual registered). Changes introduced or investigated in response to fees not covering costs fall into four broad categories:

- trying to 'make a go of it' by trying to increase existing sources of income;
- trying to reduce the risk associated with existing variability in earnings by seeking to diversify into other service areas;
- trying to minimise further losses by cutting expenditure;
- accepting that the business was failing.

Six reported not having made any changes to reduce their costs or increase income. One owner explained that she felt that it would be inappropriate, since to do so might compromise the quality of care provided, which she was unprepared to do. Others may have accepted a reduction in profit without considering it a strategy; the business was making a loss and there appeared to be little point in trying to reduce the size of further losses. Only one owner added that they had stopped re-investing in the business. This may well have been assumed to be self-evident by others, although some clearly continued to invest to try to attract more residents.

7.1 Strategies to increase income

Strategies employed to increase income included:

- changing the size of the home (instigated by two providers);
- trying to improve occupancy rates (tried by four providers – all residential homes);
- trying to increase the proportion of privately-funded residents (tried by six providers).

One owner reported de-registering two places in the last 12-18 months. Another reported increasing the number of places where they could do so without increasing costs - although this change in capacity had not been reported earlier under changes to registration. Expanding the home was also considered by another business but market research suggested that there was insufficient demand. Attempts to improve occupancy ranged from increasing advertising and marketing in general to advertising particular services such as respite care.

Other strategies to increase income identified by the interviewees included trying to improve occupancy indirectly by making improvements to the home, for example by providing en-suite facilities (reported by one owner). One assistant regional director said an attempt to increase the proportion of private payers failed because the ability to differentiate prices for residents based on source of funding was reduced, by the low level of local authority fees. The low level of local authority fee increases was said to have reduced the ability to 'cross-subsidise', so fees for private residents were effectively discounted, and market share was still lost. Another general manager also spoke of trying to increase the proportion of private payers. It was decided that referrals of publicly-funded residents would not be accepted but the home experienced a further drop in occupancy levels.

7.2 Attempts to diversify into other service areas

Four of the providers reported attempting or investigating the possibility of diversifying into other service areas. Areas considered or tried include day care, a home help agency, and intermediate care. The owner who considered day care reported being deterred by the need for it to be a separate business.

Intermediate care services were successfully introduced in one residential home but it was not enough to prevent the closure. Advantages of intermediate care were said to be the ability to specify a fee and demand had been fairly constant over a six month period. However, future demand for intermediate care was said to be an unknown quantity. If demand could not be relied on then such diversification failed to meet the aim of reducing risk and variability in existing income. In one of the in-depth interviews another manager described experiencing varying degrees of success in developing intermediate care schemes in different parts of the country. Successful schemes were associated with 'forward thinking' local authorities and Primary Gare Groups (PCGs) and Trusts working together. In other areas schemes were said to have ended due to a lack of funding.

Others reported considering changing the registration of the home. The owner of a dual registered home reported wanting to change the registration to learning disabilities but 'couldn't get permission' (a reason was not given). Owners of another dual registered home discussed changing provision to a specialist service, such as a dementia centre, with a local authority but the rural location was unsuitable. Another organisation had considered the possibility of changing from a residential to a nursing home in partnership with a local hospital management trust but this would have involved considerable time, investment and rebuild and continuing to work within a legislative and bureaucratic framework that appeared to distance them from the very people they wanted to support, the residents. In one of the in-

depth interviews another manager described extensive restructuring within a chain of homes in an attempt to develop services to match demand. Examples of such restructuring included changing the registration categories of homes from nursing to residential, and from 'nursing EMI' to 'residential EMI'.

7.3 Strategies to reduce costs

Various strategies to reduce costs were implemented. Staffing costs had been identified as constituting the greater part of costs and three respondents reported making changes to staffing levels in terms of reducing cover for sickness or reducing levels to the minimum requirement as occupancy levels fell. Two reduced staff costs by freezing wages. Others considered staff costs to be fixed. Yet others reported increasing salaries and wages in order to try to keep staff from leaving. Two providers also reported reducing additional services, such as shopping trips, outings and entertainment.

Other strategies to reduce costs consisted of economising or 'cutting corners'. Expenditure on utilities and interest payments on loans were reviewed and banks and suppliers changed. Levels of maintenance and décor were reduced or carried out internally. Such measures were reported by about a third (seven) of the interviewees. Another couple of providers reported that, although they would try to economise, they would not economise on food costs.

8. Changes that Might have Prevented Closure

When identifying factors that contributed to decisions to close and when discussing each factor in detail interviewees were asked what, if anything, could have happened to change their mind about closing the home. The improvement that might have changed decisions to close most often identified was an increase in local authority fees, identified by 13 of the 20 providers. Six respondents indicated a relaxation of the regulatory environment might have helped to change the decision to close. Just under a quarter of the providers said the home might have remained open if occupancy levels were higher. Three providers identified an improved relationship with the registration and inspection unit as a development that might have helped change the decision to close. Other improvements that were each identified by a couple of providers as potentially changing decisions to close care homes relate to contracting arrangements, service development, fee structure, labour supply and retention.

For one owner the decision to close was largely due to being refused further funding. If the bank had agreed an additional loan the owner said that he would have continued (although he

anticipated that capacity would need to be expanded from 16 places to 18 places in order for the home to be financially viable, and local authority prices would have to be increased, or the proportion of self-funded residents). Another owner reported that the home would have continued operating if property values fell.

A quarter of the closures were regarded by the providers as unavoidable as it appeared that nothing could have happened to change the decision to close. One of these had been served a closure notice. Another two respondents reported that the building could not be adapted to meet the new minimum physical standards, or that it would be uneconomic to do so; a home of 17 places would be reduced to 12 places if adapted to meet the new standards. The disparity between the value of the business and the value of the property was such that for another home it was anticipated that nothing could have changed the decision to close. Similarly, fees were judged to have been too low for too long a time by another manager for an increase of 20 per cent to have been enough to keep the home open.

None of the providers indicated that modification to the National Minimum Standards would be sufficient to change the decision to close. Several interviewees did, however, suggest changes that might make the implementation of the new standards more practicable. One interviewee suggested investment, on the scale required to meet the new physical standards, would be more feasible if there was an injection of money into the sector, perhaps via a phased grant. This could be used to upgrade buildings with a view to developing services where there was a definite need. Another manager similarly suggested the government make funding available for staff training – although in itself this would not have been enough to stop the closure.

8.1 Fee increases

The providers were asked what level of increase in local authority fees might have changed the decision to close the home. Two-thirds (13) indicated that an increase in fees might have helped the home remain open. The suggested increases ranged from 11 to 50 per cent (£26 - £168). On average an increase of 22 per cent was indicated. The number of respondents limits comparison by type of home, however, the majority (five out of seven) of the residential home providers who suggested an increase suggested 20 per cent or less (£26 - £50) whereas half of the nursing home providers who suggested an increase (two) suggested an increase of 30 or 50 per cent (£100 - £168). One manager indicated a fee increase would have had to have happened at least four years previously in order to have prevented the closure. Seven respondents said an increase would not have changed the decision to close: four of the eleven residential home providers, two of the six nursing home providers and one

of the three dual registered home providers. One owner said an increase in fees, so that they covered costs, might have delayed closure until the time when room sizes would have failed to comply with the new standards and the home would have had to close.

8.2 Fee structure

The fee structure did not appear to be an important factor in decisions to close. Only two interviewees suggested changes to the fee structure when asked if a change may have contributed to changing the decision to close the home. Both were residential home providers and said that they would prefer a greater distinction between dependency levels to better reflect the additional staff resources, including training, required to provide appropriate levels of care. Despite not saying that a change in the fee structure might have helped, another two respondents, both from nursing homes, criticised the fee structure. One said that it is 'ludicrous' and the other that prices 'should reflect the distinction between very ill patients and those with special requirements such as those who need feeding via a PEG tube or for whom special equipment has to be provided'.

8.3 Greater certainty: referrals and contracting

Four providers indicated that higher occupancy levels might have changed the decision to close. Higher and less variable occupancy levels would have prevented the long-term losses being experienced, and/or would have improved the profit margin in combination with an increase in local authority fees. One of these owners added that while more referrals might have meant the dual registered home remained open it was unlikely to have remained open for long due to an oversupply of places in the area. If occupancy had been higher one of the owners said that rather than closing, the home would have been sold as a going concern to an interested party, however, low occupancy was not identified when they were asked to consider possible decisive factors in the decision to close.

In contrast, in another home where low occupancy was said to be a decisive factor, the owners and manager said full occupancy would not have been enough to keep the home open, even for another year, due to the increase in running costs that full occupancy would entail. Full occupancy would have meant increased staffing levels and, in turn staff costs.

As discussed in relation to the physical standards for buildings one owner highlighted that providers could not borrow to invest and continue to operate with the current level of uncertainty about purchasing intentions; borrowing to invest in infrastructure is considered feasible only when combined with a greater certainty about future levels of income and the

ability to repay such a loan. One nursing home owner said levels of certainty would be improved and levels of risk reduced if there were continuing contracts. For one home however, it was said that the offer of a block contract from a health authority would only postpone rather than change the decision to close.

8.4 Service development

One operations director reported that they might have re-considered the decision to close the home if the local authority had worked in partnership with them to diversify into specialist service provision, such as a dementia centre. In another case the owners were unable to continue providing residential services to existing users (due to the new standards, staff costs and low level of fees) but said they might have been able to continue working in the care sector if funding had been available to develop an EMI unit.

8.5 Improved relationship with registration and inspection

Three residential home providers indicated that an improved relationship with the registration and inspection unit might have helped change their mind about closing the home. In one case this related to a failed attempt to comply with the regulations and standards required to change the registration of the home. Another manager who said that the decision to close was purely financial added that it would have been helpful if the registration and inspection unit could have agreed with the social services department about the standards for dual registered places. In relation to a sister home to the closure under discussion a further comment emphasising the importance of the attitude and behaviour of registration and inspection was made. The attitude of a unit was said by an assistant regional director to have accelerated a decision to close by 'forc(ing) their hand'.

8.6 Relaxation of the regulatory environment

Few examples were given of how the regulatory environment might be changed. One manager suggested that a greater relaxation of the timescale for compliance with the new standards relating to premises, particularly those relating to making all areas accessible to service users, would help. Another owner described an experience with an employment tribunal that was said to have been enough to dissuade her from wanting to continue to be in a position where such an experience might be repeated. This owner felt she had been treated with 'utter contempt' and 'never ever wanted to go through it again'.

8.7 Labour supply and retention

Two residential home providers, that had reported problems recruiting care staff and managerial staff as decisive factors in the decision to close, indicated that an improved local labour supply and availability of suitable and competent managerial staff may have helped to change the decision to close. One of these owners, however, added that even if a reliable and competent manager was in post they would not have continued for long as they felt 'battered' and disinclined to continue working in the sector.

9. Discussion

The sample provided a good range of circumstances of home closures, both geographically and in terms of the characteristics of homes. Most of the issues that lay behind the closures had been identified in previous work (Netten et al, 2001), but the interviews provided us with a greater appreciation of how these affected providers in practice and their perceptions of factors such as the relationship with commissioners and regulators.

Clearly the key issue for providers was the level of fees paid. Historically profit levels have been low, leading to a lack of reserves on which to draw. This meant that cost raising factors, such as the new regulatory requirements, inevitably were going to result in some homes going out of business. Borrowing becomes difficult if current fees are not covering current costs with sufficient surplus and there is no expectation that future fees will provide an adequate return. There is at least a perception among providers that there is little or no scope for negotiation of fee levels. It is perhaps worth noting that a quarter of the providers (four residential homes and one nursing home) who suggested the level of increase in fees needed indicated increases lower than current estimates of fee shortfalls, 'the difference between what local authorities are prepared to pay and the fee levels necessary to sustain investment in the sector' which 'vary around £50 - £70 per week' (Laing and Buisson, 2001, p. 204).

Changing fee levels is not just about an overall increase. Some of the concerns about rising dependency were related to a sense of being exploited as fee levels failed to rise in line with costs or the greater needs of residents. Fee structures that are more highly contingent on dependency characteristics can provide a more transparent relationship between purchasers and providers. Thus as dependency rises, so should income. This also helps address concerns about risk and uncertainty.

While many providers are by no means risk averse, the type of commissioning arrangements many face (call off contracts with low fees and a lack of knowledge about purchasing intentions) does not compensate them for the risks they take. Moreover, other motivational, situational and relationship factors combined with expectations about future government and local commissioning policy to make providers lose enthusiasm for operating in a climate they see as characterised by constraints. Issues for providers of homes included:

- lack of partnership with local authorities;
- regulation that was felt to be inconsistent, irrelevant and ever increasing; and
- level of red tape for small businesses.

These combined with 'sheer pressure and hard work' made providers less willing to invest more time or capital in continuing services that they feel are being inadequately funded.

Although national minimum standards for the physical environment are not due to come into force until 2007, they are clearly an important factor in homes closing now. There also seems to be some misunderstanding about what will be required. Providers that have stayed in the business despite the types of problems described above face the prospect of either having to close when these standards become law or considerable investment to meet them. It has proved difficult if not impossible to sell homes as going concerns – particularly if they require this type of investment. This put together with high property values in some parts of the country is making the decision to close almost inevitable.

One issue not raised by respondents but in wider discussions with providers was the saving factor of current low interest rates. Most providers have borrowed to start up or purchase their business. Should interest rates rise without other changes in place the rate of closure is likely to rise further.

That services need to be financially and professionally viable is recognised (Department of Health, 2001a). To support viable services local commissioning arrangements need to minimise potential economic disincentives or difficulties associated with working in the social care market, where the choices open to independent providers are relatively restricted. For example, in a competitive market, to avoid going out of business due to consistent late payment a small firm would usually have the option of raising prices in order to reflect the costs of their finances. A quarter of the providers reported delays in payment, which could not be offset due to actual and perceived lack of opportunities for negotiation about publicly-funded fees.

For small providers new service areas, such as residential or outreach forms of intermediate care, are likely to be developed alongside existing services in response to the changing needs of service users, but also in response to a need to diversify to make more effective use of capacity. In planning and implementing new schemes commissioners need to take providers' motivation, interests and concerns into account to better understand the advantages and disadvantages of different arrangements. Ways of working need to be established that promote information sharing, confidence and stability and recognise providers as partners in delivering services. For example, stability and confidence is likely to be reduced rather than promoted if funding crises interrupt financial support for new services. However, new arrangements can be supported by fees set at levels that are sufficient to compensate owners for risk, or contractual arrangements that guarantee streams of income.

Disillusionment among providers was often attributed to the levels of administration and regulation, which appeared to govern their day-to-day activities and distance them from one of their main aims, meeting the needs of elderly people. Other factors, such as frustration at a lack of consultation with local authorities about contracting arrangements and fee levels and the apparent irrelevent, inconsistent and ever-increasing regulation suggest that motivational issues may play an even more important part in providers decision making than at first appears. Combined with economic criteria and expectations about future government and local commissioning policy developments, it is motivational issues, including personal motivation, the nature of relationships with commissioning and regulatory bodies and the potential to influence and manage change that inform providers' decisions to cease operating.

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