Contingency Planning Toolkit and Guidance

directors of adass adult social services North West

ARCC

Contents

Version Control

Version	Date	Description
0.1	01/07/2019	Initial report draft
0.2	23/07/2019	Revisions and
0.3	09/08/2019	Draft shared with NW ADASS Programme Office
0.4	27/08/2019	Revisions following feedback
FINAL	09/09/2019	Final revisions following feedback

Application of this Guide

Whilst the principles of contingency planning apply to the broad range of care, this guide has been developed with a focus on regulated provision, namely: home care, residential and nursing homes and extra care housing; and is formed of 2 key parts, these are:

Part 1: Setting up Contingency Plans considers contingency planning as a whole system process and how this can be embedded into day-to-day operations, from the development of a specification through to evaluation, contract award and delivery.

Part 2: Dealing with Provider Failure addresses the event of imminent critical market failure and enacting the Contingency Plan. Part 2 explores the contents of a contingency plan in detail and a contingency plan template is provided in Appendix 1. The processes and actions are not necessarily sequential and will depend upon the reason for the closure, the time available, and the level of cooperation of the provider. Example scenario action plans are provided in Appendix 4 and should be read in conjunction with the guide.

This guide has been developed utilising best practice from the region and national approaches. It is recognised that **every situation is different** and it is up to the responsible officer to decide the best approach for the given situation, **interpreting this guide flexibly to suit the specifics of the local area and specific situation**, while still being guided by its principles[1].

The Context to Market Failure

1.1 Overview

The impact of actual or prospective failure of a single provider imposes stress on a local care market, whereas the failure of a medium or large corporate Provider can present enormous challenges that may require the involvement of several public bodies. Conversely, the National Audit Office's 'Managing Provider Failure' (2015) identified: *"The failure of a provider is not necessarily something that should be avoided at all costs. It can be the necessary price of innovation or come from effective competition, keenly priced contracts and robust contract management. However, the failure of a provider can have serious consequences and departments must manage failure effectively, in order to ensure continuity of services, and to protect the interests of people who use them"*.[2]

Whilst the impact of provider failure can be severe, failures of care providers are relatively rare events, although occurrences have been more frequent in recent years. On 5th November 2018, the CQC issued its first Stage 6 notification under the Market Oversight regime, this was in relation to the ongoing operation of services provided by Allied Healthcare. On the 29th March 2019 the North West branch of ADASS held a regional conference, 'Excellence in ensuring resilient markets and responding to provider failure', to share lessons learned from recent events and define future work programmes to

[1] 'Business failure' is tightly defined in the Care Act, to include only situations where the business has failed for financial reasons and the service is about to close. The financial reasons cited in the Act include being declared insolvent or bankrupt. As local authorities have a responsibility for the safety of vulnerable individuals and preparation is similar, regardless of cause, this guide takes a broader approach to contingency planning beyond business failure.

[2] National Audit Office's 'Managing Provider Failure' (2015) identified, page 4.

prevent or minimise future impact of provider failure. Following the event, the branch surveyed the 23 NW local authorities and contingency planning was identified as an area for development.

The recent ADASS Budget Survey 2019 identified the gravity of the situation: *"…the market is fragile and failing in some parts of the country. **72 directors say they have seen home care providers closing or ceasing to trade in the last six months** (impacting on **7,019 people**, more than double the number affected last year) and 38 directors had contracts handed back by home care providers (impacting on 3,464 people) in the same period…Despite raising fees to providers, fees do not match what providers say they need to be sustainable. Directors' biggest concern about the impact of savings made or planned is the prospect of providers facing financial difficulty and quality challenges."*

1.2 Policy Context

Local authorities must be prepared to deal with the consequences of providers failing, exiting the market or being temporarily unable to provide services due to unforeseen events. Section 48 of the Care Act 2014 requires that, if providers become unable to continue to deliver care to people because of business failure, Local Authorities must intervene and make arrangements for anyone affected so that their needs continue to be met. This includes all people using social care services, not just those whose care is funded by the Local Authority.

In 2015 the Care and Support (Market Oversight) regulations were introduced, the gave the Care Quality Commission (CQC) responsibility for monitoring the financial health of larger providers whose failure could have devastating effects on a large number of people across several local authorities. The criteria for entry are providers who, because of their size or concentration, Local Authorities would find difficult to replace were they to fail.[3] CQC will notify local authorities where it believes the whole of the regulated activity of a given provider on the scheme, is likely to fail. For example, if a single home owned by the provider is likely to fail because it is unprofitable, but the remainder of the provider's relevant regulated activity can continue. In these circumstances, it is the provider's responsibility to wind down and close the service in line with its contractual obligations and it is expected that providers would do so in a planned way that does not interrupt people's care. Where CQC determines that a provider in the regime is likely to become unable to continue with their activity because of business failure, it is required to tell the local authorities which it thinks will be required to carry out the temporary duty, so that they can prepare for the local consequences of the business failure.

The CQC's role in market oversight does not absolve councils of the responsibility to monitor the sustainability of their local market. If a large national provider were to fail and the impact was felt beyond the boundaries of a single authority or regional grouping, four key national organisations: the Care Quality Commission (CQC), the Department of Health & Social Care (DH&SC), the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) should support the provider and affected local authorities and if necessary provide leadership and coordination.

[3] Domiciliary Care providers - 30,000 + hours per week, or 2,000 + people receive care, or 800 + people receive care and they each receive 30 + hours each. Residential care providers - 2,000 + beds, or those with 1,000 to 2,000 beds and either they have beds in more than 16 local authority areas, or the capacity in each of three or more local authority areas exceeds 10%. More information about the oversight regime can be found at www.cqc.org.uk/ascmarketoversight

1.3 Definitions

Failures in social care happen for a variety of reasons and can be considered in two different ways: business and provider failure. A 'business failure' is strictly defined in the Care Act as a financial failure of the care provider's business where regulated activity (i.e. care) can no longer continue and services cease due to financial reasons. However, care providers fail for other reasons, such as de-registration of the care business following quality concerns from the CQC or force majeure type events (fire or flood). The catchall term 'provider failure' is used to cover any type of care provider failure irrespective of whether services cease. For example, when a care home goes into administration, sometimes the care provision continues seamlessly from previous operator, to administrator, to new buyer and there is no need to carry out contingency plans in full, but this is still defined by this guidance as a 'provider failure' event, although the actions of the local authority in this example may be reduced. However, there is an important distinction to be made between unplanned failure, which will require the activation of contingency plans in response to the situation and planned closure which will require robust management.

A contingency plan is a course of action designed to help an organisation respond effectively to a significant future event or situation that may or may not happen. Business Continuity is the capability to continue business operations in the event of a serious incident or disaster. Identifying what we need to do to deliver a minimum level of service and functionality to ensure that services continue with the least disruption to service users, family members and staff. As there is a great deal of commonality between the two this guidance covers both eventualities.

There are 3 key distinctions when considering market failure which may impact on the approach taken within the contingency plan; these are:

Business failure involving a provider in the CQC Oversight Regime: in this instance the local authority is likely to have less of a prominent relationship with the provider at a national level, outside of the local relationship. Where CQC considers it necessary, it may request the provider to share with it relevant information to support local authorities in the discharge of their temporary duty. CQC must give the information, and any further relevant information it holds, to the local authorities affected. However, to a certain extent intervention and recovery of the service is less dependent upon local actions, as can be seen with the 2018 experience of Allied Healthcare's business failure.

Business failure involving a provider not in the CQC Oversight Regime: where the provider falls outside the CQC Market Oversight Criteria the temporary duty on local authorities to meet needs and ensure continuity of care in respect of business failure still applies.

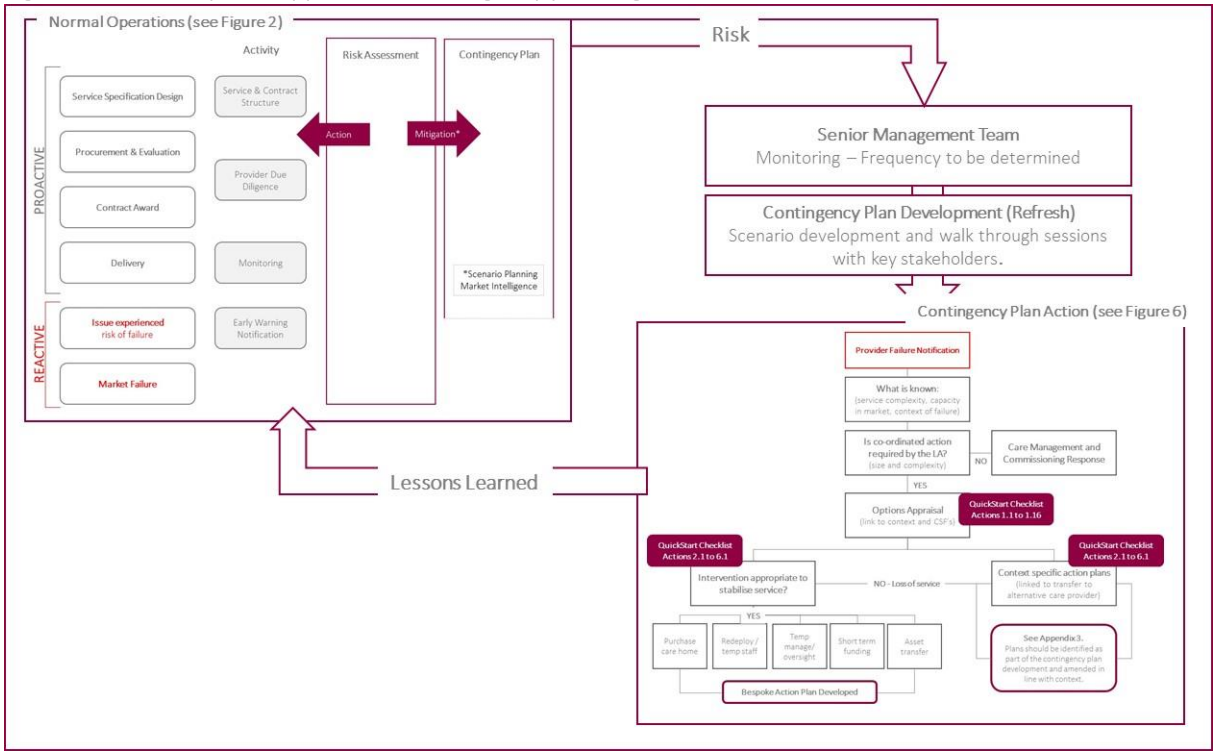
Service Interruptions other than business failure[4]: Examples of service interruptions can include loss of utilities, staff or other essential services, emergency situations such as fire or flood. The action required in relation to each service interruption should be tailored to the specific context.

[4] In situations where services fail or are interrupted but business failure is not the cause, powers detailed in Sections 18 and 19 of the Care Act 2014 can be exercised in order to meet urgent needs without having first conducted a needs assessment, financial assessment or eligibility criteria determination.

1.4 A Whole System Approach to Contingency Planning

The 2015 LGiU guide 'Care and Continuity'[5] reinforces the need to proactively manage and reduce the likelihood/impact of provider failure: "*The ways that councils commission and manage the market can support providers, but they can also create uncertainty and some of the pre-conditions for financial failure*". Examples cited included: inappropriate use of spot-purchasing frameworks for home care which do not support predictability of revenue, low fees and poor payment practice e.g. protracted payment terms. Similarly, local authorities should be cautious of triggering contingency plans 'in full' too soon, placing additional stress on management and the workforce. Local authorities' response to provider failure must be considered and overseen at a strategic level. Figure 1 identifies how the two elements (Parts 1 and 2) of the guide should interact with local authorities existing structures in relation to the development, oversight and enactment.

Figure 1: A whole system approach to contingency planning



A practical example of this feedback loop between the contingency plan and 'normal' day-to-day operations can be seen from the lessons learned from the recent Allied Healthcare failure. Access to information on self-funders proved challenging for several areas and created barriers to enacting contingency plans. This experience should be fed back into the service design and contracting phase of day-to day operations, with the opportunity to specify that providers privacy notices make provision for the eventuality of market failure and sharing information.

[5] *'Care and Continuity: contingency planning for provider failure'. LGiU,* 2015, page 12

Part 1: Setting up Contingency Plans

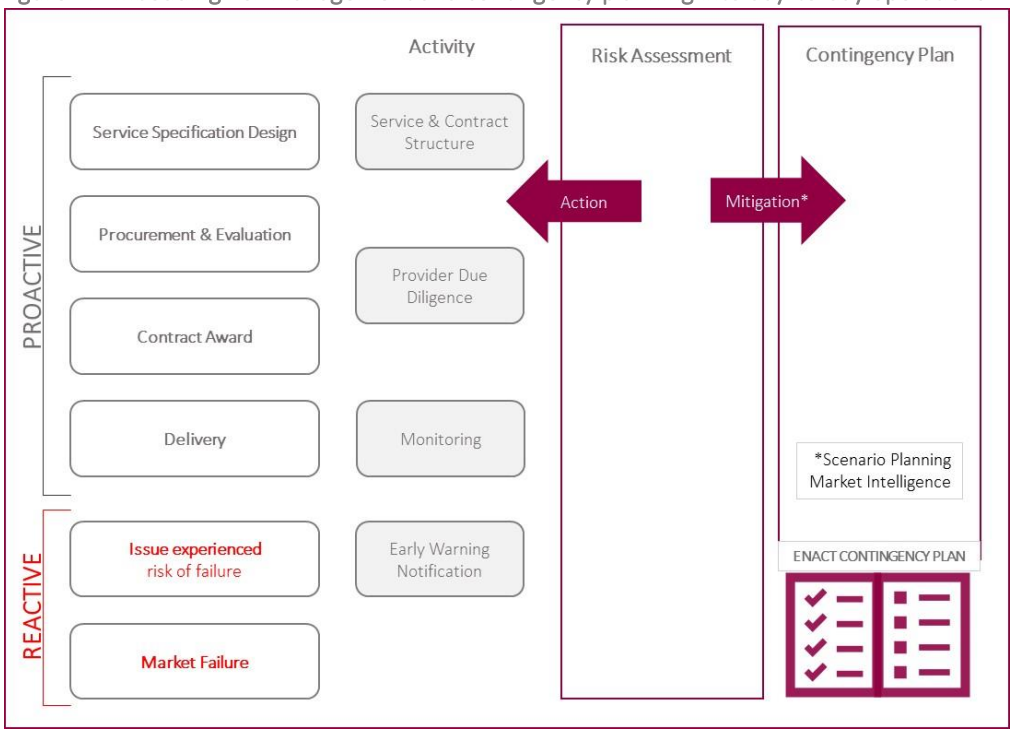
2.1 Embedding Contingency Planning into Day-to-Day Operations

Mitigating the likelihood and impact of provider failure is an activity that should be embedded into day-to-day operations. A contingency plan that is developed as a result of a crisis and is therefore sensitive to time pressures, will not be reflective of the current challenges in the market.

> *"Planning should start with deciding how a public service will be provided…. which should be informed by how much risk of failure a department is willing to tolerate".*
>
> National Audit Office's 'Managing Provider Failure (2015)

Contingency planning should be considered alongside local authorities' responsibilities to ensure a diverse market and as such is equally about removing the conditions (where possible) that give rise to failure, as it is responding to a critical event. Figure 2 (below) identifies how this process can be embedded into local authorities existing processes.

Figure 2: Embedding risk management and contingency planning into day-to-day operations



At the service specification design phase commissioners have an opportunity to review the delivery model and contractual terms considering any perceived risks, such as fee amounts and payment terms. Similarly, any decisions regarding the model to be commissioned, such as sole or lead provider, and whether these models will have a risk on market stability. A risk assessment at this stage enables commissioners to make informed decisions where risk is identified and act or consider mitigating factors and how in the event of a market failure scenario these could be overcome. This initial risk assessment can be reviewed and updated with greater market intelligence upon the award of contracts and the due diligence phase of procuring a service. Commissioners should consider how robust their measures of risk assessment and provider due diligence are, see Manchester's approach to risk stratification.

There is a wealth of information that is gathered through the delivery of services, ranging from formal inspection visits by CQC and local authority quality assurance through to the day-to-day experiences of social workers, family, friends and clients themselves. This information should form the basis of vital business intelligence. Similarly, occupancy, staff retention and complaints can form the basis of useful early warning signs that providers may be experiencing difficulties. Manchester are currently developing a risk stratification tool which can be used to analyse data sets, which when reviewed together may provide early warning indicators of provider difficulties.

Designing a risk stratification tool in Manchester

Manchester are currently in the process of developing a risk stratification tool with the purpose of better understanding of the capacity and resilience of the care home market in Manchester. The risk stratification tool will allow for earlier identification of potential provider failure from a quality or financial perspective, therefore allowing for quicker and more effective interventions further upstream, improving resident experience and minimising unnecessary closures. The draft tool currently captures:

- Establishment type/category
- Business size (No. of Beds)
- No. of establishments (regional)
- No. of beds (regional)
- Property age and ownership
- Property Value and Land Price
- Owner risk
- Competitors Nearby
- Dun & Bradstreet Rating
- Current and historic fees
- Current and required occupancy
- Placement funding (LA, CCG, OOA, Self)
- Current and historical CQC ratings
- Business overall CQC ratings
- CQC Oversight Scheme
- QPI risk rating
- Service suspensions
- Safeguarding alerts / inspections
- Complaints
- Registered Manager turnover
- Staff turnover / vacancies
- Number of falls
- NWAS Conveyances
- 111 Incidences

The data will be weighted and tolerances will be applied to allow the council to use the tool to identify potential trigger(s) for market failure. The first iteration of the tool is in development and it is expected that we will continue to evolve with increased understanding of the data flows and interdependencies.

The market failure of Southern Cross and, to a greater extent Castlebeck, illustrates the relationship between quality and market stability, i.e., where the quality of care falls to a significant extent then even viable companies are not immune to a loss of public confidence and hence will end up with occupancy levels that are not sustainable[6]. Market failures may be caused by several factors some of which may be in the control of the local authority but typically economic circumstances such as the cost of borrowing, mergers/acquisitions and investor relations can lead to market failure and local authorities tend to have little control in these external circumstances.

Situations of the above nature do sometimes occur unexpectedly, but more typically there will have been an accrual of "warning signs" over a period, and/or the providers management and staff may have openly shared information that its future is at real risk.

2.2 Risk Assessment & Scenario Planning

Risk can be defined as the probability of an event and its consequences. In the context of market failure, the risk identification will result in 2 possible scenarios: action at the point of identification or mitigation in the event of occurrence of the issue. It is important that where the risk is not actioned at the point

[6] The Stability of the Care Market and Market Oversight in England, IPC February 2014, page 10.

of identification that this, together with the potential mitigation, is reflected in the contingency plan (if applicable) or considered as a scenario (see Appendix 4). Figure 3 identifies a risk assessment scale, in which, the higher the risk score the more worthy of attention the risk is, although we should not neglect low impact risks with high probabilities.

Figure 3: Risk analysis matrix

LIKELIHOOD – Chance of the risk occurring?	IMPACT – How severe could the outcome be if the risk event occurred?				
	1 Insignificant	2 Minor	3 Significant	4 Major	5 Severe
5 Almost Certain	5 Medium	10 High	15 Very High	20 Extreme	25 Extreme
4 Likely	4 Medium	8 Medium	12 High	16 Very High	20 Extreme
3 Moderate	3 Low	6 Medium	9 Medium	12 High	15 Very High
2 Unlikely	2 Very Low	4 Low	6 Medium	8 Medium	10 High
1 Rare	1 Very Low	2 Very Low	3 Low	4 Medium	5 Medium

The risk log (Table 2) should be kept as a live document throughout the commissioning cycle, updated as required and overseen by the Head of Commissioning and the Senior Management team. The risk and mitigation should then form the basis of scenario planning within the contingency plan. Oversight of provider risk can be as sophisticated as the local authority deems appropriate and consideration should also be given to the value of applying the same risk log process to individual types of care, for example: residential & nursing, homecare and extra care.

Table 2: Generic market risk log

Risk	Impact	Likelihood	RAG Status	Mitigation
Minimum wage increase, changes to AWR and employment regulations place a significant financial burden on providers.	Severe	Likely	🔴	Cost model impact of proposed changes. Review fee levels. Options appraisal for support to providers, both fiscal and other additional benefits. Assess benefit of inclusion of a clause within contracts for both parties to trigger a fee review based on providers access to accounts. Utilise a recognised model of assessing costs of care.
Cash flow and possible use of invoice factoring to increase working capital within providers and the subsequent charges resulting in longer-term financial instability.	Significant	Moderate	🟡	Review financial due diligence checks and requirements to provide ongoing information within contracts. Explore use or regular credit checks. Assess impact of shortening payment terms.
Lack of access to information on self-funders to support the contingency planning process and swift resolution in the event of provider failure	Severe	Moderate	🔴	Seek legal advice on right to access information in event of failure in line with GDPR. Update contingency plan with any legal powers to access information. Explore inclusion of a requirement for providers to update privacy notices to include arrangement for LA to access information in the event of failure.
Information storage on historic service user files where a provider no-longer operates	Moderate	Minor	🟡	Clarify requirement for archiving and transfer of files with service contracts and build record keeping into contract monitoring process and review of provider business/ service continuity plans.
Poor CQC ratings have an impact on vacancy rates and insurance premiums (possible 2-year impact) thus effecting revenue streams and financial viability.	Major	Moderate	🔴	Regular monitoring of provider 'requiring improvement' or those not inspected for several years. Place on a monitor list and update provider capacity within Contingency Plan
Exit from the market, e.g. retirement, disinvestment, change of registration or service type.	Unlikely	Significant	🟡	In designing the service and contract type, consideration should be given to alternative providers, i.e. primary and secondary contracts and provider of last resort. Capacity and capability mapping should be regularly reviewed.

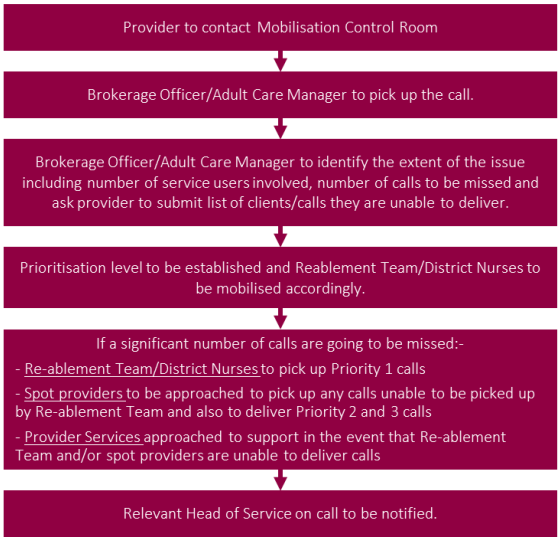
Knowsley Council have invested significant resource in the development of their provider failure policies and procedures, underpinned by a range of scenario action plans which consider "provider failure" in the broadest sense and draw upon a range of stakeholders to mitigate risk and impact.

Knowsley Council's approach to scenario planning

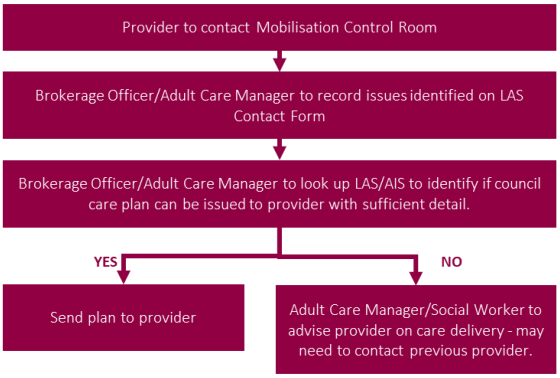
Knowsley Council's contingency planning framework is adapted to support a range of scenarios which would impact on business continuity, with unique contingency options developed for each scenario. Provider failure events are overseen by a Joint Incident Steering Group consisting of senior managers from across the local authority and partners (where necessary). In recognition of the pressures and time constraints a second, operational group, exists to develop the operational response with the full resources and support of this senior group. For example, a Steering Group was established to deal with a recent AFG strike action.

In August 2018 the steering group and a control room (with a 7:00 to 22:00 staffing rota) were set up in the mobilisation of new domiciliary care contracting arrangements which saw Knowsley transition 700 residents to new providers. In response to identified risks a range of scenario and response plans were developed (examples of these are provided below), which were utilised in response to notification (at 16:00 on a Friday) that a provider would be unable to cover 110 over the weekend. Utilising the contingency options, Knowsley were able to cover all visits within 3 hours utilising a mixture of smaller providers and Knowsley's in house re-ablement team.

SCENARIO 1: Dom Care Process for notification from providers that they do not have capacity to pick up calls resulting from TUPE transfer issues



SCENARIO 2: Dom Care Process for issues with support plans or service user needs

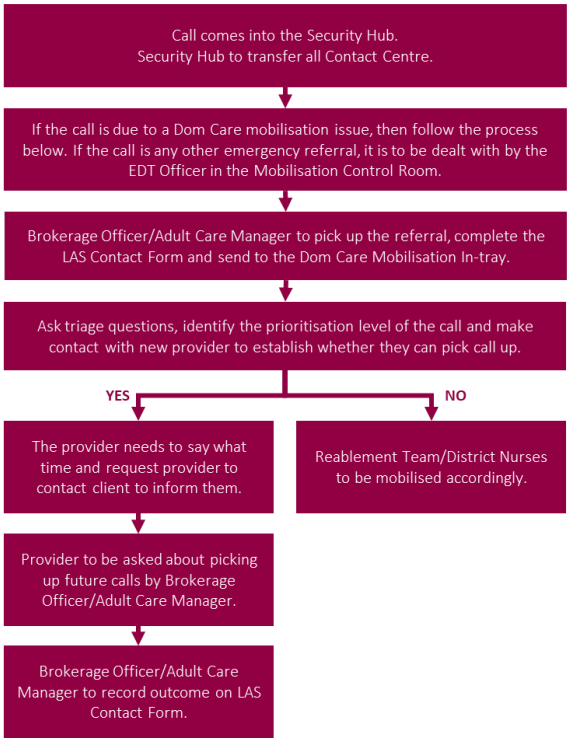


Scenario plans were underpinned by a series of triage questions which identified the urgency of support requirements. In extreme situations, Knowsley has de-prioritised low-level care and/or asked family members to undertake some care tasks for the days when care was not going to be available. Having a risk profile for each client was important together with service user triage questions which focused on the following areas:

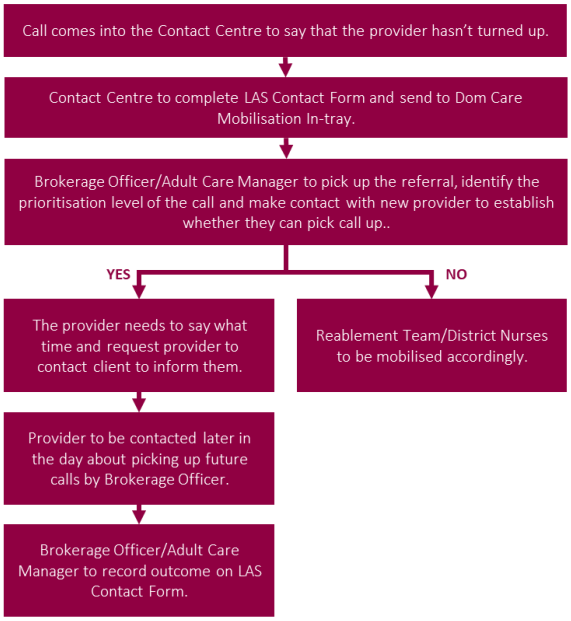
- Medication: if the call was to administer medication and whether this was time specific and can be picked up by someone else for the short term.
- Moving and handling: if the individual was mobile, could be supported by others and whether the support required specific skills or equipment.

- Continence: if the individual needs assistance to use the toilet or manage continence aids, could be supported by others and whether the support requires specific skills or equipment, e.g. stoma care or colostomy bag.
- Nutrition: if the individual was able to prepare their own food/drink or could be supported by others. Whether the support required a specific skills or equipment, e.g. peg feed.

SCENARIO 3: Dom Care Process for if the new provider fails to turn up between 5PM to 10PM



SCENARIO 4: Dom Care Process for if the new provider fails to turn up between 7AM and 5PM



SCENARIO 5: Dom Care Process for if service user refuses access to the new provider

Knowsley have identified one of the critical success factors to the robust contingency arrangements has been the availability of a in-house service to provide rapid mobilisation of resources[7]. In addition, support at the highest level of the organisation has been crucial to ensure that all the permissions are in place when scenarios occur. This senior buy-in has been achieved through the delivery of a number of contingency planning walk-through workshops in which all council departments who might be called on in the event of a major incident in health/social care were brought together to work through scenarios and resource requirements, should any of these instances happen. This included social care, communications, emergency planning, community and voluntary sector, the NHS and estates.

2.3 Responsibility for Development and Ownership

A contingency plan should be a living document, updated as and when new market intelligence is identified. Ultimately the contingency plan should feed into departmental and corporate Business Continuity Plans (BCP) as mitigating actions to potential or actual market failure can have a significant impact on local authorities financial and human resources. Internally, the development of contingency plans should be overseen by a virtual team of key stakeholders, which should include, but not be limited to, the following roles:

Director Adult Social Services (DASS)	Senior CCG Representative
Assistant Director Adult Social Services	Head of Communications
Head of Commissioning	Head of Procurement
Head of Adult Social Care (Social Work)	Head of Legal Services
Head of Financial Services	Head of Communications

The Plan Owner, typically the DASS, is responsible for ensuring that the contingency plan is reviewed, amended and re-issued on an annual basis in line with the directorate's and local authorities overall business continuity plans. The review date may also be brought forward if the plan is activated, and amendments are subsequently highlighted. It is advisable to undertake large scale testing of the plan together with desktop or simulation exercises, see Knowsley Councils approach to scenario planning.

2.4 Operating Principles

The impact of provider failure and the subsequent changes to provision upon service users, relatives and carers should be managed in the most 'person-centred' way possible. Every effort should be made to cater for the specific identified needs of each service user, and wherever practicable to keep 'friendship groups' together and take time and great care to minimise disruption and maximise the time available for preparation. This should be balanced with the urgency of the situation and the need to ensure that people are safe first and foremost. Ten key principles that should be held throughout the development and enactment of contingency plans are identified below[8].

[7] Other areas have adopted a 'provider of last resort' function.

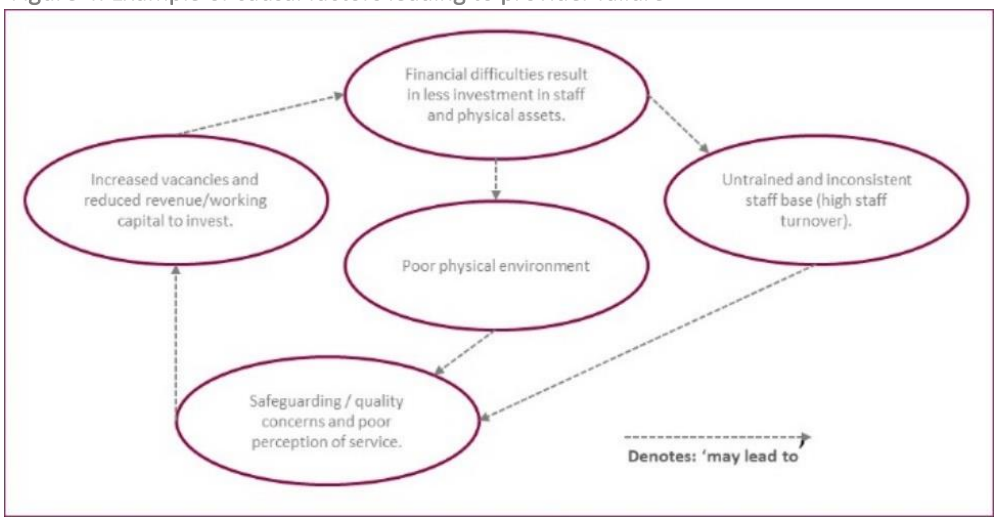
[8] The principles are identified as good practice; however, these should be considered alongside the local authorities own policies and procedures.

1. The local authority should act promptly to meet people's needs and ensure safe and effective care is provided. The lack of a needs or carer's assessment or a financial assessment for a person must not be a barrier to action.
2. Ensuring that the dignity and welfare of service users is considered at all times, placing service users' needs and wishes at the heart of care plans and consulting fully with service users and their families/carers and underpinned throughout by the principles of the Mental Capacity Act 2005.
3. All people receiving services in the local authority's area are to be treated the same. How someone pays for the costs of meeting their needs, e.g. a self-funder, must have no influence on whether the authority fulfils the duty. However, an authority may charge the person for the costs of meeting their needs, and it may also charge another local authority which was previously meeting those needs (not ordinarily resident in its area).
4. Minimise disruption and distress to service users, promoting familiarity and consistency of care, staff and surroundings wherever possible. Where new providers require additional staff to cover an increase in demand, they should give consideration to employing staff from the closing provider as this could offer service users some continuity.
5. Communicate decisions in a timely, effective and transparent manner to all stakeholders.
6. Work collaboratively with other organisations and partners to promote effective communication, timely processes and effective use of shared resources.
7. Consider equality and diversity issues throughout the closure process, respecting the cultural needs of service users and using advocates and interpreters wherever necessary.
8. Work in accordance with the principles of the Global Data Protection Regulations (GDPR), ensuring the protection/secure transfer of personal information between providers including disposal of computerised and paper records as required.
9. Managing and holding good quality data on service users and the market will support a swift and effective response.
10. Be prepared, testing and regularly reviewing contingency plans.

2.5 Market Insight and Information Sharing

The current North West Information Sharing Protocol, established 2009, is a formal agreement between authorities to provide Local Authorities with up-to-date information about service providers where there are events or concerns that may be relevant to their contractual relationship. Early warning of risks, through information sharing, will allow local authorities to enact contingency plans and mobilise resources appropriately thus minimising the impact of market failure. Whilst some failure events have no 'early warning signs', often financial failure and poor quality are inextricably linked as identified in figure 4.

Figure 4: Example of causal factors leading to provider failure[9]



At the time of writing this guide, there is a proposal across the region to update the information sharing protocol (ISP) to ensure that north-west local authorities have a flexible, responsive and legal process for sharing information about providers of adult social care. Service providers will be made aware of the new ISP and informed of any notifications about them under the new arrangements.

Through designation of a 'Information Sharing Lead' and a deputy, the revised ISP will support the region to share intelligence; actively providing information relating to local issues and risks to be shared across the region as and when requested. The proposed vehicle for sharing information will be Basecamp, which is the NW ADASS Programme Office's online communication forum and incorporates a message board and document/file storage. The NW ADASS Programme Office will create groups and oversee the membership. As messages and documents are uploaded, members will receive an automated notification. Each recipient authority will be responsible for deciding what action it takes as a result of information received under the ISP. A standard proforma will be utilised to share local intelligence when one of the following issues are identified:

- Sale or change of ownership where it effects contracting party
- Voluntary withdrawal from contract by provider
- Permanent ending of contractual relationship led by the commissioner
- Contract Default Notice relating to quality of care for services
- CQC Notice of Proposal to Cancel Registration
- CQC Cancelled Notice of Proposal to Cancel Registration
- Temporary, Restricted or Whole Suspension
- Removal of suspension
- In Administration
- Closure or cease trading

For further information on how to access the current/proposed information sharing protocols contact:

Andrew Burridge	NW ADASS Programme Manager	nwadass@nwemployers.org.uk
Tim Wilde	Tameside Council (NW Contracts Lead)	tim.wilde@tameside.gov.uk

[9] Adapted from 'Care and Continuity: contingency planning for provider failure'. LGiU, 2015 page 10

Part 2: Dealing with Provider Failure

"Departments will be better able to deal with a provider failure if they develop contingency plans. The level of detail of the planning should be proportionate to the likelihood and impact of a failure… Failure can happen very suddenly and quickly and may require resources which are not typically used in normal contractual or other forms of management to be deployed quickly. Departments will be in a far stronger position if they identify these resources in their plans, (for example legal advice, alternative providers, communications experts), and how they can be made available quickly. Where there are very specialised services, departments may be competing with others for them in a crisis".

National Audit Office's 'Managing Provider Failure (2015)

3.1 Trigger points and activation of the contingency plan

The contingency plan should be activated if any of the following criteria are met:

1	The local authority is notified of the imminent business failure of a regulated care provider registered as operating within the local authority boundaries. For example, CQC's market oversight notification or appointment of an Insolvency Practitioner.
2	The local authority is advised of the immediate suspension, closure or deregistration of a regulated care provider by the CQC, another agency or local authoirty, e.g. on the grounds of health and safety or assessed risk to service users.
3	The local authority is notified of a major and immediate unplanned business interruption, e.g. fire or flood and where the providers own business continuity plan is unable or has failed to mitigate the impact.

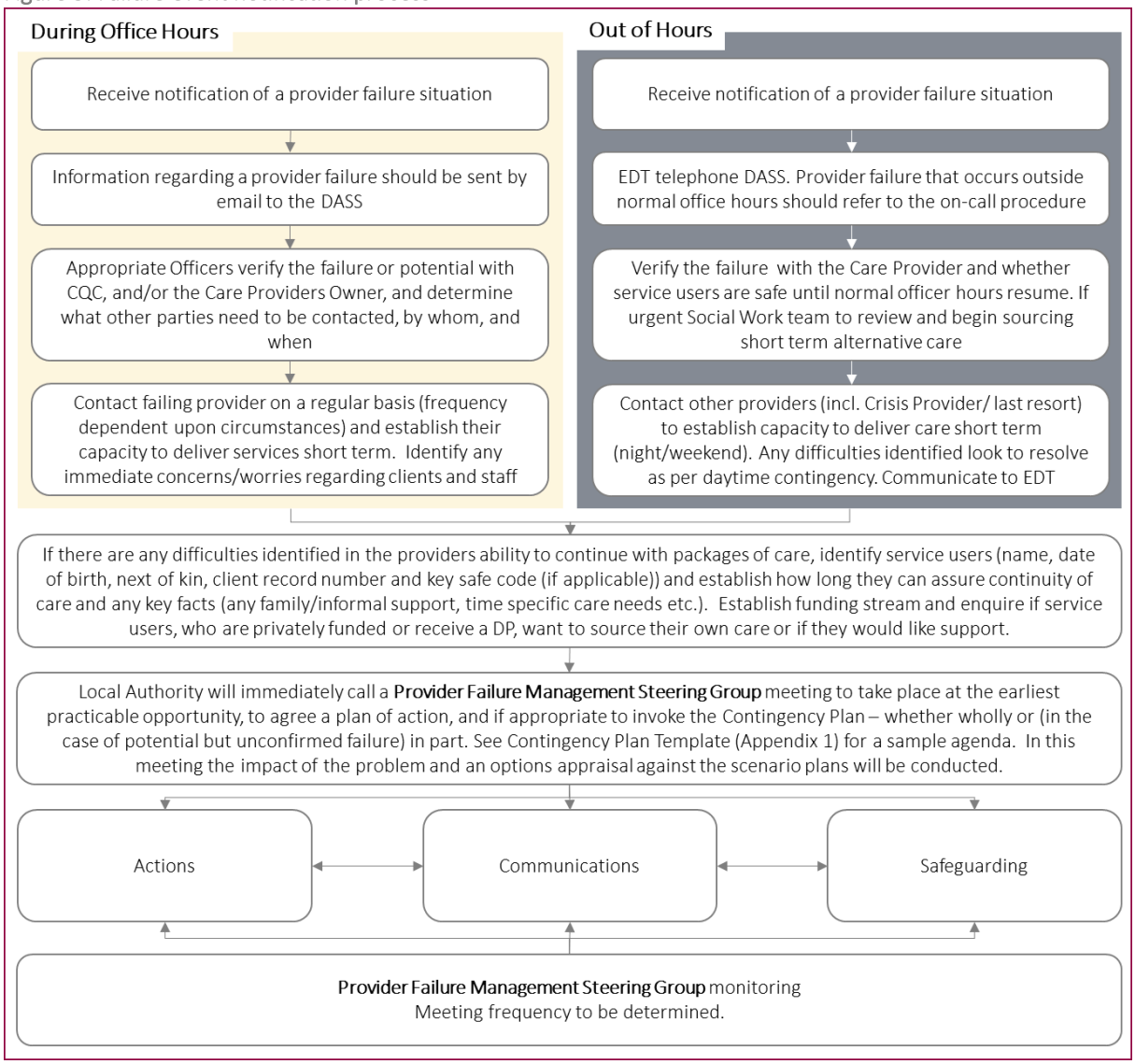
It should be made clear at the point of notification whether the failure is anticipated or actual. The recipient of the information regarding the potential failure must notify the Director of Adult Social Services (DASS) or their nominated representative immediately by telephone with confirmation in writing (email). The following people should have responsibility for activating the contingency plan:

1	Director of Adult Social Services
2	DASS' nominated representative, e.g. Associate Director

As soon as failure notification is received or real risk of failure is identified, the DASS will decide on whether the concerns should be managed through day-to-day operations or through activating the contingency plan. In emergency situations where there is an immediate risk to the safety of individuals the local authorities Emergency Planning or Civil Contingencies arrangements should be enacted.

Various terms are used to describe the collection of a group of key stakeholders who will oversee the market failure event until a successful resolution is found. For the purposes of this guide we have used the term Provider Failure Management Steering Group. If a decision is made to initiate this group, the DASS will notify the incident manager (see Roles & Responsibilities below). A sample process for activation and initial response is provided below:

Figure 5: Failure event notification process



3.2 Roles & Responsibilities

The nature of the failure is likely to dictate which public body takes the lead for oversight and management of the provider failure. Individuals funded by CHC remain the responsibility of the NHS, whereas those individual funded by the local authority or self, remain the responsibility of the local authority. This distinction will affect the make-up of the team of respondents. However, in the event of a serious or unplanned market failure overall responsibility for the planning and coordination remains with the DASS and operational oversight may be delegated to the person they nominate as most appropriate. Local authorities will assign different individuals/roles to the position of 'incident manager'; however, for the purposes of this guide we have designated the following roles:

1	Head of Service (Safeguarding or Commissioning)
2	Operations Manager or Contracts Manager

The market failure incident, dependent upon size and complexity, will require a co-ordinated response from the local authority and partner agencies. In order to facilitate this response senior staff across a

range of disciplines will form the basis of a virtual team responsible for the oversight and management of the response to the market failure, this will include, but is not limited to the following:

- Determining the strategic aim and objectives for the response.
- Ensuring clear lines of communication with key stakeholder both internally and externally.
- Collating and distributing accurate information in relation the needs of the affected service users.
- Allocating resources and expertise to meet the response requirements.
- Planning beyond the initial response to include recovery and returning to a state of normality.
- Keeping the Senior Management Team fully informed of progress and future actions.
- Implement an integrated communication strategy in liaison with the Communications Team.
- Ensure that relevant records and data is secured and stored appropriately to preserve evidence.
- Ensure the health and safety of all employees and service users during the response.
- Sourcing alternative provision to meet the needs of service users (if required).
- Identify lessons learned to inform future approaches to market failure.

Key roles and key responsibilities of the Provider Failure Management Steering Group are identified below. It is important to note that this list is not exhaustive and should be tailored to the specific context of the local area and the provider failure. Steering Group core membership should include:

Designated Lead Officer:	Nominee:
• Identify key stakeholders, calling a strategy meeting to instigate the contingency plan and develop a plan of action. • Liaise with all members of the project team to co-ordinate activities and help to resolve any issues arising, ensuring that all decisions are made and implemented in a timely manner. • Open and maintain event log. • Ensure that Senior Management (DASS, Chief Exec, Council Leader, portfolio holder for Adult Social Care) and the Communications Team are aware of the situation so that they can respond appropriately to any media. • Request additional resource if required. • Obtain senior sign-off of any options for intervention or service transfer.	Deputy:

Social Work Lead:	Nominee:
• Responsible for allocations to social work teams to undertake an assessment/review of each service user (where required); this will include: o Consult with the relatives, friends, advocates and other relevant persons involved with service user and take their needs/views into account. o Where the service user has no representative, consider capacity under the Mental Capacity Act and refer to appropriate advocacy services. o Consult with the service user's GP as to their health needs and any medical risks that may arise from the proposed transfer. o Draw up individual support plans in liaison with the provider. o Liaison with financial assessment team and liaison with mental health trusts responsible for assessments (if applicable). • Work with commissioning in the preparation for and moving of service users; following up once the new provider has commenced. • Monitor impact of change in provider on service users, relatives and carers. • In conjunction with the Commissioning Team, liaise with any other Local Authorities/CCGs/NHS Commissioners who may be funding any of the service users using that provider.	Deputy:

Commissioning [Contracts] Lead:	Nominee:
• Liaise with provider(s). • Provide support relating to contractual issues and requirements. • In the case of insolvency of the provider, work with the relevant budget holder and the provider's management to ensure that there are no viable options to avoid closure. • Liaise with other specialist providers such as advocacy and carers' support services. • Liaise with the local authorities effected by the market failure, e.g. neighbouring authorities through the ISP (see page 16) and those placing from out of area. • Share information with the CQC throughout the process, particularly about the maintenance of standards of quality and safety during the closure and future plans for service users. • Explore service transfer options and market capacity (if required).	Deputy:

Communications Lead:	Nominee:
• Develop a communication plan with all parties agreeing a policy on information sharing internally and externally. • Prepare press releases and respond to press enquiries. • Monitor social media • Develop any communication materials, e.g. bulletins, intranet pages etc.	Deputy:

Legal Advisor:	Nominee:
• Contractual enforcement and guidance • Support in the case of dispute, civil or employment claims • Legal framework in the event of local authority intervention such as loans • Assist with the legal framework and compliance in relation to data protection and information governance (see communications)	Deputy:

CCG Lead:	Nominee:
• Provide access to CCG resources where service users have CHC/FNC elements of care or complex health needs. • Consult GPs and the Acute Provider regarding any concerns re: risk and resource requirements, keeping them informed of process and progress.	Deputy:

Project Support:	Nominee:
• Ensure minutes are taken of each meeting with agreed actions and timescales are circulated to team members and key stakeholders • Provide project management support to the Lead Officer • Co-ordinate meeting rooms and access to equipment	Deputy:

Other members may include:

CQC Lead: • Access to information held about the quality of the current service and any alternative services being considered • Liaise with other effected local authorities where provision has a significant geographic footprint. This includes liaising with the provider if the CQC Market Oversight regime is invoked. • Consider bringing forward inspection or other qualitative activities for alternative providers where limited quality information is available.	**Nominee:** **Deputy:**

Mental Health Trust: • Delegated responsibility for completing social care assessments for adults with mental health issues on behalf of the local authority. • See social work lead responsibilities (above).	**Nominee:** **Deputy:**

Quality Assurance: • Undertake quality assurance monitoring visits • Provide historical insight in relation to quality reviews • Undertake any bespoke quality assurance and due diligence in relation to alternative provision	**Nominee:** **Deputy:**

Finance Lead: • Assess current service costs (LA and individual contributions and top-ups) to understand service cost. • Model cost implications of proposed options and/or new care providers • Identify contingency funds (if required) • Provide advice/guidance on providers financial position (where applicable) • Re-charge costs to self-funders, neighbouring authorities, NHS and other funding bodies (where required)	**Nominee:** **Deputy:**

Safeguarding Lead: • Take a lead on investigating any safeguarding concerns. • Advise on any quality concerns in relation to practice and service user safety • Liaise with CCG safeguarding team and CQC where failure relates to substantial concerns regarding safety.	**Nominee:** **Deputy:**

Human Resources: • Liaise with trade unions (if required). • Support internal/external staff communications and briefings. • Support TUPE process (if applicable).	**Nominee:** **Deputy:**

Provider Owner/Manager/Insolvency Practitioner:	Nominee:
• Identify a lead member of staff to work with the project team. • Strengthen relationship between provider and local authority to support continuity of care and mitigate risk to service users and staff. • Provide access to service user information. • Agree communications and engagement plan. • Take a lead role in meeting with relatives to share information (if required). • Support TUPE process (if applicable).	Deputy:

Emergency Services:	Nominee:

• Representation and support requirements will be dictated by the context of the situation, for example:
  ○ Advise on health and safety matters in relation to risk to physical assets, for example fire hazards (Fire Service)
  ○ Transfer of vulnerable service users in a critical situation (Ambulance)
	Deputy:

The composition of the team and the level of seniority required will be dictated by how urgent the situation is and the potential impact. In the case of a slow failure (such as a strategic market exit) a smaller team of people may be required, and they may be able continue to carry out their normal duties. In more sudden failures that may become disorderly, a larger team will be required as many activities will need to be carried out at the same time and may take priority over day-to-day operations.

The first meeting of the Provider Failure Management Steering Group is to be arranged at the earliest practicable opportunity following the identification of a provider failure (or potential failure)[10]. In view of the potential implications for the health and well-being of service users, the relevant Officers will be required to treat the situation as demanding their personal involvement and considered high priority; however it is acknowledged that in order to ensure timely involvement of all key parties, including CQC, this may occasionally necessitate 'virtual' meetings such as through teleconference, and/or the nomination of appropriate 'deputies'.

3.3 Initial Response [QuickStart Checklist]

At the initial Provider Failure Management Steering Group meeting the group should consider the following key activities and assign to individuals as actions. In order to support a swift mobilisation to a provider failure event it is useful to develop an initial checklist of actions with key activities that can be supplemented to reflect the specific context (see table 2: QuickStart checklist).[11]

Table 2: QuickStart Checklist[12]

1 Triggering the Provider Failure Process and Developing the Plan	
1.1 Confirmation of the Provider Failure Contingency Plan being activated	☐
1.2 Notify lead member (portfolio holder) for Adult Social Care	☐
1.3 Contact CQC to confirm/discuss the situation	☐
1.4 Establish context and timescales for potential/actual failure	☐
1.5 Assess financial viability of the company and how close it is to ceasing	☐

[10] See Contingency Plan Template: Appendix 1, for a sample draft agenda.

[11] The actions are not intended to be sequential and the priority and order of activity should be discussed at the meeting

[12] Adapted from Knowsley Council's 'Provider Failure Policy and Procedures'

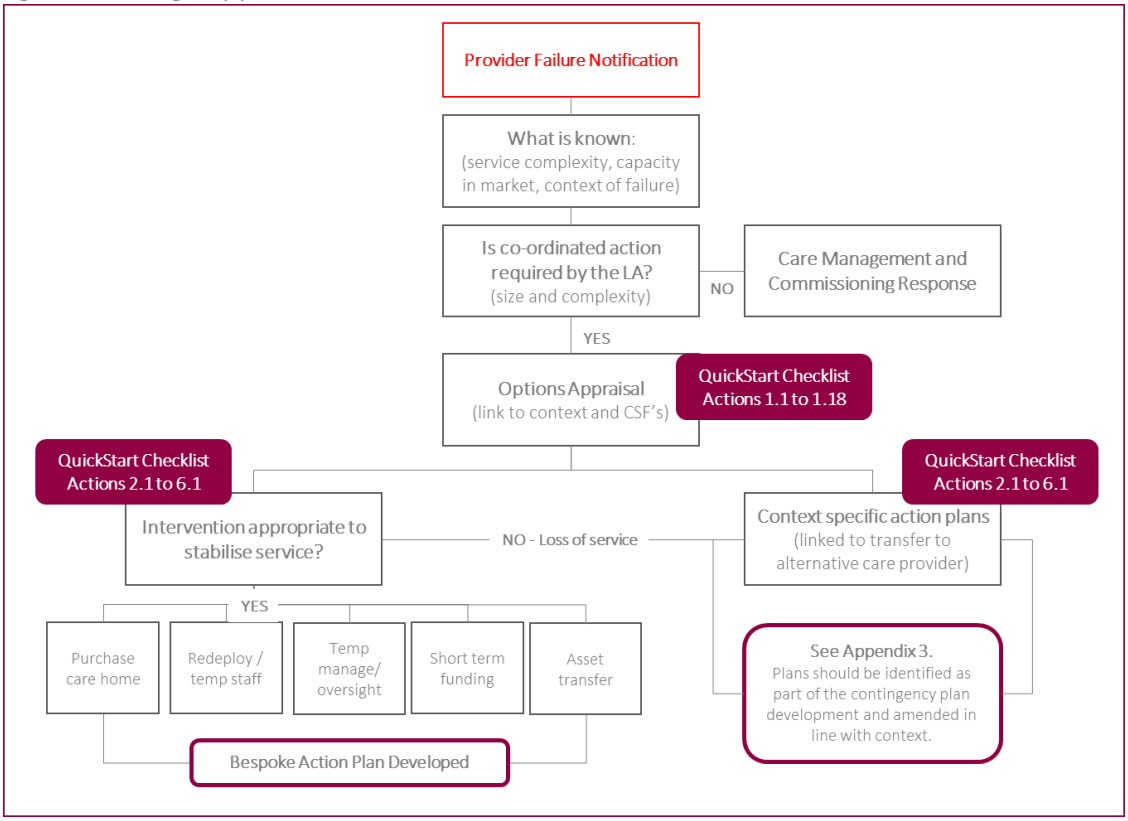
1.6 Meeting with owners/other parties (e.g. IP) to discuss open access for professionals	☐
1.7 Identify breakdown of service users affected, client groups, funding body (self-funders, OOA etc.), DoLS classification, power of attorney and staff effected	☐
1.8 Undertake an initial scoping of options for intervention and continuity of care	☐
1.9 Consult neighbouring local authorities (Notification of event through the NW ISP)	☐
1.10 Notify local stakeholders of closure and/or suspension to confirm no further placements	☐
1.11 Develop communications plan, including resident / carer notification and press releases	☐
1.12 Liaise with provider to ensure staff are aware of closure and there is continuity of care	☐
1.13 Clarify the status of the providers business continuity plan	☐
1.14 Review provider market risk log and capacity mapping to identify mitigation and capacity	☐
1.15 Open and maintain an event log, minutes of meetings and log of decisions	☐
1.16 Establish processes to maintain confidentiality, e.g. agree password to share documents	☐
1.17 Confirm frequency of meetings (e.g. daily, weekly), emergency incident room space and core group members for ongoing management	☐
1.18 Ensure managers can commit all resources required to the process	☐
2 Commissioning Actions	
2.1 Gather landlord information with regards to provider	☐
2.2 Identify business support function to be based on-site to gather records	☐
2.3 Ensure staffing levels appropriate at the provider to meet service requirements	☐
2.4 Assess impact of failure on overall market and undertake provider capacity analysis	☐
2.5 Consult with neighbouring authorities regarding additional provider capacity	☐
2.6 Assess capacity within IMCA and advocacy contracts to support clients if required	☐
2.7 Ensure provider holds client consultations with appropriate senior management	☐
2.8 Ensure all officers have considered impact upon other workstreams	☐
2.9 Consider any immediate detrimental impact on provider staff that may affect continuity of service in short term. Consider support, e.g. welfare payments.	☐
2.10 Arrangements in place for the safe removal/archiving/destruction of remaining records	☐
2.11 Amend payment schedule to prevent overpayment and/or losses	☐
3 Key Care Management Actions	
3.1 All service users have an up-to-date assessment and care plans reflect current needs	☐
3.2 Risk assessment of impact on any physical move (if applicable) for each service user	☐
3.3 Review mental capacity re: decision process and conduct best interest assessments	☐
3.4 Identify service users with 'Health and Welfare Deputies' or 'Lasting Power of Attorney'	☐
3.5 If required, identify lead workers (e.g. social worker, OT) to be based on site	☐
3.6 Identify service users wishing to change provision/move sooner	☐
3.7 Refer for financial assessment where appropriate	☐
3.8 Identify any service users who require additional support due to stress or complexity	☐
3.9 Consider, and where necessary, undertake carers assessments	☐
3.10 Liaise with commissioning re: transfer options (preferred option and scenario plan)	☐
3.11 Identify any key workers required to support transfer	☐
3.12 Allocate social workers to undertake review 2 weeks after transfer (method to be determined based on risk, e.g. face to face or telephone)	☐
4 Key Communication Actions	
4.1 Develop communications plan (see section 3.7)	☐
4.2 Agree 'need to know' information that should be shared with other parties	☐
4.3 Formal scripts to be developed with lead officer (service users, provider staff, press)	☐

5 Key Finance Actions	
5.1 Check current fee level being paid to the provider	☐
5.2 Investigate cost impact of options appraisal	☐
5.3 Suspension of payments to provider (if required)	☐
5.4 Ensure refund of any overpayment of fee is processes and close account	☐
5.5 Consider issues such as accumulated personal allowances, fees paid/owing, petty cash	☐
6 Key Legal and Procurement Actions	
6.1 Recommendations on contract termination and payments to provider	☐
6.2 Explore TUPE implications and prepare information. Factor into negotiations with current and future providers.	☐

3.4 Identifying the Extent of the Problem and Options Appraisal

Market failure does not always require the transfer of people to alternative provision. Ordinarily, there are four options; these are (1) support the current provider to continue service delivery; (2) transfer all care to another single provider; (3) transfer in-house or (4) disperse the care to a range of providers. On occasions, it may be possible for the local authority to intervene to prevent the closure or need to transfer services users to alternative care provision. **The appetite and practicality of this intervention will be dictated by the nature of the problem and the strategic significance of the failure, for example, the number of service users effected and the capacity within the market to absorb this.** It is important to establish the facts and the level of risk at an early stage, e.g. check the contract in relation to clauses for business failure of the provider and access to information on service users, including self-funders[13].

Figure 6: Contingency plan decision and action tree



[13] This links to Part 1 of this guide and the identification and mitigation of risk throughout the normal day-to-day operations.

An options appraisal is a technique for reviewing options and analysing the impact of each one. Options appraisals need to be planned, managed and resourced, irrespective of their scale, hence some failure events may not lend themselves to this approach[14]. The Provider Failure Management Steering Group will allocate responsibility for researching and pursuing potential options depending upon the specific circumstances of the event and assessing these options against the Critical Success Factors, assessing:

- Desirability: degree to which each option meets the strategic objectives/priorities of stakeholders
- Viability: degree to which each option is financially viable and sustainable
- Feasibility: degree to which each option can be implemented

Examples of critical success factors in context of market failure include:

1. Minimises disruption to service users, relatives and staff
2. Ensures the health and safety of service users and staff
3. Stable long-term solution with minimal impact to the care market
4. Compliant with legislation and duties imposed on the local authority

3.5 Scenario Plans

Scenario plans form a useful basis by which a local authority can quickly mobilise their response to provider failure, whilst simultaneously updating the plan within the specific context. In the case of 'immediate' or 'urgent' closures, there will not be time to undertake many of the planned tasks; however, the main principles should be followed wherever possible: clear communication, enabling the service user to have as much control as possible and supporting people to adapt to change by considering their needs as individuals. In the case of a planned closure, best practice should always be followed. Appendix 4 provides example scenario based contingency action plans, also refer to the Knowsley Council case study, page 12.

3.6 Continuity of Care

Local authorities must ensure the needs are met but how that is done is for the local authority to decide, and there is significant flexibility in determining how to do so, as set out in section 8 of the Care Act. It is not necessary to meet those needs through the same combination of services that were previously supplied, and temporary solutions may be sought to ensure individuals safety, which should always take precedent. However, when deciding how needs will be met, local authorities must involve the person concerned, any carer that the person has, or anyone whom the person asks the authority to involve. Where the person lacks capacity to ask the authority to do that, the local authority must involve anyone who appears to the authority to be interested in the person's welfare. The local authority should seek to minimise disruption for people receiving care, in line with the wellbeing principle and, although authorities have discretion about *how* to meet needs, the aim should be to provide a service as similar as possible to the previous one.

3.7 Communications

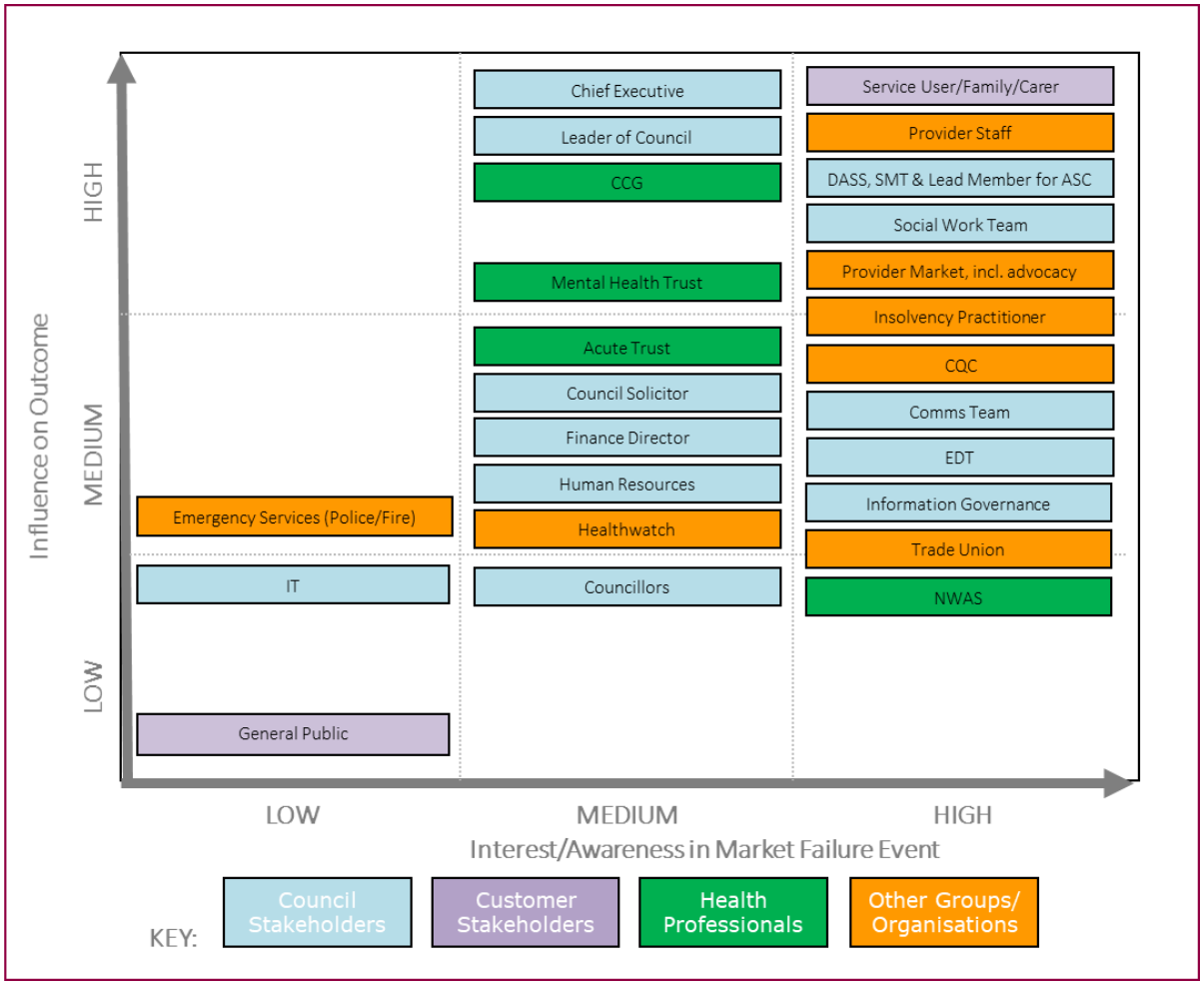
Good communication is key to avoiding misunderstanding and establishing trust with people and their families. There may be resistance to provider closures from individuals, carers, families and care staff. In the case of homecare people may be concerned about continuity of care staff and where residential providers fail this can lead to a change in home, which is understandably distressing. They may not feel

[14] The high-level approach to options appraisals includes: Phase 1: develop Critical Success Factors (CSF's); Phase 2: develop long list of options; Phase 3: identify short list of options by assessing against CSF's, desirability, viability and feasibility; and Phase 4: determine next steps for progressing.

that the care or the physical building are deficient or be aware of the full extent of the risks or failings of the provider. It is important to be clear about the reasons for the closure. Once it has been agreed that the provider will close / the service interruption requires the local authority to meet service user's needs, a communication plan must be developed.

This section of the contingency plan should identify who will be informed and when, beyond those expected to play a role in implementing the plan. How this works may depend on the type of failure. Figure 7 provides a useful framework to identify all the stakeholders across the market failure event and map them to assess levels of support and influence over the situation, which in turn can be used to identify appropriate communication channels (see table 3). It is important to note that whilst this framework can be pre-populated as part of the contingency plan, at the point that the plan is initiated this stakeholder map should be refreshed to take account of the specific context of the event.

Figure 7: Stakeholder mapping framework



In order to plan appropriate communications, stakeholders should be "mapped" against this simple matrix, considering the following two criteria:

- The level of interest that each stakeholder group has in the event
- The level of influence that each group has upon the achieving the resolution

This approach will help to identify who are likely to be the 'blockers' and 'facilitators' in resolving the failure event and the extent to which stakeholders may need to be assisted or encouraged to maintain their level of interest or influence in the response. Broadly the "map" allows identification of four types of stakeholder, which will require differing types of communication and messages:

- Stakeholders with high interest/awareness and high levels of influence. It is critical to retain the support of these individuals and groups. The response team should have individual relationships with these stakeholders and provide regular updates, but these updates do not have to be face-to-face given the support for the project. These stakeholders, however, should be in no doubt about how to communicate directly with the project and be confident that face-to-face meetings will be organised whenever necessary.

- Stakeholders with high interest/awareness and low levels of influence. These stakeholders tend to be "specialist groups" and elected Members without portfolio responsibility. Communication should be regular to avoid alienating the group but does not need to be tailored. Individuals or groups in this "quadrant" of the map can often be useful in their specialist roles to add weight and expertise to relevant issues to influence others.

- Stakeholders with low interest/awareness and low levels of influence. These stakeholder groups tend to be periphery to any response – groups such as trusts and strategic partners with no direct relationship to social care provision. For example, emergency services such as the Police and Fire services would fall into this category; however, in the event of a 'Force Majeure' event, for example a Fire or significant safety violation on a premise, these stakeholders would be placed in the high interest/influence quadrant, hence the need to tailor to a specific context. The key is to identify individuals with whom dialogue can be started because if the scope changes then these groups can quickly become more influential. Information on the Intranet is also valuable in creating a "stream" of updated information.

- Stakeholders with low interest/awareness and high levels of influence. Often the most difficult issues relate to the stakeholders in this quadrant. Tailored communication is required that addresses the concerns of this group and uses their language to demonstrate where the response to the incident is going. Face-to-face meetings are best to ensure maximum control over the way that information is received.

Table 3 (overleaf) provides an example of the approach to stakeholder communication planning.

Table 4: Example Stakeholder Communication Plan

Stakeholder Group	Lead Contact	Interest (H, M or L)	Influence (H, M or L)	Contact Frequency	Methods of contact	Comments
CCG Members		Medium	High	Ongoing	• Regular management briefing notes • Scheduled team meetings to update on progress • Media releases (where applicable)	
Lead Member for Adult Social Care		High	High	Ongoing	• Briefing note • Ongoing progress briefings	
NHS Acute Trust		Medium	Medium	Ongoing	• Management briefings	
Customers & Families		High	High	Regularly	• Initial letter and follow up meeting • Consultation events • Creation of the online resource directory • Helpline	Key messages: • Why we are doing this • Clear on risk and reasons for closure • Named social worker • Counselling/advocacy support • Next steps
Social Workers		High	High	Regularly	• Regular management and team briefings • Scheduled team meetings to update on progress	
Trade Union		High	Medium	Ongoing	• Briefing note • Q&A session	
Provider Market		High	High	Regularly	• Media releases (where applicable) • Creation of the online resource directory • Helpline	
Insolvency Practitioner		High	High	Regularly	• Email updates	
DASS and SMT		High	High	Regularly	• Regular management briefing notes • Attendance at management meetings • Steering group meeting minutes	
Chief Executive		Medium	High	Ongoing	• Regular management briefing notes • Attendance at management meetings	
Information Governance		High	Medium	Ongoing	• Email updates • Steering group meetings/minutes	
Human Resources		Medium	Medium	Ongoing	• Email updates • Steering group meetings/minutes	

Consideration must be given to what immediate communications are required, prior to the Provider Failure Management Steering Group meeting, this will link to the sensitivity of the situation. E-mail information or direction must be carefully targeted only on a need to know basis.

When a business experiences extreme financial difficulty, an insolvency practitioner (IP) may be brought in to conduct an options analysis and to help identify what recovery strategies are most suited to the current circumstances. In some cases, a business owner may bring in an IP to develop a turnaround business plan to help relieve immediate debt or cash flow difficulties. Often, IPs will be appointed by banks who are generally the largest creditor and major financial stakeholder. This is generally a last resort on the bank's part and will represent its attempt to rescue the existing business that owns a care home. Issues relating to publicity and the release of information should be considered, and a suitable balance struck so that where failure is not yet a certain outcome, the situation is not exacerbated and the Provider's entitlement to 'commercial confidentiality' is not infringed.

Communication with staff is vital to ensure continuity of care. Existing staff will also be the main source of information for people and their families and it is important that communication is factual and sensitive to ensure stress and anxiety is not heightened. While the local authority should take the lead on communications activity, this section of the plan should also outline expectations of communications activity by the provider. The council and the provider should be clear about who is communicating with whom, when and what the "messages" to each audience will be.

Communication will enable service users and their families to exercise choice and control regarding making alternative arrangements. Methods of communications and people's needs must be taken in to account, for t=example the local authority should consider:

- Does the person have sensory impairments? Is a signer or Braille required?
- Is the person's first language English? Is an interpreter required?
- Does the person have a learning disability? Are easy read versions of documents or alternative methods of communication or media required?
- Does the person have mental capacity to consent to a change in accommodation? If not an IMCA (Independent Mental Capacity Act Advocate) may be required?
- Does the person have substantial difficulty in participating in the assessment and care planning process? If so, an Independent Advocate under the Care Act may be required.

It can also be helpful to include templates of communications within the contingency plan, that can be adapted to the specific context; this could include press statements, letters and emails to staff, service users, their families and carers.

3.8 Lessons Learned

All agencies should participate in a review of the process and outcome once the incident has been resolved. The outcome of this debrief should be to identify recommendations for future inter-agency learning, including policy, procedure and practice guidance. The review should inform the refresh of the contingency plan (if required).

Trafford Council's Care Home Closure and Lessons Learned

In 2018 Trafford Council experienced 5 residential and nursing home closures, with a total 154 beds lost and 87 residents requiring relocation. Through collaborative working a resolution to these closures was found and the Council is now working proactively with the market to build capacity and future resilience. From the learning and experience of Trafford here are some points to consider:

- ✓ The logistics of transferring a large group of residents is significant and will require a multi-agency approach. It is important to have built these relationships in advance so partners understand what the expectations and established ways of working will be.
- ✓ It is important to be clear about clients' records, ensuring that computer and paper records are retained and disposed of in accordance with data protection legislation with clarity about the person responsible.
- ✓ Consider proportionate assessments, Trafford developed a shortened MHA.
- ✓ Consider the amount of traffic going into a single home while managing closure. If you can focus a single day to allocate for assessing residents there is less disruption and where possible use a single room onsite for an assessment room in the service.
- ✓ Ensure people move with a minimum 2 weeks medication as there can be delays in registering with a GP.
- ✓ It is good practice if someone is transferred that they go with a known member of staff who can describe the person and is a familiar face. Ensure there isn't one person left at the end as this can add to the distress.
- ✓ The council developed a pledge on third-party top-ups to meet the increase in fees for those effected. Whilst this had a cost pressure, it has helped manage relationships with residents and families.
- ✓ Be aware of social media. It is important to have the communications team involved from day one and prepared for any media engagement. There is also a role in championing positive stories: *"Staff were amazing, stayed to the end. Some didn't get paid."*
- ✓ The Fire Service can be a key partner in the context of closures of homes due to health and safety concerns. The Fire Service may negotiate restrictions and good partnership working can mitigate impact.

In order to ensure that a robust contingency plan is in place, further longer-term planning work may need to take place, taking account of the lessons learned from previous provider failure events. For example, updating market intelligence or revision within service contracts to ensure timely access to information (see Part 1 of this guide). Lessons learned from market failure events can also feed back into your market development and sustainability strategies.

Warrington Borough Council: Lesson Learned from Allied Healthcare [8 in flight helpful actions]

1. Communicated with the Care staff directly (via the organisation) to re-assure.
2. Incentivise staff retention. £50 for Christmas & £100 for those staying till the end of January
3. Commission 'step in' carers as insurance to cover nights and weekends (2-6 trained staff) to act as a response service. Alternatively, 'provider of last resort' relationships can be utilised.
4. Issued a no poaching letter to other providers explaining the failure scenario
5. Phoned families of those with most risk and gave honest appraisals
6. Blanket negotiated a "ban" on all user moves between agencies.
7. Writing off charges for missed calls quickly.
8. Communications with CQC and backing the step-in provider.

Appendix 1: Contingency Plan Template

Click here for a word version of the contingency plan template.

Appendix 2: Source Information & NW Contingency Plan Examples

Literature review:

Joint Working Protocol: hospital, services or facility closes at short notice. NHS England, Dec 2017. Link: click here
Assessing social care market and provider sustainability project report. DHSC, June 2015. Link: click here
Principles Paper: Managing Provider Failure. National Audit Office, 2015. Link: click here
Care and Continuity: contingency planning for provider failure. LGiU, 2015. Link: click here
The Stability of the Care Market and Market Oversight in England. IPC, Feb 2014. Link: click here
Home care in England: views from commissioners and providers. Kings Fund, Dec 2018. Link: click here
Provider failure and emergency incidents: checklist for regional response. ADASS, Sept 2017. Link: click here
Contingency planning tips for business failure of a major social care provider. LGA/ADASS, 2018. Link: click here
Working with Care Providers to Understand Costs. CIPFA, 2017. Link: click here
ADASS Budget Survey 2019. Link: click here
Developing Contingency Plans for Adult Social Care Services. The Care Provider Alliance. Link: click here
Managing Care Home Closures. NHS England et al. Link: click here
Joint Working Protocol between CQC and ADASS. Link: click here
Managing care home closures: management checklist. Link: click here

North-West Contingency Plan Example Documentation, Policies & Procedures:

Bolton	**Residential & Community Provider Failure Protocol:** covers residential, home care, specialist, registered providers in relation to business failure and other service interruptions.
Halton	**Contingency Plan for Older People's Services:** covers providers of Care Homes and Domiciliary Care. Previously, Halton had in place a Home Closure Policy.
Knowsley	**Provider Failure Policy and Procedures:** guidance framework for implementing the provider failure policy and procedures.
Lancashire	**Provider Failure Contingency Plan:** arrangements to ensure the continuation of care/support to people receiving homecare services in the event of provider failure.
Manchester	**Escalation Plan and Accountability Framework for Care Provision in Manchester:** operational guidance for MHCC, NHS Trusts, MCCG and Manchester City Council
Oldham	**Adult Social Care Provider Failure Procedure:** actions to be taken in the event of actual or prospective failure of one or more providers of care, where the Provider may not be able to plan and implement an orderly and structured exit. **Adult Social Care Provider Failure Policy:** covers service interruptions and the discretionary power to meet urgent needs.
Trafford	**Care and continuity: contingency planning for provider failure** identifies actions in the event of an unplanned or potential care provider failure, a generic approach to situations of this type and should be read in conjunction with Trafford Council's relevant Business Continuity Plans.
Wigan	**Provider Failure Policy:** overview of the procedure for Wigan Council's response to provider failure.

Appendix 3: Market Failure Case Studies

Planned Market Exit: Domiciliary Care Provider (2016)[15]	
CONTEXT: • Small provider operating in Mersey region • Withdrawing from domiciliary care market as a business citing a difficult market to operate in • Provider willing to work with Council for smooth transition but refused to extend notice period • Supporting 230 residents, 2600 hours per week	RESPONSE: • Contract variation for two existing providers (I-care for central and south and casa for south) • Worked with existing and incoming provider, but following transition incoming providers complained about omissions in information from the outgoing provider, in particular TUPE
LESSONS LEARNED: • Despite managing communications and messages until the new provider had been agreed, there was still a significant loss of staff on transfer day. This has had an impact on the capacity of providers to accept new packages of care, until recruitment caught up with the loss of staff. • Less anxiety for staff and service users as shorter transfer period	

Mental Health Supported Living Provider Failure[16]	
CONTEXT: • 2 sites supporting 38 clients • Pattern of concerns around the safety and quality • Ongoing Safeguarding allegations, investigations, and several statements from whistle blowers • Decision to decommission service and retendered the contract with a 3-month notice period • Provider did not engage with us in this process and refused to provide TUPE information or current support plans and documentation on the clients • On the day of transfer provider arrived at the service and all paperwork for staff and clients had been removed by incumbent	RESPONSE: • New provider commenced consultation with staff directly and regular drop in sessions were arranged in local community centres to enable both staff and clients to ask questions about the transfer • Council worked with provider to replace assessments and support plans in the interim • Programme of reassessment for all clients • Regular MDT meetings were undertaken for the first three months of the new contract to support new provider to manage the transfer.
LESSONS LEARNED: • Need to have robust clauses in the contract to ensure providers must engage with exit strategies • Detailed guidelines needed on the retention and transfer of staff and client files on transfer • Good practice to have sessions available for staff and clients to allay any fears or concerns face to face	

Significant market failure: Nursing and residential care (2011)[17]	
CONTEXT: • Largest provider of nursing & residential care in UK • Financial collapse due to rapid expansion of the business and a 'sell and lease back' estate strategy • Multiple homes affected across Mersey Region • Supporting 37,000+ residents in 750 homes • National negotiations for landlords to reduce rent charges short term to support restructure of business model as an interim measure	RESPONSE: • National and Local Government support for the sale of a significant proportion of the homes to new providers and the short-term purchase of businesses to ensure continuity of care • The transfer of residents from homes, deemed not fit for purpose or no longer financially viable • Ultimately, all the 750 homes were sold to new providers and the company ceased to trade
LESSONS LEARNED: • Critical for Local Authorities to understand the ownership of residential and nursing homes • Dealing with failing providers (large market share) requires a range of contingency options • Local Government may wish to consider supporting homes to find new buyers or the short-term purchase of care homes to ensure continuity of care	

[15] Source: Knowsley Council: Provider Failure Policy and Procedures

[16] Source: Wigan Provider Failure Policy

[17] Source: Knowsley Council: Provider Failure Policy and Procedures

- National government will step in to support instances of large market failure. However, local government will have a critical role in implementing the support at a local level

Specialist/complex service failure: Nursing and residential care (2016)[18]	
CONTEXT: • Specialist home providing care to adults with complex learning disabilities • Closure brought about by poor CQC inspection and impending notice to close. Provider took the decision to close prior to enforcement action. • Host LA did not commission placements in the home.	RESPONSE: • Residents needs assessed and alternative accommodation sought. Service user became more agitated due to the environment, which resulted in an increase in challenging behaviour • Significant support was needed from the Council to ensure the safe delivery of care in the weeks after closure was announced
LESSONS LEARNED: • It can be very difficult to find alternative support for people with complex needs. The process for moving people with complex needs requires as long a transition period as possible. • Need to have emergency accommodation to allow transfer of people with complex needs quickly as a contingency until alternative, permanent placements can be found. • Quality issues in homes that have closure notices are likely to continue to grow due to destabilisation. • Local Authorities who do not commission placements in the failing provider are likely to take a much more hands-off approach. A more proactive approach is required for Out of Borough complex care placements to prevent provider failure	

[18] Source: Knowsley Council: Provider Failure Policy and Procedures

Appendix 4: Example Scenario Plans

EXAMPLE SCENARIO: Residential provider closure due to insolvency. The physical asset has been deemed sub-standard for investor to continue to provide care and therefore has been identified for redevelopment. The current provider has terminated the contract with a 3-month notice period although uncertainty with the situation has led to unplanned staff turnover which may shorten the notice period and result in a COMPLETE LOSS OF SERVICE.

Workstream 1: initial communications				
Action	**Responsibility**	**Priority (RAG)**	**Timescales**	**Status**
1.1 Notify the CCG of relevant information	Lead Officer	A		
1.2 Notify communication team of relevant information	Lead Officer	R		
1.3 Notify Social Work (incl. EDT & Safeguarding) teams of relevant information	Communications	R		
1.4 Notify the Customer Service Centre of relevant information	Communications	A		
1.5 Notify brokerage/commissioning/finance of impending changes	Lead Officer	R		
1.6 Notify NW Local Authorities through information sharing protocol	Lead Officer	R		
1.7 Prepare resident and staff communications	Communications	R		

Workstream 2: resident information				
Action	**Responsibility**	**Priority (RAG)**	**Timescales**	**Status**
2.1 Obtain a complete list of all residents, including full name, DOB, next of kin, GP and financial responsibility.	Contracts Team	R		
2.2 Arrange for Independent Advocacy Services (where appropriate).	Social Worker	A		
2.3 Obtain details of residents' subject to Court of Protection arrangements, DOLS and Best Interest Assessments.	Social Worker	R		
2.4 Arrange for Health and other external professionals' input, e.g.: SALT, OT	Social Worker	R		
2.5 Establish if any appointments are affected by the transfer arrangements.	Social Worker	A		
2.6 Medication plans are in place.	Social Worker	A		
2.7 Care plans and risk assessments are in place and up to date.	Social Worker	R		

Workstream 3: liaison with the Care Home				
Action	**Responsibility**	**Priority (RAG)**	**Timescales**	**Status**
3.1 Discuss procedures for relocating residents with registered manager/owner	Lead Officer	R		
3.2 Establish whether staff in the home have been advised of the situation and request help with the arrangements.	Lead Officer	R		
3.3 Arrange meeting with relatives to inform of impending changes.	Social Worker	R		
3.4 Consider use a job fair to support temporary retention	Commissioning	G		
3.5 Liaise with registered manager/owner to identify the extent of TUPE and gather necessary records.	Lead Officer	R		
3.6 Identify a member of staff to co-ordinate/lead the transfer arrangements	Lead Officer	R		

Workstream 4: review and assessment of needs				
Action	**Responsibility**	**Priority (RAG)**	**Timescales**	**Status**
4.1 Social worker allocation	Review Manager	R		
4.2 Review and reassessment of needs in consultation with relative/NoK	Social Worker	R		
4.3 CCG to complete CHC/FNC assessments as required	Social Worker	R		
4.4 Referral to financial assessment team as required	Social Worker	A		
4.5 Refer to advocacy services where no NoK or Mental Capacity	Social Worker	A		
4.6 Explore if there are any friendship groups that need to be maintained	Social Worker	A		
4.7 Liaise with GP regarding health issues/risks associated with transfer	Social Worker	A		
4.8 Health worker allocation (if required)	Safeguarding CCG	A		
4.9 Check if residents nearing end of life need exceptional arrangements	Social Worker	R		

Workstream 5: alternative provision				
Action	**Responsibility**	**Priority (RAG)**	**Timescales**	**Status**
5.1 Undertake analysis of market capacity and initial explorations with care homes regarding transfer of cases	Procurement	R		

5.2 Confirm status of existing provider staff (TUPE) and appraisal of distribution of staff where multiple alternatives are required (if applicable).	Contract Manager	R		
5.3 Consult legal services in relation to proposed approach (above)	Procurement	R		
5.4 Contingency plans may need to be put in place for service users who may be challenging to place due to complexity or wishes	Social Work Procurement	A		
5.5 Liaise with CQC, NHS and host LA (if applicable) to ensure there are no concerns in relation to new provider. Utilise NW Information Sharing Protocol	Procurement	A		

Workstream 6: transfer arrangements				
Action	**Responsibility**	**Priority (RAG)**	**Timescales**	**Status**
6.1 Investigate potential of staff/volunteers to facilitate service users visits to alternative provision	Social Worker	A		
6.2 Ensure 'Fitness to be transported' confirmations are in place	Social Worker	A		
6.3 Develop a plan of who is to be moved and when (maximum per day to ensure control of 5-8, dependent upon urgency)	Lead Social Worker Contracts Team	A		
6.4 Ensure care plans are up-to-date and can move with the resident	Social Worker	A		
6.5 Contact NWAS regarding use of ambulance for transportation (if required)	Social Worker	A		
6.6 Confirm transport arrangements: dates/destination details with relatives	Social Worker	A		
6.7 Pharmacies to be advised of changes to residents' address and medication/MARS moves with the resident	Social Worker	A		
6.8 Complete inventory for the transfer of personal possessions	Social Worker	A		
6.9 Identify equipment which needs moving and confirm logistics for transfer	Social Worker	A		
6.10 Arrange for resources to support the residents move, such as: • Suitcases and storage boxes (not bin liners) • Food/refreshments for residents and staff • Clothing, blankets (provisions for continence issues) • Camera and photocopier	Social Worker Project Support	A		
6.11 Arrange debrief meetings each morning for 2 weeks preceding transfer to review current situation	Social Worker	A		

6.12 Consider support requirements of family and friends in relation to visits	Social Worker	A		

Workstream 7: contractual issues				
Action	**Responsibility**	**Priority (RAG)**	**Timescales**	**Status**
7.1 Monitor standards throughout the closure arrangements.	Contract Manager	R		
7.2 Clarify arrangements for archived care plans and related resident and staff information: retention, storage and destruction.	Contract Manager	A		

Workstream 8: post closure work				
Action	**Responsibility**	**Priority (RAG)**	**Timescales**	**Status**
8.1 Complete resident end dates to cease payments	Social Worker	A		
8.2 Cancel existing contracts	Contract Manager	R		
8.3 Arrange a learning session	Lead Officer	A		
8.4 Arrange follow up reviews for the residents relocated	Review Manager	A		

EXAMPLE SCENARIO: Home care agency closure due to insolvency. COMPLETE LOSS OF SERVICE

Workstream 1: initial communications				
Action	**Responsibility**	**Priority (RAG)**	**Timescales**	**Status**
1.1 Notify the CCG of relevant information	Lead Officer	A		
1.2 Notify communication teams of relevant information	Lead Officer	R		
1.3 Notify Social Work (incl. EDT & Safeguarding) teams of relevant information	Communications	R		
1.4 Notify the Customer Service Centre of relevant information	Communications	A		
1.5 Notify brokerage/commissioning/finance of impending changes	Lead Officer	R		
1.6 Notify NW Local Authorities through information sharing protocol	Lead Officer	R		
1.7 Agree communications and timeline with service users (once timeline and possible options have been established)	Communications	R		

Workstream 2: liaison with the Care Agency				
Action	**Responsibility**	**Priority (RAG)**	**Timescales**	**Status**
2.1 Discuss procedures for transfer of care packages (timescale and TUPE) with registered manager/owner. Provide guidance information.	Lead Officer	R		
2.2 Consider utilising the 'provider of last resort' (if applicable)	Lead Officer	R		
2.3 Establish whether the paid carers have been advised of the situation and their help requested with the arrangements	Social Worker	R		
2.4 Arrange meeting with relatives to inform of impending changes	Social Worker	R		
2.5 Liaise with manager/owner regarding implications of TUPE and request staff records and associated information	Commissioning	R		
2.6 Arrange input from CQC inspector	Lead Officer	A		

Workstream 3: service user information and assessment				
Action	**Responsibility**	**Priority (RAG)**	**Timescales**	**Status**
3.1 Obtain a complete list of all service users to complete risk profile and direct priorities, data includes: number of hours, service users, address, funding status, e.g. self-funders.	Contracts Team	R		
3.2 Identify high risk are service users living alone with no known support who: • Have care needs re medication and/or meals • Have continence needs/compromised tissue viability • Are known to be at risk of falls	Social Worker	R		
3.2 Arrange welfare checks on service users designated as high risk as required (telephone/visit) urgently.	Social Worker	R		
3.3 Service user preferences for replacement care package sought.	Social Worker	R		
3.4 Direct Payment options discussed.	Social Worker	A		
3.5 Arrange for Independent Advocacy Services (where appropriate).	Social Worker	A		
3.6 Establish that MCA legislation is followed re COP and Best Interest	Social Worker	A		
3.7 Arrange for Health and other external professionals' input, e.g.: SALT, OT	Social Worker	A		

3.8 Care plans and risk assessments are in place and up to date.	Social Worker	A		
3.9 Arrange input from translation service/interpreters – e.g. British Sign Language or other language interpreters, or information in accessible formats such as large print or Easy Read versions (If required).	Social Worker Comms Team	A		

Workstream 4: alternative provision				
Action	**Responsibility**	**Priority (RAG)**	**Timescales**	**Status**
4.1 Undertake analysis of market capacity and initial explorations with care agencies regarding transfer of cases	Procurement	R		
4.2 Confirm status of existing provider staff (TUPE) and appraisal of distribution of staff where multiple alternatives are required.	Contract Manager	R		
4.3 Consult legal services in relation to proposed approach (above)	Procurement	R		
4.4 Liaise with CQC, NHS and host LA (if applicable) to ensure there are no concerns in relation to new provider. Utilise NW Information Sharing Protocol	Procurement	A		
4.5 Confirmation of new provision with service user/carer and other key stakeholders (contracts, finance)	Social Worker	A		
4.6 Ensure handover of the following information to the new provider: assessments, support plan, medication sheet, special concerns, communication issues and NoK details.	Social Worker	A		

Workstream 5: contractual issues				
Action	**Responsibility**	**Priority (RAG)**	**Timescales**	**Status**
5.1 Monitor standards throughout the closure arrangements.	Contract Manager	A		
5.2 Clarify arrangements for archived care plans and related resident and staff information: retention, storage and destruction.	Contract Manager	A		
5.3 Clarify arrangements for the equipment and supplies related to individual care packages e.g. gloves & aprons etc.	Social Worker	A		

Workstream 6: finance				
Action	**Responsibility**	**Priority (RAG)**	**Timescales**	**Status**
6.1 Retain of log of costs incurred	Project Support	R		
6.2 Consider potential to incur future compensation claims	Legal Advisor	A		

Workstream 7: post closure work				
Action	**Responsibility**	**Priority (RAG)**	**Timescales**	**Status**
7.1 Complete service user end dates to cease payments	Social Worker	A		
7.2 Notify service user and NoK (where relevant) of the new arrangements via post, providing details of who to contact if there are any concerns with the new provision and also any arrangements for conducting a review.	Contract Manager Social Worker	A		
7.3 Review of client post transfer	Social Worker	A		
7.4 Cancel existing contracts	Contract Manager	R		
7.5 Arrange a learning session	Incident Lead Officer	A		