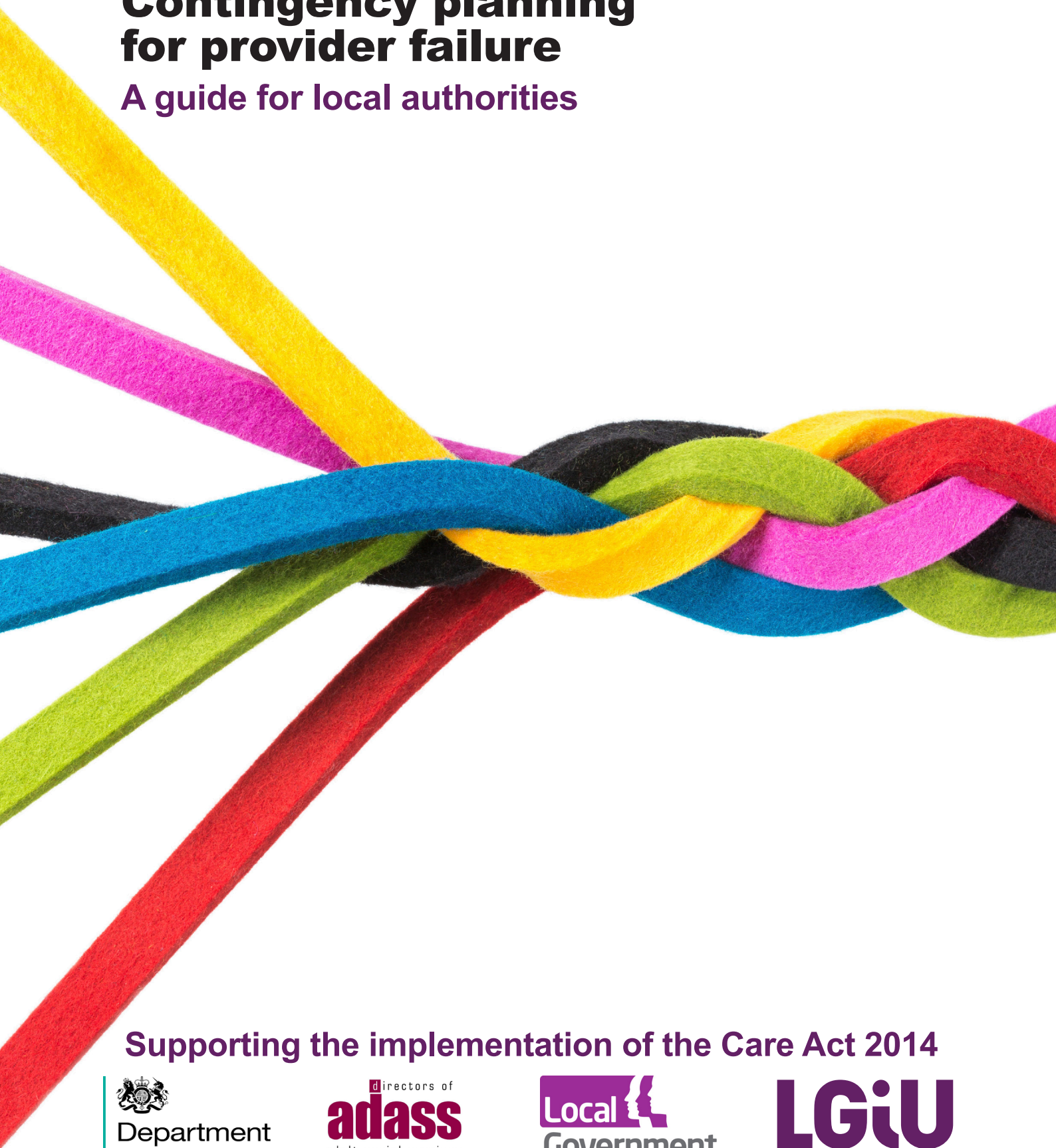# Care and Continuity: Contingency planning for provider failure

A guide for local authorities

Supporting the implementation of the Care Act 2014

Department of Health

directors of **adass** adult social services

Local Government Association

LGiU the local democracy think tank

How to use this guidance

This guidance has two parts.

Part One provides background and policy context around provider failure in adult social care. After defining 'provider failure' and other key terms, this guidance looks at some of the causes, mitigations and contingencies for dealing with provider failure. We look at how common provider failure is and how well prepared councils are to deal with it. Those that are new to dealing with provider failure or establishing contingencies or need to communicate the policy context will want to take some time to review this part of the guidance.

Part Two is a 'how to' guide to developing business continuity and contingency plans for dealing with provider failure. It includes checklists and examples to ensure all the important elements of developing or reviewing a good continuity and contingency strategy are considered. It can be used alone for those who are more familiar with the context or are simply reviewing their existing comprehensive business continuity and contingency plans.

The Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS) and Department of Health are working in partnership to support local areas in implementation of the care and support reforms in the context of the other changes and challenges for local health and care systems, including adapting to changes brought about by the Care Act 2014.

This guidance was commissioned as part of that programme and developed with the help of many local government officers in adult social care and emergency planning, the United Kingdom Home Care Association, Care England, Voluntary Organisations Disability Group, care user representatives and members of the financial services industry. More information on the programme and additional guidance can be found at www.local.gov.uk/care-support-reform.

Care and Continuity:
Contingency planning
for provider failure
(LGiU)

MaST: Market
Shaping Toolkit
(IPC)

Considering Market
Sustainability
(Cordis Bright)
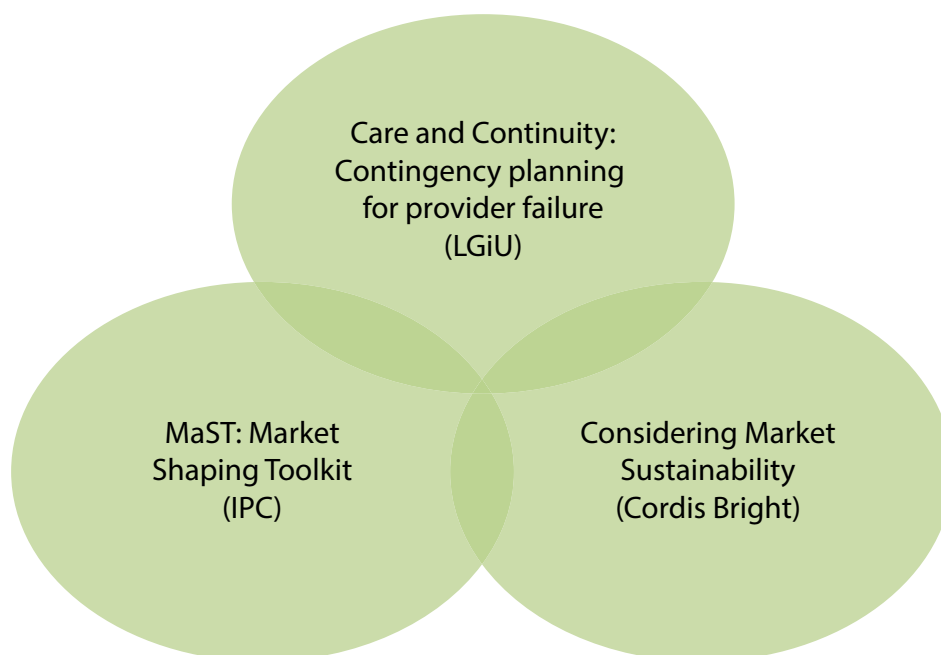
As part of supporting Care Act implementation, the LGA, DH and ADASS have also developed two other pieces of guidance which can help with market shaping, provider engagement, supporting a sustainable and diverse care market and spotting problems in the market, such as provider failure. These are:

- Assessing social care market and provider sustainability – guidance and toolkit for local authorities; Cordis Bright

- Market shaping toolkit (MaST): supporting local authority and SME care provider innovation and collaboration; Institute of Public Care.

These three pieces of guidance can and should be used in conjunction with each other.

Other help and guidance:

- The Social Care Institute of Excellence has also produced guidance on short-notice care home closure and at the time of writing it is seeking to refresh this. More information can be found at www.scie.org.uk/publications/homeclosures

- ADASS also has a good practice on care home closure: Achieving Closure: good practice in supporting older people during care home closures.

Other toolkits and guidance can be found in Appendix 4.

PART ONE: The context for this guidance

1.1 Background to the guidance

Who and what is this guidance for?

This guidance is intended to help local authorities get plans in place to support care users when care provision fails. It is aimed primarily at people who have contract, commissioning or quality roles and are actively engaged in managing the process of provider failure from identification through to helping people find new provision. Directors of Adult Social Services (DASS) should also ensure that the guidance is being carried out. Other council staff such as communications teams and emergency planning officers will also find it helpful in working with adult social care teams to support business continuity.

Providers should also find this document useful when preparing their own business continuity and contingency plans and in understanding the perspective of local authorities.

The primary focus is to help councils from the period of time when provider failure seems imminent to engage with care users, their families, staff, providers and internal and external stakeholders, to find alternative provision and to ensure continuity of care. This is best done by taking a proactive approach to failure by planning, identifying potential problems, avoiding them where possible and desirable, and recovering from them if they do occur. The following two terms are used in this guidance:

- **Business continuity**: the plans and actions to help keep services to users resilient and ensuring that no one in need is left without the services they depend on

- **Contingency planning**: the plans that need to be made in case of a business or service failure or serious service interruption.

At the centre of each of these plans should be the individual whose care provider has failed and who now needs support to find new care that is appropriate to their needs.

Throughout, this guidance tries to follow these principles of dealing with provider failure:

- Person-centred care – individuals' needs are paramount. The process should maintain dignity and respect for those who need care.

Principles of planning for provider failure

Safeguard

Wellbeing and safety always come first

Communicate

Service users, family members and stakeholders must be kept in the loop

The person

Individual choice and dignity at the centre of all decisions

Be prepared

Good plans can prevent a risky situation from becoming dangerous

Manage Information

Good quality accessible information on service user is key

- Safeguard – while providers may fail, service continuity never should. The local authority's duty to safeguard and ensure continuity of care comes first.

- Communicate – service users, their families and care workers themselves must never be left out of the loop when failures occur or are imminent.

- Managing information – holding good, accessible data on people receiving care (particularly in a home care context) can make the difference between life and death when dealing with the failure of a provider.

- Management of personal data will be crucial in fulfilling the duties in the Care Act and ensuring continuity of care for all individuals in a locality, including self-funders.

- Be prepared – preparing, testing and regularly reviewing a contingency plan allows a potentially dangerous business failure to be managed safely.

1.2 The policy context

Provider failure and the Care Act 2014

Local authorities have always been required to safeguard and support vulnerable people when their normal care arrangements fail. Under the Care Act 2014, this is now a statutory duty when care providers suffer a financial failure.

"The Care Act places new duties on local authorities to facilitate and shape their market for adult care and support as a whole, so that it meets the needs of all people in their area who need care and support, whether arranged or funded by the state, by the individual themselves, or in other ways. The ambition is for local authorities to influence and drive the pace of change for their whole market, leading to a sustainable and diverse range of care and support providers, continuously improving quality and choice, and delivering better, innovative and cost-effective outcomes that promote the wellbeing of people who need care and support."
From the Care and Support Statutory Guidance: issued under the Care Act 2014[1].

Local authorities will need to have a good knowledge of their social care market and to:

- shape the quality, diversity and sufficiency of care

- understand which providers may be experiencing trouble and are at risk of business failure

- know which providers would be able to take the place in meeting needs if any care providers fail.

Councils also need to prepare themselves to deal with the consequences of providers failing, exiting the market or being temporarily unable to provide services because of natural disasters or other emergencies.

Section 48 of The Care Act 2014 places a temporary duty on local authorities in the event that a regulated provider becomes unable to provide a regulated activity to an individual due to a financial business failure. This duty applies regardless of whether an individual's care is funded by the local authority or not. This temporary duty is engaged when all of the following criteria are met:

- the provider is a registered care provider

- the provider is unable to carry out the particularly activity

- the activity is a regulated activity.

'Business failure' is tightly defined in the Care Act[2], 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.

This guidance takes a broader approach because local authorities need to support vulnerable individuals in a variety of circumstances and the planning and preparation is similar regardless of cause.

Too big to fail?

The Care Quality Commission (CQC) has developed an oversight regime that covers providers who have a large share of their market. The CQC is tasked with monitoring the financial health of these larger providers whose failure could have devastating

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1 Care Act 2014 Statutory Guidance for Implementation https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

2 The Care and Support (Business Failure) Regulations 2015 www.legislation.gov.uk/uksi/2015/301/regulation/2/made

effects on a large number of people across a number of local authorities. The CQC role does not absolve councils of the responsibility to monitor the sustainability of their local market, nor does it mean that councils will not have responsibility for supporting people if one of these larger providers fails. More information about the oversight regime can be found at www.cqc.org.uk/ascmarketoversight

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 parties – the Care Quality Commission (CQC), the Department of Health (DH), the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) – would support the provider and affected local authorities and if necessary provide leadership.

Other statutory and regulatory issues

The Civil Contingencies Act of 2004 requires local government bodies to assess risks to human health and the environment and to make plans to deal with them. These emergency planning laws place a duty on local government to make business continuity and contingency plans. This means planning in regard to adult social care, too. The council's emergency planning department (or its equivalent) will be able to advise and support planning.

The new CQC inspection regime and the return of ratings may also have an impact on the care market. Ratings must be displayed. Poorer ratings may have an impact on vacancy rates and thus revenue streams. Additionally, the regime includes a new ability to place care providers in special measures if they are rated as inadequate overall or if they are rated inadequate on any criteria and don't improve over a period of six months. While there is still an opportunity to improve and come out of special

measures, not doing so will place a provider on a path to de-registration which means they will no longer be able to trade.
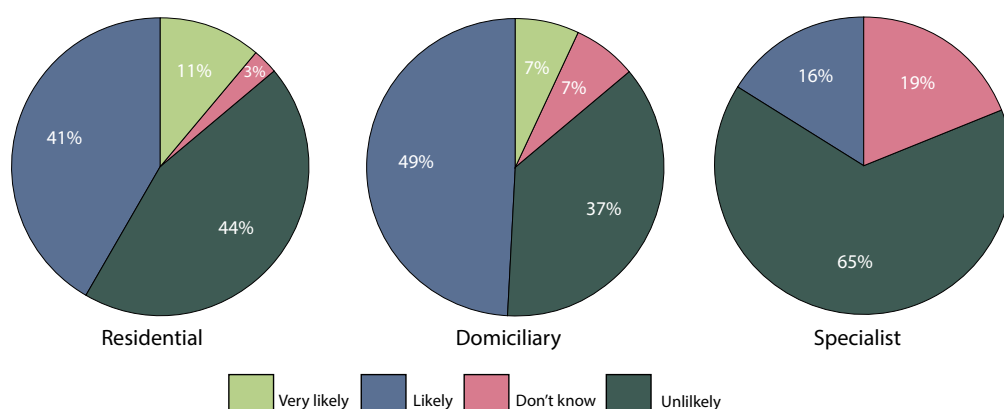
1.3 How common is provider failure?

As part of this research, local authority social care commissioning leads were surveyed to find out how many had experienced provider failure and how prepared they were for dealing with failure. Sixty-nine different councils replied, which is almost half of all councils in England providing social care.

Seventy-seven percent of councils said they had experienced some kind of provider failure in the past year (from March 2015). This included 63 per cent of councils having at least one failure in residential care, 48 per cent in domiciliary care; five per cent had a provider failure in specialist care.

When councils were asked how likely they thought it was that they'd experience another failure in the next twelve months, 74 per cent thought that it might be likely. Fifty-five percent thought that a failure in residential care was likely or very likely, 56 per cent said a failure in domiciliary care was likely or very likely. Only 16 per cent of respondents thought a specialist care failure was likely and none thought it was very likely.

Interestingly, when asked how prepared they felt for a business failure, councils felt less prepared for a specialist care failure. Just under half felt better prepared than somewhat and only five per cent felt well prepared. In other forms of care, councils are much better prepared. In home care, just under three quarters of council respondents felt prepared or very prepared for a provider failure. For residential care 86 per cent of council respondents said that they felt prepared or very prepared for a failure.

74% thought provider failure likely or very likely in 12 months

Residential: 11%, 3%, 41%, 44%

Domiciliary: 7%, 7%, 49%, 37%

Specialist: 16%, 19%, 65%

Very likely | Likely | Don't know | Unlilkely

Very few councils said that they had no plans in place: only four per cent, which tallies with the ADASS stocktake of Care Act implementation which indicated that all councils should have plans in place before the end of 2015[3] to deal with a major provider failure. Ninety-six percent of councils have some kind of plan in place to deal with provider failure, but only 36 per cent of them agreed that they had comprehensive plans in place.

continue and services cease. 'Business failure' is the type of 'provider failure' that is specifically addressed by the Care Act.

However, care providers fail for other reasons. There can be regulatory issues, such as de-registration of the care business following quality concerns from the CQC. Sometimes companies can be forced to cease operations because of fire or flood. The catch-all term provider failure is used to cover any type of

Local authorities with contingency plans in place

- Comprehensive plan
- Some plan
- No plan
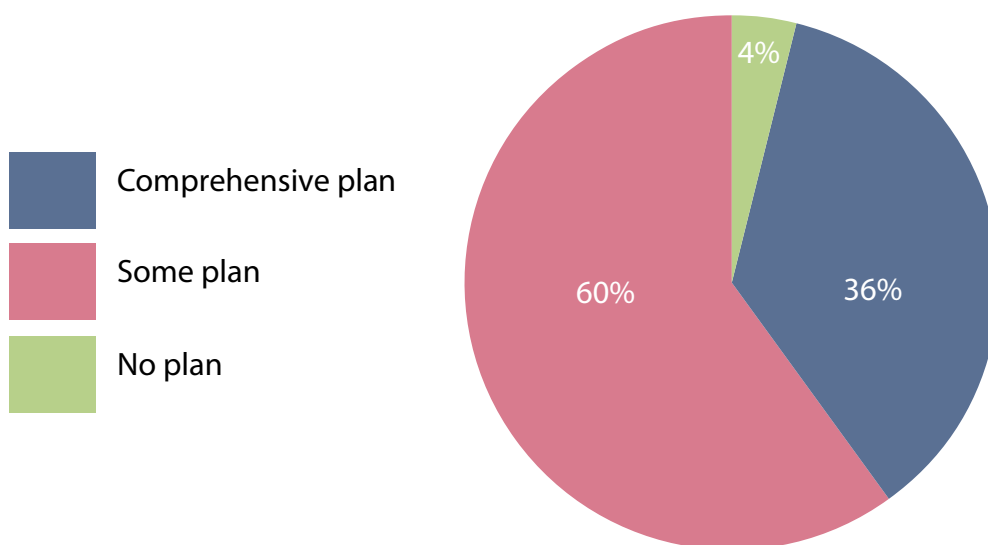
This does not mean that incidents of provider failure will be handled badly. There are examples found during this research of provider failures being handled well without a plan of any sort, but these situations depended on a high degree of individual officer experience. Councils are at risk of losing this knowledge if key members of staff leave.

1.4 What does failure mean?

Failures in social care happen for a variety of reasons. In particular, it's worth thinking about failure in two different ways: as business failure 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

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 in this guidance as a 'provider failure'.

A business in good financial health may also go out of business because of a sudden change in circumstance, such as a lease on a property not being renewed or fire, flood or other force majeure. Providers may go out of business because of mismanagement. Businesses may also be wound up because owners wish to strategically leave the market. This might be because owners cannot generate sufficient income or profit or because they choose to concentrate on other services or they retire and cannot find a new buyer. Under the definition used in this guidance that is also a 'provider failure'.

3 Care Act Stock Take 4, May 2015. ADASS, DH and LGA. http://www.local.gov.uk/care-support-reform/-/journal_content/56/10180/6341378/ARTICLE

For the purpose of this guidance, provider failure is defined as:

The inability to meet contractual obligations

Those obligations may be to a commissioning local authority, but the definition extends to self-funders or people taking direct payments who have a contract of service with the provider. A provider has failed if it is no longer able to reliably and consistently provide care at the right level to the people for whom it is contracted to provide services.

In some cases, the inability to meet contractual obligations may be temporary. For example, damage to residential homes or snow making it too difficult for care workers to visit people in their homes. This guidance covers contingency planning and business continuity so temporary failure is equally applicable. Circumstances like these do not qualify as a business failure under the Act, and indeed aren't anyone's fault or a 'failure' in the usual sense but local authorities need to make contingency and continuity plans to cover care for adults with care needs in their area – regardless of how their care is paid for.

1.5 Typology of failure

There are many types of care. However, the basic difference in organising new care after a failure arises is mainly between residential care where service users are clustered in one place and home care where service users may be dispersed over a large area. Thus this report refers mainly to residential and domiciliary care.

Although provider failure may arise for similar reasons, there are some key differences and distinct risks for home and residential care. In the residential sector, there are considerable logistical difficulties in moving residents who may be very frail when a care home fails. There are other risks for domiciliary care. Increasingly these care users are frailer and have more complex conditions, and their care may be easily missed if provider data about them is poor, inconsistent or non-existent. For example, this can happen when a provider is based mainly in one local authority area but also provides care in another area.

In the typology of failure this report identifies the main causes of provider failure and service failure or major service interruption for both home care and care homes. This typology should be used for ensuring that councils are covering the main types of provider failure in their contingency and business continuity planning.
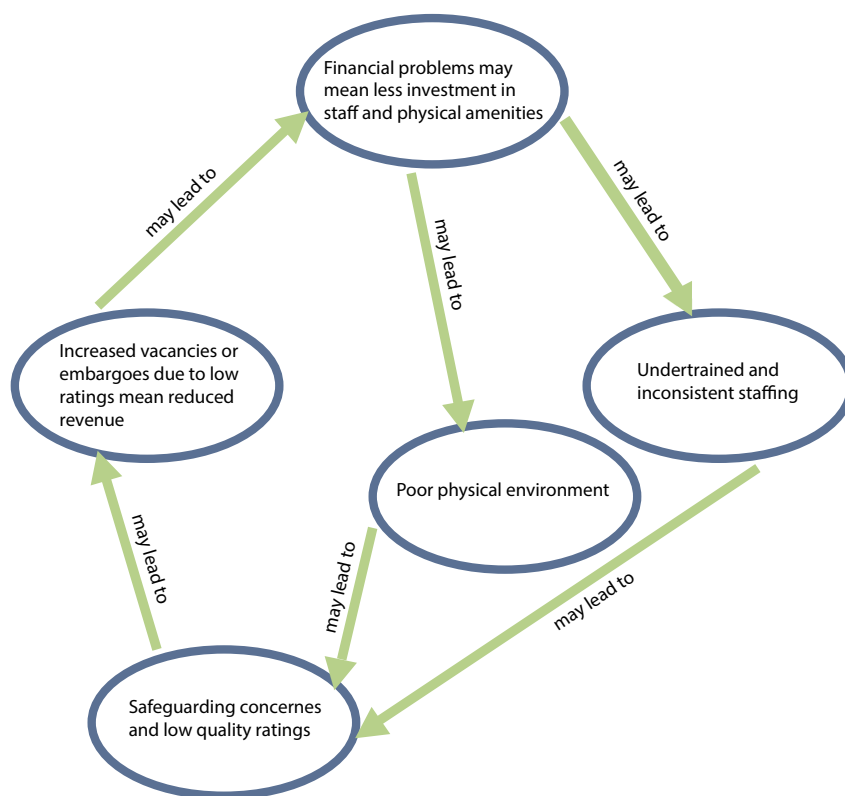
Residential Care					
	Financial	**Quality**	**Force Majeure**	**Management and workforce**	**Strategic exit**
Key features	Running out of money – for businesses with physical assets, there may be insolvency proceedings, i.e. going into administration.	Safeguarding or quality concerns, up to and including CQC de-registration.	Environmental acts of disaster, e.g. fire, floods.	Failure to reinvest in physical assets or workforce. Inability to recruit sufficiently qualified staff and/or staff with the legal right to work.	Retirement, divestment, or change of registration or service type.
Impact	If the business is sold as a going concern, there may be little impact on residents. But could mean home closure.	Quality concerns could lead to improvement or if not to de-registration or 'special measures'. This could in turn lead to embargos and increased vacancies and financial failure.	Permanent or temporary home closure depending on damage to buildings or the nature of the event.	Decline in quality and potential decline in revenues. Can mean overnight closures.	There is opportunity for a managed transition to new ownership. But could also be a quick and fraught transition requiring moving clients.
Actions	Working with insolvency practitioners. Planning for new provision. Moving residents.	May require work with the provider on quality standards. Preparing for emergency removal of residents. Planning for new provision.	Work with emergency planning or uniformed services to achieve service continuity or speedy evacuation.	Work with owners and managers to achieve quality standards.	Can be similar to financial failure, but if handled well, should be less stressful and urgent.

Home Care					
	Financial	**Quality**	**Force Majeure**	**Management and workforce**	**Strategic exit**
Key features	For small providers, cash flow can lead to sudden service interruption and business failure when care workers go unpaid.	Quality concerns are more likely to result from management and workforce issues.	More likely to be a major service interruption, such as snow or flooding, which prevents care workers from reaching clients.	Difficulties rostering staff efficiently. Late and missed visits. Insufficiently well trained staff for complex cases. High churn of workforce.	Can be related to change of contracts through commissioning cycle or sale of business.
Impact	Can lead to sudden and unexpected service interruptions, leaving people without care in their homes.	Individual complaints of poor quality care can often be dealt with as a management issue, but consistent rostering failures can have a major impact on service and lead to contract enforcement and provider removal.	Often, but not always, temporary service interruptions – which can be dealt with through emergency management procedures and shared duties between providers.	These can be of varying degrees – may only be an issue in smaller geographic areas. But can mean persistent low quality care.	Opportunity for a managed transition to new ownership. But can also tip into rostering or payroll issues.
Actions	Urgent need to ensure that all client details are obtained, including self-funders. Contacting and visiting clients. Handover to new care providers.	This is likely to be the slower failure and maybe a partial failure. Can sometimes be dealt with through new management or partial embargos.	Urgent need to capture client information and share between relevant providers. Will likely require phone calls and may require visits. Coordination between utilities, emergency services, providers and adult social care.	May only need intervention and contract monitoring. But can lead to quality or financial failures	Can be similar to financial failure, but if handled well, should be less stressful and urgent.

Although the tables identify separate sources of failure, in reality, these failings can blur across boundaries. Often financial failure and poor quality are inextricably linked. Quality, in terms of physical environment, staff training or staff ratios may suffer if there are financial problems in the business.

inability to recruit sufficient staff to provide safe nursing care has led many residential homes to withdraw nursing beds from their offer and concentrate only on providing social care. While this does not necessarily mean that the provider has failed, the clients who rely on nursing care would have to find alternative provision.

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                    ┌──────────────────────┐
                    │ Financial problems may│
                    │ mean less investment in│
                    │ staff and physical amenities│
                    └──────────────────────┘
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Financial problems may mean less investment in staff and physical amenities

may lead to

Increased vacancies or embargoes due to low ratings mean reduced revenue

may lead to

Poor physical environment

may lead to

Undertrained and inconsistent staffing

may lead to

may lead to

may lead to

Safeguarding concernes and low quality ratings

On the other hand, lower quality of provision may lead to a reduction in the occupancy rate or fewer clients for home care services which leads to revenue and cash flow problems.

In all the instances in the typology, providers may have a contract directly with the council, or may be entirely independent of the council through their work with self-funders. Often it will be a combination of both. The duties in the Care Act apply equally to all registered providers. Access to information may be more challenging in the case of non-council contracted providers, but the response to business failure is likely to follow many of the same steps.

Workforce failures

Recruitment and retention of the workforce has become a major national issue. Nursing care, in particular, has become increasingly difficult to provide as nursing staff are often paid less in a care setting than they would be if they worked for the NHS. The

Providers of all types of care are struggling to recruit and retain staff. This pressure has led some providers to employ staff without thorough checks on immigration status. In some places, immigration enforcement has led to emergency closure.

Specialist provision and failure

Specialist residential support for people with learning disabilities who have challenging behaviour, for example, or people with complex learning and physical disabilities or head trauma often draw their clients from a range of different places. It is not unusual for all the residents in a specialist provision to be from outside the local authority area in which the provision is based. This means that the usual business intelligence gathering through contract management or social work visits that could give indication of emergent issues simply doesn't take place. Host councils still have the responsibility for helping them to new provision if the provider fails. It is therefore important that the DASS makes

sure that the council knows about all providers in its locality.

It is also likely that there will not be alternative provision elsewhere in the local authority or anywhere nearby. If a specialist provider goes out of business, the search for places may be national. This will exacerbate stress for clients, carers and family members and may well destroy the relationships that have built up between residents.

Specialist providers may also be particularly vulnerable to financial risk. If they support people with complex and infrequently occurring sets of needs, they may be small units. If one client leaves, because their needs change, or they die or a place becomes available with another provider closer to home and family, this may put the financial health of the provider in jeopardy through no fault of their own.

However, the research conducted to inform this guidance indicates that specialist care providers are less likely to fail. Only five per cent of our council survey respondents said they'd experienced a specialist service failure in the last year. This may be because they can usually command higher fees, but may also be because councils are working to support these providers through their difficulties more intensively as the personal and logistical costs of finding new provision may be too high. Certainly, councils feel less well-prepared for their failure and less than five per cent of council correspondents reported that they feel very well prepared for a specialist service failure and altogether just over half felt that they were "less well prepared" for a specialist service failure.

Dealing creatively with specialist care financial problems or strategic withdrawal from the market

The **London Borough of Enfield** was host to a specialist service for younger adults with learning disabilities and mental health needs. The service was bought by a voluntary sector care provider as part of a package of care homes. However, the services offered in this newly purchased home were not consistent with the rest of the provider's portfolio and the new provider wished to sell the home. A new buyer could not be found straight away. The council stepped in to support the provider in selling the home, helping them to find a new buyer, but also encouraging them to keep the home open until a new buyer could be found. The process took 18 months and a lot of good will from both parties, but is now being run by a new provider.

Calderdale Metropolitcan Borough Council took a different approach when a residential care provider for people with learning disabilities experienced financial difficulties. The business, as it was currently operating, was no longer profitable as they used an outdated service model. A lack of emphasis on independence meant that they had trouble keeping their vacancy rates low. However, it was important for the existing residents to maintain their relationships with each other and with their support professionals. The council worked with the provider and with a registered social landlord to find and adapt a new premise that could provide a home for four of the residents (the other two residents had complex medical needs which had to be supported elsewhere). This required a creative approach and some capital support to purchase a property on the existing market and adapt it to client needs. It also meant that the council had to work with individuals to help them use their direct payments to maintain relationships with other clients in the home and also with staff who understood their needs. The work Calderdale MBC undertook led to an improved model for care for the individual while sustaining relationships and promoting independence and involvement with the local community.

1.6 Avoiding failure?

While it is not the local authority's responsibility to keep failing providers afloat, it is important to recognise that in a well-functioning market there may be good quality providers in difficulty, which councils may wish to work with to delay or avoid failure if it is possible. The reasons may include:

- a rapid transitioning of a home care contract that would place home care users in jeopardy

- the need to delay transferring clients while other places or market options are explored

- hard-to-replace specialist or geographically isolated services which are meeting need to a required quality standard.

This guidance does not provide a blueprint for supporting care providers through failure. However, it does acknowledge, and as many of the case studies show, that there can be sound reasons to delay or avoid failure or to support or work very closely with providers or even run services for a short period of time to provide service continuity. Sometimes delays of closure, even for a few days, can mean that transfers of residents can be organised more safely and pleasantly with better communication with residents, family members and staff.

While it is not entirely clear how emergency closures of residential homes contribute to mortality of residents there is some academic evidence that there is a link. Jacquetta Holder and David Jolley conducted a review of the literature on forced closure [4] They found mortality rates following an emergency move ranging from zero per cent to 43 per cent and both positive and negative outcomes following moves. They stated: "Reports of post-move mortality, physical or psychological health suggest and confirm that relocation without preparation carries higher risk of poor outcomes than moves that are orderly and include preparation".

Throughout the research for this report, it emerged that that early engagement with providers following the identification of early signs of failure almost always led to better and smoother transitions between providers and sometimes averted failure altogether.

If a council chooses to support a business that is struggling, they must be clear that any support offered is:

- **consistent** with its provider failure and business continuity plans

- **essential** to maintain client health and wellbeing

- **necessary** to sustain an adequate supply of high quality local services

- **fair** in that it what would be available to other high quality providers should they be in similar situations with similar client need.

The contingency planning approach should be widely consulted upon and co-produced with the provider market, care workers and service users. Struggling providers should be clear about the kind of communication and support they can expect. This has the additional benefit of encouraging providers to come to contract and commissioning staff early on and avoiding unforeseen problems.

1.7 Commissioning and continuity practice

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. These include:

- inappropriate use of spot-purchasing frameworks for home care which do not support predictability of revenue

- low fees for care which do not support minimum wages and other costs

- fees too low to support business sustainability and the provision of high quality care

- poor payment practice, delayed payments to providers

- poor lead-in and transition provisions for high volume contracts.

Once a provider begins to struggle, council actions can also precipitate failure by:

4 Forced relocation between nursing homes: residents' health outcomes and moderators. Holder, J and Jolley, D. Reviews in Clinical Gerontology. Volume 22 / Issue 04 / November 2012, pp 301-319

- placing embargos or suspensions on new clients

- moving targets or inconsistency around compliance or quality standards

- communications which reduce public, provider workforce and service user confidence in the provider.

There are also other ways that councils can put additional burdens on struggling businesses. Contingencies may be triggered 'in full' too soon, placing additional stress on management and the workforce. There may also be additional demands for information and councils should be wary of placing unnecessary burdensome demands on providers. Any action that places revenue streams in jeopardy may hasten failure.

These actions may be entirely right in terms of safeguarding clients and in no way should professionals stop or delay doing these things if they feel that individual safety and wellbeing is at risk. But councils should act proportionately and be aware of the possible consequences of their actions on the provider's financial sustainability.

As important as not placing undue stress on providers, is the general quality of relationships with providers. Many councils are trying to shift away from a strictly contractual and heavily performance-managed relationship to more cooperative and outcome-focused relationships that can support dealing with problems in a more constructive way. This new way of working requires a different set of 'business relationship management' skills, but can be helpful in terms of taking a continuity and recovery approach to social care rather than enforcement. The Market shaping toolkit (MaST): supporting local authority and SME care provider innovation and collaboration from the Institute of Public Care[5] and Commissioning for Better Outcomes from the University of Birmingham[6] can help support councils to develop more collaborative approaches to commissioning and relationship building skills.

Conclusion

Having set out the background and the policy context, the next section will help councils to review existing continuity and contingency plans or develop them if they do not already exist. This will help councils to prepare for and deal with potential provider failure.

Home care in Norfolk

Norfolk County Council experienced problems with a home care provider following a change of major contract in specific geographic area. The council saw early signs of trouble through an increase in client complaints and an increase in missed or late visits spotted through routine contract management. As the provider was part of a national chain, Norfolk was able to work with the provider's management structure to support better working practices. However, insufficient improvement was made, despite reducing the number of clients and Norfolk had to change its contracting arrangements. They ensured new provision for many of its home care clients by putting a new contract in place and by supporting individuals to use direct payments and use a provider of their choice. However, the problems with the contract gained significant local coverage including press and local radio, before clients were successfully supported with new provision.

Because Norfolk reviewed what happened, they have learned a lot of valuable lessons. In hindsight, Norfolk realised it could have implemented the timing of the change at a less stressful time of year, more bedding-in time could have been allowed and more regard to marrying up data systems could have been given. They have been developing an arms length organisation that can be a provider of last resort. They have also reviewed their contingency and continuity plans so that these reflect the lessons learned.

5 Market shaping toolkit (MaST): supporting local authority and SME care provider innovation and collaboration; Institute of Public Care.
6 Commissioning for Better Outcomes – a route map. Nov 2014. Health Services Management Centre at the Institute of Local Government Studies, University of Birmingham.

PART TWO: Practical steps for planning and dealing with provider failure

2.1 Setting up business continuity and contingency plans

All local authorities should have plans in place to respond appropriately to a potential provider failure. The LGiU survey found that 95 per cent of councils had some plans in place in March 2015, but only around a third of councils had comprehensive plans.

Business continuity plans are focused on maintaining services if things go wrong and recovering from them if they do. They are service focused and will necessarily be concerned with continuity of care for individuals.

Contingency plans cover what to do when things go wrong and cover the shorter-term consequences of a failure or major interruption. Most of the plans that were looked at as part of the research for this report do not distinguish between these approaches in final developed plans. Both concepts must be addressed in comprehensive plans, but do not need to be in separate plans.

Whether taking a continuity or contingency approach, the focus is always on the individual and their needs. So plans need to take account of those needs, assessing them and helping individuals choose new care provision if required, taking into account any health or social implications of a move or change of provider. For people who may lack capacity to make good decisions about their care, extra consideration is needed.

As important as having a comprehensive plan for both contingency and business continuity is, having a clear knowledge management strategy around finding, using and updating these plans on a regular basis is just as important.

There needs to be a responsible, allocated officer to develop a contingency plan and the business continuity approach in adult social care. This is likely to be (but does not have to be) someone involved in commissioning, contract management or quality.

If there are not comprehensive contingency and business continuity plans in place or they are out of the date, the following questions might be helpful:

☐ Who will be responsible for completing plans?

☐ How will key internal and external stakeholders such as care provider and service user networks, health bodies and communications teams be involved?

☐ How will the council's emergency planning and business continuity services assist?

If plans are in place, then they must be regularly checked to ensure they are still fit for purpose and reflect current conditions:

☐ Are plans easily accessible and do the right people know about them and can find them?

☐ Are they easy to find if things go disastrously wrong (e.g. power or IT outage or premises inaccessible in the case of a major incident)?

☐ Is there a named officer(s) responsible for keeping plans up-to-date?

☐ Are there governance arrangements around the plan?

☐ How are elected members kept informed?

☐ Are health and well-being boards and strategic partners aware of the plans?

☐ Is there a system that ensures regular review so that the plan is sensible, still relevant and that contact information is up-to-date?

☐ Is there a way to capture service user, carer and provider feedback on how contingencies have been executed immediately after a service interruption?

☐ Are reviews of planning and actions conducted several months later after a period of reflection?

☐ Is there a system in place to review the plans and to collect learning from any provider failures or major service interruptions?

Councils need to have clear business continuity and contingency plans that include the whole cycle of

potential failure from engagement and warning signs to supporting service users through a provider failure. Standard quality and contract monitoring arrangements should identify providers at risk. Beyond that, councils should have arrangements for dealing with the possibilities of a provider failure. They should have generic plans in place to cover each of the main types of provider failure. High risk, high impact or hard to replace providers should be covered in more detail. Assessing social care market and provider sustainability by Cordiss Bright has tools and guidance to help determine which providers should be covered in more detail.

The process for developing a business continuity plan is to:

1. Conduct a business impact analysis to help councils understand the impact various scenarios could have on service levels (a template is available at www.lgiu.org.uk/care-and-continuity).

2. Produce the plan.

3. Set business continuity objectives and train key staff.

4. Test and validate the plan.

5. Evaluate the effectiveness of the plan and amend as required.

6. Review and maintain the plan on a regular basis.

As each situation is likely to vary significantly, teams will not be able to plan for every eventuality. More important is to define roles and responsibilities with a set of named people who are likely to fill those roles. These roles should reach beyond adult social care to also include representatives from the local authority's own emergency planning or business continuity teams, communications department and elected members.

Links to other plans

Business continuity and contingency plans should never stand alone. When writing strategic commis-

sioning documents councils should be mindful of where things can go wrong and make reference to what happens if they do, providing links to the plans. Where relevant the plan should should signpost others' contingency plans, such as those developed by major providers and the CCG. Social care contingency plans should be developed with reference to the council's wider business continuity and contingency plans.

Communicating and embedding plans

For a contingency plan and business continuity approach to work effectively, staff and key stakeholders need to know where the plan is, what's in it and how it works. This means having a light touch communications plan. It also means that councils must deliver training around the plans.
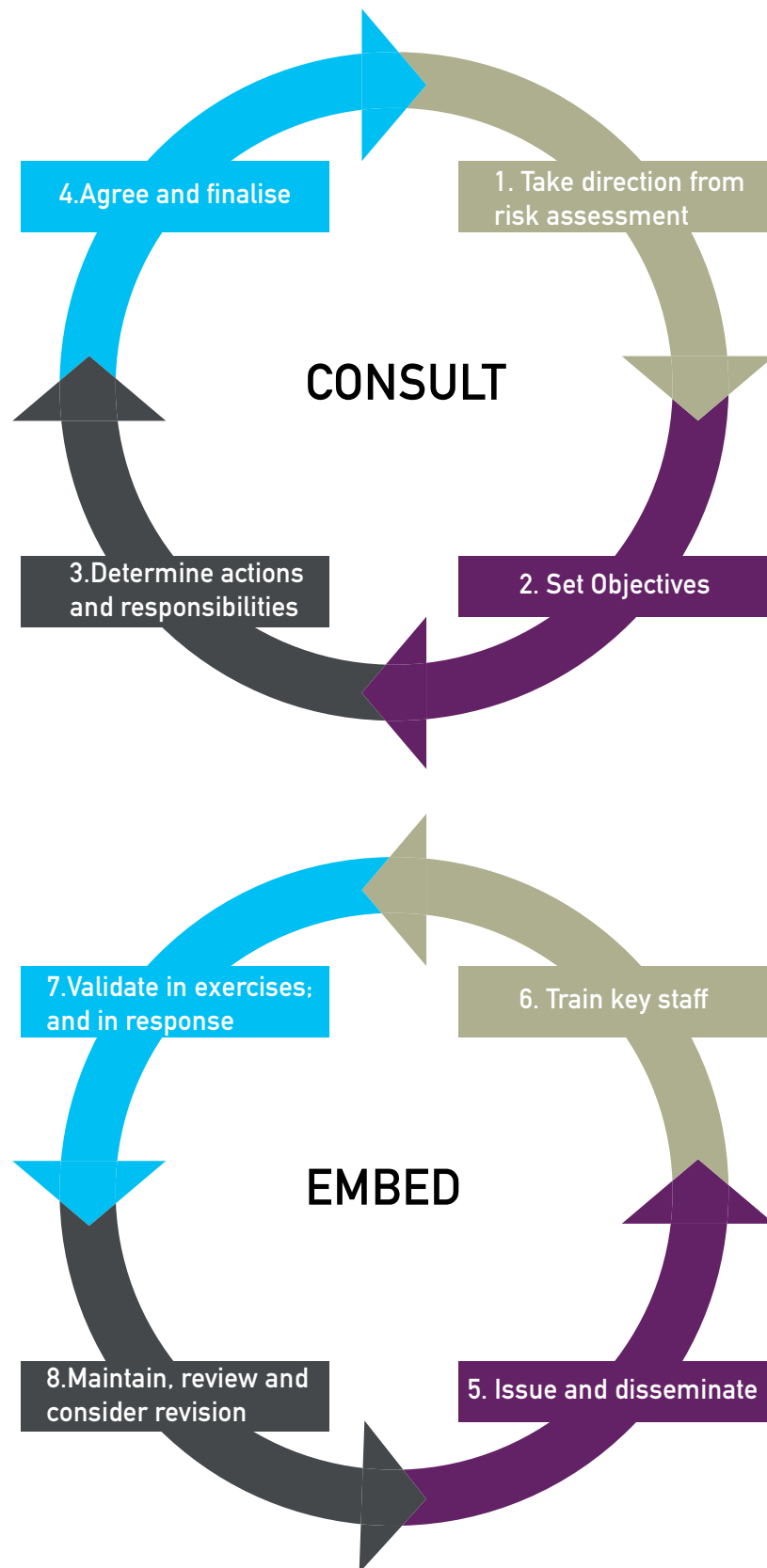
Testing contingency and business continuity plans

It is important that business continuity plans and contingency plans are tested and that key personnel, including partners, are involved in the testing. In some councils, plans have already been tested during provider failures.

It's possible to undertake large scale testing of business continuity and contingency plans. A lighter-touch approach using table top or simulation exercises may assist in seeing where things could go wrong to identify where plans may need amending or where there are gaps. In Appendix 2 there is a workshop model that was used to test this guidance and which can be used to test plans in councils.

Updating plans

Contingency and business continuity plans should be reviewed and refreshed at least every 12 months. It is particularly important to make sure that contact details are up-to-date. However, it's even more important to update plans every time they are used or when situations change, such as a change in contracting arrangements or changes in personnel.

CONSULT

4. Agree and finalise

1. Take direction from risk assessment

3. Determine actions and responsibilities

2. Set Objectives

EMBED

7. Validate in exercises; and in response

6. Train key staff

8. Maintain, review and consider revision

5. Issue and disseminate

2.2 Engaging stakeholders in planning

Engaging providers

As part of their market shaping and provider engagement councils should explicitly address potential failure, but be careful how they do so. Taking a business continuity approach, which emphasises preparing for service interruption and, if desirable, recovery to full service has benefits for business owners as well as commissioners.

One provider involved in the research for this report had businesses in two different local authority areas, one had a reactive approach to safeguarding enforcement and the other had a more proactive approach around quality of care and dignity. In

the latter, the provider felt that there was a much healthier approach to supporting providers to plan and be prepared to recover from service interruptions.

Discussions that focus on the continuity of high quality care and helping owners and managers to keep their businesses thriving can help both council and provider approach the topic more comfortably. As a council what is the approach used to:

☐ require contingency planning and **open book accounting** for contracted and commissioned providers

☐ support and engage with **networks of local and regional care providers** including providers with which there is no formal contract

☐ engage with networks to promote **good business continuity and contingency planning** and cross-provider **support**

☐ **encourage high standards of client data** collection and storage and think about how providers would pass details to the council if there needs be

☐ make clear how the **loss or interruption of preventative services** would impact on the care market and plan how to deal with potential losses

☐ **check contingency plans**, including good quality data and data backup plans as part of quality reviews or audits

☐ ask if SME providers in particular are using **standard contract terms** with service users, e.g. the United Kingdom Homecare Association, has terms to allow providers to transfer patient data to third parties – such as the council or a new provider, in case of emergency

☐ work through provider networks to support development of **best practice in quality and safeguarding**

☐ support providers to have good **financial and data management**

☐ encourage businesses to **come forward early** if they are struggling

☐ **establish good relationships** with providers who can step in if another provider fails?

Strategic commissioning offers opportunities to both engage with the market and also to work with council teams and partners for better contingency planning and preparedness in partnership with providers. However, relationships with providers that don't contract directly with the council are just as important. Supporting providers who deal primarily with self-funders to develop and maintain good records and good relationships with the council can help the relationship and exchange of information if they run into problems later on.

Further guidance on market shaping and engagement can be found in these companion pieces of guidance:

Working with Care Provider Associations

Surrey County Council works closely with the Surrey Care Provider Association. When Surrey developed its continuity and contingency plans, they worked closely with the care provider association. There was a formal consultation with the council, but the elected board of the association met with officers from the council quarterly to co-design and review development of the plans.

Working with the council, the association also put on a number of business continuity workshops that covered a wide range of issues such as financial failure and flooding and other issues that can threaten service continuity. The council also works with the association on matters like procurement strategies, which means the relationship stays strong and relevant.

This relationship has been very important as most people in Surrey are self-funders and during times of flooding, through a network of providers, the council and emergency services all home care users were reached.

- Assessing social care market and provider sustainability – guidance and toolkit for local authorities; Cordis Bright.

- Market shaping toolkit (MaST): supporting local authority and SME care provider innovation and collaboration; the Institute of Public Care.

- The LGA Care and Support Reform web resource 'Support for Providers"[7]

Reviewing provider contingency plans

Most councils require providers to have contingency plans as part of the tender or framework contract process, but it's not always clear how much these feed into the decision making process. At Tri-borough health and social care staff review contingency plans during the tender process. This is good practice, but they feel they could do more, such as checking back with providers after the 'bedding in' period and regularly reviewing shared contingency plans.

Engaging service users

As important as the provider-council relationships are, service users, their families and carers should not be overlooked when it comes to contingency planning and business continuity. Wherever possible, people who use care services and those who care for them should be engaged in planning for potential service interruption.

Good practice suggests that service users should be given guidelines about the standard of care they should expect to receive and what to do about it if they don't, whether that is through the provider's normal system of quality control, complaints to the council or to the CQC. Complaints or 'service issues' provide useful intelligence on how well a business is operating. Guidelines and information can be particularly useful if a person is a self-funder without council contact and finds themselves without services either through a provider failure or through a service interruption caused by forces outside the provider's control. This can help manage expectations and help care users and their families understand what is happening if a provider failure occurs.

Providers, especially those providing care for self-funders, should be specifically encouraged to provide detailed information to service users around service interruptions and who to call in the council. Providers should be supported to give information to self-funding clients on who to call in case of

dissatisfaction with care services, or how to join their utilities companies' 'Priority Services Register' if they are receiving home based services. The Priority Services Register is used by utilities companies as a way of offering extra support to vulnerable customers in case of water, heat or power being interrupted. It can also be a vital source of information on the whereabouts of vulnerable adults in a time of emergency.

This is vitally important as councils do not always keep records of all self-funders. For care homes, it is less important as all the clients are residents. For geographically dispersed services such as home care it can be potentially disastrous if councils do not have access to reliable, up-to-date information on clients who would be left without a service if a provider fails or is temporarily disrupted.

Engaging Clinical Commissioning Groups (CCGs)

Many councils have good relationships with their CCGs, but in some areas links are less well established, particularly where there are multiple CCGs within the local authority boundaries. CCGs are a crucial part of business continuity and contingency planning. They often pay for care through continuing care funding, will have oversight of nursing care and are an essential part of the clinical assessment procedure in the case of a change of provider.

Without full CCG engagement in planning, a critical aspect of carrying out contingencies may end up fraught and complicated. Engaging them in planning sessions, provider network sessions and training and testing contingency plans can ensure they are playing their role.

Other stakeholders

In many areas, the CQC plays a vital role in spotting the signs of failure outside the national regime. Engaging them with contingency planning early on can help when they have specific concerns about

7 www.local.gov.uk/care-support-reform/-/journal_content/56/10180/6527499/ARTICLE

providers or in planning for specific actions and will support building a relationship that will be important in the event of provider failure.

Care workers are also important stakeholders. If a provider is struggling or during cases of force majeure, they will often be expected to rise above and beyond the usual requirements. Recruitment and retention is already a pinch point in the stability of the market, so developing plans that will support continuity of care should involve care workers' representatives and trade unions to ensure that staff are not lost to the sector.

Working with insolvency practitioners

When a business experiences extreme financial difficulties, 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. More often than not, 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.

The appointment of an IP as an administrator or fixed charge receiver does not necessarily mean that care will cease, or that residents will have to move out of a care home immediately. Unless the existing trading position is irrecoverable (e.g. very low occupancy) and/or the environmental condition of the home is particularly poor, in most cases, it is undoubtedly in the best interests of the bank to support the IP in the continuation of care. His or her primary responsibility will then be to trade and sell the home as a 'going concern'. This is to maximise the financial return to the bank, which is best achieved by selling a home as a 'going concern', rather than an empty unit.

While commissioning, contracts or quality teams may have had inklings of financial difficulty the first sign that problems exist is often receiving a call from a newly appointed administrator or fixed charge receiver – the IP. In some circumstances, the IP may have been working with the business for a while, but until they have been legally appointed as administrators or fixed charge receivers, they are bound by rules of confidentiality. "I wish I could speak with the council before I'm appointed, but I can't without the permission of the company directors. That permission is almost never given," said one experienced IP. "Once I am appointed, the first calls I make are to the local authority and to the CQC."

It is now the responsibility of the IP to make councils aware of any insolvency events in relation to a financially failed provider that they contract with in order to minimise the risk of disruption to services by enabling local authorities to be better prepared to step in if required.

The role of the IP is to maximise the return to creditors (e.g. the bank) – in simple terms, this means selling the business for as much as possible, whilst expending as little cash as possible, in as short a time period as possible. However, administrators appointed over care businesses are also well aware of the importance maintaining continuity of care.

Immediately upon their appointment, the IP adopts several statutory responsibilities under the Insolvency Act 1986 and is exposed to the standard health and safety and regulatory/operational risk framework that any provider operates within.

The critical factor any IP must identify is the financial differential between the 'going concern' and 'close down' valuations. This is established by seeking formal valuations of the business/property, identifying the amount of any capital expenditure requirement and estimating the costs of rectifying any regulatory/operational and property risks that exist. This analysis will enable the IP to decide whether it is worthwhile, in financial terms, to continue to trade the home or close it.

2.3 What should go in the plan?

Good contingency plans can take different formats and must reflect local needs and circumstances. As part of this work a number of plans were reviewed. Links to some of these council plans can be found in Appendix 1. The best council plans included a number of common elements which have been listed in outline form.

I. Document and review schedule

The plan must be up to date and accessible. The plan should include information on how the document will be stored and when it should be updated.

This should identify:

☐ document control and who is the author and owner of the document

☐ version history

☐ maintenance and how often the plan will be reviewed and updated

☐ when full reviews should take place – annually, following an exercise/test, following an incident, upon a change to legislation or a change to operations

☐ storage of the plan to maximise accessibility including in situations where IT, power or buildings are out of reach

☐ how relevant members of staff are/should be trained in the use of the plan.

This information should be immediately accessible to anyone using the plan to ensure they are referring to the most up to date version. Council staff who are responsible for carrying out contingencies should also have access to up-to-date copies of the plan as well as wider civil contingencies contact information which they may wish to keep in a safe and accessible place. This is especially important for adverse weather responses.

II. Immediate action list

The immediate action list provides a checklist for anyone picking up the plan, allowing them to navigate the plan and identify the actions they must take. It is essentially a 'quick start guide' for the contingency plan. This checklist could include:

☐ deciding if trigger criteria have been met, as described in the 'when will this plan be triggered?' section of the plan

☐ ensuring the most senior person takes the lead role in managing the incident or delegates accordingly

☐ knowing who the response team is

☐ deciding on immediate actions to be undertaken to ensure continuity of care

☐ notifying relevant stakeholders (see section 2.6 Communicating Failure).

III. Background information

The plan should incorporate, at least at a high level, the policy background and powers of the council.

It should set out the statutory obligation to provide temporary care under Section 48 of the Care Act 2014, and highlight the relevance of the business failure regulations, duty to co-operate regulations and cross-border continuity of care regulations in the Act.

Principles statement: Statements which outline the approach that should be taken on supporting care users. This should be a summary reiteration of the council's care and choice policies in general but reframed in the context of a potentially short time frame. These will include statements on:

☐ an emphasis on the individual needing to be at the centre of the process and treated with dignity, compassion and respect

☐ continuity of care

☐ supporting user choice, including where there may be mental capacity issues

☐ carer choice and support

☐ employee choice and support

☐ workforce retention.

Context and key relationships: It should also include context on market oversight/ shaping and the nature of how stakeholder relationships should be maintained. Some councils include these in their

contingency plans, but they can also be in other documents and cross-referenced. These help set out the overall approach to business continuity and relationships with other stakeholders: These can include statements on:

☐ working relationships with CQC

☐ gathering intelligence on market resilience (see Assessing social care market and provider sustainability – guidance and toolkit for local authorities; Cordis Bright)

☐ engaging with the market – (see Market shaping toolkit (MaST): supporting local authority and SME care provider innovation and collaboration; Institute of Public Care) including any engagement with provider bodies, e.g. care associations

☐ safeguarding and quality feedback from within the council

☐ supporting provider relationships, e.g. supporting each other

☐ supporting providers, including those not commissioned to have good risk management, business continuity and data transfer plans

☐ understanding the impact of non-commissioned support, prevention and ancillary services on the market.

Links to related plans, support and guidance

Plans should include links to:

☐ any specific contingency plans related to sections of the market, such as home or residential care or to plans related to particular areas of the local authority geography, which are prone to flooding for example

☐ provider specific plans they may have developed as part of the contracting requirements or through the provider network.

IV. Mitigating risk

This section outlines the procedures that councils will put in place to mitigate the impact on service users in the event of provider failure.

Intelligence and information sharing

It is essential to understand who receives care and the number of service users potentially affected by provider failure. This should be part of the overall business continuity strategy. Securing this information in a time of crisis should be part of the contingency plan.

For providers with whom the council has a contract, encouraging good intelligence sharing and continuity and contingency planning may include the following:

☐ ensuring that contracts have appropriate clauses on notice of closure, transfer of clients and client information

☐ requiring all care providers to maintain business continuity and contingency plans and to have one in place when signing a contract with the council

☐ requiring all care providers to maintain a transferrable register of service users[8]

☐ requirement for care providers to provide the council with an up-to-date employee or establishment list, in the event on an unplanned or imminent failure.

For non-contracted providers:

☐ developing constructive relationships and supporting them to have similar risk management procedures (e.g. in case of closure, but also emergencies, like force majeure)

☐ supporting proportionate development of databases and the ability to share information

☐ encouraging take up of standard templates and contracts provided by umbrella bodies such as the United Kingdom Homecare Association

☐ maintaining relationships with CQC, requesting provider and user information where appropriate

☐ maintaining good relationships with local authorities who may have clients placed with these providers.

8 This could detail all named individuals placed with or using the service, their care needs, details of next of kin or representative, details of placement or service category, name and contact details of the funding authority or confirmation if the service user is a self-funder, and the home address in the case of home care services and to establish a way of transferring the data in case emergency.

Identifying and supporting alternative provision

This section will outline the information that should be available in order to help councils identify alternative provision in the event of provider failure.

Information about local providers should be held as part of the council's market shaping strategy. A full list of providers and their contact details should also be provided as an appendix to the plan. These providers may have spare capacity and may be able to help. There may be failures which cannot be solved using local spare capacity and if the council believes that may be likely it would be wise to also have contact details of providers in surrounding areas as finding alternative specialist provision may be particularly challenging.

The council should act on behalf of all the people affected, including those who were placed by other authorities and self-funders. The options for finding alternative provision for this last group may be different to finding alternatives for council-supported people.

Starting from scratch to find alternative provision at the point of failure is likely to be stressful and demanding so councils should not leave consideration of this issue to the last moment. One possibility is to identify one or more providers in advance that may be able to act as providers of last resort if failure occurs.

Establishing lines of contact with key stakeholders

This important area of the contingency plan will need to be updated regularly to reflect personnel changes. It should include both office contact details (including out-of-hours contact where relevant) and named personnel with email addresses and both office and mobile phone numbers.

The council should identify its key stakeholders but these are likely to include:

☐ CQC

☐ health services

☐ other local authorities

☐ service user groups

☐ uniformed services, particularly for force majeure scenarios.

V. Triggering plans

When the plan is triggered will need to be decided by the council, but it may include the following situations:

☐ The council is notified by CQC of the imminent business failure of a regulated care provider registered as operating in their area.

☐ A provider has come forward to notify the council that their business will imminently fail.

☐ The council is advised of the immediate suspension, closure and deregistration of a regulated care provider by the CQC e.g. on the grounds of health and safety or assessed risk to service users.

☐ The council becomes aware an IP has been appointed over a local provider.

☐ The council's own monitoring arrangements, including a mix of hard and soft intelligence, suggest failure may be imminent.

☐ The council is notified of a major and immediate unplanned business interruption e.g. a significant fire or flood, and where the care providers' own business continuity plan is unable or has failed to address the resulting service impact.

Assessing local market and provider sustainability guidance from Cordis Bright has additional information about monitoring provider sustainability and signs of potential failure.

VI. Roles and responsibilities

Who is responsible for activating the plan?

This section should include up-to-date details of those who will ordinarily be responsible, but also those who will be responsible in the event of the lead contact being unavailable.

Local authorities should already have in place clear roles and responsibilities for who can trigger a contingency plan. The council should identify the role and name of the person who should do this.

Final roles and responsibilities will need to be decided when it is clear how urgent the situation is and what the specifics of the provider failure are. In the case of a slow failure (such as a strategic market exit) only a small team of people may be required and they will 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. The number of people in the team and the amount of effort needed will be determined by the scale of provider failure, the urgency and complexity of the situation and how many people need help.

Who else needs to be involved in delivering the plan and what are their roles?

From the council the lead role must be with the DASS who has overall responsibility for ensuring that the contingency plan is carried out. Depending on the scope of the provider failure, the DASS may or may not take an active day-to-day role in carrying out the contingency. Depending on the nature of the contingency, the people involved and whose roles need to be clarified are:

☐ commissioning team

☐ safeguarding team

☐ care management

☐ emergency planning/ business continuity

☐ finance

☐ administration teams.

Outside the council this may include:

☐ CCG

☐ NHS partners

☐ neighbouring councils

☐ voluntary sector organisations.

This section should include named contact details and responsibilities as well as general office contact details and emergency numbers and these details should be regularly reviewed – at least every six months – to ensure they remain accurate.

VII. Continuity of care

This section outlines the contingency actions that need to be taken in the event of a provider failure. All actions should have a lead clearly identified and will include:

☐ assembling the response team

☐ ensuring assessment teams are ready to go

☐ securing relevant information and data about service users

☐ triggering the communications plan

☐ informing relevant funding authorities.

Contingency actions may differ according to the type of provider failure (see Typology of failure on page 7).

The assessment of people's clinical and social care needs is a critical part of the contingency plan.

Care must also be taken to ensure that there is assessment of mental capacity and whether service users need support in making decisions about their care arrangements. If it is suspected that someone lacks the capacity to make decisions about their care, then the Mental Capacity Act Code of Practice[9] should be applied and a capacity assessment should be undertaken. This may require additional resources to make sure that the assessments are done as thoroughly and in as timely a way as possible.

Assessment needs will include:

☐ plans for rapid assessment of need for clients of failing/failed services including resource and mobilisation plans

☐ assessment of social needs for care home residents, preserving friendships and other relationships

☐ assessment of health and the risk and impact of moving care homes

☐ an indication of which clinical assessment needs

9 Mental Capacity Act Code of Practice. Code of Practice giving guidance for decisions made under the Mental Capacity Act 2005; Office of the Public Guardian www.gov.uk/government/publications/mental-capacity-act-code-of-practice

to be undertaken by the CCG and who the CCG contact(s) will be

☐ other clinical and social needs:

- medical or clinical arrangements (e.g. GP, hospital appointments)

- pharmacy and medication arrangements

- financial dealings

- equipment and aids

- details of next of kin and other key contacts

- any other specific needs.

For home care, councils must ensure that there is a double-checking system to ensure no clients are missed. The council should, if needed, be prepared to support the new provider to reassess clients' care needs.

Arrangements for transfers in the case of residential care

It is important that helping people to move care homes takes place in an orderly and calm manner and that residents and their families are fully informed and involved. Therefore as much advanced notice as possible should be given to the following:

☐ communicating dates, times and logistics to all concerned parties, preferably in writing, ensuring these are well understood by residents and their families in particular

☐ arrangements for the physical move of a person to their new home and making sure that ambulance staff are notified in a timely manner

☐ social arrangements such as opportunities to say goodbye and to be greeted in the new home

☐ ensuring residents' personal items are accounted for, including valuables held by a care home's management, and furnishings they own are moved with them

☐ ensuring that care plans and other personal data is transferred securely.

Personal touches can make a great deal of difference during the stress of a move. A DASS has reported the benefits of an assessor taking a card and some flowers when settling in a self-funder to a new care home.

There is some helpful guidance on emergency and planned care home closures available, which should be used for the development of detailed plans for care moves. These are:

- Short Notice Home Care Closures from the Social Care Institute of Excellence. It includes checklists and sample forms for the assessment, arrangement of transfers and follow-ups for care home closures[10].

- Achieving Closure: good practice in supporting older people during care home closures from ADASS[11].

VIII. Communications

Both internal and external communications strategies should be established. 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.

Within the local authority those involved should be:

☐ corporate communications

☐ the wider adult social care team

☐ finance

☐ elected members

☐ senior management team

☐ emergency planning.

Outside the authority:

☐ service users and their families

☐ health partners

10 Short-notice home care closures: a guide for local authority commissioners. Social Care Institute for Excellence. September 2011. http://www.scie.org.uk/publications/homeclosures/
11 Achieving Closure: good practice in supporting older people during care home closures. Health Services Management Centre, University of Birmingham and the Association of Directors of Adult Social Services, in association with the Social Care Institute for Excellence. April 2014. http://adass.org.uk/achieving-closure/

☐ other providers

☐ third sector and local support services

☐ trade unions and other staff representatives, or all staff where the council cannot be assured that they can be reached through normal communication channels

☐ in the event of broader emergency situations such as adverse weather, uniformed services, police, fire, ambulance and civil contingencies.

While the council should take the lead on communications activity, this section of the plan should also outline expectations of communications activity by the provider involved, and plans for how these communications will be given if the provider is unable to do so. The council and the provider should be clear about who is communicating with whom, when and what the "messages" to each audience will be.

It can also be very helpful to include templates of communications that can be adapted in the situation including:

☐ press statements

☐ letters and emails to staff

☐ letters and/or emails to service users, their families and carers.

IX. Cost recovery

Self-funders are still responsible for the cost of their own care and it may be possible to recover the cost of any temporary care that has been provided, particularly if the contingency plan has been triggered subject to the conditions under the Care Act 2014.

In some cases, it may also be possible to recover costs from care providers. When councils support struggling care providers, such as putting additional staff in place, it is sometimes possible to be reimbursed for this. This can happen with advanced agreement from a parent company in the case of national or regional businesses. In other cases, staff are put in place to avoid an emergency closure which can put clients at risk and it may not be possible to recover costs. However, if local authorities incur unforeseen costs because of a provider failure, the Care Act 2014 provides in Section 48 particular powers under which recovery of those costs may be sought. This recovery power exists only in respect of business failures as defined in the Care Act and in respect of particular costs as defined. There is no power in the Care Act to recover costs in other circumstances. Local authorities should always seek out their own legal advice before attempting to recover any costs, setting out the circumstances in which the costs were incurred. There is case law on local authorities' powers to recover costs and which costs may legitimately be recovered from whom.

Contingency plans should include a prompt for cost recovery as part of the follow-up, including the contact information for legal officers within the council.

2.4 Understanding when to trigger contingency planning

Monitoring risk

Nottingham City Council has developed robust continuity and contingency planning procedures. As part of routine monitoring, the council meets regularly with other key stakeholders such as the CCG and the CQC to review the health of care provision and to highlight concerns about any providers.

These close working relationships have meant that problems are raised early and can be investigated through their 'provider investigation process' and then can either be dealt with or concerns can be escalated up to and including trigger contingencies and helping people to change providers.

There are clear roles and responsibilities. For example, if a provider failure is purely financial it's dealt with in one part of the council and if it's a quality or safeguarding issue it's dealt with by another team. This division includes the responsibility for triggering the contingency plan and overseeing its implementation.

Once contingencies have been triggered there are clear operational procedures for dealing with a failure. Individual well-being is paramount so Nottingham prioritises safeguarding and the assessment of needs. Even though there is a clear protocol for everything from communication to moving people to new homes, each situation is different and can throw up new challenges. Having a set of clear roles and responsibilities and good working relationships with stakeholders has helped them deal with anything that cannot be planned in advance.

As part of their continuity process, Nottingham maintains a lessons learned log for care provider failure. They hold a team debriefing immediately after a failure and then a further review some months later to capture any longer-term reflections. Continuity and contingency plans are then updated accordingly.

Knowing when to start acting on likely failure is difficult. If councils start the engagement process and review contingency plans regularly this can help with early intervention.

Contingency plans should be triggered as soon as the person responsible for activating the plan decides that failure seems likely. Plans can always be stepped back if failure does not occur.

A number of councils have regular monitoring meetings as part of their market shaping and these include members from both the assessment and care management side and the contracting and commissioning side, as well as representatives from local CCG and sometimes also from the CQC. In these meetings concerns can be discussed about particular providers, continuity and contingency plans can be reviewed alongside who would be responsible for carrying them out if providers should start to struggle or show signs of imminent failure.

Potential signs of trouble

East Riding of Yorkshire Council has developed a list of indicators that can hint at problems. None of these alone should trigger a contingency plan, but several of these together could help to prompt a conversation about whether the plan should be triggered.

Market issues:

- Over reliance on local authority contracts as only business

- Difficult to replace providers

- Competition from new care developments

Financial indicators:

- Annual accounts (or lack of them)

- Valid insurance cover/increase in insurance rates

- Credit scoring

- Wages/bills not being paid

- Financial issues – asking for early payment

Occupancy issues:

- Size of home/bed vacancy levels and comparators/ percentage of bed vacancy over time

- Duration of vacancies

- Length of stay/high turnover of residents – particularly in non-elderly provision

- Suspended or embargoed placements

Feedback:

- "Why pick this home?"

- Choice of Care Home survey ratings

- Residents survey feedback

- Complaints – high number/ none

- Complaints about quality/quantity of food

Regulatory and safeguarding:

- Non-compliance with council contracts

- Non-compliance with CQC

- Safeguarding – high number of alerts vs no alerts

- CQC reports/ feedback

Workforce:

- Staff/family/carer survey feedback

- Staff levels reducing significantly/senior manager turnover/high staff turnover

- Indications that proper checks on immigration and employment status have not been undertaken

Quality:

- Lack of activities

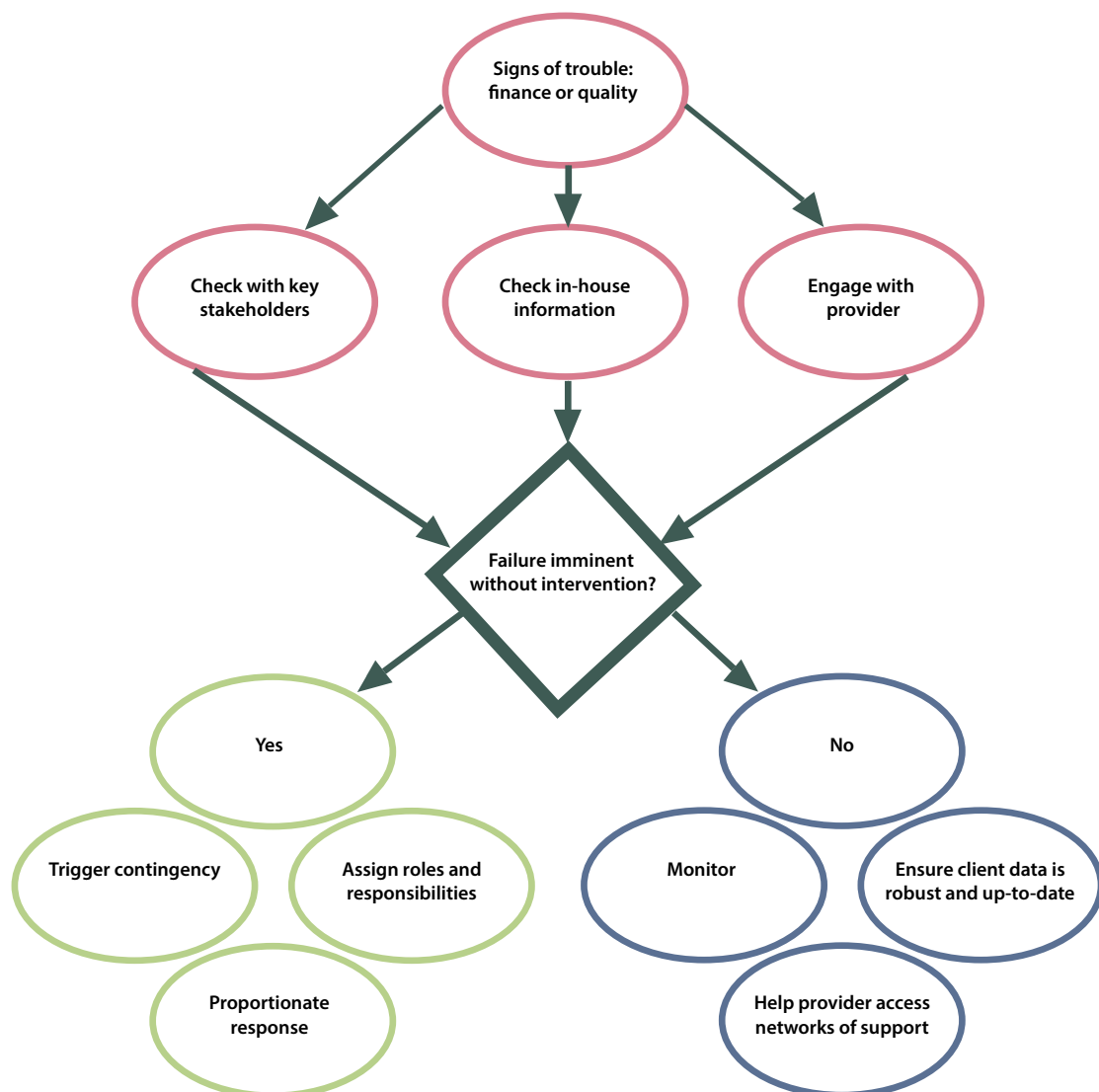- Poor cleanliness

- Lack of maintenance to physical assets

Management issues:

- Change of ownership/operator occurs or partnership breaks up for any reason

- Size of organisation? Number of homes, regional/national, expansions – over stretched

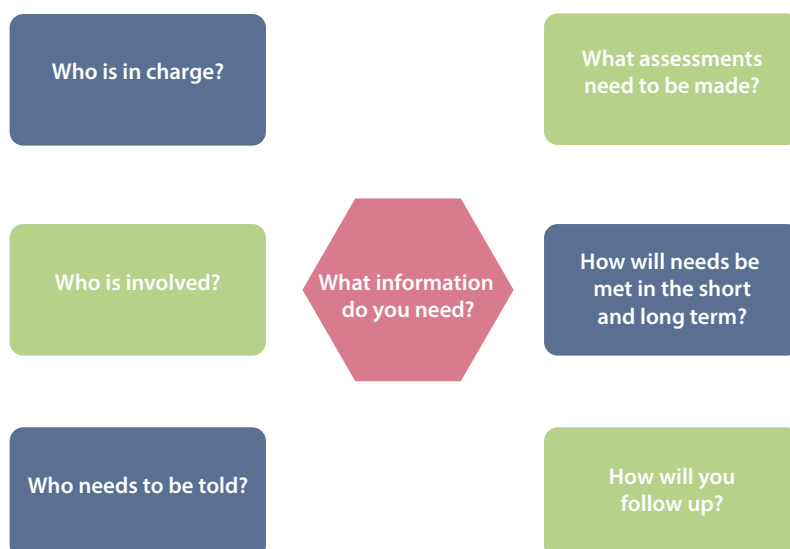- Poor invoicing – vulnerable to cash flow issues

Assessing local market and provider sustainability guidance also covers some of the risk factors and signs of failures as well as providing guidance on market sustainability in general.

2.5 Dealing with failure

Who is in charge?

What assessments need to be made?

Who is involved?

What information do you need?

How will needs be met in the short and long term?

Who needs to be told?

How will you follow up?

Once a council has decided that trigger criteria have been met and failure is inevitable, the quick start guide of the contingency plan (see subsection II of Section 2.3 above) should be followed. The most important thing is having the right person in charge and the decision of who that is should be made by or with the close knowledge of the DASS.

What if there is no plan?

If there isn't a plan in place, the following is a summary of the key decisions that need to be made in dealing with the provider failure. Depending on the urgency of the situation, these key areas can be divided up and a more detailed plan can be developed quickly for action.

Who is in charge?

☐ Who will have day-to-day responsibility for ensuring that key decisions are made and followed through?

What kind of oversight and support arrangements will there be from:

☐ Senior social care managers (if they are not handling the contingency themselves)?

☐ Elected members, including portfolio holders, ward members and district council ward members in two-tier authorities?

Who needs to be involved and to what degree?

☐ CQC?

☐ CCG?

☐ Other local authorities?

☐ Other providers who may have spare capacity?

☐ Other key stakeholders such as unions, care provider networks and banks?

☐ Any IPs that may have been appointed?

☐ Other local authority departments such as emergency planning or communications?

☐ The current provider?

Who needs to be told?

☐ When and how will service users and their families be told?

☐ When and what will care workers be told?

☐ How will unions be worked with to support unionised staff?

☐ How will non-unionised staff be told?

☐ Will the provider make these statements?

☐ Is there a need to make a public statement?

What data is needed?

☐ Does the council have all the relevant service user data? Although this is critical for every type

of provider, it may be more difficult to obtain for home care.

☐ How can client data be obtained if not easily available?

☐ Is there information support available for self-funders who may wish to arrange their own care and for local authority clients to support full choice?

What health and social care assessments of the needs of the service users need to be made?

☐ Is the council ready to make needs assessments for social care needs of clients?

☐ Is mental capacity being properly considered when making needs assessments?

☐ Are health and social risk assessments of a move being carried out if a move is being considered?

☐ Is emergency home closures[12] guidance being followed?

☐ Are the right health bodies involved, including GPs, CCGs, and pharmaceutical services to assess and meet health needs?

What actions are needed to arrange for needs to be met?

☐ Is there a provider of last resort who can provide support in either residential or other settings?

☐ Is full choice supported for people with care needs and allowing them enough time to make informed choices of options to meet needs for both self-funders and local authority clients?

☐ In particular, are relationships between people inside and outside the residential care home being supported?

What follow-up assessments are needed?

☐ Are there plans in place to review care packages and ensure clients are happy and settled in to new provision within a few days and slightly longer after settling in?

☐ Are costs assessed and re-charges being made

accordingly where legally permitted such as support for self-funders or clients placed by other local authorities?

☐ Will contingency actions be reviewed and plans amended accordingly?

Those who have a supervision or governance role can also use the checklist above to ensure that the key elements of a contingency plan are being carried out accountably during a provider failure or afterwards to review how it was dealt with.

2.6 Communicating failure

An absolutely critical aspect of dealing with failure is communication. Adult social care teams who handle provider failure well work closely with their communications teams to ensure that there are clear, consistent messages to everyone who needs to know when they need to know. Telling people before failure is imminent could move emotions from concern to alarm and could well precipitate conditions that make failure more likely. At the same time, this must be balanced with people's right to know about their care, their home or their livelihood.

Some councils have standard information packs already prepared including draft press releases and draft letters to staff and service users, friends and families. And other councils ensure that they work from scripts tailored to each incident.

The following checklist can help ensure clear and effective communication.

Who

☐ Who should craft the messages?

☐ Who should deliver messages?

☐ Who should have access to pre-prepared message scripts?

☐ Who should be told? Do messages need to be tailored?

☐ Who is the go-to person for further communication?

12 Short-notice home care closures: a guide for local authority commissioners. Social Care Institute for Excellence. September 2011. http://www.scie.org.uk/publications/homeclosures/

What

☐ What has happened?

☐ What will happen next?

When

☐ When should be people be told what is happening?

☐ When should people be updated?

☐ When will actions like moving, change of provider, etc. happen?

Where

☐ Where will people move?

☐ Where can people get more information?

Why

☐ Why did the failure happen and what can we learn?

How

☐ How will information for people be managed, especially about alternative provision for both local authority clients and self-funders?

☐ How will people find messaging and information?

☐ How can the right people find contingency support as they need it?

Conclusion

These practical checklists support the development of comprehensive and actionable continuity and contingency plans and a means to oversee how effectively they are being carried out. The Care and Support Reform pages on the LGA website will continue to provide additional materials and support to help councils deal with provider failure.

Supporting staff and retaining the workforce

One of the key stress points for adult social care in many areas is having enough well-trained, experienced care staff. While a care provider may go out of business, the last thing a council will want is to lose the workforce.

If failure seems inevitable, the local authority should make contact with the workforce and, if relevant, unions to begin to allay concerns of staff regarding payment of wages, future of the service and the wellbeing of service users – to counter the inevitable swirl of rumour. If this is not done promptly, problems can arise around staff wellbeing and staff exiting the service. This, in itself, can accelerate failure and potentially turn an orderly transition into an emergency situation. At Nottingham City Council, they ensure that speaking with staff is done at around the same time as speaking with care users and their families and carers and that messages are consistent.

Providers and local authority contingency teams should work with relevant trade unions to cover any statutory obligations that may exist around TUPE transfers. But the union cannot be the sole point of contact for dealing with workforce matters and the needs of non-unionised workers must also be considered.

Many councils have made assurances to staff about wages being paid, covering those costs temporarily as part of the contingency plan and to ensure continuity of care. Some councils have also offered support in finding a new job if staff will agree to stay on during an emergency closure, which is both reassuring to staff and helps to keep experienced care workers in the sector.

Appendix 1

Sample plans

There are several sample plans used by councils which are available on the LGiU website at: www.lgiu.org.uk/care-and-continuity

These include:

- Nottingham City Council's provider failure procedure

- London Borought of Ealing's Contingency Plan

- Cumbria County Council's Procedures for Managing the Closure of a Care Home

We have also included the London Borough of Enfield's overarching policy document on dealing with provider failure.

Templates

A selection of contingency planning and business continuity templates can be found on the LGiU website at www.lgiu.org.uk/care-and-continuity

This includes business impact analysis which includes core functions, the minimum amount of time needed to recover any critical systems and resources.

Wiltshire County Council has developed guidance, including templates, to support continuity planning for small businesses. This is available at www.wiltshire.gov.uk/business-continuity-guide-for-small-businesses.pdf

Appendix 2

Testing contingency and business continuity plans: a workshop

As part of the contingency planning process people will need to be trained in the plan and it will need to be tested and reviewed.

How to run the workshop

Depending on how many attend, divide people into multidisciplinary teams. If this is not possible, consider the different roles of communications and civil contingency teams, elected members, other providers, CCG and so on. This workshop runs better if people with different perspectives are mixed together.

Provide teams with one or two scenarios to work through and to develop a plan based on the existing contingency plan, some scenarios are provded below. If there isn't a well-developed contingency plan, use the checklist in Section 2.3 from subsection VI to VII.

It's possible to develop scenarios based on local circumstances, or adapt the ones provided. If testing well-developed plans, more detail will be required. There should also be time to allow teams to make up details and assumptions as they go along, because it will never be possible to provide enough detail to match a real world situation and it's better for participants to make up details rather than get stuck on 'not enough information'.

If running this as a high level exercise, give people around 45 minutes to complete the task. If looking at a more detailed case study exercise of the council plan, allow up to two hours, supply templates (some of which can be found in our template pack) and require a fairly detailed action plan.

Case Study 1

Borsetshire County Council uses a block-contracting home care commissioning framework based on geographic zones. Four months ago the council changed providers for the areas covering Felpersham (an urban district) and Ambridge DC a sparsely populated rural area. Shortly after the change of contract to Care-In, a regional provider who has recently expanded into Felpersham, there was an increase in complaints about missed and late visits mostly in the Ambridge DC area and the situation is deteriorating further with significant complaints about quality of care and missed visits now coming from Felpersham as well.

A recent CQC inspection highlighted significant concerns and two weeks ago emergency cover had to be used to for weekend visits in Felpersham town centre.

Case Study 2

Weatherfield MBC uses a variety of providers for home care which are procured on a case by case basis using a spot market. One of the providers, Loving Hands, supports self-funders but also has a number of local authority clients. Recently they have been asking for additional payments for more complex cases and additional time. The council has received a call from the owner/ registered manager who says they will not be able to make payroll this week.

Additional information:
By chance, the council knows that Loving Hands also has a few self-funding clients in neighbouring Rutshire (a unitary) but the initial client list that you receive doesn't list anyone with a Rutshire address. Their list also does not tally with the council's list of Direct Payment clients who use Loving Hands.

Case Study 3

Middlemarch is prone to flooding. Recent floods have made some rural roads in the southern part of the county impassable and you know there are some local authority home care clients in this area.

To make matters worse, Mossy Grove, a mid-sized independent residential care home with some nursing care beds is in the flood zone. Emergency service workers tell you flooding is likely in the next six hours.

Case Study 4

The council has had concerns about Royston Vasey Care Home for a while, but recently the administrators have been called in. A recent CQC inspection also found that the care 'requires improvement'. The IP has indicated that the bank would like to sell the home as a going concern.

Additional information:
- Royston Vasey is operating at around 75 per cent capacity
- most care homes in the area are operating at 90 per cent plus capacity
- two thirds of residents are self-funders.

Case Study 5

Sunny Dawns provides support to working-aged adults with learning disabilities and behavioural problems. It is the only residential provider of its kind in the London Borough of Walford and over half of its clients are not normally resident in Walford.

It was part of a small chain of residential care homes which have been bought by a new provider who mainly caters to over-65s. The new company wishes to divest itself of this provider because they don't feel this home is consistent with their main strategic aims. They have also indicated that although they would like to sell it as a business, they might also consider simply closing Sunny Dawns.

Case Study 6

Wyvern Constabulary were called following the sudden death of a client at Glen Court, a care home which caters for clients with dementia. It seems likely that there was serious negligence on the part of staff or possibly worse. The CQC has found the home inadequate on all measures and wants to take immediate de-registration action. The residents have complex needs and some are under 65. The Wyvern Valley area (a unitary) does not have many vacancies for those with a needs profile like a number of Glen Court clients.

Appendix 3

This guidance was developed with considerable support from a wide range of people including a virtual reference group through an open development and consultation process. Our steering group for this project was:

- Colin Angel, Head of Policy, United Kingdom Homecare Association

- Richard Campbell, Deputy Director, Department of Health

- Kim Curry, Interim Director of Adult Social Care, Somerset County Council, ADASS

- Rhidian Hughes, Chief Executive, Voluntary Organisations Disability Group

- Ann Mackay, Director of Policy, Care England

- Bev Maybury, Director of Adult Social Care, Calderdale Metropolitan Borough Council, ADASS

- Laura Smith, Policy Manager, Department of Health

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Debbie Young; West Sussex Council
Amina Begum; Wokingham Borough Council
Lynne McFetridge; Wokingham Borough Council
Mike Stillman; Wokingham Borough Council

Appendix 4:

Additional useful guidance:

The Care and Support Reform web pages hosted on the LGA website

Assessing social care market and provider sustainability – guidance and toolkit for local authorities; Cordis Bright

Market shaping toolkit (MaST): supporting local authority and SME care provider innovation and collaboration; Institute of Public Care

Principles Paper: Managing Provider Failure; National Audit Office; July 2015. This paper looks at the failure of providers of outsourced services

Short Notice Home Care Closures; Social Care Insti-

tute of Excellence. It includes checklists and sample forms for the assessment, arrangement of transfers and follow-ups for care home closures

Achieving Closure: good practice in supporting older people during care home closures; ADASS

Mental Capacity Act Code of Practice. Code of Practice giving guidance for decisions made under the Mental Capacity Act 2005; Office of the Public Guardian

Commissioning for Better Outcomes; University of Birmingham

The government has prepared a business continuity planning guidance as part of its wider toolkit on Resilience in Society: infrastructure, communities and business

Author: Ingrid Koehler, LGiU

This report is part of a suite of resources commissioned by the Department of Health in partnership with the Local Government Association and Association of Directors of Adult Social Services to support those commissioning and providing care and support in implementing the Care Act 2014. To find out more, visit www.local.gov.uk/care-support-reform.