Committee: Healthier Communities and Older People overview and scrutiny panel

Date:

Wards: All

Subject: Market Provider Failure

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Lead member: Cllr Tobin Byers – Cabinet Member for Adult Social Care and Health

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Recommendations:

1. That members note and comment on the content of the report and the work of Community and Housing Department to reduce the risk of provider failure and the procedures in place to manage a provider failure event.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This paper sets out the responsibilities of the council, in the event that a third party provider of care and support fails. Provider failure procedures form part of the overall approach to contract management and quality assurance of providers. It is not only for reasons of failure that the council may end its' contractual relationship with a provider. Breach of contract, quality and safeguarding concerns can lead to suspension and indeed termination of contracts.

1.2. However, this report focuses on the catastrophic failure of regulated social care providers such that the provider closes and care is at risk of ending. It is not concerned with other safeguarding or quality failures. The three main types of provider failure seen in adult social care are:

1.3. Business failure – whereby the business is no longer viable and is put into administration or insolvency, or is put up for urgent sale.

1.4. Regulatory closure – CQC can issue a range of warnings, improvement and closure notices. A closure notice should be the last resort, but in extreme cases may be the first action taken.

1.5. Discretionary closure – A provider or their ultimate owner, may choose to close a unit, branch or subsidiary due to loss making and/or loss of reputation. In some circumstances, this action pre-empts enforcement by CQC or wider business failure.

1.6. Local authorities have a responsibility under the Care Act 2014 to ensure the safety of service users and continuity of care in provisions that they host, whoever is the commissioner or whether they are a self-funder. This responsibility means that, should if other alternative re-provision is not viable, the local authority is the default provider of last resort.

2 DETAILS

2.1. National and local legislation and policy context

2.1.1 In 2011, the largest national care provider, Southern Cross, faced severe financial difficulties which put thousands of people across the UK at risk of losing their care service: the actions of local authorities, other providers and other stakeholders such as the Department of Health and Southern Cross's own landlords prevented this happening but it did cause significant concerns for residents of Southern Cross' homes and their families at the time. This led the Government to establish a new system in England to better predict a similar situation happening in the future. The Market Oversight scheme ('the scheme') at the Care Quality Commission (CQC) is the result.

2.1.2 Since April 2015, the Care Quality Commission has had a statutory responsibility to monitor and assess the financial sustainability of those care organisations in England that local authorities would find difficult to replace should they fail and become unable to carry on delivering a service. Collectively, these providers represent around 30% of the adult social care market in England.

2.1.3 Quality of care and the financial performance of a care organisation are closely linked. If one starts to deteriorate, the other can quickly suffer too. CQC have a national role in overseeing the quality of adult social care services and collecting information and intelligence about them. Therefore, the responsibility for the Market Oversight Scheme rests with the CQC.

2.1.4 The scheme includes only those providers who are large in size, regional presence or specialism. If any of these providers were to fail and their services closed, they would be very difficult to replace at local, regional or national level. Failure would present significant challenges for local authorities in affected areas to ensure that people continued to receive a care service that meets their needs. Providers are not in the scheme because it is thought they are more likely to fail – it is only that they would be difficult to replace.

2.1.5 Legislation sets out criteria to identify providers who are large in size locally, regionally or nationally. Different criteria apply to both residential and non-residential adult social care services.

2.1.6 For a residential care provider, the provider must have bed capacity:

(a) of at least 2,000 anywhere in England (i.e. significant size of provider); or

(b) between a total of 1,000 and less than 2,000 with at least 1 bed in 16 or more local authority areas (i.e. significant scale regionally or nationally); or

(c) between a total of 1,000 and less than 2,000 and where capacity in at least 3 local authority areas is more than 10 per cent of the total capacity in each of these areas (i.e. significant scale in a local or geographic area).

2.1.7 For non-residential care, such as domiciliary care, the provider must:

(a) provide at least 30,000 hours of care in a week anywhere in England (i.e. significant in size); or

(b) provide at least 2,000 people with care in a week anywhere in England (significant in scale); or

(c) provide at least 800 people with care in a week anywhere in England and the number of hours of care divided by the number of people provided care must be more than 30.

2.1.8 CQC has no responsibility or regulatory power to monitor and assess the financial sustainability of the adult social care sector as a whole. Local Authorities are required to have market oversight for their own regulated providers who fall outside of the CQC Market Oversight Scheme. A small independent provider with specialism may be just as difficult to replace, though impacting a smaller number of people. Therefore, it is important that we have an assured approach to local oversight and market management.

2.1.9 Locally the majority of our providers fall outside the criteria for inclusion in the CQC scheme.

2.1.10 The Care Act 2014 section 48 places a temporary duty on local authorities in respect of the carrying on of a regulated activity where a provider in the local authority area becomes unable to carry on that activity because of business failure. This duty falls to the local authority as soon as it is aware of the business failure.

2.1.11 CQC has no responsibility or regulatory power to intervene to prevent the failure of an individual corporate provider that is subject to CQC's financial monitoring and assessment. Instead, it is required to inform local authorities when it is believed that service cessation as a result of business failure is likely to happen, in order to seek to assist local authorities with their responsibility to ensure continuity of care.

2.1.12 The local authority is required to provide continuity of care by ensuring that care and support needs are met in the same way as they were immediately before the registered care provider became unable to carry on the regulated activity.

2.1.13 The local authority has these responsibilities irrespective of whether an individual is ordinary resident of the borough, irrespective of whether a needs assessment has been carried out and irrespective of whether the needs being met by the regulated activity meet the national eligibility criteria. Thus, the emphasis is on continuity of care and support for any individual impacted by a provider failure in the borough.

2.1.14 In September 2017, ADASS published a checklist for provider failure. It set out the following key principles:

- Person-centred care – individuals' needs are paramount and any process/practice should maintain dignity and respect.
- Safeguard – while providers may fail, service continuity should not. The local authority's duty to safeguard and ensure continuity of care comes first.
- Communicate – service users, carers, their families and care workers themselves must never be left out of the loop.
- Managing information – holding good, accessible data on people receiving care.
- 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 contingency plans.

2.2. <u>Recent examples of failure</u>

2.2.1 In 2011, the largest national care provider, Southern Cross, faced severe financial difficulties which put thousands of people across the UK at risk of losing their care service: the actions of local authorities, other providers and other stakeholders such as the Department of Health and Southern Cross's own landlords prevented this happening but it did cause significant concerns for residents of Southern Cross' homes and their families at the time. This led the Government to establish a new system in England (CQC MO) to better predict a similar situation happening in the future.

2.2.2 More recently Allied Healthcare and Medacs Homecare have both been examples of provider failure where the Merton, as a local authority impacted directly, has acted to ensure continuity of care.

2.2.3 Two of these three examples have made the headlines because they were amongst the largest national providers. Beneath these headlines, however, there have been numerous take-overs, re-structures and re-financing actions as well as smaller provider closures.

2.2.4 Business failure is not the only cause of catastrophic provider failure. Providers and units can be closed by CQC taking regulatory action. It can also be caused by other government agencies, such as the Home Office raiding providers and removing staff who do not appear to have the right to work. Business owners may also choose to close provision due to adverse publicity, attribution of blame for deaths by a coroner, loss making and so on.

2.2.5 Business failures can be drawn out, through administration or liquidation, but providers can hand back contracts at short notice. Whilst there might be notice clauses and legal remedies, neither of these will protect service users against an unwilling provider.

2.3. Types of failure and risks involved

The three main types of provider failure seen in adult social care are:

2.3.1 Business failure – whereby the business is no longer viable and is put into administration or insolvency, or is put up for urgent sale. The national Market Oversight programme led by CQC monitors the major providers and provides warnings on potential failure. However, recent experience suggests that the regime does little more than provide warnings, although they have more powers than they seem prepared to use. Action is left to local authorities.

2.3.2 Regulatory closure – CQC can issue a range of warnings, improvement and closure notices. A closure notice should be the last resort, but in extreme cases may be the first action taken. Closure notices are immediate. However, the protocol agreed with ADASS suggests that the host authority can ask CQC for a few days to arrange alternative provision. CQC do not routinely inform authorities of this, and in a recent case an authority moved vulnerable clients late into the night when they could have managed it over several days.

2.3.3 Discretionary closure – A provider or their ultimate owner, may choose to close a unit, branch or subsidiary due to loss making and/or loss of reputation. In some circumstances, this action pre-empts enforcement by CQC or wider business failure.

2.3.4 Such failures can affect providers of all sizes, from small sub-borough providers to national providers with international ownership.

2.3.5 The key risk is to the safety and wellbeing of service users. The local authority has a duty to all users of regulated services in their area, whoever placed them or pays for their care. There is an obvious risk of non-delivery of essential care, and risk of harm or death as a result. There are also risks from disruption of care, such as not understanding an individual's needs, loss of dignity, increased medication errors etc.

2.3.6 Allied to this, is the risk of loss of care staff from the threat of loss of employment and general disruption. There is a shortage of care staff and any losses are difficult to replace. In any contingency plan, there must be a clear understanding of the likely TUPE implication in respect of business transfer or service provision transfer and the extent to which this would rely on staff transfer. The risk of TUPE for a commissioner is that it is a right for the individual employee and is a process between employers. Commissioners have no formal role or powers to intervene. In many such transfers, there is a loss of key staff during the process.

2.3.7 There is a risk of loss of provision and choice, particularly in relation to buildings based provision. Closed units tend not to be replaced. As a result the overall supply diminishes.

2.3.8 There are a range of risks to authorities, including prosecution, reputational loss, financial penalties and the cost of recovery operations. This is not an exhaustive list, but gives a flavour of the seriousness of the issues involved.

2.4. <u>Planning for potential future failure</u>

2.4.1 There are a number of steps we are taking to plan for further events of provider failure

2.4.2 **Preventative** – improving our quality monitoring to provide better intelligence on potential failure of local providers. Quality issues can be an issue in themselves and a flag to potential business failure. We have an effective Joint Intelligence Group with CQC, the CCG and Merton Seniors Forum, but current capacity means we are often limited to undertaking reactive monitoring visits.

2.4.3 In developing our new Target Operating Model we recognise this deficit in capacity to proactively monitor contracts and quality. We are investing in a Head of Service for Commissioning and Market Development to lead and have oversight for our statutory commissioning duties. In addition we are investing in more contract and quality assurance staff. This will give greater ability to proactively monitor providers and assess the risks of potential failure before they arise.

2.4.4 **Suite of documents** – having templates letters, guidance and draft plans stored alongside other business continuity documents.

2.4.5 **Training** - ensuring managers and key staff are aware of the risks and expected responses. We cannot predict who will be available in the event of a sudden failure evet. We all need to be aware of the ADASS guidance, our statutory responsibility and the role of CQC etc.

2.4.6 **Reviewing capacity** - we need to consider how we could develop greater capacity in the independent sector. At present there are beds available but home care is in short supply. This might include greater in-house capacity or in partnership.

2.4.7 **Arm's length company** – This may be required in order to transfer in an operation at short notice. The council has to consider the best and most efficient way to ensure continuity of care within the legal and regulatory frameworks in the event that the independent sector is unable to step into the breach. Whilst a company can be registered online in 24 hours and at a cost of £12, more time is required to create memorandum and articles of association, choice of directors etc, to ensure

that it is fit for the intended purposes. A company can be created and left dormant, but there are still regular returns required and this task (usually the Company Secretary) needs to be assigned. HR and payroll would also need to be primed to issue contracts and on-board new employees at short notice. There are also issues such as Vat recoverability to be considered.

2.4.8 Responding to failure

2.4.9 Like every business continuity event, each provider failure is unique and response needs to be tailored to the particular circumstances. There are some common tasks that are key, however:

2.4.10 Establish contact with provider, CQC and ADASS – to ascertain the most up to date information

2.4.11 Risk assessment – An assessment of the risk to the provider/unit and service users, needs to be undertaken. As the situation develops, the service user risk assessment needs to be refined to identify those who might be more at risk, e.g. those with complex care arrangements. The risk assessment should also document the key legal, procurement and financial risks based on the predicted timetable of the failure being managed.

2.4.12 Ascertain service users at risk – we need accurate lists of all users of the service at risk, including self-funders and those placed by other agencies. The host authority has responsibility for all service users in a failing service, although would naturally coordinate action with other commissioners.

2.4.13 Emergency response – In the event of significant risk to individual or cohorts of users, we may need to move the urgently. Where care arrangements (eg home care package) cannot be replicated at short notice, a move into a residential or nursing home might be required in the short term. Service users and families should be consulted first. In some cases, families may be able to step in in the short term. In extremis and as a last resort, service users may need to be conveyed to hospital as a place of safety.

2.4.14 Consideration of precipitation – Authorities can precipitate failure by acting prematurely. For example the removal of significant numbers of service users can force closure and the movement of all users, when a unit or branch could have been sold as a going concern. The best interests of service users takes precedence over the interests of the authority.

2.4.15 Communication with service users, families and care workers – We need to communicate our role and reassurance to these key groups. Families can be an important additional safety measure, and often will increase their own contact during periods of disruption.

2.4.16 Communication to members and the media – these are key conduits for information to the public and ensuring accurate messaging is important. Professional media outlets are generally responsible and responsive to requests not to cause undue alarm, but social media needs to be monitored.

2.4.17 Establish alternative capacity - internally and externally, in similar or alternative provision.

2.4.18 Develop contingency options - There will usually be a range of options, such as transfer of staff and service users to new providers, transfer of care only, novation of contract on prospective sale. Ensure that contractual terms allow us to implement contingency plans successfully – these centre on termination clauses, release of information, cooperation from providers

2.4.19 Risk mitigation – this might involve moving some, eg higher risk, service users quickly utilising available capacity.

2.4.20 Execute contingency plan – this may be novation of contract to a new owner, transfer of staff and service users or transfer of care only.

2.4.21 Learning from the Allied Healthcare business failure scenario in November 2018, it is clear that we can place very limited reliance on CQC and DHSC in the event of national failures. The CQC was clear its role is to issuing warnings and was very clear that local authorities must act to satisfy themselves of their contingency plans and ability to enact continuity of care. DHSC and ADASS have tried to coordinate discussions at a national level, but as a result communication was limited in detail. Commitments were made by the outgoing provider which were not kept, but none of the national agencies seemed willing to try to enforce these. It is hoped that national bodies will, in time, provide learning from the apparent flaws in the market oversight regime which put service users and care workers at unnecessary risk during a time of intense and detailed work at a local level.

2.4.22 We are fortunate to have a brokerage team, which means we have people with detailed provider knowledge and capacity to respond. We were able to establish lists of service users quickly. We are also able to use our homecare electronic call monitoring system to access carer information, where a provider proves unwilling or uncooperative in providing this level of detail.

2.4.23 In the event of provider failure, beyond the safety and continuity of care to the individual; ensuring the workforce is supported in a difficult time and communicating that they are a vital and valued part of the local system goes a long way to ensuring people continue to carry out their work duties, even facing an uncertain personal future. The care workforce is itself vital to mitigating some of the risk of provider failure and in our most recent experience they value the local authority giving clear communication about the actions we take during these events.

3 ALTERNATIVE OPTIONS

3.1. n/a

4 CONSULTATION UNDERTAKEN OR PROPOSED

5 TIMETABLE

5.1. n/a

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

Temporary financial support and additional resource requirements, including additional human resource are considerations required for each individual event and will vary based on the decisions taken to manage risk and avoid provider failure wherever possible. Short term support to providers who are able to support continuity of care is also a consideration, unique to the situation.

7 LEGAL AND STATUTORY IMPLICATIONS

7.1 The responsibilities for continuity of care and market oversight as set out in the statutory regulations of the Care Act 2014

7.2 Consideration of CSOs and EU Procurement regulations as a result of providing continuity of care, and the long term impact on compliance with these regulations.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1 The nature of regulated services failure is such that in most, if not all cases, the individuals affected will have protected characteristics. Ordinarily these will relate to age and disability. During provider failure events these individuals will be disproportionately and directly affected. The council makes every effort to ensure no one is severely or negatively impacted by provider failure and that people experience continuity of care, are kept save and that their wellbeing is of prime importance whilst failing providers are managed or replaced.

9 CRIME AND DISORDER IMPLICATIONS

9.1. n/a

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. Risks of provider failure are managed within our commissioning and contract management functions and form part of the overall contractual management of providers and quality assurance framework. The risk and risk mitigation plans feed into departmental business continuity planning.

11 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

- n/a

12 BACKGROUND PAPERS

12.1. n/a