Health and Care Scrutiny Committee

Report from Commissioning Director: Adults and DASS

June 2017

Cleevelink Liquidation

This report aims to outline the summary of events, actions and lessons learnt following the liquidation of Cleevelink Limited (hereinafter referred to as Cleeve) in early March 2017.

Context

Cleeve was one of the largest non-national / locally owned providers of adult social care provision within Gloucestershire operating a number of care homes and delivering the largest percentage of home care in the county, up to circa 60% of all health and social care funded provision at one point They were also the key deliverer of Hospital Rapid Discharge and the Rapid Response (prevention of hospital admission) services. The Cleeve home care service had the highest number of complaints and safeguarding referrals from service users and their families.

GCC were made aware by the previous owner that Cleeve was being acquired by another provider, Primus Care Plc during the latter part of 2015. This acquisition was finally completed in February 2016. The delay meant that Cleeve were unable to pass the financial components of the tender process for the Urban Home Care Contracts.

GCC and CCG were aware of the financial sustainability concerns of Cleeve prior to the sale and worked closely with Primus during 2016 and early 2017 to reduce the financial liabilities associated with the payments in advance legacy from the old block contracting arrangement.

Cleeve's business model was predominantly based on recruiting eastern European care workers providing accommodation and means of transportation. By doing this, Cleeve was able to meet the increasing demand for home care that local recruitment was unable to achieve.

Primus were proactive in addressing the complaints and safeguarding issues by improving processes, practice and training. Primus did not continue recruiting from eastern Europe and worked with existing care workers to find alternative accommodation not linked to their employment. At the same time, in agreement with GCC, Primus stopped taking any new packages of care despite the continued demand for home care.

This resulted in their share of provision reducing from 60% to around 40% alongside a significant reduction in the number of complaints and safeguarding concerns.

Primus was very keen to build a new working relationship with the CCG, GCC and the Commissioning and Brokerage for Older People Team (CBOP) and at the end of 2016 indicated a new shareholder was investing in the Cleevelink arm of the business in February 2017.

The liquidation of the home care arm of Cleeve directly impacted on 246 employees who were delivering care to 376 people commissioned by Gloucestershire County Council and / or Clinical Commissioning Group and an additional 108 self-funders (people who pay for their own care) in the County.

Lessons Learnt

Due to the duration of the situation and ongoing associated work with liquidators and the insolvency service, the workshop for lessons learnt took place on 8 June 2017. Support Services also had a workshop on 8 May 2017, recommendations from which have been incorporated into this report.

1. Did we know this was going to happen?

Whilst GCC were aware that Cleeve were an “at risk” company there was no way the liquidation could have been predicted, nor the pace, so soon after the new investor had been confirmed.

Neither could GCC have foreseen that the provider would have little or no regard for either the service users continuity of care, or for their care workers employment, homes and means of transportation.

GCC had identified Cleeve as a provider that carried a high degree of risk and had been taking mitigations to manage and reduce that risk by reducing its service user numbers from approximately 600 to 400 over the last year. By having fewer service users, we saw an increase in quality of care, evidenced by the reduction of complaints.

Cleeve failed the financial viability test for Urban Home Care contract despite continued assurances of new investment as well as no further requests for advanced payments. Cleeve had given the impression that their financial situation was resolving itself and had not been honest about its intentions.

There was evidence in hindsight that the steps to place the company in administration were planned for weeks perhaps months before. None of this was communicated to the Council or their workers or service users.

Lesson	Comment / Action / Resolution
GCC commercial and market risk management did not take into the intentions of the investors. We lost the opportunity to understand the intentions of the investors and business at an earlier point in time. There were no conversations with GCC or CCG with the investor prior to investment, though no doubt its contracts will have been seen as an asset of the company. There were issues with contracts - needed to be clear on insolvency timeline. GCC could have potentially been liable for TUPE.	GCC needs to accommodate a wider set of risks, incorporating the intentions and financial viability of new investors. Insolvency mitigation planning must be incorporated into contracts or at least business rules when GCC notified of change of ownership.
GCC Company 'health-checks' focused and takes into account its financial standing at time of placing its accounts with Companies House and not at the company's cash flow position at time of pre-crisis. We need to enhance existing procedures for potentially 'at risk' suppliers e.g. red flags. GCC had to rely on Cleeve staff who were working without being paid but on the understanding that GCC would support via fuel, foodbanks, welfare payments and reimburse new providers for work carried out on behalf of Cleeve. This carried risks of implied TUPE. Need to have a greater understanding in future. As this only impacted on Adult Social Care this was not deemed an 'emergency' under the corporate definitions. Whilst the core team were effective, there was a lack of administrative support and, for example, the emergency control room was not considered for daily meetings.	CBOP Commissioning Officers already undertake 'market management' functions gathering intelligence such as safeguarding referrals, complaints and financial issues. The CO's work closely with Operational, Financial, HR and Commercial colleagues to develop and manage its **Market Risk Matrix**. The Matrix needs further development to give a more detailed view of: • Quality • Finance • Capacity • Market Position The Market Risk Matrix will take into account requests for cash payments or advances outside the standard Electronic Call Monitoring (ECM) route. The CBOP Team will call on its support colleagues when the Providers hit key risk indicators. When a Provider has enough 'red flags' the Business as Usual situation will escalate to ***Severe,*** requiring

	Cross Functional Team intervention. Positive action and intervention will happen much earlier (pre-crisis). When in crisis the situation will be escalated to full implementation of a plan. Intervention teams of all key stakeholders can work together to mitigate the visible risks cohesively.
GCC learnt that reduced calls e.g. 30 minute calls translated into 15 mins calls with no travel time, introducing new impossible practices that GCC were not aware of. Cleeve rotas were unmanageable with carers leaving daily. There was a need for consistency and continuity.	We need to ensure all key Home Care providers have adopted the ECM system. GCC needs to monitor our ECM information for operational red flags.
The Cleeve operating model was asset heavy and non-domicile staff fully supported with transport and accommodation. This made the company attractive to investors to split the company,(asset heavy care home business and cash flow dependent Home Care Business), effectively stripping out assets.	GCC needs to consider the Cleeve Provider Operating model and its associated risks, especially where a Home Care Provider is widening its scope to include cost heavy assets such as Care Homes, or using non domicile staff, paying their accommodation and transport en-masse. Home Care Providers operating a similar model may carry the same risk.
The shortage of Home Care within Gloucestershire meant that there was little choice but to rely on Cleeve for its services. There is a county wide and nationwide shortage of carers.	GCC ‘Proud to Care’ work both regionally and locally. An external facing recruitment and retention post has been appointed to support independent sector providers to advertise, recruit, offer training and clear ‘care as a career’ pathways – website goes live in July 2017.

2. Could we have done something about it?

It is not unusual for a change of shareholders or ownership of home care companies without any service interruption on regular basis. Even if GCC were aware of the plans, our ability to influence private business decisions is at best, very limited.

Lesson	Comment / Action / Resolution
Though the teams worked well together, there was no visible plan or operating structure / control document for the teams to work with during the crisis. There is a need for better planning and dissemination of work. There were delays in Communications with possible legal implications. Members were briefed by Senior officers and Communications Team. Wanted more assurance, which was not always possible in the circumstances. There was a need to understand what steps GCC could take without it impacting on the council e.g. withholding finances to provider. This should form part of any future contingency plans.	We need a Crisis Management Plan in the event of a provider showing levels of risk that they may fail the market. Levels of contingency captured within a plan should possibly be: • Moderate • Severe (requires intervention) • Crisis Cross functional team intervention should start if a Provider flags risks as a potential crisis (Severe) and a full crisis team formed in the event of presented Crisis.
There was criticism that parts of GCC were slow to act and this impacted on what followed. There was no time to look at the bigger picture, just had to "hit the ground running" e.g. GCS response with Reablement - confusion over ownership and role. The majority of In-house services were unable to offer support due to low numbers of staff Record keeping and note taking was ad hoc, largely because staff were actively	The Crisis Management Plan must have clear details of responsibilities and roles to be adopted in terms of a cross functional intervention or crisis. The plan must demonstrate who makes the business decisions and therefore responsible for the risk and who advises of risks and delivery of outcomes. The plan must follow clear laid out deadlines, as well as describe the operational logistics of the intervention and crisis teams.

dealing with problems.	Business Continuity plans should clearly indicate escalation plans and which in-house services could be temporarily closed to redirect resources Intervention and Crisis must follow proper auditable record keeping and documentation process.
GCC should have stepped in earlier and intervened. There was a need to plan for the whole month not just day to day. Removal of front line staff to provide cover for a month would have avoided last minute planning - the volume of carers required escalated daily. Comfort Call in Cheltenham were unable to start taking calls for nearly a month. GCC non-essential services e.g. Day Care should have closed for the month.	The Care Act is clear that managing provider failure is a GCC duty. If a care home is failing GCC are able to step-in in a caretaking role. GCC do not have the same authority for a home care provider under CQC regulations.
There is no blueprint of what GCC expects for home care provider record keeping. Some were years out of date.	The contract monitoring should form part of the review. Reviews should be looked at in more detail.

3. What went well?

- A core team was established across adult social care operations, commissioners and CBOP, support services including finance, legal, commercial, communications and human resources. Wider support received from ITU, Districts (housing), Gloucestershire Fire and Rescue and Gloucestershire Care Services. There was rapid access to expert legal advice.

- Daily meetings / conference calls with nominated leads – timely decision making and / or delegation of tasks for follow up meetings / calls.

- GCC staff rallied, above and beyond expectation by many involved. Good practices were carried out on goodwill. However, it was not sustainable and the duration did push staff to the limit.

- GCC relied on the goodwill of service users and their families and at times were delivering less than planned services.

- Mobilisation of 24 helpline for service users and families, as well as Cleeve staff to access fuel, food bank and welfare payments.

- All expenditure incurred was logged separately and / or forecast to robustly respond to liquidators and insolvency service. Any payments due to Cleeve were suspended.

- Effective transition to 5 of the 6 identified providers by CBOP when liquidation was confirmed.

- Managed transition to the 6th provider, who required longer, to takeover Cheltenham area due to this being the largest cohort with considerably challenging rotas as staff left or chose to stay with Cleeve in another capacity.

4. What did not go so well?

In addition to some of the comments above the common themes were:

- Lack of clarity as to whether this was a directorate or corporate 'emergency' and hence who was leading the response.

- No 'formal' plan when relying on staff or partner agencies working long hours, re-deploying to support the situation particularly given the duration.

5. Could we have done anything different?

Issue	Comment / Action / Resolution
Reablement isn't directly managed by GCC, the Coldharbour system (rota system) is owned by GCC but managed by GCS. This extra layer of organisation presented issues in mobilising the Reablement Service to support the situation.	We need to adopt a working model to take over the temporary management of mobilising of the Reablement Service should such a crisis occur again. CQC domiciliary care registration needs to be in place. Need and desire to firm up on protocol with GCS and CQC. Further discussions with CQC about 'step in' rights for home care providers. Positive feedback locally and nationally from CQC that GCC managed the situation well in very difficult circumstances.
We currently have cabinet authority for	Plans being looked at with current

one Dynamic Purchasing System model and would need cabinet authority for another model (DPS) as this would be a significant change. Approval would be required given problems experienced with Cleeve.	providers, if situation should occur again, to be on board beforehand. Dynamic Purchasing System..
GCC did not have knowledge of self-funding clients. GCC would need to have sight of this from the provider.	
GCC staff believed they had an open and honest relationship with Cleeve staff however there was a breakdown in trust with one member of staff which caused issues. This highlighted trust is an important issue.	