NRS Market Failure

Lessons Learned Review

July 2026

Local Government Association | Directors of adass adult social services | Partners in Care and Health

Contents

1 Executive Summary

1.1.1 The collapse of NRS Healthcare in August 2025 exposed structural weaknesses in the UK's community equipment and Technology Enabled Care (TEC) market, with widespread implications for social care and NHS services. As one of the largest suppliers in the market, the failure of NRS created immediate risks to continuity of care, hospital flow, and user safety.

1.1.2 This review, commissioned by Partners in Care & Health (PCH), draws on stakeholder engagement from over 50 organisations to understand the events and lessons from the market exit, specifically in relation to England. It finds that NRS's collapse was not due to a single event, but rather a culmination of factors, including, weak financial resilience, rapid expansion, unsustainable pricing models and insufficient oversight. These challenges were exacerbated by a major cyber-attack in 2024 and NRS leadership instability, which appeared to accelerate service decline. It is important to note that this report is presenting the collective opinion of participants rather than expressing PCH's own view (unless indicated otherwise).

1.1.3 The incident response demonstrated strong local leadership, collaboration, and commitment across the sector, with commissioners and suppliers acting rapidly to maintain essential services. Emergency procurement, mutual aid, and workforce transfers ensured that a major national care failure was largely avoided. However, the response was hindered by poor access to critical data, inconsistent contingency planning, limited national coordination, and some partners being unclear about roles across government bodies.

1.1.4 The review highlights several key systemic vulnerabilities, which are stated here and elaborated on throughout the report:

- Market fragility and reliance on a small number of large suppliers.
- Unsustainable commissioning practices, often prioritising lowest cost over long-term viability and system impact.
- Weak financial oversight and lack of early warning systems.
- Inadequate data governance, limiting access to essential personal and operational information.
- Gaps in business continuity planning, particularly in outsourced models.
- Supply chain risks, disproportionately affecting SMEs.
- Varying levels of strategic leadership and direction across the sector at local, regional, and national level and amongst different organisations.

1.1.5 Despite successful short-term stabilisation, significant residual risks remain, including data gaps, workforce pressures, financial disputes and market concentration. These things mean that without reform, the sector remains vulnerable to future supplier failure.

1.1.6 The report concludes that community equipment and TEC services should be recognised as critical infrastructure within health and social care. It calls for a fundamental shift toward more sustainable, transparent, and resilient models of commissioning and delivery. This includes strengthening market oversight, improving data access and ownership, enhancing contingency planning, fostering a more diverse supplier landscape, and aligning national leadership with local delivery.

1.1.7 Ultimately, the NRS failure presents a critical opportunity and warning to redesign large parts of the system, moving from cost-driven procurement toward outcome-focused, resilient services that better support independence, prevention, and integrated care.

1.1.8 Section 6 provides a detailed set of considerations and recommendations; with proposed immediate next steps being to:

- Convene a working group of stakeholders from across the sector to consider the findings and recommendations from the report.
- Survey Integrated Community Equipment Services (CES) to understand one year later (August 2026) what the impact of NRS's exit has been, the current situation with commissioning and provision and intentions and timeline are for future recommissioning.
- Undertake a rapid review of contingency and business continuity plans in light of the lessons learned.
- Undertake a call for evidence of alternate models (in-house, Teckal, partnership, sub-regional etc.) for CES and TEC and disseminate information on best practice and the 'art of the possible'.

1.1.9 The report should be considered as two parts; these are:

1.1.9.1 Part 1: this is an account of what happened (Section 3: The NRS Closure: Timeline and Context; and Section 4: Incident Response).

1.1.9.2 Part 2: this is reflections and learning from the event and what actions we need to take as a result (Section 5: Lessons Learned and Section 6: Recommendations).

1.1.10 Finally, the review team would like to extend sincere thanks to all those who contributed their time, expertise and reflections to this review. We are particularly grateful to commissioners, suppliers, regional networks, national bodies, representative organisations and individuals with lived experience who engaged openly and constructively. The candour, professionalism and collective commitment to learning shown throughout the process were instrumental in shaping the findings and recommendations of this report. Without this breadth of insight and willingness to share experience, it would not have been possible to develop such a comprehensive and balanced account of the events surrounding the NRS market exit or to identify meaningful opportunities for system improvement.

2 Introduction

2.1 Scope of the Review

2.1.1 On the 1st August 2025, winding up orders were made against Nottingham Rehab Limited[i] and NRS Healthcare Limited. The court appointed the Official Receiver as liquidator together with special managers to allow the business to continue operating temporarily under supervision.

2.1.2 Prior to summer 2025, NRS Healthcare was one of the UK's largest suppliers of community equipment to the health and social care sector. It supplied wheelchairs, specialist beds, hoists, fall-monitoring pendants and other aids to the NHS and around 44 local authorities. This scale led to a reliance on this provision across the country, meaning that as this situation developed, commissioners had to move quickly to switch to alternative arrangements/suppliers as there were fears of delays in hospital discharges, risks to continuity of care and equipment supply for vulnerable residents.

2.1.3 Whilst the core business of NRS was centred around Community Equipment, Technology Enabled Care (TEC) was also severely impacted and is included within the considerations of this report.

2.1.4 Following the closure of NRS, PCH agreed to lead a retrospective, sector-wide review of the overall situation. It was felt most appropriate to do this at a point where the immediate crisis response was coming to an end, to capture the learning but also to avoid diverting the attention of those involved in crisis management. Hence, PCH commissioned ARCC-HR Ltd to undertake this work to begin in January 2026, with a particular focus on:

- the impact of the NRS's market exit in the adult social care system across England
- how organisations responded and the lessons learned for the wider system; and
- insight to inform market-shaping, oversight, contingency and resilience planning.

2.1.5 The purpose of this report is **not to apportion blame in respect to the causes of the events**, but to reflect on the underlying foundations, contributing factors, **what we can learn for the future and what action could be taken** to reduce the likelihood and impact of this happening again.

2.2 Methodology

2.2.1 A mixed-method approach was utilised that combined quantitative (where available) and qualitative information (e.g. stakeholder engagement), alongside the report author's knowledge and understanding of the various factors at play. This provided a rich and nuanced mix of subjective and objective information that has helped understand the events surrounding NRS's exit. This approach strengthens the validity of findings by allowing themes that emerge from qualitative evidence to be tested against quantitative trends, and vice versa. It also supports a balanced view, capturing operational realities, stakeholder perspectives, and contextual factors that numbers alone may obscure.

2.2.2 At the start of this process, various communication routes were used to invite a wide range of stakeholders to contribute their views to this work, in a way they felt most appropriate and effective. The approach was largely agnostic of the organisation (i.e. didn't target specific suppliers or commissioners) and instead focussed on engaging those most affected and impacted and whose perspective and experience would best

inform this report. Between January and March 2026, the team leading this review conducted **60 individual and group interviews**, drop-in sessions and workshops with **105 stakeholders** across **54 organisations**. Most of these people were suppliers or commissioners of services affected by the NRS situation, representatives from key partners (such as DHSC, CQC and NHS) and people with lived experience of using community equipment and TEC were also involved.

2.2.3 All local areas were made aware of this review and invited to participate. This invite was open to anyone connected to the local CES or ICES, regardless of exactly who they were employed by or if they previously commissioned with NRS or not. This approach recognised and reflected the different local arrangements, which consisted of a mix of consortium, integrated systems, shared roles and some organisations taking a commissioning lead on behalf of others. To be clear, most commissioners that input into this report were; i) from areas that directly commissioned with NRS and ii) employed by local authorities as they typically took the lead in CES / ICES commissioning arrangements.

2.2.4 A desktop review of key publications and information shared from organisations engaged in the review was also conducted.

2.2.5 In conducting the stakeholder interviews, the review team were careful to avoid making assumptions, so whilst a detailed list of questions was created and underpinned the interviews, discussions were formed around an overarching story arc (figure 1).

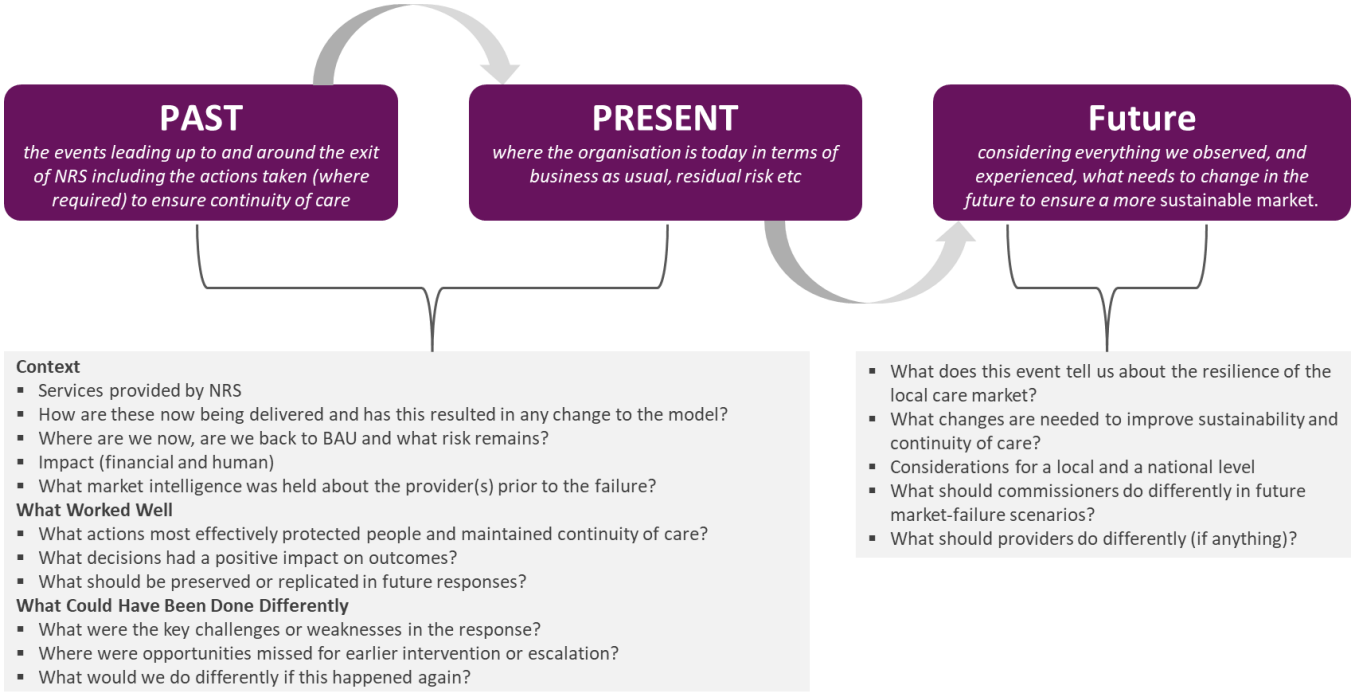

Figure 1: lines of enquiry

2.2.6 Information gathered through interviews has been analysed to identify observations that were common or repeatedly raised across multiple stakeholders. The review team has also applied their professional judgement, experience, and insight to interpret the evidence, form observations, and draw informed connections.

2.2.7 The analysis deliberately moves beyond isolated or purely subjective accounts, focusing instead on shared themes, recurring patterns, and systemic issues that cut across individual perspectives and support reflective learning. This approach helps ensure the findings reflect the experiences and views shared, are balanced and constructive, do not rely on single or unique perspectives and minimise the risk of apportioning blame or

singling out individuals or organisations. Similarly, information shared throughout the course of the engagement has been treated confidentially, acknowledging commercial sensitivity and that individuals may have shared candid reflections or experiences that could be personal or emotive[ii].

2.2.8 Finally, as this study has been undertaken in a short period between January and March 2026, the ability to gather full qualitative and quantitative data, together with the time for multiple rounds of stakeholder testing, verification, or thematic analysis, has been limited[iii]. The review team believes this report represents a comprehensive account of the lessons learned, but is best seen as the start of an ongoing reflection and dialogue, rather than a definitive and final account of the events and actions required.

2.3 Glossary

2.3.1 As would be expected, the purpose of this glossary is to define and explain terms that play a key role in this report but that either may not be fully understood by all readers, or where readers may have a different understanding of what each means.

Association of Directors of Adult Social Services (ADASS)	The national association representing Directors of Adult Social Services in England, providing leadership, policy influence, peer support and sector coordination.
Alarm Receiving Centre (ARC)	A monitoring centre that receives alerts from TEC devices, such as pendant alarms or falls sensors, and coordinates an appropriate response, often on a 24/7 basis.
Business Continuity Planning (BCP)	Plans and arrangements that ensure essential services can continue during disruption, including provider failure, cyber incidents, or other major operational risks.
Commissioners	The public officials and organisations responsible for the commissioning of CES / ICES / TEC arrangements in their local area. The exact arrangements and organisational and individual roles will differ from place to place and use of this term covers all these different arrangements in a non-specific way.
Community Equipment Services (CES)	Services commissioned by local authorities and the NHS to provide, maintain and recycle equipment that supports independent living, safety and care at home e.g. hoists, pressure mattresses, mobility aids.
Data Governance	The framework of accountability, controls and processes governing how data is owned, accessed, shared and protected.
Integrated Community Equipment Service (ICES)	A form of CES, where this is jointly commissioned by local authorities and NHS bodies, often using pooled budgets, to deliver equipment services across health and social care. The exact relationship between the local authorities and NHS bodies various across the country and so 'ICES' is a general reference to this type of joint commissioning arrangement, rather than a description of something specific.
Insolvency / Liquidation	A legal process that occurs when a company cannot meet its financial obligations and often involves the appointment of an Official Receiver.
NRS Healthcare Limited	This is the official name of the company. During this report they will be referred to as NRS.
Official Receiver (OR)	A public official appointed to manage a company in compulsory liquidation, acting primarily in the interests of creditors but responsible for overseeing the process.
Open-Book Pricing	A commercial model where providers disclose underlying costs and margins to commissioners,

Partners in Care and Health (PCH)	PCH is jointly delivered through the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) to support councils improve the way they deliver adult social services. PCH is funded by DHSC.
Planned Preventative Maintenance (PPM)	Scheduled inspection and servicing of equipment to ensure safety and functionality, particularly critical for items such as hoists and specialist beds.
Procurement Act 2023	UK legislation reforming public procurement, including transparency and payment-term requirements that may help address supply-chain risk.
Soft Market Intelligence	Informal or qualitative information (e.g. supplier concerns, prescriber feedback, payment delays) that can provide early warning signs of provider distress.
Supplier	This is a generic term used to refer to any organisation that manufactures, produces, supplies or sells products or services within the scope of this report. This is regardless of size, scale, role in the supply chain or product or service focus. This term has been used for clarity, though it is recognised that some organisations included may use a different term to refer to their role in this sector.
Supply Chain	The network of manufacturers, distributors, subcontractors and service providers that support delivery of CES and TEC services. These organisations are individually and collectively referred to as 'suppliers' in this report (see above).
Technology Enabled Care (TEC)	The use of digital and assistive technologies, such as alarms, sensors, wearables and monitoring platforms, to support independence, safety and wellbeing.
Transfer of Undertakings Protection of Employment	Referred to as TUPE, relates to employment regulations that protect staff terms and conditions when services transfer between providers.
Teckal Company	A company owned and controlled by a public authority that can deliver services without competitive tendering, provided it meets strict legal criteria.

3 The NRS Closure: Timeline and Context

3.1 The National Market Context

3.1.1 CES, often delivered through an Integrated Community Equipment Service (ICES), are local authority and NHS-commissioned services that provide equipment to help people live independently at home, maintain safety, and avoid or reduce care needs[iv], and is underpinned by the statutory duties contained within the Care Act 2014.

3.1.2 Services typically focus on provision, delivery, maintenance and retrieval of community equipment to meet assessed needs and share similar structural features:

3.1.2.1 Most ICES/CES are **jointly commissioned** by local authorities and NHS Integrated Care Boards, often under Section 75 partnership agreements, enabling pooled budgets and shared responsibility. Each area will agree specific roles (including those described in 3.1.2.3) and responsibilities to support this arrangement, but there is no standard approach, and these differ from area to area. The work to produce this report revealed that, where joint commissioning arrangements exist, the local authority and its employees typically act as the lead commissioner.

3.1.2.2 Whilst some commissioners may utilise in-house provision or a Teckal company[v], there is a significant private sector market, which is dominated by **a small number of suppliers** (Medequip, Millbrook and up until recently NRS Healthcare). Suppliers are typically responsible for; stocking equipment (standard items pre-approved by prescribers, plus procurement of non-stock and bespoke); delivering, fitting and collecting equipment; maintaining and repairing items; providing decontamination and recycling.

3.1.2.3 Professionals such as occupational therapists, physiotherapists or trained social care staff **prescribe equipment** based on an assessment.

3.1.3 CES is a large and complex market (figure 2) with 3 dominant suppliers (up until the exit of NRS, now 2) of fully managed service offers. However, this market is underpinned by a large manufacturing and supply chain.

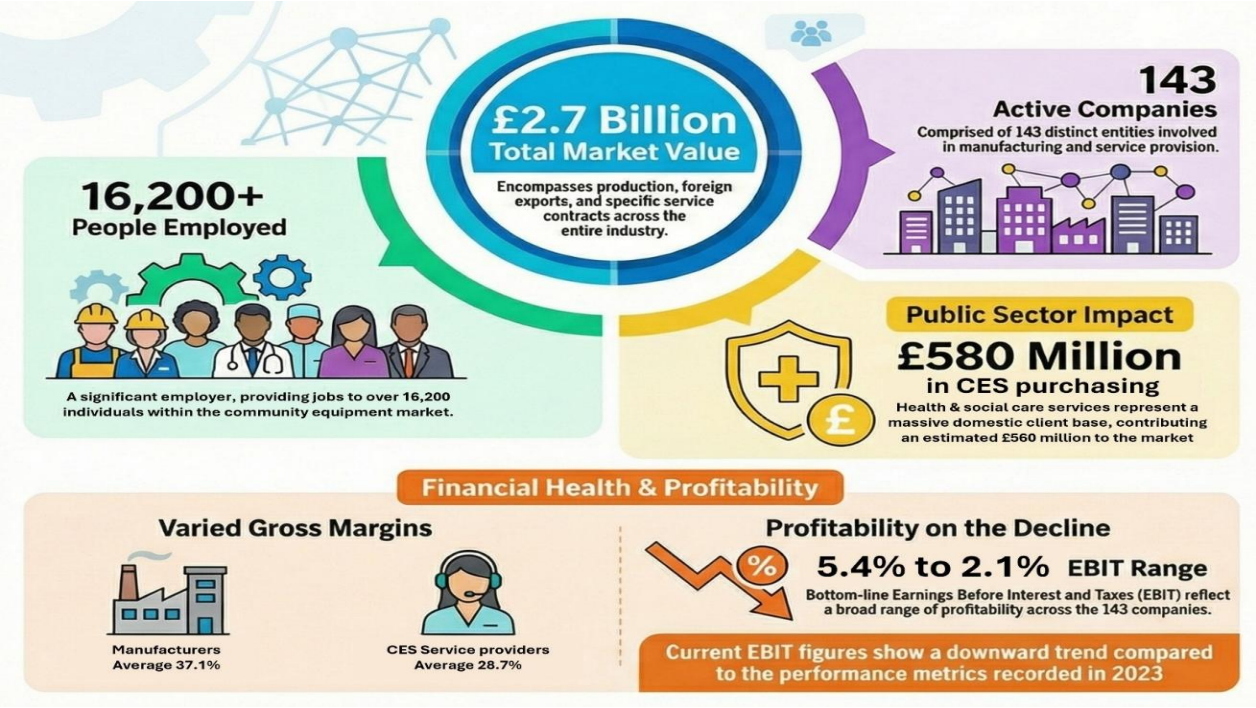

Figure 2: Community Equipment Market Overview[vi]

3.1.4 TEC refers to the use of digital tools, devices and remote monitoring systems[vii] to support people to live independently, maintain safety and wellbeing, and reduce reliance on traditional care services. The TEC Services Association (TSA)[viii], which is the National Industry Body for the Technology Enabled Care Sector, TEC Services and Suppliers defines what this is and includes. Their definition for TEC is "encompassing everyday consumer devices through to specialised monitoring systems, integrated with proactive interventions such as wellbeing calls and falls response services". Services are typically structured around:

3.1.4.1 Local authorities, ICBs and possibly housing bodies working closely to provide these services through an in-house model, or commission from an external supplier; this may or may not be delivered in conjunction with community equipment. The TEC market features specialised digital suppliers and is more diverse (In terms of scale and spread of suppliers) than the CES market, although each of the big three (above) have an offer.

3.1.4.2 Service providers and monitoring centres supply; trusted assessments (in some instances), devices and sensors, installation and maintenance, 24/7 monitoring and response services.

3.1.4.3 The TEC sector is supported by the TSA Quality Standards Framework[ix] (the UKAS-accredited TEC quality system) and CQC guidance on consent, data protection, and surveillance where TEC is used in regulated care settings.

3.1.5 The wider market for CES and TEC in England, beyond what is purchased through public bodies, is undergoing a period of rapid transformation, prompted by demographic pressures, digital migration and other factors. Specifically in relation to the commissioning arrangements of public bodies, transformation is also taking place such as continuing to support people to live at home for longer and the roll out of virtual wards as part of the NHS' 10-year plan. Whilst some public funding streams, such as the Better Care Fund (BCF), are supporting this transformation, areas such as the Disabled Facilities Grant (DFG) have arguably not kept pace with the system changes. There also remains disparities in funding arrangements, 'who-pays-for-what' and 'how much' across areas. The NHS is consistently the higher user (c. 60% of the volume of referrals), despite local authorities typically being the lead commissioners and contract holder. These dynamics all affect how CES arrangements operate.

3.1.6 The All-Party Parliamentary Group (APPG) 'Barriers to Accessing Lifesaving Disability Equipment' published in October 2025[x] concluded that the *"UK's community and medical equipment system is in crisis"*. The report describes systemic failure, not isolated poor practice and whilst some APPG observations are wider than the scope of this review; the APPG report correlates with the findings of this report, by highlighting:

3.1.6.1 Commissioning prioritises lowest cost over fitness for purpose, subsequently, there needs to be a shift from short term cost control to long term value.

3.1.6.2 Stronger regulation and oversight of suppliers is required, underpinned by commissioning frameworks that reward quality and durability, support innovation and SMEs and reduce market instability.

3.1.6.3 An absence of a strategic direction and approach to CES and TEC nationally.

3.1.7 The collapse of a national supplier, such as NRS, reinforces the above. Similarly, Baroness Casey describes in the Independent Commission on Adult Social Care[xi], a social care system dependent on under-resilient infrastructure and inconsistent commissioning.

Casey stresses the lack of clear national accountability and ownership within adult social care, which is an emergent theme from this review.

NRS Pre-Insolvency

3.1.8 Prior to entering insolvency, NRS occupied a strong position within the CES and TEC market in England. The organisation held contracts with c.44 local authorities and integrated care boards. These contracts were predominantly focussed across the south of England and included a consortium of 21 London local authorities, covering both CES and TEC provision. This gave NRS an estimated 36% share of the national outsourced market commissioned by local authorities and health, with an annual contract value of c.£157 million. The remainder of the externally commissioned market was split across Medequip (c.46%), Millbrook (c.8%), smaller suppliers and not for profit organisations (c.11%).

3.1.9 NRS operated from 27 sites across the UK, delivering services through a (mostly rented) depot-led model in which equipment was stored, cleaned, repaired, and dispatched via a large fleet of leased vehicles. Each contract had a dedicated relationship manager holding day-to-day operational responsibility, supported by an online ordering platform and a national contact centre. The service portfolio covered:

- Integrated Community Equipment Services c.85% of business
- Technology Enabled Care across nine integrated and four standalone contracts
- Wheelchair services and mobility devices, including 24/7 breakdown recovery
- Clinical and assessment services, including significant use of contracted occupational therapists
- Maintenance and testing of specialist home-based equipment

3.1.10 The scale of NRS's operational footprint was substantial. At any one time, NRS managed in excess of 3 million items of equipment in the community, supporting approximately 250,000 households across the UK. ICES activity was central to health and social care system flow, enabling around 65,000 hospital discharges each year, with much of this equipment required on a same-day, urgent basis. Similarly, TEC services monitored 45,000 vulnerable individuals via 24/7 alarms, sensors, and first-responder arrangements, interruptions to which carried clear safety and safeguarding risks.

3.1.11 Prior to its demise, NRS employed around 1,350 staff, including depot operatives, drivers, technicians, contact centre teams, and specialist clinicians. This was supplemented by a complex supply chain of 800 stock suppliers and around 50 key suppliers (such as sub-contracted alarm receiving centre suppliers) whose withdrawal would immediately compromise NRS operations.

3.1.12 NRS operated a complex, multi-system IT landscape involving a mix of in-house developments and externally managed platforms. Different service lines (ICES, TEC, retail) used different systems, each with its own supplier arrangements.

3.1.13 NRS also operated a retail arm which supplied direct to customers (D2C) and a manufacturing division which supplied some products to in-house services and competitors. Therefore, its role in the sector was significant and so its failure had profound implications for continuity of care, market stability, and the resilience of local commissioning arrangements.

3.1.14 As of early 2026, the CES market is further consolidated because of the NRS exit and the re-distribution of their previous provision, with a shift in the outsourced market share towards Medequip (c.57%), followed by Millbrook (c.27%) and other (c.16%).

3.2 Chronology of Events

3.2.1 The factors which contributed to the NRS closure are explored in section 3.4; however, to understand some of the contributing reasons **why** this event happened, we have first explored **what** happened through an overarching chronology of events (see figure 3).

3.2.2 Warning signs were visible from 2023 through to early 2025, although they became more prominent in early 2024. Throughout this period, NRS Directors expressed confidence in the business. Stakeholders interviewed as part of this process felt that NRS Managers dismissed issues as localised operational challenges as opposed to structural problems. The cyber-attack in 2024 put operational challenges on a centre stage.

3.2.3 By early 2025, NRS showed escalating financial distress, with local authorities reporting growing issues, such as out-of-stock items and requests for early invoice payments. Suppliers were increasingly raising concerns about unpaid invoices, leading to suspended deliveries and accelerating service deterioration.

3.2.4 In June 2025, NRS leadership, alongside PwC who were supporting NRS in this situation, signalled distress, and in agreement with DHSC, PCH quickly mobilised support, convening national response calls utilising the ADASS National Commissioning Network. The purpose of these calls was to cascade information, draw in external support where required, act as a conduit with NRS representatives and central government (SITREP updates), share knowledge and create a space for commissioners to work through issues. This support was universally regarded as beneficial to the response. At the same time, ADASS regional teams in affected areas utilised their limited resources to the best of their ability to set up more localised incident response and coordination.

3.2.5 NRS, with the support of PwC, soon issued letters addressed to the DASS of every LA that contracted with them. This correspondence clearly set out the financial support NRS were requesting from each local authority to enable their continued operation. This boiled down to 3 'asks'; i) payment by the local authority for 'their' stock held by NRS, ii) payment of outstanding invoices within 7 days and iii) an inflationary uplift to all contracts backdated to the 1st April 2025. The consensus from local authorities was that this ask; i) was too great without further detail, which had not been provided, ii) was too late in the process and iii) gave local authorities very little confidence that agreeing to meet these terms would do anything other than slightly delay the inevitable closure of NRS. No local authority provided what NRS had requested. Further attempts were made by NRS and PwC to secure some of these conditions, verbally and in writing and towards PCH and local authorities. Whilst there were some aspects where agreement was informally reached (e.g. all local authorities expressed comfort in paying outstanding and agreed invoices), this fell short of a level of support that PwC felt would allow NRS to continue trading.

3.2.6 By late July, PwC's attempts to secure a buyer had failed, and NRS was described as close to insolvency, prompting government intervention. On 1st August 2025, compulsory winding-up orders were issued for Nottingham Rehab Limited and NRS Healthcare Limited (an affiliated company), with the Official Receiver appointed as liquidator and PwC as special managers to oversee service wind-down.

3.2.7 During July and August 2025, commissioners had begun launching emergency plans to maintain equipment delivery, establishing interim arrangements while sourcing replacement suppliers. Rapid transitions to new services began under emergency procurement, including data access requests, TUPE transfers, and fast mobilisation of new suppliers.

3.2.8 On 28th August 2025, the NRS product sales division was sold to Mobilitas Group, preserving that part of the business and associated jobs.

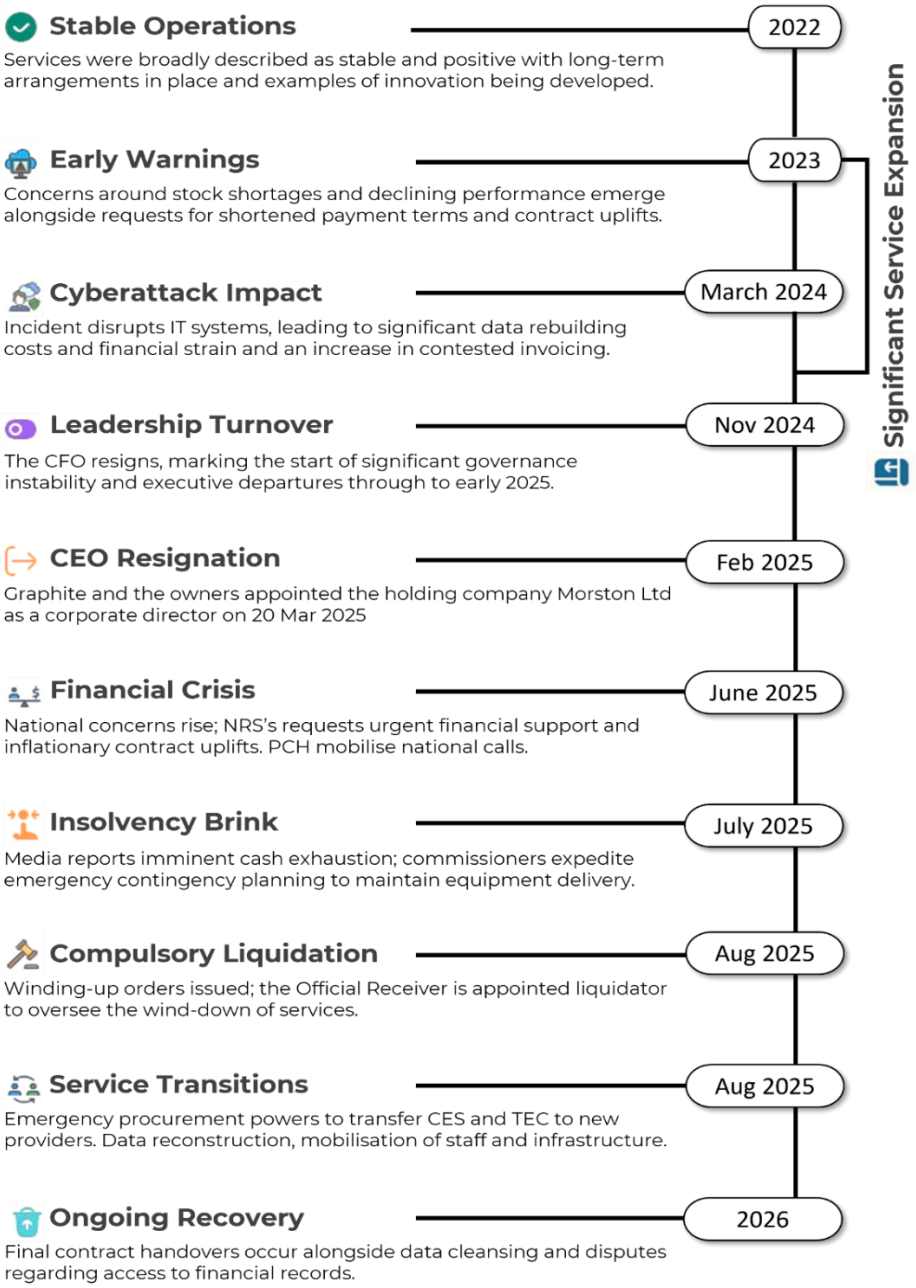

Figure 3: timeline surrounding NRS exit

3.3 Contributing Factors to the Failure

3.3.1 It is clear, NRS's collapse was not the result of a single event but a cascade of financial and operational pressures, demonstrating many of the hallmarks of a business in financial distress (overtrading, losses, margin erosion, increasing debtors and creditors, significant loans). Insights from local authorities, providers, and national bodies paints a

consistent and compelling picture that NRS had been experiencing structural fragility for some time, and this was intensified by a series of acute shocks.

> *"How did you go bankrupt? Two ways. Gradually, then suddenly."* **Ernest Hemingway**

3.3.2 Market failure in this context does not mean a literal failure of free markets in general, rather a breakdown where private provision of public-service goods does not deliver reliable outcomes. In the case of NRS, essential services were outsourced to a private supplier, but the firm was unable to sustain itself financially, even though demand was stable or growing. This highlights structural problems, set out below, which must be considered to prevent future occurrences.

Rapid Growth and Contract Economics (see figure 4).

3.3.3 A central driver of NRS's collapse was the organisation's rapid growth strategy, most notably the pursuit of large contracts such as the London consortium. Feedback suggested these contracts were aggressively priced to win the contract, despite requiring higher levels of service, complex logistics, and significant upfront investment. The expansion diverted operational and managerial capacity away from other regions, creating performance risks across the business. One stakeholder framed the issue as *"they grew too big too quickly,"* and the stress of trying to service that growth over the 12-18 months, prior to liquidation, precipitated visible cracks. This should serve as a warning that a similar pattern could recur given the current constricted market.

3.3.4 The evaluation criteria used by local authorities when tendering for these services are typically weighted towards price (c60-80%). Feedback suggests contracts were underpriced by NRS from the outset, so whilst this often led to them winning a contract, this approach threatened their financial and operational resilience. As a result, NRS operated on extremely thin margins, typically in the region of 2–4%, leaving almost no financial buffer to deal with volatility or operational shocks, such as the cyber-attack.

3.3.5 At the same time, rising employer and operational costs intensified the financial pressure facing NRS. Increases to National Insurance, the national minimum wage, and general inflation pushed cost bases upward. The financial challenges experienced by local authorities (and to some extent the contractual stipulations), meant that in general, annual price increases were not commensurate with the cost pressures, effectively locking suppliers into multi-year agreements that became progressively less viable. This sustained margin compression meant that even modest increases in costs could wipe out profitability and operating surplus.

3.3.6 Cashflow constraints are a defining feature of NRS's financial distress. Significant capital investment was required to mobilise new contracts. Simultaneously, NRS experienced increased costs and relatively high levels of disputed invoices, paying less or later than NRS would have budgeted for. This created a cycle of liquidity pressure, with difficulties paying suppliers on time being an early warning sign of systemic strain in service-delivery firms.

3.3.7 Several commissioners noted NRS's offer of a 1% discount for invoices paid early. Given NRSs extremely tight margins, this will have had an impact on operating reserves. Commissioners also raised instances where they withheld fee uplifts due to poor contractual performance; given that inflationary pressures (worker pay and national insurance) are statutory, these actions will also have had an impact.

3.3.8 The company's heavy reliance on income from ICES contracts, combined with tight payment schedules and limited working capital, made the business vulnerable to even short-term fluctuations in revenue. This would further compound the cycle of decline as supplier's placed stop notices thus limiting stock and creating contract defaults.

3.3.9 Operational issues and *"stretching themselves thin"* led to additional resource strains. Collection rates were reported as dipping, which resulted in a reliance on purchasing new stock (poor stock management), reports of multiple trips to fulfil orders and delays in deliveries led to inefficiencies and activity which could not be charged for. Simultaneously, redirecting staff to mobilise new sizeable contracts resulted in noticeable performance issues in services which were well established.

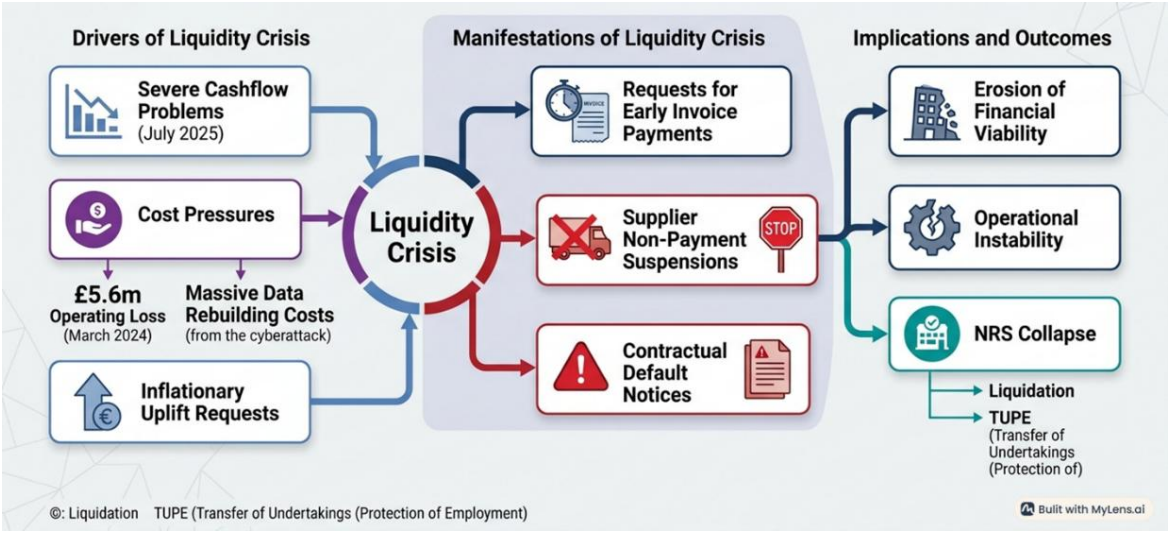

Figure 4: the impact of a liquidity crisis

Impact of the Cyber Attack in 2024 (see figure 5).

3.3.10 It is important to view the cyber-attack that struck NRS during Easter 2024, in the context of the financial landscape described above. It is likely this was a key moment in the organisation's operational and financial decline. What began as a ransomware incident rapidly escalated into a prolonged shutdown, forcing staff to revert to manual processes across core service areas. The sudden loss of digital systems severely disrupted workflow continuity, created significant backlogs, and undermined data accuracy at scale.

3.3.11 The attack triggered an accelerated IT recovery programme, requiring the replacement of a significant amount of hardware and extensive system restoration work. Although the immediate financial impact was initially reported as limited within the formal accounting period, it is clear the recovery effort placed ongoing strain on cash reserves and caused further cost pressures into 2025.

3.3.12 The combination of system outages, resource diversion, and mounting recovery expenditures is likely to have weakened organisational resilience during an already fragile period. Rebuilding critical datasets became a major undertaking, with several areas subsequently issuing contractual default notices as the organisation struggled to regain stability. It is important to connect this point to the high level of disputed invoices. By nature of the dispute, there will be different perspectives on the cause, but it is clear that post Easter 2024, the ability of NRS to produce timely, accurate and substantiated invoices was severely impacted, as would have been their ability to quickly resolve any invoice disputes.

3.3.13 Operationally, the cyber incident eroded confidence among prescribers and partners, many of whom were already concerned about performance issues. With workflows destabilised and data integrity compromised, the service saw growing frustration among frontline clinicians and commissioners who relied on timely, accurate equipment services.

3.3.14 Crucially, the cyber attack struck at a moment when NRS was already managing structural challenges and significant mobilisation of contracts; therefore, amplifying existing vulnerabilities.

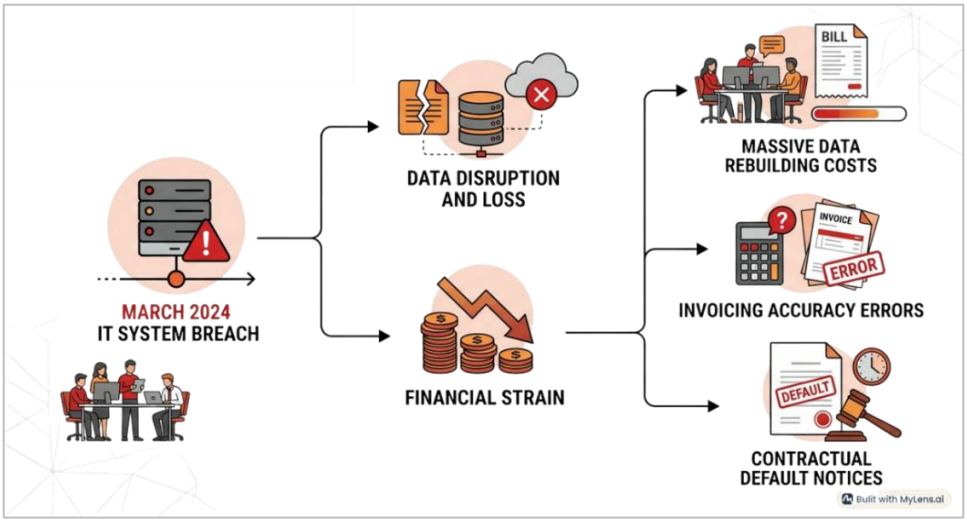

Figure 5: the impact of the cyber attack

Significant Leadership Changes (see figure 6).

3.3.15 In late 2024 and early 2025, NRS entered a period of substantial leadership disruption, marked by the departure of long-standing executives and a rapid turnover in critical governance roles. For several years, the organisation had benefited from stable leadership under CEO David Myers and Chief Financial Officer (CFO) Simon Hall, who, together with other directors, provided continuity through multiple phases of private equity ownership. This stability shifted dramatically as the business approached the period in which performance and financial pressures became more visible.

3.3.16 The first major change occurred with the resignation of the CFO in November 2024 and then the short tenure (c.5 months) of the replacement. This rapid turnover in the finance leadership, during a period when robust financial management and reporting would have been critical, represented a significant risk. Alongside these departures, several other board changes reinforced the sense of transition, with a new Company Secretary (August 2024) and Chief Community Services Officer (November 2024). Further instability followed when the long-serving CEO resigned from the board in February 2025. Shortly after his departure, the holding company Morston Ltd (Sean Sullivan), was appointed as a corporate director in March 2025.

3.3.17 This instability would have inevitably contributed to weakened oversight, inconsistent strategic direction, and diminished financial leadership, factors that collectively played a material role in the events leading up to NRS's exit.

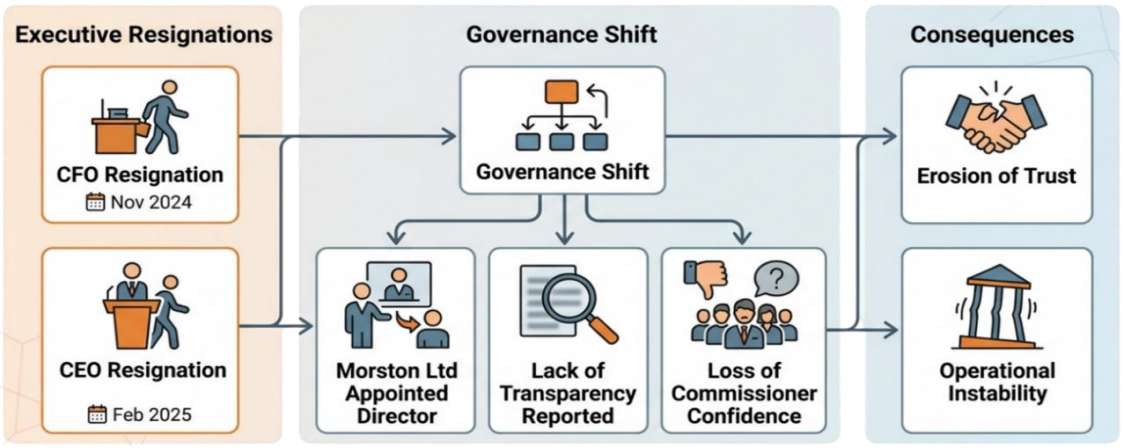

Figure 6: the impact of leadership changes

4 Incident Response

4.1 Ensuring continuity of care

4.1.1 Once it was established that NRS was on the brink of failure, commissioners acted quickly to ensure the impact on the services received by local people was minimised. From June 2025, commissioners were in a very difficult situation where they knew NRS was failing but they could not communicate this officially, as there was the potential that this would inadvertently accelerate the collapse. The reminders from NRS on what they titled 'commercial confidentiality' were often repeated and heavily emphasised. This adherence to strict commercial sensitivity and non-disclosure (legal risk), was felt by commissioners to be a significant impairment to their contingency planning, which they had to undertake with their *"hands tied"*.

Common themes across commissioner and local authority responses included:

4.1.2 Nationally, **PCH coordinated calls** to bring together commissioners (not just local authorities) who were impacted by the possible failure of NRS. These calls continued until September 2026. They were overwhelmingly described as an important feature of the response, as the single engagement channel and clarity of expectations helped align key stakeholders where required. They were an opportunity for commissioners to each understand what each other was experiencing and planning and also gave a simple means for NRS, PwC, DHSC, the Official Receiver and other stakeholders to join and talk to commissioners affected. This was a particularly important environment for commissioners who were the only ones in their region that contracted with NRS.

4.1.3 Simultaneously, several **regional ADASS networks stepped up support**, aligned to the severity of impact, in particular London and the South-East, who had many local authority areas (50%+ across the region) impacted by this situation. These regions immediately mobilised support for their local authorities and health commissioners, which included fora to bring together senior leaders (see figure 7). In the case of London, issues had been apparent much earlier than June 2025, and therefore incident response had already begun by this point, given the real-time risks and issues that were being observed and experienced.

Figure 7: Regional support offers

4.1.4 **Enacted contingency plans and protocols for business continuity** (see figure 8). There were differing levels of preparedness across commissioners in the key period between June and August 2025 as the system entered a critical period. Some commissioners decided to terminate contracts, via default, and enact business continuity steps earlier than others. This was partly due to their local operational situation, but also their assessment of the legal risks of doing so prior to NRS going into liquidation.

Spotlight: Blackburn with Darwen's Community Equipment Provider Failure Plan

The commissioning team in the Council and in Lancashire and South Cumbria Integrated Care Board engaged Medequip (given sub-regional infrastructure) as the incoming provider, requiring both an immediate operational response and a phased plan to fully stabilise service delivery. To minimise disruption and maintain essential equipment provision, a three-tiered mobilisation strategy was implemented:

1. Short-term (First 4 Weeks) **rapid stabilisation:** Medequip agreed to take over a significantly scaled-back service immediately, ensuring critical pathways and essential equipment needs continued uninterrupted.
2. Medium-term (From Week 4 Onwards) **gradual expansion to full service:** a structured scale-up plan enabled Medequip to expand operations, workforce capacity, and logistics to deliver the complete community equipment service.
3. **Retail model continuity:** simple aids to daily living continued to be supplied via the existing retail model, reducing pressure on the new provider and maintaining easy access for prescribers and service users.

To ensure safe handover and operational clarity, several foundational elements were put in place:

- Communication channels and escalation points were defined to ensure prescribers and partners could reach teams quickly.
- Short-term equipment ordering pathways were created for prescribing essential items, including confirmation of accessible stock and a protocol for escalating requests for alternative equipment.
- Approved prescriber list of 15 authorised prescribers across six centres was implemented to avoid overwhelming the new provider and ensure safe, prioritised ordering.
- Strict protocols were introduced to prevent a surge of non-essential orders, helping Medequip to stabilise operations.
- Tailored messaging and comms outlined the who, what, where, when, and how of the new arrangements. Special versions were created for high-risk elements such as out-of-hours repairs (EDT/Front Door).

Rapid action was supported by commissioners having a direct line into decision makers, and joint ICB and Council director-level meetings facilitated prompt decision making.

Figure 8: Spotlight on Blackburn with Darwen's Provider Failure Plan

4.1.5 **Rapid mobilisation of alternative suppliers**, securing temporary storage sites, coordinating mutual aid and creation of temporary equipment stores (see figure 9). Across the country, Medequip and Millbrook stepped in swiftly, accepting multiple contracts and beginning the process of service transfer, establishing the operational infrastructure and onboarding prescribers onto the new systems. In the London area, several smaller local suppliers did the same. Workforce transfers (TUPE) stabilised operations quickly, although data and staff communication proved to be an obstacle.

4.1.6 The contracts accepted by Medequip and Millbrook were typically transferred according to proximity to existing contracts, which was vital to allow rapid mobilisation temporarily utilising neighbouring areas depots and operational infrastructure under mutual aid. Similarly, alternative provision in the TEC space was secured quickly and whilst Livity Life and Medequip Connect were utilised in a similar fashion to the above, there were more alternatives available within the TEC space.

4.1.7 Emergency decisions and **triage of the limited resources** focused on protecting people with urgent needs, such as those awaiting hospital discharge and people with disabilities, ensuring that critical daily-living equipment was provided even during transitions. Areas quickly established a shortlist of priority equipment which they worked with alternative providers and suppliers to ensure access to.

Spotlight: Plymouth City Council and Livewell Southwest – Mount Gould Super Peripheral Store

The team mobilised an operational group, working extremely quickly to ensure the Plymouth healthcare system and public continued to receive a service. Plymouth City Council agreed an emergency two-month contract with Millbrook Healthcare, which started on Friday 1st August providing key equipment deliveries and repairs only (limited to just 20 critical and larger items like beds, hoists etc). To address the remaining 'lower level' equipment supply need, the team set up a temporary 'Super P store. Millbrook supported supply to the store and in under 2 weeks there was a functional workspace and a mini depot set up ready to process orders, take in equipment and returns, and maintain equipment in moderate stock levels. Staff from various Livewell therapy teams rallied together to help support managing and running the store.

Some key highlights that made this emergency service work:

- Supplied c.75 different equipment products and created a temp decontamination zone.
- With support from Livewell Comms, hosted an external website for all Plymouth prescribers to access, using bespoke sized spreadsheets that mirrored our CES equipment catalogue to display stock levels in the P-store.
- Utilised Microsoft Forms & Teams for orders, with MS Forms automatically generating into a word document that was sent to a mailbox where the order form could be converted, printed, and attached to equipment orders ready for processing.
- Used an NHS clinical notes barcode scanner to speed up cataloguing inventory.
- Sourced appropriate cleaning products to be able to de-contaminate returned equipment so that stock could be re-issued. In later stages Millbrook staff joined us at the Super P store and supported with this.
- Livewell ASC OT Lead and OT Practice Lead acted as a point of contact for all prescribers Plymouth wide to problem solve, risk manage and find solutions for equipment provision.
- Hosted Millbrook customer service staff to work alongside the P-store whilst we waited for access to our Plymouth depot.

Since opening the peripheral store to take orders on the 7th August (closing on the 14th November 2025), the service received 1,590 equipment orders through the P-Store and fulfilled 1,490, issuing 2346 pieces of equipment.

Figure 9: Spotlight on Plymouth's Peripheral Store

4.1.8 Commissioners **issued updates and communications** to residents, explaining transition plans and how to contact new suppliers, reassuring them that previously issued equipment should still be used and fielding concerns from across a range of stakeholders. This was an integral step given the issues with access to data and accuracy, as muti-channel communication also provided an opportunity for users to identify themselves and any concerns they may have (see figure 10).

Spotlight: Kent's approach to stakeholder engagement and communications

Key stakeholders met to develop and implement a communications plan, the objective was to target people using equipment requiring a Planned Preventative Maintenance (PPM) visit, and to keep individuals informed about the current service offer and the transition to our new provider. The plan was developed in collaboration with KCC and ICB commissioners, communications teams, Occupational Therapists, and project management support. Multi-channel approach of:

Social media posts were issued to inform residents of the service updates. Comments received on these posts were monitored, collated, and analysed. Any recurring themes identified were incorporated into the FAQs shared with prescribers and published on the KCC website.

Master stakeholder list utilised and were **emailed** to notify them of the current service offer and provided with FAQs and PPM information. Updates were issued every other month using both commissioning and operations distribution lists and comms teams own channels.

Information was included in staff, ASC and resident **newsletters**

Posters were displayed in GP's and pharmacies. Also shown on digital screens in waiting areas.

FAQs were updated and distributed weekly to ensure consistency and respond to emerging concerns.

Where data was available, Medequip sent **letters directly to residents**, with information about the service and any required PPM activity.

Figure 10: Spotlight on Kent's approach to communications

Actions undertaken by the **Department of Health and Social Care (DHSC)** included:

4.1.9 Acting to understand the emerging risks in the ICES market and NRS's financial position. This involved consolidating intelligence across government and developing core briefing materials to support decision-making. DHSC engaged with Devolved Administrations and other departments to share information and align understanding, while initiating broader cross-government coordination, including with NHS England, MHCLG, devolved nations, PCH and others. At the same time, officials began developing a reasonable worst-case scenario to assess potential impacts and inform contingency planning.

4.1.10 The Adult Social Care Team in DHSC establishing a formal incident response structure alongside regular core and cross-government meetings to coordinate activity and maintain oversight. The national response was divided into two strands: an NHS England strand, which coordinated regional NHS leads, and a PCH-coordinated strand to engage impacted local authorities.

4.1.11 DHSC agreeing with PCH that PCH would act as the conduit to local authorities and other key stakeholders. This approach recognised the unique position PCH hold in the system and that they are funded by DHSC to convene and support the sector. Alongside this, DHSC also established formal and informal ways of working with PCH. Wherever possible, these sought to make best use of existing relationships and communication channels between PCH, local authorities, ICES suppliers and the team leading on NRS' insolvency. It was agreed with DHSC that PCH would lead direct engagement with Local Authorities, whilst DHSC maintained frequent reporting to Ministers and senior leaders through situation reports and submissions.

4.1.12 The most significant action taken by DHSC, and which aimed to prevent disruption to adult social care services, was that Ministers agreed to intervene via a **government funded insolvency process**. DHSC secured approval from HM Treasury for financial cover and engaged the government Insolvency Service. This enabled the Official Receiver to continue operating services temporarily following NRS entering insolvency, while adhering to their legal duty of prioritising NRS's creditors. During this phase, DHSC worked with local authorities, who agreed to fund ongoing service provision and manage transition costs and maintained regular engagement with the Official Receiver to monitor the liquidation process and ensure continuity of services. The intervention was formally communicated to Parliament through a Written Ministerial Statement and supporting documentation.

4.2 Barriers and obstacles

4.2.1 Commissioners faced a range of operational, strategic, informational, and system-level barriers as NRS collapsed. Whilst 'workarounds' and significant effort meant these challenges were often mitigated or overcome, they did create risks to service continuity, ensuring safety, and coordinating an effective response.

Access to service data and information

4.2.2 Commissioners and suppliers repeatedly raised that by far the most severe obstacle they faced in moving provision from NRS to other suppliers, was obtaining current client data from NRS. Requests from commissioners to NRS for this data were all refused, with varying reasons given. Contingency plans for data varied across contracts and whilst some commissioners were able to extract data from the NRS system early on or obtain

partial data sets from NRS, other had little or no data. Once the insolvency procedures were enacted, this blocked access to critical information.

4.2.3 The only proposed solution to the data problem through this whole process came from the administrator, who offered to provide critical data to each ICES area at a cost of £50,000, irrespective of the size of contract. At the request of commissioners, the administrators provided a basic breakdown to show the cost they would incur to provide data, but commissioners felt this breakdown provided little logic, rationale or justification for the cost or approach. During and since this situation, commissioners expressed strong concerns about the operational impact, including on patient safety, of not having this data. Whilst people understood that the drive for this action was rooted in legal duties, many experienced commissioners expressed their surprise that data was being withheld in this way having never encountered this situation before.

4.2.4 Understandably, this was a very contentious subject, with the majority of stakeholders we spoke to describing the situation as *"ransoming"* critical data, thus creating an information vacuum. Whilst some commissioners did pay the £50,000, most opted not to and instead worked intensively with the data they had, and their new suppliers, to build a picture of provision and maintenance of equipment. Where commissioners did obtain data from NRS, the quality of the information was described as poor, which likely reflects the issues stemming back to the cyber-attack in 2024.

4.2.5 The description in 4.2.2 - 4.2.4 makes it clear that commissioners and replacement suppliers were operating with incomplete and inaccurate data, such as equipment histories, planned preventative maintenance (PPM) records, or client lists. The absence of this information put vulnerable people in the community at risk, for example unknown PPM data could result in a potential failure, such as a hoist breaking, which could cause injury.

4.2.6 Similarly, the absence of data had a significant impact on the ability for alternative suppliers to mobilise and continues to pose challenges today; issues included:

- 4.2.6.1 the need for extensive data rebuilds, cleansing and line-by-line validations to address overinflated datasets;
- 4.2.6.2 reaching out to residents and users to identify people who may be in receipt of equipment and overdue/upcoming PPMs (see Kent communications, figure 9);
- 4.2.6.3 dealing with complaints emanating from miscommunication with TEC funded clients who were being invoiced as self-funders

4.2.7 TUPE data was not quick to be transferred, and the incoming supplier and commissioners were not always cited on the communications to staff.

Coordinated national response

4.2.8 Commissioners expected a swift, coordinated and visible national response from central government given the scale and impact of the market failure. Many commissioners stated that they did not feel this materialised. Through this review it has become apparent, but was not widely communicated or understood at the time, that central government undertook a range of actions that are set out earlier in this report. These included providing short-term funding to the Official Receiver (OR) to cover essential operating costs, with the intention of buying time for commissioners to find alternative suppliers. Stakeholders spoken to in producing this report felt this extended period (at short notice) resulted in a slowdown in the flow of data to mobilise operational responses. Many commissioners also queried; i) if it was reasonable for the OR to charge commissioners (typically local authorities) for critical operational data and ii) if the

proposed cost was reasonable and within the bounds of the engagement to support the transition. The OR maintained that their approach throughout NRS' insolvency was driven by their legal duties. In the period immediately after the OR became involved, commissioners felt that information flow was patchy and inconsistent and discussions / negotiations were indirect, largely through insolvency advisors and informal routes. People did not feel they were part of an agreed, candid, multi-agency forum to design an affordable safe exit and future setup.

4.2.9 Commissioners commonly reported that they felt the support offer from DHSC during the situation was unclear and undefined and would have benefitted from agreed roles and responsibilities and clarity around DHSC's involvement. Whilst commissioners felt that many parties provided various forms of valuable support to navigate the liquidation and insolvency situation, there was a general feeling that this would have been more effective if coordinated formally as a structured and visible national response, utilising a recognised and agreed approach. This would have involved central government having a clearly defined role. There were differing views on exactly what this 'national response' would look like, but consensus on the value of greater structure, clarity and consistency, The absence of this contributed to uncertainty on various matters, opened-up the response to a multitude of different approaches and led to an inequitable impact. For instance, some commissioners chose to continue paying NRS to keep the operation temporarily viable, while others did not, and some areas terminated their NRS contract early, whilst other did not. Those that acted early to move to another supplier reported that this was partially out of fear there would not be any alternative supply options left if they did not move early. These variations highlighted challenges in maintaining fairness and collective decision-making across commissioners during a period of risk, concern and instability.

4.2.10 Commissioners reported that there was good, effective work at local level between local authorities and ICB colleagues, but as stated elsewhere, the national level response was not always visible from the local level. In hindsight, it would have been useful if NHS England (NHSE) were more directly, such as through attendance at the PCH-led commissioner calls. Commissioners have stated that they felt further support would have been helpful, and NHSE could have provided valuable input at that level on matters of supply chain management or other areas.

Communications

4.2.11 The twice weekly meetings held by PCH and the regular communication from PCH and ADASS through established communication channels, were highlighted by commissioners as being supportive and effective. However, for some significant and complex communication challenges, commissioners felt there was not a single national strategy or advice and so they had to navigate their own approach. An example of this is with the matter of commercial sensitivity and what could be said to who and when. This was described as a hinderance in preparation for contingency arrangements.

4.2.12 These challenges were compounded by late disclosure by NRS of their fragile financial position, limited national coordination, poor data visibility, and system-wide fragility in the community equipment market. The combined effect was a response effort that relied heavily on local collaboration, improvisation, goodwill, and 24/7 working, rather than robust national contingency planning.

4.3 Enablers of effective responses good practice

4.3.1 By providing clear and decisive leadership and using emergency procurement powers to quickly activate teams, resources, and alternative suppliers (in as little as 3 weeks), commissioners were able to minimise (though not avoid) the impact on local people that rely on community equipment. This illustrated similarities with the response mobilisation during Covid, i.e. staff from across various teams, together with external suppliers, rallied around the issue (extended hours, redeployment etc.) to ensure service continuity and prevent a major crisis under extreme pressure.

4.3.2 Colleagues at a local level communicated in a transparent way with stakeholders and undertook proactive safeguarding and risk assessment to ensure the scarce resource (the capacity to obtain and deliver equipment) was targeted towards the most vulnerable and critical pathways e.g. to support end-of-life situations.

4.3.3 Cross-agency collaboration (commissioners, suppliers, regional bodies) strengthened the collective capacity, knowledge and coherence. Regions benefited from commissioners sharing insights, resources, and approaches to stabilisation. This was facilitated by national bodies, such as PCH and ADASS who played critical roles in convening partners, coordinating intelligence, and supporting consistent practice.

4.3.4 Commissioners with local data backups or extracts were better positioned to manage service transfer, similarly those areas with the resources for rapid data reconstruction and cleansing enabled service continuation.

4.3.5 Suppliers mobilised quickly, often overcoming significant obstacles and very challenging timescales, to access and use a combination of ex-NRS assets, their existing assets and new assets. Suppliers also enabled TUPE transfers, which helped maintain operational continuity and supported the workforce previously employed by NRS.

4.3.6 The BHTA and TSA were widely praised for their support in bringing together stakeholders and quickly and effectively sharing information. They demonstrated a very positive, 'can-do' attitude that balanced practical support, relationship building and stakeholder management (with people they had not previously worked) and other support for people in difficult situations (e.g. suppliers owed large amounts of money by NRS).

4.3.7 To strengthen the response to this incident, DHSC commissioned S&W to provide support to partners across the sector. S&W's independent role and expertise as an 'honest broker', created an effective communication channel between central government, commissioners and the team leading on NRS' insolvency.

4.4 Impact and residual risks

4.4.1 Supplier failure of this magnitude will inevitably have significant impacts across the system. Whilst areas are still working through the process of getting back to business as usual and quantifying the impact of the events, we have identified both the initial perceived impacts, together with the residual risks that remain for local authorities, the NHS, suppliers, and service users.

Operational

4.4.2 The NRS insolvency resulted in abrupt interruptions to collections, deliveries, repairs, and planned maintenance which created significant backlogs, particularly around PPM and non-urgent activity, which was paused. This will impact community teams and is likely to manifest itself in backlogs in OT assessments. It is also likely that this directly

impeded discharge pathways and slowed movement through acute hospitals as well as negative outcomes for vulnerable people. Whilst none of these impacts were able to be quantified in the scope of the review, the consequences may result in downstream demand implications and should be explored through the data in coming months.

4.4.3 Strategically, the events resulted in the disbanding of the London Consortia into several local and sub-regional arrangements, such as the North London Equipment Partnership. As a result, several new emergents have entered the CES space. There are examples of innovative service design that present new models for CES and demonstrate the 'art of the possible' in respect to commissioning and procuring services differently in the future.

4.4.4 Operations are still not back to 'normal'. Whilst most services are close to a full catalogue, most areas are still grappling with PPM, forcing teams to operate reactively. Significant backlogs continue to require additional resources to manage.

Financial

4.4.5 Manufacturers, particularly SMEs, were hit hardest by the exit of NRS, having to write off millions of pounds of debt which has resulted in stricter credit controls; similarly, increased performance on recycling rates has impacted order levels within the supply chain, the actions of under-bidding on tenders and supporting the drive down margins has stopped. Despite these challenges, suppliers we spoke to were cautiously optimistic as pricing on new contracts has improved. However, there remains vulnerability to external shocks e.g. geopolitical supply chain disruptions and inflation, underscoring structural financial risk.

4.4.6 Local authorities incurred emergency procurement costs, including higher-than-planned mobilisation and transitional expenditure. Presently, most commissioners that moved to new suppliers are still operating with a 'cost + % margin' model which supports stabilisation and sustainable rate setting. Whilst there is a desire to move back to the traditional set rates, this should be approached with caution, not rushed and appropriately modelled and co-produced with suppliers to avoid some of the pitfalls under NRS, e.g. fixed rates that do not fully reflect the complexity of the activity.

4.4.7 Early cost data is mixed, current unit prices may be higher than under NRS (ranges between 5%-20% were cited) but overall activity dipped due to suppressed prescribing and increased recycling. Whilst the change in prescribing behaviour was necessitated due to restricted "emergency catalogues"; this has resulted in some areas reviewing what and how we prescribe and whether our practice can change.

4.4.8 Local authorities also incurred substantial additional costs in staff time, the purchase of new equipment (or payment for equipment where the title deed was contested), client refunds and legal expenses resolving disputed charges with the administrator.

4.4.9 There were multiple examples of commissioners withholding payments from NRS towards the end of the contract due to failure to deliver key services or disputed amounts. This debt has been passed to debt agencies and ongoing discussions are being had, which means the final financial position and impact is still unresolved.

Human

4.4.10 The fact that the implications of NRS's exit were not more widely reported in the news (see figure 11) is testimony to the response from stakeholders, carers and suppliers to mitigate the impacts. Whilst it is likely that people reliant upon CES and TEC experienced delays, reduced responsiveness, or gaps in service, it is hard to quantify

these at this point. However, it is likely that people experienced heightened anxiety at the prospects of loss of services and delayed hospital discharges.

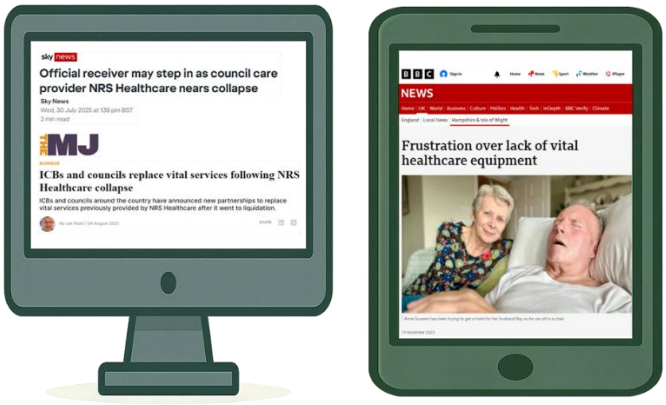

Figure 11: NRS in the News

4.4.11 The impact on the workforce is likely to be significant. NRS staff will have encountered considerable uncertainty and emotional strain and many of these people continue to be employed in the sector due to TUPE transfers to other suppliers. Similarly, those staff interviewed within commissioners reported considerable strain, long working hours and a sense of burn out during and following the events.

Residual Risks

4.4.12 It is important that we acknowledge that the events and implications of NRS's exit are far from over, whilst areas are working to return to business as usual there remains significant risks and challenges which must be worked through, as alluded to below.

4.4.12.1 Wider impact on routine community work and caseloads, particularly on OT assessments which typically experience backlogs outside of events such as NRS.

4.4.12.2 Some areas are still operating with an incomplete picture of who has received NRS supplied equipment and the maintenance history (PPM) of the equipment. Whilst plans are in place to better understand this situation it presents a risk to safety, as well as legal challenge and reputational damage[xii]. Similarly, a risk remains that there are clients not included within the transfer to new suppliers, particularly self-funders.

4.4.12.3 Continuing disputes with insolvency practitioners and debt collection agencies over outstanding invoices, which remain unresolved and pose a risk to already stretched budgets, as well as placing further demands on staff capacity.

4.4.12.4 The market's dependence on a limited number of alternative national suppliers (such as Medequip and Millbrook) to absorb over 40 council contracts underscores significant structural risks within the community equipment sector, although the emergence of new suppliers following NRS offers some grounds for cautious optimism.

4.4.12.5 The sudden expansion of the two national suppliers, each taking c.7-8 contracts, together with some of the smaller emergent suppliers in London will stress test supplier capacity. Suppliers were given freedoms and flexibilities during the mobilisation to reflect the context they were operating within. This 'honeymoon period' is starting to wind down and commissioners are starting to ask the usual questions in respect to performance, operational challenges as part of a move to 'business as usual'. The pressures this may place on a supplier cannot be ignored in the context of the lessons.

4.4.12.6 Although urgent stabilisation was successfully achieved, the subsequent emphasis has, understandably, been on restoring local services, to the detriment of forward-looking contingency planning. The events highlighted gaps in business continuity planning (e.g., warehouse capacity, restricted transparency due to NDAs, and challenges with data extraction during liquidation). As a result, residual risks remain elevated; without strengthened contingency arrangements, the sector continues to be vulnerable to future disruptions, particularly given evidence of regional and sub-regional dependence on single suppliers.

5 Lessons Learned

5.1 The lessons learned have been structured to reflect two levels of analysis, namely:

Strategic Approach: covers the design and structure of commissioning arrangements and the CES market as a whole (i.e. what is bought, how it is bought, at what price and governance). These factors contributed to the fragility of the market and the conditions that NRS operated in before their demise. Alternative approaches could have made a supplier failure less likely and prevented foundational weaknesses. These reflect the choices made by many stakeholders, over time in relation to the shape and function of the market.

Operational Oversight: covers the day-to-day contract management, financial understanding and risk mitigation. These factors may not have prevented the failure of NRS but could have provided a greater ability to detect, manage, or offset underlying risks and weaknesses in the market.

Lesson 1: Procurement practice and price sensitivity

5.2.1 It is common in publicly funded community equipment tenders for assessment criteria to be heavily weighted towards price. A price / quality weighting of 80/20 or 70/30 is common. Setting aside the rationale for this, the practical implication is that an organisation who submits a technically compliant bid, is very likely to win the contract if they submit an especially low price at tight margins. In a sector with 3 large suppliers, there is also a very good understanding of market rates and operating models, which mean a supplier would have a good idea of the prices their competitors were likely to submit. Interviewees cited instances where commissioners raised queries/clarifications with NRS regarding their pricing assumptions, but these were robustly defended by NRS. In the absence of stronger mechanisms to challenge, commissioners felt legally constrained from rejecting bids once minimum compliance thresholds had been met. Commissioners reported lacking the specialist knowledge or insight and the limitations of publicly available information, which would help give them an evidential basis to challenge bids that in practice, carried a high risk of failure over the life of the contract. Assurance was often reduced to basic checks, without the analytical depth required to distinguish credible efficiency from under-pricing.

5.2.2 In some cases, limited understanding of operating models, cost drivers and charging structures resulted in specifications and commercial terms that some described as being *"disproportionately weighted towards the commissioner"*. A key issue reported by interviewees was the fixing of prices over long contract periods in a highly volatile operating environment, thus exposing suppliers to inflationary pressures and labour cost increases (e.g. minimum wage and NI). This risk was exacerbated by the use of 'indicative' activity volumes that on occasion proved inaccurate, despite suppliers carrying largely fixed cost bases which were modelled on assumed volumes. With thin operating margins, any unforeseen or unaccounted costs or dips in volume significantly eroded operating surplus over time. Suppliers described the impact of factors such as the increase in Employer National Insurance contributions, which was not expected and so fell outside of the annual inflationary uplifts suppliers may have received.

5.2.3 Contract structures were often rigid, with limited flexibility to adapt delivery in response to user need or learning over time. Rigidity also constrained collaboration and innovation; both commissioners and suppliers reported being 'hampered' in responding to unforeseen challenges by fear of deviating from strict contractual terms, even where joint solutions could have mitigated risk. This had downstream consequences of under-performance, invoice disputes and service interruptions.

5.2.4 In their interviews, suppliers and some commissioners raised the likely value of stronger market engagement, through early soft market testing and independent review of specifications, as a means of improving contract viability and alignment with operational realities. Engagement across large suppliers, supply-chain organisations and subject matter experts would strengthen commercial understanding, specification quality and evaluation practice.

Lesson 2: Pricing models and transparency

5.3.1 The prevailing credit-based reuse model generated mixed views, while reuse remains an important efficiency mechanism, the credit approach was seen as complex and, in some cases, misaligned with operational and financial realities, particularly for lower-value items. Concerns were raised that credit-on-reuse mechanisms can distort incentives, potentially discouraging appropriate pickups and reuse activity where margins are low. Some commissioners expressed a preference for clearer public ownership of assets. However, any shift in ownership (credit) models must be carefully aligned with pricing, payment and operating models to avoid creating new points of instability or inefficiency or other unintended consequences.

5.3.2 Some commissioners reported that where they sought to engage directly with manufacturers and suppliers, they have encountered resistance as the historic model has typically kept manufacturers and commissioners apart from each other. Commissioners emphasised the importance of "seeing what they are actually buying," including access to underlying invoices, audit rights and clearer accountability for procurement decisions. Strengthening commissioner capability and confidence in this area was seen as important to improving market behaviour.

5.3.3 Interim 'open-book + % margin' arrangements were reported as improving confidence and transparency, allowing commissioners to understand actual costs throughout the supply chain and performance more clearly. Whilst this approach has stabilised the market, there is growing commissioner appetite to revert to traditional fee structures, partly driven by concerns that the interim model is more expensive. This is despite flat activity fees being widely regarded as unsuitable for logistics-intensive services, as they reduce operational flexibility and heighten exposure to volume volatility.

Lesson 3: Market fragility and reliance on a limited market

5.4.1 The review team felt that the current design of the market is best described as "implicit acceptance of a fragile market structure". Whilst of course there is ongoing contract management and a strong desire from all parties to create a different model and way of working, there is little evidence of robust, proactive market stewardship. In areas that transitioned to one of the two remaining large suppliers, there was a prevailing perception that the available options for them, given the exit of NRS, was one of two very different options. Either they continue to outsource supply to one of the two large national suppliers or they bring the service in-house (see Figure 12). The in-house option was consistently characterised as resource-intensive and requiring substantial lead-in time to design and implement.

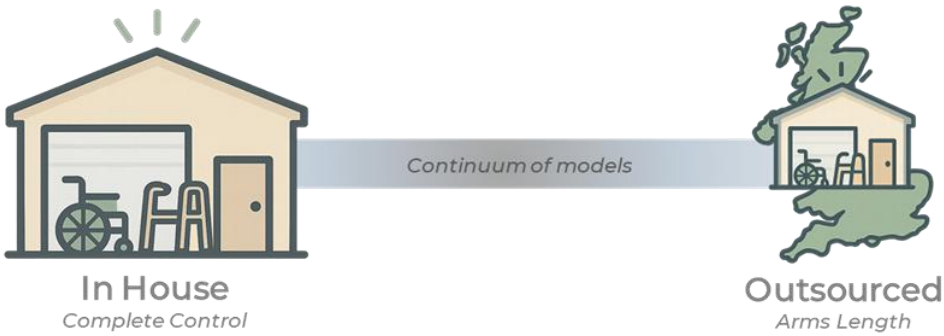

Figure 12: continuum of models

5.4.2 The longstanding view within the sector that viable options are confined to either in-house delivery or one of the three major national suppliers has been examined over the past 12 months. Early findings suggest this is a considerable oversimplification of what is, in practice, a highly diverse landscape, varying significantly in the types of organisations involved, the functions they perform, and the ways in which they operate and are funded. Alternatives identified through interviews included the use of arm's-length (Teckal) organisations, the retention of specific elements of the supply chain (such as procurement or data platforms), and the encouragement of new market entrants and sub-regional partnerships, as exemplified by arrangements in London.

5.4.3 Learning is beginning to emerge of different operating models, beyond the prime-contractor approach. Stakeholders highlighted the importance of enabling greater plurality in the market, including recognition of manufacturer-led service capability, particularly for more complex equipment, which has been a model adopted in existing in-house models for some time.

5.4.4 Previous market consolidation was driven by the assumption that large-scale logistics offer superior efficiency through bulk purchasing power and advanced distribution. This may or may not be true, but this assumption is increasingly being challenged. Early discussions are emerging around sub-regional collaborative purchasing models, including the potential to deliver in-house services at greater scale. This interest is partly driven by perceptions of increased resilience, as areas operating in-house models were less exposed to the disruption resulting from NRS's exit and are not reliant on a constrained external market.

5.4.5 In-house provision is often perceived as more expensive; however, the extent of this cost differential has not been robustly quantified, thus limiting informed comparison. Evidence suggests that smaller-scale and locally managed models can operate effectively, albeit possibly more expensively, with some indications that purchasing at economies of scale may not be the significant barrier as previously thought. Whereas logistics, IT and infrastructure require significant investment.

5.4.6 The failure of a single supplier should not be interpreted as evidence that the outsourcing model itself is inherently flawed. When well designed and effectively managed and operated, outsourcing can offer significant benefits, including efficiency, innovation and responsiveness, particularly where scale, logistics capability and specialist expertise are required. However, effective outsourced arrangements cannot function effectively at arm's length, they require a partnership-based approach, supported by mature commissioning and contract management and of course, sound and effective delivery. Without this, even well-intentioned contracts risk drifting into underperformance, misaligned incentives or financial instability. The lesson from NRS is

therefore not to abandon outsourcing, but for commissioners and suppliers to reflect on how this can work most effectively (see lesson 7, figure 13).

5.4.7 At this stage, a key barrier to expansion and diversification appears to be awareness of alternative models. While there appears to be an appetite to explore new approaches, further evidence of 'what good looks like' will be essential to support confident decision-making.

5.4.8 Similarly, there is potential for further development of direct-to-consumer (D2C) models. Maintaining a prescriber 'gatekeeper' role across a broad equipment catalogue can create complexity and inefficiency. This was partially evidenced during the incident, when a reduced catalogue demonstrated that some items could be accessed without formal prescription pathways. A more prevention-focused approach, enabling individuals to purchase appropriate equipment directly through retail or online channels, could alleviate pressure on contracted services and support a reconfiguration of supplier roles towards assessment, specialist provision and support. However, further work is required to define the scope, safeguards and system impacts of such an approach. Widespread adoption would likely require a clear mandate within a national strategy to ensure consistency, equity and clinical assurance. Notwithstanding this, some areas reported that they are beginning to explore and pilot D2C approaches as part of their future service design.

Lesson 4: Lack of national leadership and oversight

5.5.1 The potential for vulnerable individuals to be adversely affected by market shocks reinforces the critical role CES and TEC play in maintaining independence, safety and wellbeing. This experience confirmed that supplier failure in this sector is not solely a commercial or contractual matter. It also represents a safety risk, with interruptions to the supply, maintenance and monitoring of essential equipment increasing the likelihood of harm, hospital admission and unmet care needs. Community equipment and technology-enabled care services underpin the effective functioning of health and social care systems. Indeed, approximately 60% of ICES activity comes from the NHS, yet commissioners felt that national NHS colleagues were absent from the critical period surrounding the insolvency and enactment of contingency plans.

5.5.2 Roles and responsibilities across the DHSC, NHS England and local commissioners in relation to market management, were perceived to be unclear, resulting in fragmented and inconsistent responses across the system. Despite PCH coordinating a national response across local authorities, many felt there was limited visible coordination across central government. This resulted in local commissioners developing solutions independently, leading to duplication of effort and variable outcomes dependent on local capacity and experience.

5.5.3 Stakeholders expressed concern about the absence of formal regulatory oversight for the CES and TEC market, despite the function providing critical infrastructure. While the Care Quality Commission (CQC) Market Oversight Scheme exists for the largest and most 'difficult to replace' providers of regulated adult social care, CES and TEC suppliers are not within the scope of this scheme. With no other organisational body performing this role, a gap exists in strategic market oversight, particularly in relation to financial resilience, data governance and continuity planning, which has to be filled by each contracting authority, despite the commonality of suppliers.

5.5.4 Whilst quality standards exist, such as the Quality Standards Framework (QSF) for TEC, there is no equivalent, comprehensive mechanism for monitoring supplier viability, operational risk and system resilience across CES and TEC more broadly.

5.5.5 Finally, the insolvency process was widely viewed as poorly suited to services involving vulnerable individuals and did not appear to adequately recognise or account for the risks to people that receive this provision when essential health and care infrastructure fails. Commissioners reported that they understood insolvency practitioners and receivers had statutory duties, principally focused on the interests of creditors, as required under the prevailing legislative framework. However, it was a commonly held view that this had the effect of transferring significant operational, legal and safeguarding risks to commissioners. Particular concern was expressed regarding access to data, with instances where information critical to service continuity was effectively inaccessible during the insolvency process due to the absence of clear legislative provisions ensuring its availability. Participants highlighted that this reflects a broader limitation within the current regulatory framework, which does not sufficiently accommodate the unique requirements of essential health and care services. There was a consistent view that such services require distinct legislative safeguards, including guaranteed access to operational data regardless of supplier financial status. In response to these experiences, some commissioners have indicated that future contracts will include direct data access as a non-negotiable requirement. This report does not seek to assess whether insolvency practitioners and receivers involved in this situation acted in accordance with their legal and statutory framework, rather, it highlights how the framework itself may not be well suited to certain contexts and examines the effect this has had on the wider system. In doing so, it identifies an area in which commissioners have experienced, and continue to experience, heightened pressure arising not from individual actions, but from the limitations of the legislative environment in which those actions occur.

Lesson 5: The model has not kept pace with the complexities of the system

5.6.1 Balancing sustainable commissioning with cost, outcomes and system impact is increasingly complex. The current approach to CES and TEC may no longer be well suited to rising demand, complexity of needs, financial pressure, and the changing nature of health and social care delivery. As the wider system modernises through hospital discharge transformation, virtual wards, frailty pathways and “home-first” models, CES and TEC may need to be recalibrated, or at least re-considered, accordingly. Service expectations have increased in speed, complexity and clinical dependency, yet commissioning models, budgets and market structures remain largely static.

5.6.2 Despite the NHS driving a large proportion of demand through discharge activity, funding and accountability largely sits with local authorities. A consistent message from stakeholders was a need to ensure a whole-system view of value, where CES/TEC are appropriately resourced vehicles to deliver system savings, rebalancing a cost and activity driven narrative towards impact and quality. A shift toward outcome-based commissioning was widely supported, as this could support the redirection of investment. Such a shift could include:

- Contracts aligned to system objectives e.g. supporting discharge, controlling spend, reducing care demand
- Gain share mechanisms that reward outcomes rather than activity
- Flexibility for suppliers to innovate, something which is more proliferate in in-house models, but can be replicated in the outsourced model with more forward-thinking tendering and contract management.

5.6.3 The adoption of locally defined operating models, each with their own nuances, has in some areas contributed to fragmentation and avoidable duplication, particularly where

suppliers operate across multiple local authority areas, leading to inefficiency and unwarranted variation. For example, a single supplier may support several commissioners within a region, each requiring different equipment catalogues, KPIs, monitoring templates and ordering processes. While these challenges are often associated with the absence of formal consortia arrangements, the findings indicate there are clear opportunities to improve coordination and alignment through less formal, more flexible approaches to collaboration. Opportunities for greater efficiency include:

- Establishing national benchmarks for CES and TEC delivery, irrespective of operating model, with a potential role for NICE guidance on effective interventions. This could support greater consistency in equipment catalogues, prescribing criteria and clinical accreditation, while still allowing for local operational discretion.
- Aligning elements of service delivery across wider footprints (for example, ICB geographies) to reduce duplication and enable suppliers to operate more efficiently, without requiring the creation of formal consortium structures.

5.6.4 The current market, in a number of areas, exhibits an unattractive risk-reward profile. The issue is not whether suppliers generate profit, but whether returns are reasonable, transparent and proportionate to the risk assumed and value delivered. A more mature commercial dialogue is required, underpinned by realistic views of operating surplus as resilience capital and the relationship between margin, quality, and system stability.

5.6.5 Existing quality frameworks, such as the TEC Quality Standards Framework (QSF), are designed to assure service quality, safety and procedural compliance, but they are not universally adopted or designed to function as market resilience or continuity frameworks. Wider adoption of these frameworks could have strengthened assurance through consistent incident reporting, structured risk escalation, audit driven improvement and clearer governance expectations. However, they would not have prevented or necessarily foreseen the failure, as they do not assess financial sustainability or commercial viability. Therefore, to help in situations like this, future assurance models would need to explicitly integrate financial resilience, continuity planning and transparency.

Lesson 6: Inadequate data governance and access risked continuity of care.

5.7.1 Access to data represented one of the most significant problems during the NRS collapse. Almost all commissioners experienced difficulties accessing essential operational information, including individual's records, equipment locations and maintenance histories. This materially constrained their ability to assure continuity of care and manage risk. Incoming suppliers similarly faced challenges. Several alarm receiving centres (ARCs) stated that they were contractually unable to share monitoring data in the absence of explicit data-sharing agreements, even where service continuity was at risk. ARCs were also required to implement emergency outbound automated calling processes to validate customer details and maintain service contact, highlighting existing data dependencies. This underscored the need for explicit, enforceable data-access provisions that extend across the full delivery chain.

5.7.2 Similarly, delays and gaps in workforce information, particularly relating to TUPE, created uncertainty for staff, suppliers and commissioners, which impacted transition planning (in severely constrained timescales) and increased risks to service continuity.

5.7.3 The precise rationale for the approach taken by the administrators at the stage of liquidation is unlikely to be fully understood. However, the existence of written correspondence provides clarity on the position presented to commissioners who were

repeatedly advised that access to contract-related data, which they reasonably understood to be theirs under the terms of their contracts, would only be available on payment of £50,000. This issue has been described earlier in the report but is restated here due to its significance. From a commissioning perspective, this situation was both unexpected and unprecedented; interviewees consistently reported that they had not encountered comparable barriers to data access in previous provider failure scenarios, nor had they anticipated such an approach in this instance. Preventing a recurrence of this situation was therefore seen as a priority area for learning.

5.7.4 In considering how this situation arose, it is helpful to reflect on the data governance arrangements that typically exist prior to provider failure. Contracts for CES and TEC services usually contain explicit provisions relating to data ownership, access, use and sharing, covering both business-as-usual operation and contract termination. In most circumstances these arrangements are clear, practical and undisputed, and generally operate effectively. When NRS initially signalled financial distress, commissioners therefore expected that contractual requirements relating to data transfer would be enacted. However, such provisions assume a degree of cooperation and capacity on the part of all parties. In practice, provider failure often causes rapid reduction in capacity, due to staff departures, and a diminished incentive to prioritise orderly data management or transfer. Where insolvency becomes imminent, contractual protections may also become ineffective, limiting commissioners' ability to rely on them as enforcement mechanisms. What stakeholders reported as particularly novel in this instance was the perceived "leverage" of data. Even without this, multiple practical and legal factors combined to significantly reduce the likelihood that commissioners would receive the data they expected to.

5.7.5 Several lessons emerge from this experience. While reliance on contractual terms is entirely reasonable in most circumstances, in scenarios of provider failure, contracts alone may offer limited practical protection. Contingency planning should therefore assume a worst-case scenario in which an outgoing provider is unable or unwilling to fulfil contractual data-transfer obligations and may in some circumstances actively impede access. Adopting such an assumption would better equip commissioners to manage the operational and safeguarding risks associated with provider exit. One example from an affected commissioner illustrates a more resilient approach in practice. Their contract required the submission of a complete service dataset alongside each monthly invoice and provided the local authority with access to the supplier's underlying data system. As a result, once supplier failure became apparent, the authority was able to extract a full dataset relating to its contract and establish a functioning dataset within its own IT environment. Although some information was up to four weeks old, the authority retained visibility of individuals and equipment, materially reducing risk. Commissioners may also wish to require suppliers to implement robust technical safeguards, such as routine backups of segregated datasets, to support continuity in a range of failure scenarios.

5.7.6 Looking beyond the immediate commissioner–supplier relationship, stakeholders suggested that clearer and more explicit standards for data governance would help mitigate future risk. Alignment of such standards with existing frameworks, such as the TEC Quality Standards Framework, was seen as a practical route forward. Areas for consideration include:

- Segregation of data at individual contract level
- Clear ownership and title of all client and operational data
- Use of unique identifiers and auditable access controls

- Guaranteed commissioner access to data backups and mirrored environments

5.7.7 More broadly, both the 2024 cyber-attack on NRS and the subsequent supplier failure exposed the extent to which data oversight had become disconnected from commissioner control. Issues relating to data quality, system resilience and access were not consistently identified or escalated, suggesting an over-reliance on supplier assurance and limited challenge in relation to core information governance. This was reinforced where commissioners that later gained access to their data reported variable quality and accuracy, despite a significant data rebuild having taken place only a year earlier. Taken together, these events underline the need to treat information systems as critical infrastructure within CES and TEC services, requiring active oversight, routine access and clear safeguards, rather than reliance on contractual provisions alone.

Lesson 7: Arm's length contract management exacerbated the risk

5.8.1 Approaches to commissioning, contract management and governance varied significantly amongst commissioners affected by the NRS situation, particularly in relation to levels of oversight, performance monitoring, enforcement and escalation. Interviews highlighted a wide spectrum of capacity and capability, ranging from well-resourced teams incorporating clinical expertise, contract management, commissioning, analytics and business support, to arrangements relying on one or two commissioners covering the full contract management function.

5.8.2 A key lesson here is that outsourcing should not be 'arms-length'; successful and sustainable partnerships require commissioners to understand and be actively engaged in key aspects of service operation along with strategic oversight and shaping. Commissioners with knowledgeable and experienced personnel, particularly those with prior operational experience in community equipment services, demonstrated a stronger understanding of the operational risks and day-to-day performance drivers.

5.8.3 More mature contract and partnership arrangements included good working relationships underpinned by daily access to operational data, unfiltered system access, and dedicated analytical support. These approaches enabled earlier identification of emerging issues and, in some cases, contributed to efficiency savings and improved performance management.

5.8.4 Interviewees highlighted clear advantages in improving localised coordination across contracts where there is a reliance on a single supplier within a region. These included greater alignment of performance expectations, the use of shared data standards, and improved visibility of contract end dates and re-tendering timelines. Together, these measures would support a better assessment of the risks arising from reliance on a single supplier and enable procurement activity to be planned and sequenced more effectively.

5.8.5 Several examples of integrated and partnership approaches to delivering and managing the services were identified during the engagement, this included Leicestershire, Leicester and Rutland's ICES, Kirklees Integrated Community Equipment Services (KICES) and Surrey (see figure 13). Key features of these enhanced models included:

- Co-designed service specification with users, partners, and supplier.
- Robust contract management framework and clear KPI structure to drive quality, foster innovation, and encourage accountability.
- Strong operational relationships with depot-based staff. Staff were often co-located within the depot with offices, training rooms etc, where they could observe (first-hand) some of the early signs of a business in distress.

- Commissioner teams included dedicated clinical resource where prescribers and suppliers could shape the service offer (using innovation, freedoms and flexibilities afforded through the specification, see section 5.4), oversee prescribing behaviour and financial stewardship.
- Focus on recycling rates and active recall (agnostic to the wholly owned or credit model), to deliver financial efficiencies.

Spotlight: Surrey Approach to Contract Management

Surrey's ICES has been provided through Millbrook Healthcare since 2009 and operates deliveries, repairs, planned maintenance, collections, cleaning, and reissuing of equipment. The service is sizeable, in 2024-25 121,000 items were issued, supporting 26,300 people, excluding peripheral store provisions.

Upon first issue, Millbrook invoices SCC and provides the unique PUK identifier. The item now permanently belongs to Surrey. When returned, MHC cleans, repairs, tests, and shelves the item. Reissue incurs only delivery cost to SCC. SCC uses PUK and Secure File Transfer Protocol (SFTP) data to verify previous activity and ensure financial assurance. SCC has weekly, monthly and quarterly contract meetings with MHC. Key features include:

- There is a requirement for SCC to have an office and be co-located within the CES warehouse. This enables day-to-day oversight, real-time issue management, and close operational engagement, this approach also builds strong working relationships with the provider.
- Monthly/quarterly formal contract review meetings for performance monitoring and KPI scrutiny and review of risk and issue logs, including safeguarding, operational, and delivery risks.
- Review of management information and data provided via secure SFTP, the team has invested in dedicated analytical resource which is integrated into the providers systems. This supports data assurance, transparency, informed decision-making and enables independent scrutiny of performance and service activity, providing a significant RoI.

Since the exit of NRS the team have reviewed the BCP to reflect some of the challenges encountered, this includes: depot access, loss of system access, communications, critical stock inventory, TUPE protocols.

Figure 13: Spotlight on Surrey's approach to contract management

Lesson 8: Oversight and early warning systems were insufficient

5.9.1 Commissioners reported that they had observed warning signs of supplier distress, such as non-payment of suppliers, deteriorating service performance and stock availability issues; however, NRS provided assurance that these issues were localised and time limited. This was compounded by a reliance on annual audited accounts and commercial credit ratings to try and understand NRS financial position. These proved insufficient, as they do not capture real-time cash-flow stress. By way of comparison, had, for instance, NRS been eligible to sit within the CQC Market Oversight Scheme a team of experienced, knowledgeable and dedicated accountants at CQC would have statutory responsibilities that grant them full and instant access to comprehensive financial records that would have revealed the full extent of NRS financial situation.

5.9.2 Multiple suppliers reported indicators of financial distress, including unpaid debts, paused orders and credit restrictions, months before concerns were formally recognised. However, this 'soft intelligence' was not systematically captured, shared or made actionable. The key lesson is that effective financial oversight must combine quantitative metrics with qualitative intelligence drawn from suppliers and frontline practitioners. Potential improvements identified include:

- Structured mechanisms to gather intelligence from prescribers and suppliers (e.g. surveys to capture payment delays, stock unavailability or product substitutions), ensuring anonymity for suppliers and practitioners.
- Routine audit and monitoring of key elements of the supply chain.

- Working in partnership with sector bodies, such as the British Healthcare Trades Association (BHTA) and TSA, to support market intelligence gathering and escalation.

5.9.3 Opportunities were also identified to strengthen early detection of systemic risk through improved collaboration between commissioners at regional and national levels. Coming together to share concerns would enable patterns to be identified earlier and establish what are isolated local issues or wider concerns. Suggestions included: agreeing a common set of leading indicators to flag early risk across contracts and suppliers and establishing cross-supplier forums and intelligence-sharing arrangements.

5.9.4 Extended and inconsistent payment terms were identified as a systemic risk to supply-chain stability. In some cases, intermediaries imposed payment terms on suppliers that diverged significantly from public-sector norms, creating cash-flow pressure and increasing the risk of supply interruptions. This practice was viewed as a red flag for market fragility, particularly where SMEs relied on timely payment to continue trading. The Procurement Act 2023 was referenced as a potential lever to improve payment discipline, through requirements for 30-day payment terms, to be passed down the supply chain. Similarly, the transparency agenda under the regulations could enable more centralised visibility of supplier market share, contract values and expiry timelines, supporting earlier identification of concentration and continuity risks.

Lesson 9: Business continuity and contingency planning need to be refreshed

5.10.1 The NRS collapse exposed gaps in commissioner contingency planning, particularly the reliance on supplier-owned data systems, which in some instances constrained the speed of local responses and the ability to get back to business as usual. Similar challenges were evident in the following areas:

- Workforce transition and TUPE
- Data access, security and transfer protocols (e.g. SFTP)
- Access to depots and warehousing
- Clarity of equipment ownership and title
- Interim contact centre and call-handling arrangements
- Availability of critical stock
- Continuity of SIM and connectivity for TEC services

5.10.2 The absence of a formal national incident response model, such as the NHS Emergency Preparedness Resilience and Response Framework, within adult social care was observed. While local government does have incident response models working through Local Resilience Forums, this format was not appropriate to this incident. As a result, commissioners were largely left to develop responses independently, increasing the risk of duplication, inconsistent practice and variable outcomes depending on local capacity and experience. Although, this was somewhat mitigated by the information sharing and regular meetings held by PCH at a national level and through regional ADASS forums.

5.10.3 Linked to the above, the formation of operational contingency plans for major supply chain failure would be beneficial as this could addresses many challenges experienced during the NRS collapse, including early detection, rapid access to continuity datasets, supplier and commissioner coordination, communications and clarity over national,

regional and local roles. The plans could span the role that national bodies could take in conjunction with action required at local levels, including local continuity plans from each commissioner.

5.10.4 Communication failures significantly compounded the crisis; NRS was reported to be unresponsive to commissioners at critical points and provided limited updates, leading to confusion and delayed action. Effective crisis management requires predefined communication protocols, clear escalation thresholds (a place to escalate, such as DHSC), mandatory response times and transparent engagement with stakeholders.

5.10.5 During national coordination calls, all commissioners were asked to indicate agreement with proposed actions. However, the relative impact of decisions varied significantly, for example, the top ten commissioners accounted for over half of total expenditure. Future incident management arrangements should identify priority stakeholders whose contractual exposure and operational scale mean their decisions are likely to have a disproportionate impact on outcomes.

Lesson 10: Similarities with the lessons learned from Allied Healthcare in 2018

5.11.1 Whilst the market context differs, there were several striking similarities with lessons learned from the failure of Allied Healthcare in 2018, these include:

5.11.2 **Communications and messaging**: frequent calls between national partners were beneficial. However, the number of attendees was too large on occasion and more focused approaches could have reduced the length of the calls but maintained the value. The supplier seemed to communicate well with DHSC but less so with commissioners, some of which perceived a lack of cooperation. For example, they only spoke with commissioners when absolutely necessary, branch offices (in the case of Allied) were often 'blockers' and did not always seem know what was going on. There are parallels to the experience during the transition of services from NRS to new suppliers.

5.11.3 **Workforce & TUPE-related challenges:** TUPE information was delayed (28-day statutory period) and incomplete; this disrupted planning and risked staff dissatisfaction. NRS transition planning was similarly hindered by lack of timely workforce, HR, and TUPE data, causing uncertainty for staff and commissioners.

5.11.4 **Information quality and data sharing:** supplier data was poor quality, with unclear client lists, difficulty identifying self-funders and uncertainty over what could be shared. NRS data (assets, users, logistics, workforce) was inaccurate or outdated, creating delays in continuity planning and hampering the ability to quickly mobilise services.

6 Recommendations

6.1 Operational actions and next steps to stabilise and mitigate future risk

The below should be considered as the 'do first', short to medium term recommendations and next steps.

6.1.1 Strengthen arrangements for market oversight and contract management

Commissioning organisations should reflect on their contract management and oversight functions, ensuring that regular performance monitoring, risk assessment, and use of contractual levers are standard practice. Governance frameworks should support early intervention when warning signs appear. Considerations and next steps include:

6.1.1.1 Linked to 5.4.2, showcase the various models and approaches to contract management, including evidence of 'best in class' and returns on investment.

6.1.1.2 Introduce requirements for full supply chain visibility, including mapping of subcontractors and dependencies. Establish supply chain registers and ensure commissioners have direct access to key suppliers where necessary.

6.1.1.3 Introduce a confidential reporting route for suppliers and practitioners to flag concerns to commissioners. Routine monitoring against a short list of early warning indicators, including; supplier payment delays, stock availability issues, service performance (KPI) deterioration, prescriber feedback surveys, leadership and management turnover, which require escalation to regional or national level when two or more indicators are breached.

6.1.1.4 Maintain a live contract risk register, reviewed quarterly and escalated regionally and nationally where required. Non-payment of invoices, due to disputed amounts, should be added to formal risk registers with pre-agreed tolerances for escalation.

6.1.1.5 Formalise regional networks to support information-sharing, joint risk monitoring, and coordinated responses to supplier instability. Develop shared tools, templates, and communication frameworks to improve consistency.

6.1.2 Refresh and test contingency and business continuity plans to mitigate risk

Contingency plans and arrangements for business continuity should be refreshed to take account of the challenges, lessons learned and local experience of the NRS exit. Considerations and next steps include:

6.1.2.1 Undertake an urgent review of existing contingency plans across all contracts, identifying gaps in fallback arrangements, for example: depot access, clarity around TUPE processes, communication standards and supplier continuity. Where necessary, implement interim contingency measures to ensure service resilience. These plans should be tested through scenario-based exercises involving commissioners, providers, and key suppliers.

6.1.2.2 Detailed arrangements for access to information across a range of scenarios (planned and unplanned exit) should form part of the contingency planning and business continuity plan arrangements. Require all contracts to state explicitly that all operational and user data is owned by the commissioning authority and data-access provisions such as mandatory export ready monthly data backups and/or real time commissioner access to the system.

6.1.2.3 Introduce minimum information request from the outset to support (and speed up) the process of gathering and transferring data. Development of pre-prepared minimum and ideal data requests for each market type which can be reviewed and adapted by the group of stakeholders would support any future events of this nature. For example:

- Clients, including: Client Reference; Case Management ID; Name; Contact Details (address, telephone); DoB; Gender; Ethnicity
- Orders/stock, including: Order ID, Item ID; Client Reference; Item Code; Item Description; Unique Stock Ref; Assessment Date; Referral Date; Order Date; Prescriber Email; Delivery Date; Collection Date; Last Service Date; Address; Notes

6.1.2.4 Contracts should include clear obligations for suppliers to maintain clean, segmented, up-to-date datasets on self-funders. Monitoring suppliers should also maintain direct contact permissions (through updated privacy statements within appropriate DPA frameworks) for continuity-only scenarios.

6.1.2.5 Promotion of accredited quality standards schemes as part of the contractual requirements, ensuring that data quality and access standards are emphasised for both health and social care and self-funding users.

6.1.2.6 DHSC, NHS England, and relevant regulatory bodies should define clear roles, responsibilities, and escalation pathways (between local, regional and national bodies) in the event of supplier failure, with particular attention to: early warning triage, intervention thresholds, support available and leadership in insolvency scenarios.

6.1.3 Establish robust safeguards in the event of future supplier failure events

6.1.3.1 Review liquidation procedures and special administration regime for essential non-regulated services to safeguard data which is critical to service continuity and safeguarding. Review in the context of other critical infrastructure services, such as water, gas, and electricity.

6.1.3.2 Whilst some stakeholders indicated a preference for bringing the market within the CQC's Market Oversight Scheme, this would in practice necessitate either reclassifying these services as personal care or amending the scheme's current remit. Alternatively, a more proportionate approach could involve creating a light-touch national oversight function for system-critical, unregulated services—potentially led by DHSC or a similar body—to conduct annual account management meetings with strategically significant suppliers.

6.2 Strategic actions and next steps to develop and strengthen the market

Whilst some of the below recommendations and next steps may run concurrently with the above, these should be considered as longer term actions as they may require multiple stakeholder involvement and investment.

6.2.1 Strengthen approach to procurement and tendering for services

6.2.1.1 As local systems reprocure services, these should be designed to prioritise long-term sustainability over short-term cost savings. Evaluation criteria should give greater weight to financial viability, operational realism, and quality of service. Commissioners should ensure that activity data and cost assumptions are accurate and robust and there is greater engagement with market during

tender design to test model and assumptions. Considerations and next steps include:

6.2.1.2 Survey all commissioners to understand their current supplier arrangements and contract end date. Utilising the mapping of re-tendering dates, regional/national coordination should support a phased approach to re-tendering.

6.2.1.3 Develop best practice guidance on development of specifications, understanding the commercial model and procurement approaches, including standardised templates (where applicable). Co-produce with suppliers to address challenges, what 'best in class' looks like and how procurement legislation can provide freedoms and flexibilities. This may be delivered as a 'how to' guide or a series of workshops and master-classes.

6.2.1.4 Review evaluation thresholds for quality, deliverability and price.

6.2.1.5 Stop fixed multi-year pricing without inflation indexation or some other agreed means for reviewing annual pricing. This should be appropriate to the nature and structure of the contract, the supplier / commissioner relationship and the services being commissioned and the outcomes being sought.

6.2.1.6 Introduce mandatory sustainability tests for abnormally low bids, including verification of cost assumptions, delivery model walkthroughs, workforce, supply chain and logistics viability.

6.2.2 Strengthen approach to commissioning and market development

To reduce systemic risk, commissioners should actively consider options for the future market in the event of planned and unplanned service cessation. Systems should also reflect on the lessons learned in respect to commissioning practice and models of care. Considerations and next steps include:

6.2.2.1 Undertake a call for evidence for alternate models (in-house, Teckal, partnership, sub-regional etc.) for CES/TEC and disseminate information on best practice, including working with trade associations such as the BHTA and TSA.

6.2.2.2 Promote the use of the joint ADASS and TSA commissioning blueprint[xiii].

6.2.2.3 Whilst the market remains fragile it would be advantageous for CES and TEC concerns to remain on the national and regional agenda, to continue open dialogue regarding any residual risks or concerns. This could be underpinned by a survey in Summer 2026 (one year on) of all commissioners to assess the level of confidence with current arrangements and the market.

6.2.2.4 Facilitate regional and national networking with the trade associations to build partnerships and collaborative practice. Utilise this platform to begin the dialogue around fair and sustainable fee structures and margins.

6.2.2.5 Strengthen the requirement for suppliers to adopt accredited quality standards, such as the TEC Quality and undertake independent audits against these standards.

6.2.3 Standardise practices and reduce system fragmentation

National minimum standards should be established for commissioning, data management, contingency planning, and supplier oversight. Standardised templates, processes, and guidance will improve consistency across regions and reduce variability in preparedness and response capability. Greater alignment between commissioners

will also support more effective collaboration during crises. Suggested actions and next steps:

6.2.3.1 Publish a national contingency framework for critical CES/TEC supplier failure. The NHS supply disruption reporting process[xiv] provides a structured escalation and mitigation model for medical equipment and consumables that local authorities can adapt for community equipment resilience. Suggested areas for inclusion for a CES/TEC incident coordination protocol, are:

- Clear trigger points for national involvement and articulation of the government's support offer, including access to legal advice and programme management capability
- Creation of a step-by-step response checklist, with emphasis on data, workforce, communications and finance
- Pre-prepared 'crib sheets' addressing common blockers e.g. lawful data access under GDPR, managing supplier insolvency risk.
- Communications templates for key stakeholders: system partners and leaders, commissioners, suppliers, staff, service users and carers.

6.2.3.2 Introduce regional BCPs and risk registers for supplier failure. Shared data templates, risk dashboards, commissioner forums (quarterly).

6.2.3.3 A formalised financial risk monitoring framework should be introduced across the sector. This should include regular financial health checks, mandatory disclosure of key financial indicators by suppliers and structured escalation protocols when risks emerge.

6.2.4 Establish a national strategic direction

6.2.4.1 Publish a national CES and TEC vision and market strategy, giving due consideration for: shape and function; how the market is funded and what success looks like[xv]

6.2.4.2 Publish forward national demand assumptions (5–10 years) to support supplier investment decisions.

6.2.5 Shift toward outcome-based commissioning models

6.2.5.1 Linked to the formation of a national strategy (above) and evidence of impact using existing best practice; commissioners should define clear, measurable outcomes. Activity measures should be retained for assurance, but outcomes could be elevated to primary success metrics.

6.2.5.2 Embed lived experience in design of services, governance, monitoring and impact assessment in line with Making It Real[xvi], this is supported by the APPG's recommendation that a National Advisory Board is formed which embeds lived experience in policy and service design and includes users, carers, professionals, commissioners, charities, and suppliers.

6.3 Local, regional and national alignment of recommendations and next steps

The actions outlined above are interdependent and require coordinated implementation across local, regional, and national levels. The table (overleaf) is an indication of where these actions can and should sit, based on; local (commissioning organisation, supplier); regional (local authorities, ICB's, regional ADASS) and national (ADASS, PCH, DHSC, CQC, supplier market and associations).

Recommendation	Local	Regional	National
6.1.1.1 Showcase models and approaches to contract management		☑	☑
6.1.1.2 Introduce supply chain registers and visibility	☑		
6.1.1.3 Introduce confidential reporting for suppliers & practitioners	☑		
6.1.1.4 Maintain a live contract risk register	☑		
6.1.1.5 Formalise regional networks to support information-sharing	☑	☑	
6.1.2.1 Undertake an urgent review of existing contingency plans	☑		
6.1.2.2 Detailed arrangements for access to information	☑		
6.1.2.3 Introduce minimum info request	☑	☑	
6.1.2.4 Obligations for suppliers to maintain up-to-date datasets	☑		
6.1.2.5 Promotion of accredited quality standards schemes	☑		
6.1.2.6 National bodies define roles and responsibilities			☑
6.1.3.1 Review liquidation and special administration regimes			☑
6.1.3.2 Establish a light touch national oversight function			☑
6.2.1.1 Tighten re-procurement of services	☑		
6.2.1.2 Survey LAs for current supplier and contract end date.		☑	☑
6.2.1.3 Best practice guidance on specs and commercial model		☑	☑
6.2.1.4 Review evaluation thresholds for quality and price	☑		
6.2.1.5 Align inflationary processes to other care types	☑		
6.2.1.6 Introduce sustainability tests for abnormally low bids	☑		
6.2.2.1 Undertake a call for evidence for alternate models		☑	☑
6.2.2.2 Promote the joint ADASS and TSA commissioning blueprint	☑	☑	☑
6.2.2.3 One year on survey of LAs to assess impact			☑
6.2.2.4 Networking with the trade associations	☑	☑	☑
6.2.2.5 Requirement to adopt accredited quality standards	☑		
6.2.3.1 Publish a national contingency framework			☑
6.2.3.2 Introduce regional BCPs and risk registers for supplier failure		☑	
6.2.3.3 Creation of a formalised financial risk monitoring framework		☑	☑
6.2.4.1 Publish a national CES and TEC vision and market strategy			☑
6.2.4.2 Publish forward national demand assumptions (5–10 years)			☑
6.2.5.1 Commissioners should define clear, measurable outcomes	☑		
6.2.5.2 Embed lived experience in design, governance, monitoring	☑		

7 Concluding Thoughts

7.1.1 The failure of NRS is best understood as a symptom of deeper structural fragility within the market, combined with longstanding weaknesses in system design, governance and oversight. As highlighted in recent independent analysis, *"insolvency risk within this sector has increased and remains elevated; commissioners should therefore assume ongoing volatility rather than stability"* (BDO, Pre-Insolvency: Early Warning, Engagement and Readiness, March 2026). Without deliberate intervention, a repeat failure, potentially on a larger scale, is possible as the conditions that contributed to NRS's collapse have not been addressed or removed.

7.1.2 The market's dependence on just two or three suppliers to service more than 40 ICES contracts highlights a lack of market depth and reinforces the need for more proactive market stewardship and development. Currently, were a major supplier such as Medequip or Millbrook to fail, there are no readily deployable "off-the-shelf" alternatives. This would inevitably require local areas to put contingency arrangements in place, often under significant pressure and at an inopportune time. However, evidence from some areas shows that alternative models are viable. Where there has been dedicated time, effort, and resource and, in the case of NRS, a clear 'burning platform', different and effective arrangements have been successfully developed.

7.1.3 The All-Party Parliamentary Group (APPG) on disability equipment has been unequivocal; access to community equipment is foundational to independent living, safeguarding and dignity and as such, must be treated as critical public infrastructure. Continuing to commission these services primarily on the basis of lowest price, thin margins and arms-length governance is incompatible with their role in protecting hospital flow, safety and independence outcomes. A strategic shift is required, from price-driven procurement toward resilience, safety and system-wide benefit.

7.1.4 This shift cannot be achieved through isolated actions or short-term fixes. A multi-year, sector-wide reform programme is required to build a more plural, stable, data-secure and clinically aligned CES and TEC market. This includes:

- 7.1.4.1 Strengthening market diversity.
- 7.1.4.2 Embedding robust financial monitoring and early-warning mechanisms.
- 7.1.4.3 Resetting commercial expectations and having the difficult conversations around margins, risk transfer and the cost of instability.
- 7.1.4.4 Adopting better-designed tenders that hinge on accurate activity assumptions, flexible pricing models resilient to shocks and contribution margins sufficient to support reinvestment and resilience.
- 7.1.4.5 Rebalance evaluation criteria toward quality, resilience and deliverability.
- 7.1.4.6 Data continuity must be treated as a non-negotiable requirement; commissioner-controlled platforms, escrow arrangements and mandatory exports and should become standard practice.

7.1.5 Finally, this report should be seen not as an end point, but as a starting position. The "so what" is clear: without reform, the system risks sliding back into a cycle of fragile contracts, repeated procurement failure, loss of institutional knowledge and escalating risk to users. The "how" requires deliberate action, locally, regionally and nationally, to reshape expectations of the market, strengthen safeguards and rebuild confidence in a service that underpins the health and social care system.

References

[i] Including its subsidiary companies and brands such as: Complete Care Network Limited; Care Superstore Limited; Care Basics Limited; Complete Care Rentals Limited; NRS Mobility Care Limited; NRS Telecare Limited.

[ii] The views and opinions expressed are those of the individuals involved and do not necessarily represent those of their employing organisations.

[iii] The review team cannot guarantee the completeness of the data received and does not accept liability for any errors, omissions, or decisions made based on this report. All insights should be interpreted as indicative rather than exhaustive, and readers are encouraged to consider them alongside other sources of assurance and organisational context.

[iv] Examples of equipment include: daily living aids (e.g., grab rails, bathing equipment, kitchen aids); moving and handling equipment (e.g., hoists, slings, transfer aids), pressure-relieving mattresses and hospital-style beds, wheelchairs and mobility products.

[v] A Teckal company is a legal entity owned and controlled by a public authority (such as a local council) that can receive contracts for services directly without undergoing competitive tender. To qualify, the authority must exercise control similar to its own departments and >80% of the company's activity must serve that authority.

[vi] Data and insights provided by an industry expert utilising publicly available information submitted in the form of annual company accounts from Companies House. Accounts have been reviewed, categorised and aggregated to produce sector-level estimates, covering accounting periods ending between 1 January 2024 and 31 December 2024. Some assumptions have been made, based on the available published data, to allocate turnover and market participation to the different 'groups'. These assumptions are applied consistently across both years (2023 and 2024) to enable comparison, but the resulting figures should be interpreted as indicative sector estimates rather than precise measurements. Known limitations: (1) product groups and market channel totals are aggregated and anonomised; (2) no firm-level turnover figures are reported, and market participation is presented as proportional activity only; (3) employment and headcount are gained through Companies House where possible. Results are subject to the completeness of the underlying inputs and any differences in accounting periods, reporting scope, and classification within the dataset. The recorded activity within the underlying data is allocated to the technical file owner or primary importer, with each product linked to the entity responsible for its initial placement on the UK market. The methodology excludes onward distribution within the market to minimise double counting and avoid duplication, thereby focusing on first placement activity. While the underlying data is limited, the consistent methodology enables the analysis to provide a directional indication of the wider market.

[vii] Examples include: falls detectors and motion sensors; telecare alarms; medication dispensers; smart-home sensors; remote monitoring platforms; wearables and voice activated technology.

[viii] www.tsa-voice.org.uk

[ix] See https://www.tecquality.org.uk/

[x] See Barriers to Accessing Lifesaving Disability Equipment (APPG, 2025)

[xi] See: https://caseycommission.co.uk/

[xii] See "Ofcom fines Virgin Media £23.8 million for putting vulnerable customers at risk of harm" failure to identify, record, and protect customers using telecare services, source: ofcom.org.uk

[xiii] See Unlocking the Power of Proactive and Preventative Care Services (TSA & ADASS)

[xiv] See: https://www.england.nhs.uk/long-read/reporting-potential-supply-disruptions-of-medical-equipment-and-consumables/

[xv] What we should provide (state v.s. self-funding/D2C) based on clinical impact and alignment to the NHS prevention and independence agendas.

[xvi] See Making It Real: what it is and how to use it (Think Local, Act Personal (TLAP))