**Hull City Council**

**Adults Social Care**

**PROVIDER FAILURE OPERATIONAL PROCEDURE**

**Document Management:**

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| **Title of Document** | **Provider Failure Procedure** |
| **Type of Document** | Guidance for Internal Use |
| **Description** | This procedure identifies actions to be taken in the event of actual or prospective failure of one or more providers of care which appears likely to occur in circumstances where theprovider may not be able to plan and implement an orderly and structured run-down of their services. |
| **Target Audience** | Hull City Council and partner staff involved in the support and monitoring of this Sector and its Individuals. |
| **Author** |  |
| **Department** | Contract Performance & Quality Team |
| **Directorate** | Adult Social Care |
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**Hull City Council Provider Failure Plan**

**Introduction**

The Care Act 2014 gives local authorities in England the responsibility for market shaping, to facilitate a vibrant, diverse and sustainable market for high quality care and support in their area. This will be for the benefit of the whole local population, regardless of how the services are funded.

The procedures are based on guidance provided by ADASS (the Association of Directors of Adult Social Services) and the Local Government Information Unit (LGIU).

It must be noted that provider failure is a relatively rare event. However when provider failure occurs it does require Council and Clinical Commissioning Group (CCG) intervention immediately. The assessment and transfer of residents to alternative care providers may need to take place within a very short time frame.

The impact of the changes to provision upon Individuals and their relatives and carers must be managed in the best person-centred way possible by working to the framework set out in this document.

Every effort should be made to cater for the specific identified needs of each Individual, and wherever practical to keep friendship groups together. Time and great care must be taken to minimise the disruption and transfer trauma for these very vulnerable Individuals.

Further good practice guidance is set out in research by ADASS (the Association of Directors of Adult Social Services) and the University of Birmingham on achieving positive outcomes during transfers: <http://www.birmingham.ac.uk/Documents/news/BirminghamBrief/AchievingClosureReport.pdf>

The ADASS good practice guidance document is especially useful for unplanned or short-notice failures. Any assessment and planning processes involving vulnerable adults affected by a potential failure will also be need to be underpinned throughout by the principles of the Mental Capacity Act 2005.

**Provider Failure**

The Council have duties under Section 5 of the Care Act: Duty to promote the efficient and effective operation of a market for meeting care and support needs, Section 49: Managing Provider Failure and Section 56 by providing better market Oversight.

Failures may be caused by a number of factors - for example:

* Closure by the Regulator
* Termination of the contract by Commissioners
* Loss of premises due to damage
* Closure by Owners due to increasing financial pressures; or the outright failure of their business leading to the appointment of a Corporate Insolvency Practitioner (e.g. a Receiver, Administrator etc.)

Any resulting requirement for the transfer of individuals to an alternative care provider would be dependent on the assessed needs of the individual and the availability of spare capacity and resource within the local market place.

When this happens, lead responsibilities for placements will be as follows: (see also Section 6)

* Council-funded, joint and self-funded – Local Authority
* Out of County – Local Authority to identify relevant funding authority and agree responsibility for managing transfer
* Continuing Care funded – Clinical Commissioning Group
* Nursing (Health funded beds) – Clinical Commissioning Group

Actual or prospective failure of a single provider imposes stress on a local care market. The failure of a medium or large corporate provider - often involving several care services in the same area at the same time, will present enormous challenges that may require the involvement of a number of Local Authorities. If this situation occurs, the key priority will be to identify alternative capacity and to maintain service provision.

It is recognised that every situation is different and it is up to the responsible statutory managers to decide the best approach for the situation presenting at the time, interpreting this operational procedure flexibly to suit the specifics of the case whilst still being guided by its principles.

Any case-specific ‘contingency’ or ‘resilience’ planning will to a large extent be determined by the time available prior to failure, and the lead lfficer will need to adapt the procedures and use available resources to minimise the disruption to individuals as far as possible.

Factors such as the cause of the failure, the timescale, local availability of provision and staffing resources, will all affect the feasibility of using a standard management approach – however the Management Checklist in Appendix A provides a useful framework.

**Market Oversight**

The Contract Performance and Quality Team (CP&QT) has a proactive approach to risk management. Effective engagement and contract management is in place to manage the risk of provider failure. This enables the team to identify the risks early enough to mitigate the impact.

Mechanisms and formal information sharing protocols are in place where partners and stakeholders can be informed of the potential indicators of poor performance or provider failure including information about non-contracted regulatory services in Hull.

All commissioned service providers and contractors will be expected to have local policies and procedures in place to deal with and report incidents and serious incidents.

Compliance with the requirements for reporting and managing incidents and serious incidents will be included in all contracts and will be standard for the monitoring of performance and quality. The service provider shall review and test the Business Continuity Plan every twelve months and produce a report to the council of the success or failure.

**2. Aim and Purpose of this Operational Procedure**

2.1 The main aim of this document is to provide a framework for managers to ensure:

* the health and emotional wellbeing, safety and welfare of the vulnerable individuals that are affected, this would include their families and carers.
* effective coordination and communication between all parties involved in the proposed and/or actual failure arrangements.

2.2. This procedure identifies the actions required in the event of an unplanned or potential care provider failure, including the officers responsible for these actions.

2.3. This procedure is intended as a generic approach to situations of provider failure and should therefore form part of, and be read in conjunction with, a Resilience or Contingency Plan dealing with the specific circumstances of each case.

2.4. The options for alternative provision will depend upon individual circumstances. This is outlined in **Section 8.**

2.5. In the case of an unplanned failure of a major service provider that overwhelms the ability of Hull City Council (HCC) and the CCG being able to relocate service users, HCC and the CCG may also want to consider activating emergency planning procedures for the Council and its partners.

2.6. The procedure for emergency failures resulting from fire, flooding, explosion etc, will be dealt with as part of major emergency planning responses (if required), and care providers’ business continuity plans.

**3. Activation of the Procedure**

3.1. This procedure will be invoked in full or in part when notification of provider failure has been received. Provider failure may be as a result of but not limited to the following scenarios:

* A decision by the regulator to close the care provider.
* A decision to decommission the care provider following the outcome of the serious concerns meeting in line with Council’s Escalation Concerns procedure.
* The Provider may give the appropriate ‘Contract Termination Notice’.
* The provider may themselves decide that the financial position of the individual service, or their overall portfolio of services, is becoming so very acute that it cannot continue to operate for a period, sufficient to market the business and attract a new owner, nor to effect a planned ‘orderly run-down’ of the operation, i.e. one that would probably require a timescale of some months before failure.
* The rrovider’s business may have become “insolvent” (i.e. it can no longer meet its bills as and when they routinely fall due for payment, and/orits liabilities materially exceed its assets and there is no reasonable prospect of that being reversed in a realistic time-frame). In these circumstances the Directors/Owners have a legal duty not to continue trading while insolvent, so they should follow one of several Corporate Insolvency processes, which are likely to result in the appointment by the Courts of an Administrator or Receiver. That Officer’s principal duty is to maximise the return for the Creditors (the people to whom the business owes money).

Therefore they will often be willing to continue to operate the services(s) for a short period of time in the hope of finding a buyer, for it to be sold as a ‘going concern’.

3.2 Situations of the above nature do sometimes arise “out of the blue”, but more typically there will have been an accrual of “warning signs” over a period of time, and/or the services management and staff may have openly shared word that its future is at real risk, possibly accompanied by media reports. HCC and CCG Officers should be alert to such signs and should notify their senior management so the implications can be considered and the likelihood risk assessed. These providers are more than likely to already be subject to the Council’s Escalation & Concerns Procedure.

3.3 As soon as a failure notification is received or real risk of potential failure is identified, HCC’s Director of Public Health and Adult Social Care, Director for Adults Social Care, Head of Service Contract Performance & Quality, Brokerage, Strategic Service Development, HCC’s Head of Procurement, CCG’s Accountable Officer or the CCG’s Director with responsibility for safeguarding or quality must be **notified immediately** by telephone with confirmation in writing (email). The contacts are subject to the potential impact to the people in receipt of services.

3.4 Staff passing information to either of these leads**must** ensure it has been received and formally acknowledged. If they are unavailable the contact should be made to their nominated deputy. It is not acceptable to leave a message with administrative staff.

3.5 The lead within the Commissioning Team will instruct appropriate officers to verify the failure or potential failure with CQC, and/or the care provider’s owner. They will also confirm to the Head of Service Contract Performance & Quality, Brokerage, Strategic Service Development and lead within CP&QT and determine what other relevant parties need to be contacted, by whom, and when.

3.6 Should the failure be related to the alleged abuse of one or more vulnerable adults, the Adult Safeguarding Team Manager must be notified and should ensure that Safeguarding Alerts are made in accordance with the Council Adult Safeguarding Policy and Procedure.

3.7 The Head of Service Contract Performance & Quality, Brokerage, Strategic Service Development and/or leads within the Commissioning Team, CP&Q T, will immediately call a Business Continuity Planning Group (BCPG) meeting, to take place within 24 hours after the notification has been received.

The purpose of the meeting is to agree a plan of action, and if appropriate to invoke this Operational Procedure – whether wholly or (in the case of potential but unconfirmed failure) in part.

In view of the potential implications for the health and well-being of service users, the relevant officers will be required to treat the situation as a high priority. To ensure timely involvement of all key parties, including CQC, this may occasionally necessitate ‘virtual’ meetings such as through teleconference, and/or the nomination of appropriate ‘deputies’. See **Section 6**‘BCPG’ for meeting membership.

3.8 Dependent upon the urgency of the situation, it may be necessary to convene such a meeting outside of normal office hours. Provider failures that occur outside of normal office hours should be referred to the HCC on call arrangements.

**4. Key Contacts**

4.1. The ‘Key Contacts’ who should be notified and invited to the initial BCPG Meeting are identified in the Table in **Appendix D.**

4.2. The HCC lead will undertake to update revised contact list at 6 monthly intervals.

**5. Responsibilities and Roles**

5.1. Whilst the responsible agency for fully health funded Individuals receiving care from providers at risk of failure is the Hull CCG, HCC will work jointly with the CCG to find alternative provision and for ensuring that any move is well managed.

5.2. HCC is the responsible agency for part-funded and fully social care funded individuals whose places have been commissioned or funded by the Council. HCC also has a duty to support self-funders to find alternative provision and for ensuring that any move is well managed.

5.3. HCC will take responsibility for co-ordinating and ensuring the immediate welfare of all individuals funded or commissioned by other Local Authorities; however funding responsibility and the detailed longer-term care planning of affected individuals will remain with the placing authorities. The principles here would also be applied for Hull individuals who are placed “Out of Area”.

5.4. All officers will need to commit to the process and identify any impact upon usual work to their line manager. Officers will need to confirm their delegated authority throughout the process to ensure timely decisions can be made.

**6. Business Continuity Planning Group**

6.1. The first meeting of the BCPG meeting, is to take place within 24 hours after the notification has been received. The chairing arrangements will be confirmed at the first meeting. Until this is confirmed the HCC lead officer from within the Contract Performance & Quality, Brokerage, Strategic Service Development Team act as the chair.

6.2 Those to be invited to form the BCPG group must include:

* HCC Locality Team representative
* Care Quality Commission
* Lead Minute Taker
* Communications lead
* HCC lead CP&QT
* HCC lead Commissioning Team
* Appropriate NHS Continuing Health Care lead
* HCC Adult Safeguarding Team Manager
* Clinical Commissioning Group Quality Lead

*It may be appropriate also to invite other “interested parties” to certain meetings, or parts of meetings, where they have a specific contribution to make, but not as “ongoing” participants. These could include, for example:*

* HCC Portfolio Holder for Adult Social Care - to be co-opted or briefed in
* HCC Legal representative (optional)
* HCC Procurement representative
* Relevant provider management
* Advocacy representative
* Family/carers representatives

6.3. The first meeting will confirm who will be the Council’s lead officer for the group. The lead officer will:

* Have responsibility for ensuring that all decisions are made and implemented in a timely manner.
* Ensure minutes are taken of each meeting with agreed actions (timescales noted), and circulated to team members and copied to the relevant Heads of Service.
* The group will decide on the frequency of its meetings, agreeing a core group of members who are kept informed and responsible for the proactive cascade of information to colleagues in their own service area (e.g. copy appropriate emails and reports to relevant people who are not necessarily group members but may have a ‘need to know’)
* Issues relating to publicity and the release of information will be considered, and a suitable balance struck so that where failure is not yet a certain outcome, the situation is not exacerbated and the provider’s entitlement to ‘commercial confidentiality’ is not infringed.
* The group will also discuss, if deemed appropriate, potential measures to prevent or delay failure e.g. short-term additional funding or assistance from HCC or the NHS.

6.4. At the first BCPG meeting an **operational group** will be set up to lead the work on the closure. The operational group is responsible for identifying all affected Individuals and ensuring all Individuals are supported to move to alternative provision in a timely manner. The operational group would include key representatives from Locality Teams to reflect the client group of those affected by the provider failure. (Older people, mental health, physical disabilities and learning disabilities). The chair of the operational group will become a member of the BCPG. The chair will provide timely updates to the BCPG group.

6.5. Those to be invited to form the operational group must include:

* HCC Locality Team representative
* Lead administrator/coordinator
* Lead Minute Taker
* HCC lead nominated by Commissioning
* HCC lead nominated by CP&QT
* HCC lead nominated by Brokerage
* Appropriate NHS Continuing Care lead (if required)
* HCC Adult Safeguarding Team Manager
* Clinical Commissioning Group Quality lead (if required)

**7. Potential Options for Alternative Service Provision**

7.1. Potential options may include:

* Spot purchase from other care providers
* Reserving services in other suitable locations
* Temporary staffing, (e.g. via local agencies)
* Temporary management, (e.g. via using a consultancy company)
* Alternative contracted management/nursing team provision
* Short-term additional funding
* Fee variation over and above normal ‘expected to pay’ rates to secure suitable service provision
* Other actions as deemed necessary based on individual circumstances

7.2 The BCPG will allocate responsibility for researching and pursuing the above options depending upon the specific circumstances of the case.

7.3 It should not simply be assumed - especially in the case of a provider operating a number of services, and/or where an Insolvency Practitioner is acting - that any payments we make which are intended by us for supporting the continuation of service provision at a specific service will necessarily be applied for that purpose, in that location, by the provider or Insolvency Practitioner. An explicit written agreement must first be sought and obtained. Payments may need to be withheld by commissioners and only paid when situation is resolved.

7.4 Wherever possible all transfers of individuals between care providers should occur within normal working hours.

**8. Distribution list:**

|  |
| --- |
| * HCC Director of Public Health and Adult Social Care
* HCC Portfolio Holder for Adult Social Care
* HCC ASC Director of Adult Social Care
* HCC ASC Head of Service Contract Performance & Quality, Brokerage, Strategic Service Development
* HCC Head of Procurement
* HCC ASC Manager Contract Performance & Quality Manager
* HCC ASC Strategic Safeguarding Manager
* HCC ASC Manager Brokerage
* HCC ASC Safeguarding Team Manager
* HCC ASC Operational Manager – Locality
* HCC Press & Communications Officer
* HCC ASC Commissioning Manager
* HCC Contract Finance
* HCC Legal Services
* Clinical Commissioning Group Director for Clinical Governance
* Clinical Commissioning Group – Continuing Health Care
 |

***Appendix A***

**Management Checklist**

The following checklist provides a **framework for managing care provider failure.**

***Please note that this list is not exhaustive.*** The BCPG must determine actions as necessary based on the circumstances.

The checklist should also be used in the event of a **potential failure where the timescale is unknown.** In this case, although all aspects should still be considered,and appropriate preparatory work based on these points should be begun wherenecessary, not all points will yet be applicable until the position clarifies.

This checklist can be used by the operational group too.

|  |  |
| --- | --- |
| **Date initiated:** |  |
| **Name of Service(s):** |  |
| **Joint Steering Group** **Members:****(Confirm Chair)** |  |

|  |  |  |
| --- | --- | --- |
|  | Action | Responsibility(to be completed by the BCPG). |
|  |  | **HCC** | **CCG** | **Provider** |
|  |  | **Initials of responsible Officer** |
| 1 | BCPG |  |  |  |
|  | For Group membership – **see Section 7** |  |  |  |
| 1.1  | 1.1 Assemble Team and plan the work |  |  |  |
| 1.2  | 1.2 Appoint Team Leader(s) |  |  |  |
|  | **Initial work/clarification** |  |  |  |
| 2.1 | Establish timescales for failure(s) |  |  |  |
| 2.2 | Establish number of Service Users affected, andUser category, and who funds them |  |  |  |
| 2.3 | Seek an up to date list of other Providers withpotential capacity (liaise with CQC as necessary)and contact details of Staffing Agencies it wouldbe acceptable to use |  |  |  |
| 2.4 | Consult adjacent Local Authority officers asnecessary |  |  |  |
| 2.5 | Establish tasks and timescales and allocate them |  |  |  |
| 2.6 | Allocate lead workers, (preferably based on site) and equipment & management support requirements |  |  |  |
| 2.7 | Consider equipment issues: mattresses, furniture, hoists, packing boxes etc. Who owns it? Can it be transferred?  |  |  |  |
| 2.8 | Arrange a meeting with Owners/other relevantparties |  |  |  |
| 2.9 | Clarify if the service provider has a BusinessContinuity Plan in place as part of the contractual arrangements that can be used. In the current circumstances, is it still viable?Is the home for sale?Is the home for sale as a going concern? |  |  |  |
| 2.10 | Agree when and how Individuals and Carers areinformed (and by whom) of the need to changeprovider at an early stage, and in a calm andstress-free manner” to reduce transfer trauma |  |  |  |
| 2.11 | Check that the Owner allows free and openaccess by professionals to the service over therelocation period |  |  |  |
|  | Agree the ‘need to know’ information that shouldbe shared with other parties e.g. careprofessionals; GP; NHS urgent care lead; otherpotential Care Providers[***Note*** that even though a Provider may beconsidered at serious risk of ‘business failure’,their affairs are still covered by the principle of***‘commercial confidentiality’***, and care should be taken that without the Provider’s agreementspecific information is not disclosed to third parties which might actually precipitate the business’s final demise]. |  |  |  |
| 2.12 | Formal scripts to be developed with the leadCommunications Department for: -* staff working with Individuals and relatives
* provider staff
* press
 |  |  |  |
| 2.13 | At the time of a potential failure, investigate thepotential of staff or voluntary groups to facilitateIndividuals/carers visiting other provision |  |  |  |
| 2.14 | Identify key Care Provider Management staff to be involved |  |  |  |
| 2.15 | Contact details of Care Provider Owner/Manager |  |  |  |
| 2.16 | Identify site(s) for offsite meetings forManagement Team/Care staff if required |  |  |  |
| 2.17 | Other agencies to be involved? |  |  |  |
| 2.18 | CCG/NHS to follow Serious Incident Procedure. HCC to follow Notifiable Incident Procedure, and in addition, does this situation meet the criteria for a “Critical Incident”? If so, invoke that Policy. |  |  |  |
| 2.19 | Consider whether failure of this Provision is likely to have a have a significant impact on overall local market supply for this type of service |  |  |  |
| 2.20 | Ensure all officers have considered the impact ofthe failure process upon other work streams andescalated as necessary to line manager |  |  |  |
| 2.21 | Identify agency to provide an administrative leadto collate all records |  |  |  |
| 3 | **Service User records** |  |  |  |
| 3.1 | Assemble an accurate list of all Individuals, and their needs – and confirm numbers with provider. Also any special factors (such as ‘friendship groups’ where it may be desirable to keep people together if possible) |  |  |  |
| 3.2 | Confirm where responsibility lies for assessing any Self- Funding or Out of County Individuals |  |  |  |
| 3.3 | Check current Registration category? |  |  |  |
| 3.4 | Assess Individuals to identify possible change in need or category of care |  |  |  |
| 3.5 | Check if any very frail people and those nearingend of life need exceptional arrangements, change in care need |  |  |  |
| 3.6 | Identify Individuals wishing to change provision/move sooner rather than later |  |  |  |
| 3.7 | Identify Individuals who should be assessed early inthe project work due to their predisposition tostress, anxiety or complexity, or for other factors |  |  |  |
| 3.8 | Consider two-stage Assessments of Service User’s capacity to make decisions about accommodation move where mental capacity is identified to be at issue, Accompanying record of Best Interests decision making process to be made. IMCAS appointed for those lacking family/friends. |  |  |  |
| 3.9 | Identify need for generic advocacy to supporttransfer. |  |  |  |
| 3.10 | Identify Individuals with active ‘Deprivation of Liberty’ (DOL) authorisations and ensure the provider as Managing Authority refers all those who are DOLS-liable to the City DOLS Team for new assessment on a standard authorisation request or urgent request, depending on the speed of the anticipated move. Contact IMCA and Paid Representatives as appropriate. |  |  |  |
|  | Organise and agree how service user records will be securely archived |  |  |  |
| 3.11 | Identify Service Users with ‘Health and WelfareDeputies’, and those with ‘Lasting Powers ofAttorney’ for Health and Welfare decisions, andensure contact is made with the relevant parties. |  |  |  |
| 4 | **Financial Responsibilities** |  |  |  |
| 4.1 | Ensure managers have the ability to commit allresources to the failure process including financial as well as staffing |  |  |  |
| 4.2 | Any Out of County funded Service Users? Makeexternal commissioners aware of situation, andconfirm whether they wish the Steering Group toact on their behalf to relocate Service Users |  |  |  |
| 4.3 | Identify NCC-funded residents, and identify anySection 117 MHA funded residents in particular. |  |  |  |
| 4.4 | Identify CCG/NHS-funded residents |  |  |  |
| 4.5 | Identify whether there are any private self-fundedService Users and who will take responsibility for their care. Check capacity and theirrepresentation *(see 3.8. above)* |  |  |  |
| 4.6 | Identify any remaining Service Users who arefunded by the Department of Work and Pensions or have ‘Preserved Rights’ |  |  |  |
| 4.7 | Check current fee level being paid – will the transfer cost be the same fee level?  |  |  |  |
| 4.8 | Investigate cost of potential new provision |  |  |  |
| 4.9 | Take a legal view and response, on the period ofcontract payment/termination issues etc |  |  |  |
| 4.10 | Consider issues such as petty cash etc |  |  |  |
| 4.11 | Identify Individuals with Deputyship in relation tofinancial affairs, all Enduring Powers of Attorneyand all those with Lasting Powers of Attorney forProperty & Affairs. Contact relevant parties andensure records of their involvement are made,particularly in relation to any changed cost to new placements. |  |  |  |
| 4.12 | Agree the process for authorisations. Set a panel date if required for those where a change in need has been identified. |  |  |  |
| 5 | Carers and ‘Significant Others’ |  |  |  |
| 5.1 | Ascertain the list of names, addresses andtelephone numbers. |  |  |  |
| 5.2 | Identify Carers who may themselves have special factors to consider – own health, Out of County etc. |  |  |  |
| 5.3 | Seek fullest involvement of relatives/’significantothers’ in the relocation process. |  |  |  |
| 5.4 | Consider necessity for commissioning advocacyfor carers affected (but bear in mind resourcesimplications before proceeding) |  |  |  |
| 5.5 | Consider and where necessary undertake carersAssessments. |  |  |  |
| 6 | Consultations/information Management |  |  |  |
| 6.1 | To ensure the process runs smoothly it is essentialthat all groups are consulted:* Service Users
* Care Staff
* Families/representatives
* Portfolio holders/councillors in relevant
* ward
* Public/press, via Communications lead
* Appropriate internal staff all agencies
 |  |  |  |
| 6.2 | A careful balance will need to be struck so that the existing difficulties of the situation and/or thetimescales are not exacerbated |  |  |  |
| 6.3 | Ensure Residents meetings are arranged withappropriate levels of management representation |  |  |  |
| 6.4 | Ensure Relatives meetings are arranged withappropriate levels of management representation |  |  |  |
| 6.5 | Ensure clarity of roles for each agency in meetings with residents, relatives and staff |  |  |  |
| 7 | **Relocation (if decision is made to close)** |  |  |  |
| 7.1 | Re-assessment of Individuals and adequate resource requirements to complete |  |  |  |
| 7.2 | Check choice (s) of area/services available thatare compatible with service user need/categorywith resident/carer to “reduce trauma” |  |  |  |
| 7.3 | Maximise resident/carer ability to make aninformed choice about compatiblearea/services/Homes available, in adherence tothe principles of the *Mental Capacity Act 2005* |  |  |  |
| 7.4 | Are there friendships between Individuals that need to be maintained? |  |  |  |
| 7.5 | Ensure new provider is registered for the category of care required and can meet needs. |  |  |  |
| 7.6 | Liaise with CQC, NHS, NCC staff to ensure there are no concerns about the Care Provider |  |  |  |
| 7.7 | Offer opportunity for Individual/carer to view/visit/trial visit Care Provider. |  |  |  |
| 7.8 | Seek Care staff help to inform/visit potentialprovision with Individual where applicable |  |  |  |
| 7.9 | Decision by Individual/carer on new provision and date to move. |  |  |  |
| 7.10 | Help of Care Staff to take or escort Individual topotential new providers on placement? |  |  |  |
| 7.11 | Arrange schedule transport to new provision, inand out of county e.g. car/minibus/ambulance –identify cost and who pays. |  |  |  |
| 7.12 | Consideration of equipment issues, andarrangements for its transfer and installation.*(see also 2.7 above)* |  |  |  |
| 7.13 | Ensure Individuals are accompanied by someone familiar on the day of the move, including carers if possible. |  |  |  |
| 7.14 | Use current Care staff to the fullest; passing ontheir knowledge of Individuals to new providers,escorting, transporting etc. |  |  |  |
| 7.15 | Staff handover to new providers – verbal andwritten. Care summaries, including care plan that details health and social care needs. |  |  |  |
| 7.16 | Respect Care staff friendships with residents and likely concerns for their future welfare. Findopportunities for current Care Staff to verballydiscuss Individuals care needs summary with receiving Care Staff, where appropriate. |  |  |  |
| 7.17 | Maintain a log of decisions and movement of Individuals. |  |  |  |
| 7.18 | Move Individuals at their own pace/convenience as far as possible. |  |  |  |
| 7.19 | Establish a programme of Social Worker/Nursing reviews and resource implications to ensure Individuals well-being after the move. Establish a Team if required. |  |  |  |
| 7.20 | Individual medications and treatment details to go with residents. |  |  |  |
| 7.21 | Particular attention to be made to ensure correctidentification of relocated Individuals. |  |  |  |
| 7.22 | Any changes of GP and new provision to berecorded in all appropriate systems of allnecessary organisations involved. |  |  |  |
| 7.23 | Placements made Out of County should benotified to the receiving NHS/Local Authority. |  |  |  |
| 7.24 | Provider Service User information/casefiles/summaries/transfer with Service Users where possible or copies made and transferred. |  |  |  |
| 7.25 | Consider how many family members/friends might visit the resident in the new Care provision; can we assist them to do so? |  |  |  |
| 7.26 | Notify Department of Work and Pensions ofchange of Home. |  |  |  |
| 7.27 | Liaise closely with the NCC Quality & EfficiencyCommissioning Team and NHS Continuing CareTeam (new contracts need to be issued, oldcontracts terminated) |  |  |  |
| 7.28 | Consider whether moves should be arranged tocoincide with the moving of other Individuals orspread over more than a week (if time is available) |  |  |  |
| 7.29 | Consider the desirability of temporary/secondMoves. |  |  |  |
| 8 | **Quality Assurance** |  |  |  |
| 8.1 | Ensure there is an effective process for recording and resolving complaints and disputes, and that it is widely understood and universally applied between the ‘interested agencies’. |  |  |  |
| 8.2 | Conduct a debrief after every incident to identifygood practice, lessons identified and furtheractions to be taken. |  |  |  |
| 9 | **Record Keeping** |  |  |  |
| 9.1 | Maintain a record of meetings, decisions made |  |  |  |
| 9.2 | Designate an administrative lead to collate all records. |  |  |  |
| 9.3 | Service User outcomes should be recorded,particularly with regard to their health andemotional well-being. |  |  |  |
| 9.4 | Maintain a risk log that is reviewed throughout the failure process. |  |  |  |
| 10 | **Lessons Learned** |  |  |  |
| 10.1 | All agencies should participate in a Review of the process once the procedure is completed. The outcome of this de-brief should be to identify Recommendations for future inter-agency learning, including policy, procedure and practical guidance. |  |  |  |
| 10.2 | The Review should produce a Report andRecommendations to be submitted to the relevant groups and management levels within each agency, including the Adult SafeguardingPartnership Board. |  |  |  |
| 10.3 | Consideration of referral to the NCASPB Seriouscase Review, or Safeguarding Quality assurance sub-group,should be included in the de-brief and review. |  |  |  |

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| Additional Notes: |

**Appendix B**

**Provider Failure Plan Templates (includes lessons learnt and risk log:**

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**Appendix C**

**Provider Failure Chart**

The quick glance provider failure process overleaf is to be used in conjunction with the Councils safeguarding policy, escalation concerns procedure, emergency procedures and management of serious incidents procedure when appropriate. A checklist is provided in Section 7.

CP&QT Team contact CQC ascertain facts

CP&QT Team coordinate – Share information with Partners – Use Appendix A

Provider Alert comes through

Agree communications strategy including how to manage media enquiries?

Civil Protection Officer Care Management. Safeguarding Communication Team. Clinical Commissioning Group Director of ASC Commissioning Legal Team

See Appendix 7

Check ConTrocc/LAS to confirm LA placements

BCPG to include Representation from each Partner.

Representatives from the BCPG to meet with the Provider to ascertain facts.

Agree a BCPG to manage the provider failure and to understand the immediate risk.

Invoke the Provider Failure Plan. Complete a risk assessment.

Identify support/services from Emergency Planning that can be accessed.

CP&QT Team identify what resources can be utilised from other Providers? Access information from the Business Intelligence Tool

 Share with BCPG to inform Provider Failure Plan.

CP&QT Team contact Provider. How many people affected? How many self-funders, direct payments? How many privately funded? How many from other LA? When will individuals be affected? Provider to invoke their own Business continuity plan where appropriate.

***Appendix D***

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| ***Title*** | ***Organisation*** | ***Name*** | ***Contact Details*** |
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***Appendix E***

**Glossary**

**Care Quality Commission (CQC)**

The Care Quality Commission (CQC) is an independent regulator of health and social care in England. The CQC regulates health and adult social care services provided by NHS, local authorities, private companies and voluntary organisations. The CQC also protects the rights of people detained under the *Mental Health Act 1983.*

**Clinical Commissioning Group (CCG)**

Took over responsibility for commissioning NHS services from PCT’s on 1st April 2013. CCG’s commission some community services, hospital and mental health services.

**Deprivation of Liberty Safeguards (DOLS)**

These Safeguards form an additional element to the *Mental Capacity Act 2005*. They provide legal protection for those vulnerable people aged 18 or over who are, or may become, deprived of their liberty in a hospital or care home, whether placed under public or private arrangements. They relate to people who lack capacity to consent to particular treatment or care that is recognised by others as being in their best interests, or which will protect them from harm. Where this care might involve depriving people of their liberty in either care homes or hospitals, extra safeguards have been introduced to protect their rights and to ensure that the care and treatment they receive are in their best interests. They do not apply to people detained under the *Mental Health Act 1983.*

**Deputy**

Someone appointed by the Court of Protection with ongoing legal authority to make decisions on behalf of a person who lacks capacity to make particular decisions.

**Enduring Power of Attorney**

A ‘Power of Attorney’, generally, is the legal authorisation to act on someone else's behalf in a legal or business matter. An ***Enduring*** Power of Attorney in our current context deals with the donor’s property and financial affairs. It will have been have been set up while the donor had capacity, and it was/will be activated by the Court of Protection when the donor’s capacity to take decisions is at issue. An EPA does not come to an end if the donor becomes mentally incapable of managing his or her own affairs. The attorney named under an EPA ***does not*** have the power to make decisions about personal care and welfare. Since 2007 these have been replaced by ***Lasting*** *Powers of Attorney (see below),* though existing EPAs will continue to operate, and those signed before 2007 but not yet registered may still be registered.

**Independent Mental Capacity Advocacy (IMCA)**

The *Mental Capacity Act 2005* provides a statutory framework for acting and making decisions on behalf of individuals who lack the mental capacity to do so for themselves. In response the Government created provision for the Independent Mental Capacity Advocate (IMCA) service. The purpose of the IMCA Service is to help vulnerable people who lack capacity who are facing important decisions made by the NHS and Local Authorities about serious medical treatment and changes of residence e.g. moving to a hospital or Care Home. NHS bodies and Local Authorities will have a duty to consult the IMCA in decisions involving people who have no family or friends.

Individuals - This term is used to refer to both service users, customers, residents and patients. In some contexts it may also include carers.

**Lasting Power of Attorney**

A Lasting Power of Attorney is a legal document. It allows a person giving it (the ‘donor’) to appoint someone they trust as an ‘attorney’ to make decisions on the donor’s behalf. A Lasting Power of Attorney cannot be used until it is registered with the Office of the Public Guardian.

There are **two different types** of Lasting Power of Attorney:

* **A Health and Welfare LPA** allows the donor to choose one or more people to make decisions for things such as medical treatment. A Health and Welfare Lasting Power of Attorney can **only** be used if the donor lacks the ability to make decisions for him/herself.
* **A Property and Financial Affairs LPA** lets the donor choose one or more people to make property and financial affairs decisions for them. This could include decisions about paying bills or selling their home. They can appoint someone as an attorney to look after their property and financial affairs at any time, **or** they can include a condition that means the attorney can only make decisions when the donor loses the ability to do so. *[See also ‘****Enduring*** *Power of Attorney’, above]*

**Mental Capacity Act (2005)**

A law providing a framework for people who lack capacity to make decisions about themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this.

**NHS Professionals**

NHS Professionals is the national body that manages temporary staff in the NHS. It aims to improve the delivery of temporary staff to local NHS organisations. NHS Professionals was launched as a nationally branded service to improve the quality of patient care and performance of temporary staff by investing in NHS staff and setting common standards for quality and clinical governance.

**Safeguarding of Vulnerable Adults**

Relating to the legislation, policy and procedures *(especially the Hull City Council Adult Safeguarding Policy and Procedures)* that deal with the safeguarding of vulnerable adults.