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**North East Lincolnshire Humber and North Yorkshire Integrated Care Board [ICB] – NEL Place Market Intelligence and Failing Services**

**Policy & Procedure**

**(Applicable to adult health and social care)**

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#### The on-line version is the only version that is maintained and valid. If this document has been printed or saved to another location, the reader must check that the version number matches that of the on-line version.

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# 1.0 INTRODUCTION

Despite best efforts to regulate the local care market, services are interrupted and sometimes fail. Difficulties can occur for many reasons. The role of commissioners is to monitor and identify threats within provider organisations and to intervene early where appropriate. This policy sets out how responses to relevant interrupted and/ or failing services will be made in North East Lincolnshire.

Via an agreement under s75 of the National Health Service Act 2006, North East Lincolnshire Council (NELC) largely delegated its adult social care responsibilities to The Humber and North Yorkshire Integrated Care Board [NEL Place] (‘the ICB’). The ICB – NEL Place commissions a number of health and social care providers to deliver health and social care functions on its own behalf, and on behalf of NELC for which it acts as delegate. The ICB also delivers continuing healthcare functions (CHC).

As an integrated health and social care commissioner, the ICB – NEL Place ICB operates within two legislative frameworks i.e. both health and social care. Where legislative (or common law) duties apply in respect of an interrupted or failing service, the ICB- NEL Place – with the membership of the Market intelligence and Failing Services Group (the ‘MIFS Group’) - will act to ensure that those duties are discharged. Where such duties do not apply, the MIFS Group will consider whether an exercise of relevant legal powers is appropriate. A summary of relevant legislative provisions can be found at Appendix F.

This policy and procedure is issued and owned by the ICB – NEL place and must be used in conjunction with its strategies and Market Position Statement, which set out how the ICB intends to develop and manage all provision through contract management and procurement arrangements. This policy and procedure is governed by the Health and Care Contracting Group (‘the HCCG’) which has delegated responsibility for operational initiation of this policy and procedure to the MIFS Group, which is chaired by the ICB-NEL Place. MIFS Group members should bring all relevant intelligence regarding the stability, interruption or potential failure of any commissioned service to MIFS Group meetings on a regular basis.

# 2.0 SCOPE AND DEFINITIONS

This policy and procedure relates to any care service in North East Lincolnshire governed by health and social care legislation. It is in place to address the failure of, or interruption to, any such services, which may include (but may not be limited to):

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| --- | --- |
| * Residential, nursing home and CHC services * Home care services, including housing with care * Supported living * Extra care housing schemes * Adult placement schemes * Day services * Supported employment schemes | * Carers’ services * Intermediate tier services * Mental health services * Primary care services * Secondary care services * Allied health professionals’ services * Out of hours services. |

Whilst this policy and procedure was initially created to address service interruption or failure within social care or CHC, the principles and practicalities of addressing a failing health service are likely to be similar. Interruptions or failures within the social care and CHC sector may be more common than those within the health sector. Nevertheless, interrupted or failing health services will require a response in accordance with this policy and procedure. The core MIFS Group membership may be required to work with additional co- opted members to support and/ or manage interruptions/ failures within health services.

The focus of this policy and procedure is on responding to service interruptions or failures within normal office hours (generally Monday to Friday, 9-5pm). Responses outside of normal office hours will be made via the Single Point of Access (‘SPA’), in accordance with the guidelines set out within this policy and procedure.

# 3.0 PURPOSE

This policy and procedure details how the ICB – NEL Place, with the membership of the MIFS Group, will coordinate and manage responses to a service interruption or failure. Actions and procedure will differ depending on the type of service provision in question.

In all circumstances, the purpose of this policy and procedure is to ensure the ICB’s approach is legally compliant. This includes careful consideration of the state’s positive obligations under the European Convention on Human Rights, to ensure that any interference with Convention rights arising from service interruption or failure is necessary and proportionate.

The ICB – NEL Place, with the membership of the MIFS Group, will:

* + - ensure that the interests of individuals, informal carers, families and representatives affected by interrupted/ failing care services in NEL are protected
    - provide clear direction and guidance to staff within the ICB\_NEL Place and partner organisations to ensure a coordinated and multi-agency approach to interrupted/ failing care services
    - ensure that the approach taken to interrupted/ failing care services is lawful, and that available contractual levers are considered and utilised where appropriate
    - ensure that lessons are learned from every service interruption or failure and that this learning is reflected in the ICB’s market management and market shaping activities
    - consider any impact and mitigate any risks which a service interruption/ failure may have on the wider care market to ensure that individual needs can still be met.

The MIFS Group has researched national best practice guidance and pooled its collective learning from real life scenarios. In all situations and across all provision, the Group’s collective approach will be to:

* + - ensure that the regular flow of information and intelligence is pooled and analysed collectively by the right professionals (including with the involvement of regulatory bodies such as the CQC and NHS Improvement, where appropriate)
    - ensure well-defined lines of responsibility so it is clear who is leading on what
    - ensure the process is managed collectively and that there is good, regular communication on progress between all relevant parties
    - ensure a person-centred approach that engages individuals fully and promotes wellbeing
    - try to create time for individuals to make considered decisions, and for good preparation and planning, wherever possible
    - maximise continuity, keeping friends together, and individuals near to their families, wherever possible and appropriate
    - ensure good, clear and honest communication with individuals and their informal carers, families or representatives, particularly regarding their choices
    - ensure good assessment and care planning (although assessment and care planning may initially be minimal in an emergency situation)
    - ensure strong emphasis on delivering rights-based care, safeguarding, MCA and statutory compliance
    - complete all necessary actions connected with an incident of service interruption/ failure within a timescale of two to six months, wherever possible
    - ensure that on completion of each incident of service interruption/ failure, opportunity is provided to follow up, learn lessons and reflect.

# 4.0 IMPACT ANALYSES

* 1. Equality

This policy and procedure has been created with due regard for the ICB’s public sector equality duty under the Equality Act 2010, s149. All staff connected with the implementation of this policy and procedure, in the exercise of their public functions, must also have due regard to the matters within s149(1).

An Equality Impact Assessment (EIA) has been conducted with regard to this policy and procedure. In seeking to allocate care and support resources equitably, the policy and procedure is largely neutral regarding Protected Characteristics. A single area of concern has been identified: whilst the policy/ procedure itself is unlikely to have an impact on grounds of race, it is recognised that some nationalities may have difficulties understanding the policy/ procedure due to limited English language skills. Mitigating actions are set out within the EIA. A copy of the EIA can be accessed through this [hyperlink](https://portal.yhcs.org.uk/documents/5665646/17351999/EIA+MIFS+Policy/882995d6-978b-46ff-a5dc-9f81245e682f).

* 1. Bribery Act 2010

The Bribery Act 2010 is relevant to this policy. Under that Act it is a criminal offence to:

* bribe another person by offering, promising, or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so; and
* be bribed by another person by requesting, agreeing to receive, or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so
* to bribe a foreign public official - A person will be guilty of this offence if they promise, offer or give a financial or other advantage to a foreign public official, either directly or through a third party, where such an advantage is not legitimately due
* if commercial organisations fail to embed preventative bribery measures. This applies to all commercial organisations which have business in the UK. Unlike corporate manslaughter this does not only apply to the organisation itself; individuals and employees may also be guilty.

These offences can be committed directly or by and through a third person and other related policies and documentation (as detailed on the ICB intranet) when considering whether to offer or accept gifts and hospitality and/or other incentives.

Anyone with concerns or reasonably held suspicions about potentially fraudulent activity or practice should refer to the Local Anti-Fraud and Corruption Policy and contact the Local Counter Fraud Specialist.

# 5.0 NHS CONSTIUTION

The NHS Constitution, which aims to safeguard the principles and values of the NHS, forms part of the backdrop against which the ICB operates. The ICB is required by law to take account of the Constitution, and to act with a view to securing health services that are provided in a way which promotes the Constitution. The values within the NHS Constitution are reflective of those within the Care Act 2014, particularly within s1 (setting out the wellbeing principle). There are some obvious differences regarding the way NHS principles might apply to delivery of social care, but many of the principles are equally pertinent. Those responsible for acting in accordance with this policy and procedure are expected to consider how the constitution applies in each set of presenting circumstances.

# 6.0 ROLE AND RESPONSIBILITIES

All intelligence relating to sustained underperformance (including failure to meet the minimum contractual requirements, sudden multiple safeguarding referrals, regulatory body notifications or acquired knowledge about the imminent or possible interruption/ failure) of a service should be immediately reported to the ICB’s contracting team and the service’s strategic lead by the MIFS Group membership or wider partners.

An initial informal and rapid investigation should take place to establish the facts. In most cases the contracting team will be best placed to undertake this informal investigation, the findings of which will be presented to the MIFS Group for a joint discussion and initial decision on what response should be triggered and at what stage.

When this policy and procedure is triggered, the ICB\_NEL Place will need the on-going input and support of all MIFS Group members and wider partners – contributions from focus independent adult social work (focus), Care Plus Group, NAViGO, and NELC will be crucial. MIFS Group members and wider partners are reminded that service interruptions/ failures can be very labour intensive and require them to temporarily suspend their day job in order to manage crisis situations. It is expected that MIFS Group members and wider partners will contribute in any way reasonably required of them, for as long as is reasonably required.

It is anticipated that the membership of the MIFS Group will suffice to manage responses to the majority of service interruptions or failures during normal office hours (generally Monday to Friday, 9-5pm).

# 7.0 OVERVIEW OF PROCEDURE

#### Stage 1: Risk Identification and Risk Management

**“Reports of poor care and/ or other concerns, but no imminent risk of closure”**

Reports can be made via quarterly contact monitoring, audit, via information passed directly to the ICB from its partners, via staff, via whistleblowing etc. Reports may also be received via regulatory bodies.

The MIFS Group will deal with the report at the next scheduled meeting or, if deemed urgent, an interim meeting will be convened as soon as possible.

An assessment will be made by the MIFS Group as to how best to intervene. At any time if it is established that an acceptable level of care cannot be guaranteed and there is a real risk of harm, neglect or imminent interruption/ failure then the situation will be escalated to Stage 2 of the policy/ procedure.

If the matter can be dealt with through routine contract compliance, the relevant ICB contract officer will send a “Notice of Improvement” to the service explaining the concern and what remedial action is required from the provider, by when, to restore the normal contracting relationship and “business as usual” status. Any Notice of Improvement should be accompanied by notification to the relevant regulatory body e.g. the ICB’s contracting team will notify the CQC when a contractual notice is issued and keep the CQC updated thereafter.

In addition to, or separately from the ICB’S contractual Notice of Improvement, the relevant regulatory body may issue its own notice of improvement which will set out a timetable for response. The receipt by the provider of a notice from either NHS England/ NHS Improvement or the CQC may provide the MIFS Group with its first alert of difficulties with a particular provider or may form part of an already developed picture of difficulty. The ICB’s response to any notice served by NHS England/ NHS Improvement/ the CQC will be coordinated by the MIFS Group in accordance with this policy and procedure, and in liaison with the regulator.

If the situation warrants it and the MIFS Group is in agreement, further referrals to the service in question will be temporarily suspended until the situation has been remedied. This action is described and proscribed within the terms and conditions of the standard ICB contract. When deciding if this course of action is appropriate consideration will be given to the safety and risk to individuals, the effect it will have on service capacity, and the wider implications across health and social care.

The ICB’s contracting team will seek agreement via the MIFS Group to restart referrals if a temporary suspension has been put in place.

Following agreement reached at the MIFS Group to impose, continue or lift a suspension, the Chair of the MIFS Group will make a recommendation to HCCG in accordance with that agreement. Where MIFS Group recommendations are endorsed by HCCG, they will be referred back to the Group for action. Where MIFS Group recommendations are not endorsed, HCCG will either make its own recommendations for action by the MIFS Group or seek alternative suggestions from the Group. Where for some reason HCCG recommends an action, which cannot be acted upon, the Chair will report back to HCCG promptly regarding the reason why the action could not be taken.

All actions and outcomes will be recorded in the MIFS notes and contract team files. The MIFS Group will decide if the provider should stay on the MIFS agenda until the next scheduled visit/ inspection, or if a special visit needs to be planned. The MIFS Group will agree when a provider or establishment can be removed from the MIFS agenda.

#### Stage 2: Imminent Risk of Interruption/ Failure or Removal of Contract due to Persistent Failure or Following Breach of Contract

The Chair of the MIFS Group will notify the ICB\_NEL Place senior management of the situation identified via the relevant Director (Director of Adult Social Services) and will also notify the named MIFS members from the ICB, focus, Care Plus Group, NAViGO; those named MIFS members will ensure all relevant staff within their own organisations are informed of the situation. If they have not already been notified at Stage 1, the Chair of the MIFS Group or the ICB’s contracting team will notify the relevant regulatory body of the identified risk and keep them updated thereafter.

A lead officer will be appointed (drawn from the MIFS Group or a senior practitioner in the ICB focus, Care Plus Group, NAViGO) to manage the ICB’s response to the situation identified. The lead officer will be informed of all the information collected to date and will make contact with the provider’s manager and or proprietor/ administrator, with the assistance of a ICB contract officer if appropriate.

The MIFS Group will be convened within 24 hours of a situation escalating to Stage 2. The lead officer will explain the background and the specifics to the Group, and will work through the appropriate checklist (Appendix A to D) to ensure that all necessary steps have been considered, planned and actioned in respect of the situation.

Wherever possible, the lead officer will work with the provider to ensure a smooth transition through the identified difficulties.

All MIFS Group members will be asked to provide a named officer/ member of staff to assist the lead officer in applying this policy and procedure.

Each representative at the MIFS Group is responsible for the co-ordination of required activity within their own organisation and for the dissemination of information within it, subject to the application of appropriate confidentiality based on “need to know” principles.

The lead officer will co-ordinate activity and meetings as necessary until resolution of the identified difficulties, and arrange any on-going support for the individuals, informal carers, families and representatives who have been affected.

On completion of the process, the lead officer will draft a post resolution report and feed any new learning into the development of this policy and procedure. The post resolution report will be shared appropriately. The completed checklist (see Appendix A to D) will form the basis of a detailed diary of both planned and unplanned actions and events.

#### Managing Service Transfers and Establishing the Facts

As the checklists highlight, during this time it is vital that adequate assessments and reviews of social and/ or clinical need are undertaken, and up-to-date profiles created, of all those in receipt of the failing

service. Assessments will include identification of individual risk factors and possible adverse impacts, and consideration of ways in which such risk/ impacts might be mitigated.

Following appropriate documented capacity assessments, those who lack capacity to make relevant decisions for themselves should be quickly identified, along with any representatives legally appointed to make decisions on their behalf. Evidence of such decision-making authority must be sought and copy documents retained. In the absence of legally appointed decision makers, best interests decisions will be made and documented on behalf of those lacking relevant capacity. Where independent advocates are needed, these will be secured without delay.

Individuals, informal carers, families and representatives will be consulted and kept informed throughout these processes. Individuals’ preferences for particular new providers will be considered. A new care plan/ care record should be developed as soon as is practicable to assist in identifying/ providing services to meet the needs of individuals. Reablement and self-directed support options should be considered. Equally, alternative accommodation options should be considered (e.g. Extra Care Housing) where appropriate. All reasonable steps will be taken to agree with the individual (or if the individual lacks the relevant capacity, with their representative) how their needs will be met.

These tasks will be carried out by a relevant partner (e.g. focus) in partnership with other professionals, as needed.

#### Issues & Challenges to Consider Whilst Planning Service Transfers

Needs must be assessed prior to service transfer. Specialist assessments may be required, and risk assessments will be essential, especially in respect of coping with any physical move and the potential impact on individual wellbeing. Mental capacity issues must also be considered, and documented, throughout. This will include consideration of a) any existing authorisation for deprivation of liberty in the individual’s current setting, b) whether new arrangements being made for the individual will amount to a deprivation of liberty, for which authorisation is required.

Although the closure of a service and transfer of placements can be traumatic, good care management can reduce anxieties. The existing provider must be encouraged to ensure all records, medication and care plans/ care records are up to date to facilitate service transfer. Where relevant, financial assessments must be current and any potential payment issues addressed.

The decline or closure of a residential service will often result in residents transferring from one home to another. This can be an especially traumatic experience for residents, informal carers, families and representatives. Many home closures are well managed and planned. However, experience has shown that homes sometimes close in an unmanaged way, especially when the reason is a business failure. Much of the actual process, therefore, may be beyond the ICB’s direct control.

MIFS Group members with wider partners and provider organisations will do their utmost to ensure that the process is as managed as possible, so that vulnerable people have time to make key decisions about their choices, on the basis of good information. This means ensuring that the failing provider gives as much notice of any closure as possible. The ICB will endeavour not to prematurely withdraw people from the failing service and will work to maintain service provision until transition to another provider has been completed, wherever this is safe and appropriate.

A key part of the MIFS Group’s role is to provide sensitive and timely support and advice to help individuals, informal carers, families and representatives through a difficult and sometimes distressing situation. It may be necessary to facilitate a safe and managed transfer to another service. Support must also be offered to residents who are self-funding or receiving services through any form of self- directed care. The amount of support each individual needs will vary depending on their degree of independence/ capacity and other sources of personal support, but as a matter of principle and practice, this policy deems all local care users to have an entitlement to assistance, regardless of funding source, capacity and informal care arrangements.

There must also be liaison with other local authorities if they have individuals placed in a residential service that is interrupted or failing, and agreement should be reached between the ICB and the other council as to who will provide support for each individual concerned. Funding responsibility will usually remain with the placing authority.

The ICB considers that the local residential provider market has sufficient capacity to support relocations from failing providers, such that no provision is required for a ‘provider of last resort’ (e.g. a designated ward at Diana Princess of Wales Hospital).

#### The Need for Accurate and Consistent Information

Information and advice that is provided quickly and accurately can alleviate a lot of anxieties and help the process to move smoothly. Unfortunately, in failing services, usual channels of communication can also easily fail. Staff from the service are often the primary source of information because of their day to day contact with individuals, but staff may themselves be poorly informed because communication channels within their employing organisation have broken down. They may be anxious about their own position. Clear answers may be difficult to give because of the uncertainties of the situation. Staff may start to leave, and temporary staff be brought in. It is in such a situation that MIFS Group members and their organisations’ staff have a key role in providing authoritative and unbiased advice. It is important therefore to establish quick and regular communication with individuals, informal carers, families and representatives, and to provide accessible contact details and written information. The lead officer should become the first point of contact for information.

The information offered should include:

* Information about care options
* Up to date information about vacancies in alternative care homes or care services
* Information about support available and how to access it
* Information about deprivation of liberty and the requirement to authorise it, if relevant
* Information about funding options, where relevant (including encouraging individuals to seek independent financial advice).

In the case of a failing care home, those affected will be offered a face-to-face meeting and/ or written information.

#### Staffing / Workforce

MIFS Group members must make available sufficient staff from their organisations to provide support and take on the practical tasks associated with transferring people to another care service. Where individuals know existing staff members within the failing service, those staff members should remain involved, where possible, to provide continuity. It is essential that MIFS Group members’ staff work in partnership with the provider, individuals, informal carers, families and representatives.

In some situations, staff from MIFS Group members’ organisations may be required to work within the interrupted or failing service to ensure safety and continuity until the crisis is alleviated.

Where a service interruption or failure results in the affected providers’ staff losing their job, support to find alternative employment will be offered wherever possible and appropriate.

#### Choosing Alternative Provision

When a service closure is unmanaged, there is often a feeling of urgency. Individuals become anxious to take the first available vacancy elsewhere in case they are left with nothing. Although the pace of developments may sometimes be outside the ICB’s control, MIFS Group members/ their organisations’ staff must do their utmost to ensure that transitions are planned, that individuals (and appropriate others) have been involved and consulted in decision making, and that all necessary assessments have been carried out. Access to advocacy services is now widely available; those who

require advocacy will be provided with it under the relevant legislative provision (the Care Act, Mental Capacity Act 2005 or Mental Health Act 1983).

In the case of a transfer to an alternative residential/ nursing home, unless explicitly agreed prior to relocation to be detrimental to them, all residents should visit proposed new placements. Residents must be consulted on their views, wishes, feelings and beliefs; where the resident no longer has capacity to express views etc, account should be taken of any previously expressed views etc. Informal carers, families and representatives, and any other person the resident requests, must also be involved. MIFS Group members’ staff must offer to arrange to transport residents to visit alternative accommodation if they have no one else to do this for them. If the resident is considering a move, they must be encouraged to spend time in the new home before making a decision (where time allows). Receiving homes must be encouraged to meet the prospective resident either in the existing or proposed home. Alternative accommodation (such as Extra Care Housing) or support options should also be considered if they are appropriate for meeting individual needs.

MIFS Group members’ staff must ensure choices reflect the individual’s wishes, wherever possible. In the case of transfer to alternative accommodation, consideration must be given to existing relationships such as whether several residents want to remain together, or whether the resident wants to remain near certain relatives. Whilst in the short-term there may be circumstances in which choice of accommodation is restricted by timescales, availability, or the particular needs of the resident, choices must be supported in accordance with the Care Act, Annex A of the Statutory Guidance and supporting Regulations. Consideration of Article 8 Convention rights will be particularly pertinent in this context.

The ICB’s approach is that alternative placements from failing homes must be made into homes that are, as a minimum, compliant with the NEL ICB’s long term care contractual requirements. Practitioners must use the intelligence that the ICB holds on the quality and reliability of homes, including liaison with CQC, and make decisions on the suitability of prospective placements based on this intelligence.

MIFS Group members/ their organisations’ staff are expected not to make placements into homes that are subject to failing services intervention. Self-funders must be advised strongly against such a choice.

Where individuals invoke their rights under the Care Act to choose a home that is subject to an intervention, or when self-funders do so against advice, the reasons for the ICB’s position must be recorded and communicated to the individual succinctly and factually in writing.

# 8.0 IMPLEMENTATION

This policy will be disseminated via MIFS Group members and key individuals within their organisations, in addition to wider partners, with the expectation that each will cascade the information within it amongst their relevant teams. The policy and procedure will be lodged on the ICB’s intranet, and MIFS Group members will be expected to ensure that it is available electronically to their organisation’s staff. The policy will be further communicated through team briefings, and training sessions, as necessary.

Breaches of this policy may be investigated and may result in the matter being treated as a disciplinary offence under the ICB’s disciplinary procedure, or that of the MIFS Group members’ organisation which employs the staff member in breach.

# 9.0 DISSEMINATION, ACCESS & TRAINING

This policy will be drawn to the attention of all MIFS Group members, wider partners and their organisations’ staff as part of the implementation process.

# 10.0 REVIEW, MONITORING AND COMPLIANCE

This policy and procedure will be reviewed every three years (or earlier where a change in the law/ an incident necessitates it), as instructed by the senior manager responsible for this policy.

The policy will be reported to the HCCG.

# 11.0 REFERENCES AND LINKS TO OTHER DOCUMENTS (for this policy)

External Documents

* + - The current data protection legislation and general data protection regulations (GDPR) (EU) 2016/679
    - Care Act 2014
    - Children and Families Act 2014
    - Health & Social Care Act 2012
    - Equality Act 2010
    - Health and Social Care Act 2008
    - Mental Capacity Act 2005
    - Human Rights Act 1998
    - The Freedom of Information Act 2000
    - NHS & Community Care Act 1990
    - Mental Health Act 1983
    - The NHS Constitution
    - ‘Care and Continuity: Contingency planning for provider failure, a guide for local authorities’, Department of Health/ ADASS/ LGA/ LGiU 2015
    - ‘Achieving Closure: good practice in supporting older people during care home closures’. Health Services Management Centre, University of Birmingham and ADASS, in association with the Social Care Institute for Excellence, April 2014: <http://adass.org.uk/achieving-closure/>
    - ‘Short-notice home care closures: a guide for local authority commissioners’. Social Care Institute for Excellence, September 2011: <http://www.scie.org.uk/publications/homeclosures/>

Internal Documents

* ICB\_NEL Place Micro-Commissioning in Adult Social Care and Continuing Healthcare: Principles of Consistent, Pragmatic, and Ethical Decision Making
* ICB\_NEL Place Joint Funding Principles and Practice for NHS Continuing Healthcare and Social Care
* ICB\_NEL Place NELC Mental Capacity Act 2005 and Deprivation of Liberty Policy

# 12.0 APPENDICES

Appendix A – Care Home Closure Checklist

Appendix B – Out of Hours Checklist for Care Home Failure Appendix C - Homecare Provider Failure Checklist Appendix D - Out of Hours Checklist for Homecare Failure Appendix E – Out of Hours Responses to Provider Failure

Appendix F - Responding to Business Failure and Service Interruptions – the Law under the Care Act 2014 and the Care and Support (Business Failure) Regulations 2014

Appendix G – Communications Protocol Guidance

# APPENDIX A – Care Home Closure Checklist



# APPENDIX B – Out of Hours Checklist for Care Home Failure

**Out of Hours Checklist for Care Home Failure**

In the event that an incident occurs at a provider’s premises which results in immanent/ immediate inability to deliver care, prompt action may be required to meet need. This checklist of immediate ‘must dos’ has been created following scenario planning in which an out of hours flood at a care home was envisaged, causing severe implications for safe delivery of care. It may be useful in other emergency scenarios, where ability to consider the full checklist (see Appendix A) is impossible in the short term.

It is anticipated that an out of hours provider situation which requires an immediate response is most likely to be received via the Single Point of Access (SPA). The SPA staff member receiving the call will be responsible for informing the focus on call duty manager, to initiate action. Alternatively, in the event that any other member of staff within the health and social care system (or outside of it) is alerted to an out of hours provider situation which requires an immediate response, they must telephone SPA to ensure that the information is passed to the focus on-call manager.

It is assumed that a basic outline of the situation requiring a response has already been ascertained by the focus on-call manager (either directly or via a SPA staff member).

The focus on call duty manager (FOCM) will:

|  |  |  |
| --- | --- | --- |
|  | Action | Complete |
| 1 | If the situation requires, contact NELC’s contingency planning/ emergency response team |  |
|  |  |  |
| 2 | Use the details within the Out of Hours Response to Provider Failure (Appendix E) protocol to contact as many of the key members on call  managers (focus, Navigo, Care Plus Group (CPG) etc) as the situation warrants, to secure initial support |  |
|  |  |  |
| 3 | Secure further information:   * If necessary, send a representative directly to the provider’s premises to investigate. This representative will act as the on-site operational manager (‘OPSM’), able to report back to SPA * Confirm the response set out within the provider’s contingency plan, which may assist in addressing the situation |  |
|  |  |  |
| 4 | Convene meeting of key member on-call manager(s), or their designated representatives) at SPA |  |
|  |  |  |
| 5 | Be responsible for coordinating responses to the situation. At the meeting, the convened team will:   * Receive initial report from OPSM * Agree roles and responsibilities of other attendees (see roles at 7, 8, 9 below for suggestions): create a temporary team for dealing with the current situation * Liaise with OPSM to agree which out of hours teams might be required to provide additional support * Agree whether each attendee needs to stay at SPA or relocate to support OPSM, on-site at the provider’s premises |  |
|  | * Consider whether further call handlers are required at SPA to support any likely increase to calls from concerned residents’ representatives * Consider coordination with NELC contingency planning if relevant * Consider budgetary requirements- see Appendix F   NB not all of these tasks may be immediately possible, but will be reliant upon receipt of the below information from OPSM |  |
|  |  |  |
| 6 | Ask OPSM to delegate tasks on site, calling on available out of hours teams. OPSM will also need to liaise with others (e.g. NELC, emergency services etc) to combine efforts. OPSM to report back to FOCM with further detail re the following, as quickly as it becomes available:   * Any business support required e.g. an admin staff to rota additional provider staff/ access provider systems * A summary of who requires what care (i.e. basic outline of needs and special requirements e.g. who’s immobile, who needs equipment, who lacks capacity etc), and when it is required * On the basis of the above summary, a plan of triaged/ prioritised needs, inc needs to accompany any relocating individual * Contact details for informal carers, relatives, representatives of those with needs; confirmation of which/ what contacts are being/ have already been made by provider staff   1st priority is to get residents to safety: where an immediate secure/ warm location is needed, utilise SPA (emergencies to DPoW) |  |
|  |  |  |
| 7 | Ask designated team members to:   * contact other homecare providers, care homes, etc to secure additional staffing provision to deliver care, in accordance with the triaged/ prioritisation of need information received from M * secure other responses as relevant to particular individuals e.g. Meals on Wheels, Carelink etc * Report secured emergency provision to FOCM and OPSM   NB this action will need to happen in tandem with 8 below – i.e. to establish if representatives can offer short term support to individuals |  |
|  |  |  |
| 8 | Ask designated team members to:   * offer to support provider staff in contacting individuals/ their representatives to apprise them of the situation and offer reassurance * in the absence of availability or cooperation from providers, contact those individuals/ representatives directly   Establish whether representatives can offer care to their individuals in the short term, whilst longer term options are secured |  |
|  |  |  |
| 9 | Ask designated team members/ comms team to utilise comms protocol to ensure media messages are managed, e.g. release press statement containing SPA number for further enquiries, be available for interviews etc. Comms team to liaise with provider and others (e.g. NELC, emergency  services’ staff etc) to ensure coherence of messages |  |
|  |  |  |
| 10 | Once the immediate emergency/ response has been dealt with, attend to any other matters within the ‘standard’ checklist (Appendix B) which appear  to be relevant/ necessary in the short term. When ‘normal hours’ resume, the standard MIFS protocols will be triggered and the FOCM will need to update the MIFS Chair with details of the action taken. |  |

#### NB decision making must be logged throughout the above process, to provide evidence in the event of later challenge

**This checklist is not intended to fetter the discretion of the FOCM/ OPSM in responding to the situation as they find it. It is intended to offer guidance only.**

# APPENDIX C – Homecare Agency Failure Checklist

**Homecare Agency Failure Checklist**

*\*To be used in conjunction with the electronic care home intelligence database – to be completed by the assigned lead officer*

| **Name of provider** |  |
| --- | --- |
| **Date ICB notified** |  |
| **Method of notification** |  |
| **Brief description of situation** |  |
| **Legal status of business (eg sole trader, partnership, limited company)** |  |
| **Business owner and/or director contact** |  |
| **Manager/contact** |  |
| **Administrator contact** |  |
| **CQC status** |  |

| **Number of individuals** | **Commissioned** |  | **Self-funded** |  |
| --- | --- | --- | --- | --- |
| **Number of hours** | **Commissioned** |  | **Self-funded** |  |

|  |  |
| --- | --- |
| **Assigned Lead Officer** |  |

|  |
| --- |
| **Communication with Agency/Manager/Owner/Administrator/CQC** |

| **Action** | **Notes** | **Whom?** |
| --- | --- | --- |
| Have we made contact with the owner/manager? |  |  |
| Are they amenable to working with MIFS/relevant others? |  |  |
| Does the manager need support, if so what, how? |  |  |
| What support is offered within the provider’s business continuity plan? |  |  |
| Is the provider in administration (or equivalent), or likely to be so in the near future? |  |  |
| Have we made contact with the administrator, if applicable? |  |  |
| Is there an indication of timescales from the providers point of view? |  |  |
| Have we given any indication of the timescales from our point of view? |  |  |
| Is the registered manager staying until closure? |  |  |
| If not, is the provider providing a replacement? |  |  |
| Is there a need to install a temporary manager? |  |  |
| Is there sufficient staff capacity to run the business/deliver care? |  |  |
| Do we need to embed a member of staff to act as a point of contact? |  |  |
| Have we established how many individuals require what care, and when they require it? |  |  |
| Have we identified a lead officer/co-ordinator? |  |  |
| Is the CQC aware? |  |  |
| Who is the lead officer at the CQC? |  |  |
| Has any notice been served by the CQC to which a response is required? Within what timescales? |  |  |

|  |
| --- |
| **Communication with Staff** |

| **Action** | **Notes** | **Whom?** |
| --- | --- | --- |
| Have the staff been informed – when, how? |  |  |
| If not informed, when would be appropriate to inform them? |  |  |
| What is the feeling – will staff stay until closure? |  |  |
| Are there arrangements to pay the staff until closure? |  |  |
| Do the staff have any representation? |  |  |
| Is there a role for the CAB? |  |  |
| Do we have an idea of levels of staff expertise? |  |  |
| Do any of the staff have specialist skills particular to any individuals? |  |  |
| Would staff be interested in moving to a new provider? |  |  |
| Have we notified the JC+? |  |  |
| Can JC+ offer any assistance to staff? |  |  |
| Have we arranged a staff meeting – how/when? |  |  |
| Who is to be present? |  |  |
| What is the message? |  |  |

|  |
| --- |
| **Communication with Individuals/Informal Carers/Families and Representatives** |

| **Action** | **Notes** | **Whom?** |
| --- | --- | --- |
| Have individuals been informed – when, how? |  |  |
| Have informal carers, families and representatives been informed – when, how? |  |  |
| What do we need to communicate? |  |  |
| Do we need to draft a letter? Who is drafting and distributing? |  |  |
| Are we organising an individuals’/families forum – when? |  |  |
| What’s the message – who is to deliver the message? |  |  |

|  |
| --- |
| **Profiles** |

| **Action** | **Notes** | **Whom?** |
| --- | --- | --- |
| Do we have an up to date profile note for each individual (to include identification of individual risk factors/adverse impacts and potential mitigating actions)? |  |  |
| If not, when can this be done? |  |  |
| Has a risk stratification exercise been undertaken to clarify critical care delivery? |  |  |
| Do we have a clear idea of which individuals have been assessed as lacking capacity? |  |  |
| Do we know who requires IMCA, IMHA or Care Act advocacy? |  |  |
| Have we arranged IMCA, IMHA or Care Act advocacy input? |  |  |
| Is there an existing authorisation in place for deprivation of liberty? |  |  |
| Do we know who the GP is for each individual? |  |  |
| Have relevant GPs been notified? |  |  |
| Do we know what specialist equipment is needed? |  |  |
| Do we know who owns what equipment? |  |  |
| Have we identified any other specialist needs eg controlled medication, capacity, communication issues? |  |  |
| Has the provider made available all individuals’ records, so that these can transfer with them to a new provider? Have necessary permissions been sought from the individual/their representative or other responsible local authority to remove records, if the records are not supplied by the provider? |  |  |
| Is there any ongoing police investigation for which records might be required? If so, has agreement been reached with the Police re who is to take which records? |  |  |

|  |
| --- |
| **New Providers/Alternative Arrangements** |

| **Action** | **Notes** | **Whom?** |
| --- | --- | --- |
| If additional staff support is required to ensure delivery of care, has this been secured? From where has it been sourced (eg another homecare agency, Care Plus Group)? |  |  |
| If additional staff support is required, is it agreed how this will be paid for and/or from which budget? |  |  |
| Have we checked with individuals, informal carers, families and representatives if anyone can provide alternative support in the interim? |  |  |
| What other options might contribute eg Meals on Wheels, Careline etc? |  |  |
| Should respite/short term residential care be offered (as a last resort)? |  |  |
| Have we discussed options with individuals, and where relevant, their informal carers, families and representatives? |  |  |
| Where individuals do not have capacity, has a best interests meeting taken place? |  |  |
| Have we made a judgement on the most appropriate solution for each individual for which MIFS is responsible? |  |  |
| Do we have a full picture of which individuals’ needs will be met – when and how? |  |  |
| Are there any individuals in respect of whom particular mitigating actions are necessary? |  |  |
| Has authorisation been sought for any deprivation of liberty? |  |  |
| Is there sufficient staff to manage the move to a new service? |  |  |
| Do we need to deploy staff to assist? From where (eg another homecare agency, Care Plus Group)? |  |  |

|  |
| --- |
| **Money Matters** |

| **Action** | **Notes** | **Whom?** |
| --- | --- | --- |
| Do we have a financial profile of individuals?  Eg direct payments |  |  |
| Have we offered individuals, families etc a 1:1 finance review/ advice session? |  |  |

|  |
| --- |
| **Managing the Messages – Press and Partners** |

| **Action** | **Notes** | **Whom?** |
| --- | --- | --- |
| Have we informed the senior team? |  |  |
| Have we briefed local MPs? |  |  |
| Have we briefed the parish council (if applicable)? |  |  |
| Have we briefed the relevant GP(s)? |  |  |
| Have we informed the LA? Who, how? |  |  |
| Are the Press aware of the situation? |  |  |
| Have we prepared a press statement? |  |  |
| Have we released the press statement? |  |  |

|  |
| --- |
| **Other** |

|  |  |  |
| --- | --- | --- |
| **Action** | **Notes** | **Whom?** |
| Where an individual is the responsibility of another local authority, has that authority been notified of the position and our intended purpose? |  |  |
| Where an individual is the responsibility of another local authority or is a self-funder, has consideration been given to recovery of any costs incurred on behalf of the resident? |  |  |
| Have the Police, Fire and Ambulance Services been informed? Is it appropriate to include them in the MIFS meeting? |  |  |
| In cases where the CQC is involved, and a home is at serious risk of closure and/or deregistration, has the SAB been notified? |  |  |
| Is there any requirement to inform DBS re any staff regarding which there are relevant concerns? Who is attending to this? |  |  |

|  |
| --- |
| **Post Provider Failure Wash Up** |

| **Action** | **Notes** | **Whom?** |
| --- | --- | --- |
| Have we informed CCF? |  |  |
| Have we updated the service records as appropriate? |  |  |
| Have we updated Services4Me? |  |  |
| Have we visited individuals to follow up? |  |  |
| Has the post resolution report been presented to MIFS and agreed as marking closure of the incident? |  |  |
| Are all safeguarding enquiries connected with the provider concluded, and has the outcome been recorded in the post resolution report? |  |  |
| Are all legal and/or Police enquiries connected with the provider concluded, and has the outcome been recorded in the post resolution report? |  |  |
| Has the agreed post resolution report been appropriately circulated? |  |  |
| Has this policy and procedure been updated with any new learning? |  |  |

**NB all necessary actions connected with an incident of service interruption or failure should be completed within a timescale of two to six months, wherever possible**

|  |  |  |
| --- | --- | --- |
| **Action** | **Notes** | **Whom?** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

# APPENDIX D – Out of Hours Emergency Summary Checklist for Homecare Failure

**Out of Hours Emergency Summary Checklist for Homecare Failure**

In the event that notice is received unexpectedly of a homecare provider’s immanent/ immediate inability to deliver care, prompt action may be required to ensure delivery of care to significant numbers of individuals across North East Lincolnshire. Delivery of care across a wide geographical area may be more challenging to respond to than the failure of a single care home. This checklist of immediate ‘must dos’ has been created following scenario planning in which the sudden insolvency of a homecare provider was envisaged. It may be useful in other emergency scenarios, where ability to consider the full checklist (see Appendix C) is impossible in the short term.

It is anticipated that an out of hours provider situation which requires an immediate response is most likely to be received via the Single Point of Access (SPA). The SPA staff member receiving the call will be responsible for informing the focus on call duty manager, to initiate action. Alternatively, in the event that any other member of staff within the health and social care system (or outside of it) is alerted to an out of hours provider situation which requires an immediate response, they must telephone SPA to ensure that the information is passed to the focus on-call manager.

It is assumed that a basic outline of the situation requiring a response has already been ascertained by the focus on-call manager (either directly or via a SPA staff member).

The focus on call duty manager (FOCM) will:

|  |  |  |
| --- | --- | --- |
|  | Action | Complete |
| 1 | If the situation requires, contact NELC’s contingency planning/ emergency response team |  |
|  |  |  |
| 2 | Use the details within the Out of Hours Response to Provider Failure (Appendix F) protocol to contact as many of the key members on call managers (focus, Navigo, Care Plus Group (CPG) etc) as the situation  warrants, to secure initial support |  |
|  |  |  |
| 3 | Secure further information:   * If necessary, send a representative directly to the provider’s premises to investigate. This representative will act as the on-site operational manager (‘OPSM’), able to report back to SPA * Contact the appointed administrator (if relevant) to establish their knowledge of the situation and intended approach/ response * Confirm the response set out within the provider’s contingency plan, which may assist in addressing the situation |  |
|  |  |  |
| 4 | Convene meeting of key member on-call manager(s), or their designated representatives) at SPA |  |
|  |  |  |
| 5 | Be responsible for coordinating responses to the situation. At the meeting, the convened team will:   * Receive initial report from OPSM and/ or administrator * Agree roles and responsibilities of other attendees (see roles at 7, 8, 9 below for suggestions): create a temporary team for dealing with the current situation |  |

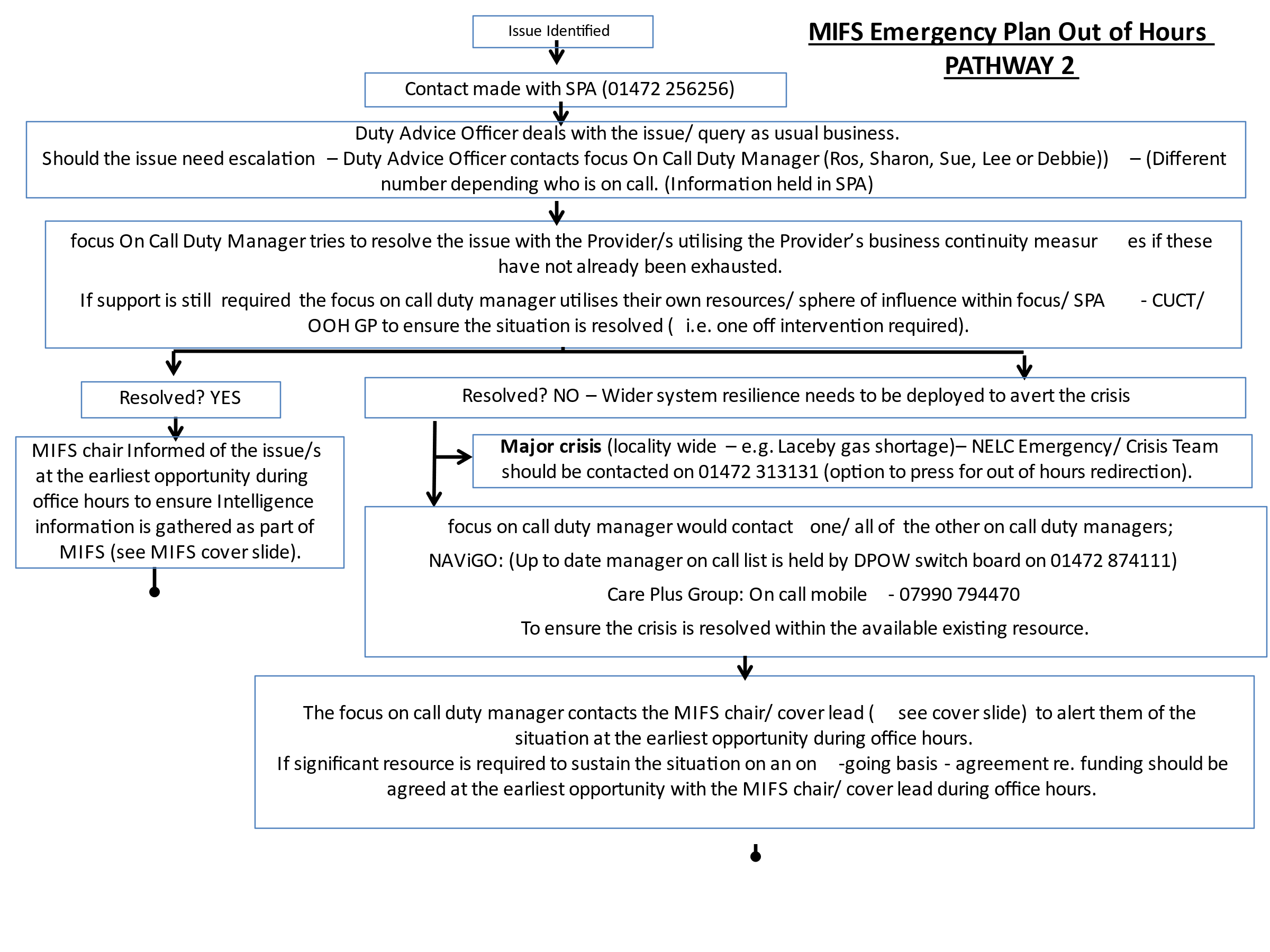
|  |  |  |
| --- | --- | --- |
|  | * Liaise with OPSM to agree what additional support is required (e.g. additional homecare provider staff, use of out of hours teams etc) – establish who will deliver the care required by service users * Agree whether each attendee needs to stay at SPA or relocate to support OPSM, on-site at the provider’s premises * Consider whether further call handlers are required at SPA to support any likely increase to calls from concerned individuals/ their representatives * Consider coordination with NELC contingency planning if relevant * Consider budgetary requirements- see Appendix F   NB not all of these tasks may be immediately possible, but will be reliant upon receipt of the below information from OPSM and/ or administrator |  |
|  |  |  |
| 6 | OPSM to delegate tasks on site, calling on additional support if/ as required. OPSM will also need to liaise with others (e.g. NELC, emergency services etc) to combine efforts. OPSM to report back to FOCM with further detail re the following, as quickly as it becomes available:   * Any business support required e.g. admin staff to rota additional provider staff/ access provider systems. NB CONTACT WITH EXISTING PROVIDER STAFF WILL BE KEY TO ENSURING RETENTION DURING CRISIS * A summary of who requires what care (i.e. basic outline of needs and special requirements e.g. lack of capacity etc), and when it is required (e.g. 4 calls per day at approx. what time) * On the basis of the above summary, a plan of triaged/ prioritised needs (i.e. which calls are absolutely essential/ cannot be missed) * Specific identification of any care that cannot be delivered (e.g. the shortfall in staffing equates to X hours of care delivery, in respect of X individuals) * Contact details for informal carers, relatives, representatives of those with needs; confirmation of which/ what contacts are being/ have already been made by provider staff |  |
|  |  |  |
| 7 | Ask designated team members to:   * Contact other homecare providers, care homes, etc to secure additional staffing provision to deliver care, in accordance with the triaged/ prioritisation of need information received from OPSM * Secure other responses as relevant to particular individuals e.g. Meals on Wheels, Carelink etc * Report secured emergency provision to FOCM and OPSM   NB this action will need to happen in tandem with 8 below – i.e. to establish if representatives can offer short term support to individuals |  |
|  |  |  |
| 8 | Ask designated team members to:   * Offer to support provider staff in contacting individuals/ their representatives to apprise them of the situation and offer   reassurance |  |
|  | * In the absence of availability of/ cooperation from providers, contact those representatives directly * Establish whether representatives can offer care to the individual in the short term, whilst longer term options are secured |  |
|  |  |  |
| 9 | Ask designated team members to utilise comms protocol to ensure media messages are managed, e.g. release press statement containing number for further enquiries, be available for interviews etc. Comms  team to liaise with provider and others (e.g. NELC, emergency services’ staff etc) to ensure coherence of messages |  |
|  |  |  |
| 10 | Once the immediate emergency/ response has been dealt with, attend to any other matters within the ‘standard’ checklist (Appendix D) which appear to be relevant/ necessary in the short term. When ‘normal hours’ resume, the standard MIFS protocols will be triggered and FOCM will  need to update the MIFS Chair with details of the action taken |  |
|  |  |  |

#### NB decision making must be logged throughout the above process, to provide evidence in the event of later challenge

**This checklist is not intended to fetter the discretion of the FOCM/ OPSM in responding to the situation as they find it. It is intended to offer guidance only.**

# APPENDIX E – Out of Hours Responses to Provider Failure

**Out of Hours Responses to Provider Failure**



Should a crisis occur which a provider is required to respond to under contract e.g. ensuring domiciliary care calls are delivered/ a care worker shift is covered within a care home, the provider should be made aware that they will need to fund any additional resource made available – e.g. payment of CPG staffing.

Where funding is required to meet a crisis situation that falls within the MIFS policy, the MIFS budget can be utilised as long as this is proportionate to the crisis. Should significant resource be required for a sustained period, MIFS funding can be utilised without agreement to ensure a prompt response to the crisis. A discussion with the MIFS Chair is then required at the earliest opportunity during office hours to agree significant levels of spend against the MIFS budget.

E.g. if a crisis occurs on a bank holiday, the MIFS budget should be utilised to make arrangements for the bank holiday and next day. However, on – going draw down of the budget for further days needs to be discussed with the MIFS Chair at the earliest opportunity during office hours to ensure the budget is not overspent.

# APPENDIX F – Responding to Business Failure and Service Interruptions

**Responding to Business Failure and Service Interruptions – the Law under The Care Act 2014 and the Care and Support (Business Failure) Regulations 2014**

**Introduction: the legal basis for meeting needs**

Under s1 of the Care Act, the ICB[**i**](#_bookmark0) has a general duty to promote the wellbeing of individuals when exercising its care and support functions. In addition, under s18 of the Care Act, the ICB must meet a person’s eligible needs where –

* + The person is ordinarily resident in its area (or is present, but of no settled residence), and
  + there is either a) no charge for the care and support offered to meet need, or b) there is a charge and
    - the person has assets under or at the upper capital limit (UCL)
    - the person has assets above the UCL, but asks the ICB to meet their needs (NB the ICB is currently only obliged to accede to the request where care is provided outside of a residential setting)
    - the person lacks capacity and there is no one to make arrangements for them.

The duty to meet need applies to those falling within s18 whether or not a provider fails. Where a provider fails (as defined within s48 - see below), additional considerations apply.

**Meeting needs in the event of provider failure: where and when the s48 duty applies**

When a provider is **meeting needs in the ICB\_NEL Place’s area**, s48 of the Care Act 2014 applies where –

* + the *provider* (i.e. a person registered under the Health and Social Care Act 2008, Pt 1 Chapter 2, or under the Care Standards Act 2000 Pt 2 in respect of an establishment or agency)
  + becomes *unable to carry on a regulated activity* (i.e. activities defined by the Health and Social Care Act 2008, s8)
  + *because* of *business failure*
* *Unable to carry on a regulated activity* (or to carry on/ manage an establishment or agency) means: unable to do so because of business failure, if the provider’s inability to do so follows business failure
* *Business failure* means:

Where a provider is not an individual:

* + the appointment of an administrator, a receiver, or an administrative receiver
  + a resolution is passed for a voluntary winding up, in a creditors’ voluntary winding up
  + a Winding Up Order is made
  + where the provider is an unincorporated charity, the charitable trustees become unable to pay their debts as they fall due (as defined at 2(5) of the Regulations)
  + where the provider is a partnership, every partner has been declared bankrupt, or the partners have presented a joint bankruptcy petition
  + a voluntary arrangement is approved under the Insolvency Act 1986

Where the provider is an individual:

* + the individual is adjudged bankrupt
  + a voluntary arrangement under the Insolvency Act is proposed or entered into by the individual.

The ICB is subject to duties under s48 as soon as it becomes aware of the business failure.

**The s48 Duty**

When the duty is triggered, the ICB must, **for so long as it considers necessary** (and in so far as it is not already required to do so by s18), **meet those of an adult’s needs** for care and support/ carer’s needs for support **which were being met by the registered care provider** by the carrying on of the activity, **immediately before the provider became unable** to carry it on.

The ICB is required to meet needs regardless of—

1. whether the adult is ordinarily resident in its area
2. whether the authority has carried out a needs/ carer’s/ financial assessment
3. whether any of the needs meet the eligibility criteria
4. whether the adult is a self-funder
5. whether the ICB contracts with the provider (Statutory Guidance 5.8). All people receiving services in the ICB’s area must be treated the same.

Where the ICB is meeting needs in discharge of this duty, it is *not required* to

1. carry out a needs/ carer’s/ financial assessment[ii](#_bookmark1)
2. determine whether any of the needs meet the eligibility criteria.

The lack of an assessment must not be a barrier to action, or whilst taking action.

NB whether or not the duty under s48 is triggered, the ICB is remains obligated to continue meeting the needs of those who fall within s18. Further information regarding duties to self- funders is provided below.

**How to Discharge the s48 Duty**

The ICB must ensure that needs are met, but how that it done is for the ICB to decide. It is not necessary to meet needs through exactly the same combination of services that were previously supplied, but the ICB should aim to provide a service as similar as possible to the previous one. The ICB should seek to minimise disruption, in accordance with the wellbeing principle.

In accordance with s8, the ICB may (by way of example) meet needs by providing the following –

1. accommodation in a care home or in premises of some other type
2. care and support at home or in the community
3. counselling and other types of social work
4. goods and facilities
5. information, advice and advocacy.

The ICB may meet needs by -

1. arranging for a person other than it to provide a service
2. by itself providing a service
3. by making direct payments.

NB there are exceptions which apply in respect of persons subject to immigration control (see s21).

In deciding how to meet an adult’s needs for care and support under s48, the ICB must involve—

1. the adult,
2. any carer that the adult has, and
3. any person whom the adult asks the ICB to involve or, where the adult lacks capacity to ask the ICB to do that, any person who appears to the ICB to be interested in the adult’s welfare.

In deciding how to meet a carer’s needs for support under s48, the ICB must involve—

1. the carer,
2. any person whom the carer asks the authority to involve.

The ICB must take all **reasonable steps** to reach agreement with the adult or carer about how it should meet the needs in question.

#### Obtaining information about the failed business

Where the ICB considers it necessary to support the discharge of its duties under s48, it may request the registered care provider, or such other person involved in the provider’s business as it considers appropriate, to provide it with specified information (e.g. up to date records of those requiring support).

The CQC must inform the ICB if it thinks the ICB will be required to carry out duties under s48(2), in respect of a provider which falls within its market oversight regime. Where the CQC considers it necessary to do so for the purpose of assisting the ICB to discharge its duties, it may request the provider, or such other person involved in the provider’s business as the CQC considers appropriate, to provide it with specified information. Where the CQC has information about the provider’s business that it considers may assist the ICB in discharging its duties, the CQC must give the information to the ICB.

There is no definition of specified information, other than that elaborated upon in the Guidance.

#### Liaison with other authorities

If the adult is not ordinarily resident in the ICB’s area, the ICB must, in meeting needs under s48 for which arrangements were made by another local authority and/ or were being paid for by another local authority (whether via direct payment or otherwise), cooperate with that authority.

Where there is a dispute between the ICB and another local authority re whether/ how s48 applies, this must be referred to the Secretary of State in accordance with s40. Where the dispute relates to cross-border authorities (see s49), it must be dealt with in accordance with Schedule 1, paragraph 5 (see also the Cross-Border Placement Dispute Resolution Regulations).

#### Making a Charge/ Recovery of Costs

In meeting needs under s48, the ICB may –

* under s48(5), make a charge for meeting those needs (except re the provision of information or advice). The charge must cover only the actual cost that the ICB incurs in meeting need. The ICB cannot make a charge in cross-border cases
* under s49(3), recover the cost it incurs in meeting those needs, as follows:
  + s49(3)(c) - where arrangements to meet need are being met by a cross-border local authority (including via making direct payments) the ICB may recover its costs from that authority
  + s49(3)(d) - where an individual makes their own arrangements to meet need, the ICB may recover its costs from the individual themselves.

There appears to be no prohibition within s49 re charging for the costs of providing information or advice.

**When the Duty does not Apply**

If the provider’s business has failed but the service continues, the s48 duty is not triggered. This may happen in insolvency situations where an administrator is appointed.

It is not for the ICB to become involved in commercial aspects of the insolvency, but it should cooperate with the administrator if requested. The ICB should, in so far as it does not adversely affect people’s safety or wellbeing, support efforts to maintain service provision, e.g. by not ceasing to commission/ permanently withdrawing people from the affected service.

NB s18 duties apply to those falling within it, whether or not the s48 duty is triggered. Further information regarding duties to self-funders is provided below.

**Power to Act, in the Absence of a s48 Duty**

Where the duty to act under s48 does not apply, the ICB may nevertheless utilise powers to act.

#### Power under the Care Act s19

The ICB may utilise s19 to meet needs which appear to it to be urgent. The power can be exercised–

* whether or not assessments have been conducted, or eligibility determined, and regardless of whether the adult in question is ordinarily resident in the ICB’s area
* whether or not the provider which has been meeting the needs is registered (i.e. the provider provides an unregistered care activity).

Whether or not to act under s19 is a decision for the ICB but it should consider the examples below, in which the power may be exercised –

* where the continued provision of care and support is in immanent jeopardy, and there is no likelihood of returning to business as usual in the near future, which results in urgent needs
* where a provider cannot or will not meet its contractual responsibilities, which results in urgent needs
* where a service closes temporarily e.g. due to an act of God (flood etc) or complications with suppliers (e.g. unforeseen absence of qualified nursing staff), which results in urgent needs
* where a service closes permanently e.g. a care home is sold for use as a hotel, resulting in urgent needs.

In deciding whether to meet needs, the test is whether the ICB considers that there is an urgent need to be met. In considering whether to act the ICB must balance the risk to providers (if the ICB acts in a way that precipitates business failure) with the risk of not meeting urgent needs. Each service interruption should be considered on its facts via a process of risk assessment. The ICB must act lawfully, including taking decisions that are reasoned and reasonable.

NB where a service user is the responsibility of another local authority and the ICB intends to use its powers under s19 to meet that user’s needs, it must notify the other authority of its intention to do so (s19(2)(3)).

#### Power under the Local Government Act 1972 (LGA), s111(1)

Support for action can be found within the subsidiary powers found within the LGA; s111(1) provides local authorities with a power to “do anything (whether or not involving the expenditure, borrowing or lending of money or the acquisition or disposal of any property or rights) which is calculated to facilitate, or is conducive or incidental to, the discharge of any of their functions”. This power is limited by the provisions of that Act, and any other earlier or subsequent enactment, so care should be taken before assuming that s111(1) authorises the action proposed in a given case.

**NHS Continuing Healthcare (CHC) Cases**

The Care Act imposes certain restrictions on the provision of health services by local authorities (see s22), and these apply to meeting needs under s48 (see s52(7)). In meeting need in CHC cases, the ICB will be doing so under other legislation/ Guidance such as:

* the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (amended by the 2013 ‘Standing Rules’)
* National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care October 2018 (Revised)
* NHS Funded Nursing Care Best Practice Guidance.

Disputes with other ICBs should be handled in accordance with the responsible ICB’s dispute resolution procedure, including securing agreement on how funding will be provided during the dispute, and on how reimbursement will be secured following the dispute (see Care Act Statutory Guidance and ‘Who Pays’ Guidance).

The NHS Act 2006 s2 provides a power to meet needs similar to that within the LGA s111(1).

**Supporting self-funders – summary**

The Care Act 2014 clarifies responsibilities in respect of self-funders; these include:

* The duty to promote wellbeing applies when carrying out any function under part 1 of the Care Act in respect of an individual. The duty applies equally to those who have no eligible needs (s1)
* The duty to provide/ arrange for preventive services applies to all adults including those without current or eligible need. Self-funders are entitled to access intermediate care and reablement support services to meet need (s2 and the Care and Support (Preventing Needs for Care and Support) Regulations 2014)
* Information and advice provision must meet the needs of the whole population, not just those who are in receipt of commissioned services. Access to information and advice (including financial information and advice) is fundamental to making well- informed care and support choices (s4)
* The duty to ensure the care and support market provides a variety of high-quality services is intended to benefit any person wishing to access those services (s5)
* All adults with an appearance of need for care and support are entitled to an assessment, regardless of the level of their resources, or need (s9)
* Assuming that an individual is assessed as having eligible needs, and is ordinarily resident in North East Lincolnshire (or is present here, but of no settled residence), self-funders seeking access to chargeable services can ask the ICB to meet their needs (s18(3)). Care practitioners must accede to this request unless it is anticipated the self-funder’s needs will be met by a care home placement. Where an individual lacks capacity to arrange their own care and support (whether within a care home or otherwise) and has no one to make arrangements for them, care practitioners must arrange to meet their needs (s18(4))
* Safeguarding duties apply to all adults with care and support needs who are experiencing (or at risk of experiencing) abuse or neglect, and who as a result of their care and support needs, are unable to protect themselves (s42)
* There is a duty to ensure needs for care and support are met temporarily where a registered care provider fails in the circumstances set out within the Care and Support (Business Failure) Regulations 2014 (s48)
* The duty to arrange for an independent advocate applies for all adults on assessment, care planning, care review, or safeguarding enquiry or review, where the adult has substantial difficulty in being involved in these processes and has no one appropriate to support them (see s67 and 68 and the Care and Support (Independent Advocacy Support) (No. 2) Regulations 2014).

Where duties to meet need are triggered under s18(3) or 18(4) additional duties are owed

1 The Care Act imposes duties on Local Authorities. As adult social care duties have largely been delegated to the ICB, references to local authorities within the Act have been substituted for references to the ICB

# APPENDIX G – Communications Protocol Guidance

**Communications Protocol Guidance**

This guidance has been prepared to assist staff, particularly those at the Single Point of Access, if they are approached by a member of the media for comment or for information relating to MIFS and/ or a failing or interrupted service.

#### Normal office hours

To ensure consistency of information and approach, members of the media should be asked to contact the North East Lincolnshire ICB media line on **03300 249301.**

If callers press for information, they should be thanked for their call but informed politely that any information or response to their enquiry will come via the ICB Communication team and they should redial **03300 249301**.

#### Outside normal office hours

**Failing services enquiry/general enquiry**

Members of the media should be asked to contact the North East Lincolnshire ICB media line during normal office hours (from 8.30am until 5pm) on **03300 249301.**

If callers press for information, they should be thanked for their call but informed politely that any information or response to their enquiry will come via the ICB Communications team when office hours resume, and they should redial **03300 249301** during office hours.

#### Emergency Situation – e.g. fire/ flood at a care home

If the emergency services are in attendance at an incident, ~~then~~ members of the media should be advised to contact Humberside Police/ Fire and Rescue via their usual channels of communication for the most up to date information.

Callers should be informed that any general information or response to their enquiry will come via the ICB Communications team when office hours resume, and they should redial **03300 249301** during office hours.

#### Large scale emergency

If a large-scale emergency is declared, ~~then~~ any communications in the public interest will be dealt with under North East Lincolnshire Council’s emergency plan. The Single Point of Access will be advised about this and issued with contact information for the media, and a script for responding to public enquiries.

#### If members of the media attend premises in person

Providers/ MIFS members/ ICB/ Council/ staff should politely inform members of the media who arrive at any premises that any information or response to their enquiry will come via the ICB Communication team during office hours and they should telephone **03300 249301**.

There is nothing to prevent members of the media remaining in a **public** place (such as on the street) or politely approaching families/ carers for comment but they should not do this on the premises and members of the public should not be harassed or pursued (this would be a police matter).