Derby City Council

Managing Provider Concerns
to Provider Failure

Derby City Council

Derby City Council

People Services Directorate
Adult Social Care
Guidance 2024/25
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Summary

This document was originally developed in co-operation with Derby City Council (DCC) Officers and with valued input from Integrated Care Board (ICB) (previously CCG) and Care Quality Commission (CQC) colleagues. It provides operational guidance for addressing concerns about a provider through to managing provider failure and supports implementation of this aspect of the Care Act (2014).

For the purposes of this guidance document care providers include all organisations which provide all types of care and support within the local area not just those which are regulated – although Care Act duties are only applicable to organisations providing regulated care and support.

Failures of care providers are comparatively rare events but would present challenges in that DCC and partner intervention could be required immediately. The assessment and potential transfer of customers to alternative care providers may need to take place within a very short time frame and would be dependent on the individual needs of those customers and the availability of spare capacity within the local market.

Changes to provision for customers and the impact on them and their family and carers should be managed in the best ‘person-centred’ way possible. Every effort should be made to cater for the specific assessed needs of each customer, and wherever practicable to keep ‘friendship groups’ together and take time and great care to minimise the disruption and maximise the time available for preparation.

It is recognised that every situation is different, and it is up to the responsible Officers to decide the best approach for the situation presenting at the time, interpreting this Operational Procedure flexibly to suit the specifics of the case while 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 Officers will need to adapt procedures and use available resources to minimise disruption to customers as far as possible.

The following describes the duties under the Care Act (2014), clarifies what these mean including the role of the CQC and provides a clear and localised process through which concerns regarding a provider can be escalated and de-escalated with appropriate level decision making and action planning/implementation.

1. Introduction

The Care Act 2014 (Sections 48 to 52) and associated guidance have provided local authorities with powers to discharge its duties where customers are at risk due to a planned or unplanned closure or interruption to a service. This is primarily where a provider’s business has failed but also explains more general duties. This document is the local interpretation of that guidance and explains to DCC staff and providers of care and support what will be done to manage a service interruption and/or Provider Failure.

In addition to the duties highlighted above, DCC wants to ensure that it has a Quality Assurance process that can be implemented in the early stages of concerns around a

provider so that support and measures can be introduced in a timely way maximising the opportunity to address those concerns to reduce or prevent escalation in risks to customers well-being and safety.

In the application of this guidance DCC will ensure customers' safety and wellbeing is at the centre of activity, keeping them and their families/carers involved and informed, whilst working in co-operation with its partners to enable this approach.

2. Aims & Objectives

The main aims of this document are to provide a framework for Managers to ensure:

- the health and the emotional wellbeing, safety, and welfare of the adults with care and support needs that are affected, and of their families and carers.
- concerns are addressed early through a formal mechanism to reduce/prevent escalation but if the Provider response is unsatisfactory there is.
- effective coordination, co-operation and communication between all parties involved in the proposed and/or actual failure arrangements.

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

It is intended as a generic framework for situations of this type 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.

The options for alternative provision will depend upon individual circumstances.

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. Care Act (2014) – Temporary Duty

Section 48 of The Care Act (2014) Care Act 2014 (legislation.gov.uk) imposes a temporary duty on local authorities if a regulated provider becomes unable to provide a regulated activity to an individual due to a business failure. This duty applies regardless of whether the individual's care is funded by the local authority or not. This temporary duty is engaged where the following criteria are met:

1. The provider must be a **registered care provider.**
2. The provider must be **unable to carry out the particular activity**. Where the provider can continue the activity despite business failure the duty will not be triggered.
3. The activity that the provider is unable to carry out must be a **regulated activity.**
4. The inability to carry out the activity must be due to the provider's **business failure.**

Business failure is defined in the Care and Support (Business Failure) Regulations 2014 and references to business failure in this document should be construed accordingly. The Care and Support (Business Failure) Regulations 2014 (legislation.gov.uk)

The Act states that a local authority must ‘for so long as it considers necessary’ meet the needs that were being met by the provider immediately before the provider became unable to carry on the activity. It is not necessary to meet those needs through the same combination of services that were previously supplied. When deciding how needs will be met, DCC must involve the person concerned, any carer that the person has, or anyone whom the person asks DCC to involve.

DCC has the power, where it considers this necessary to discharge the temporary duty, to request that the provider, or anyone involved in the provider’s business as it thinks appropriate, to supply it with information that it needs.

In discharging this duty, DCC is not required to carry out a needs or financial assessment or decide of eligibility. Local authorities have the power to charge for the cost (except for the provision of information or advice) in meeting the person’s care and support needs. Where the person is ordinarily resident in another local authority’s area, the local authority discharging its temporary duty may recover its costs from the former.

Where the failed provider’s clientele consists of persons in receipt of NHS Continuing Healthcare (CHC), unless their needs appear to have changed, it is reasonable for DCC to conclude that it was not necessary to do anything to meet those needs. The duty to provide NHS CHC is the responsibility of the NHS and DCC cannot provide it.

The local authority must take all reasonable steps to reach agreement with these interested parties which will include ensuring that health colleagues adhere to their obligations under Continuing Health Care guidance National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - July 2022 (Revised) - corrected May 2023 (publishing.service.gov.uk) and that they also provide information and advice in relation to meeting Health needs. The Council also has the expectation to work positively with case managers under the co-operation duties and principles of the Care Act.

Where a dispute occurs staff must inform their Head of Service in writing of this and discuss if there is the need to involve Legal Services in the resolution of the dispute.

4. Definitions

Business Failure

A business failure is strictly defined in the Care Act as a financial failure of the care provider’s business where a regulated activity can no longer continue and services cease.

“Business failure” is defined in the Care and Support (Business Failure) Regulations 2014. Where a provider is not an individual, business failure means that, in respect of that provider:

a) an administrator is appointed.
b) a receiver or an administrative receiver is appointed.
c) a resolution for a voluntary winding up without a declaration of solvency is passed.
d) a liquidator is appointed.
e) a winding up order is made by a court.
f) a members' voluntary winding up becomes a creditors' voluntary winding up

g) an order by virtue of Article 11 of the Insolvent Partnerships Order 1994 (joint bankruptcy petition by individual members of insolvent partnership) is made.
h) administration moves to winding up pursuant to an order of a court.
i) the charity trustees of the provider become unable to pay their debts as they fall due.

Where the business failure relates to an individual person, business failure means that the individual has been declared bankrupt.

Service interruption because of "business failure" relates to the whole of the Regulated Activity and not to parts of it. The following link will give information on Regulated Activities:

http://www.cqc.org.uk/guidance-providers/registration/regulated-activities

The Council would expect that those providers which are starting to experience financial difficulties would raise these as early as possible so that the Council is aware and can work with the provider on solutions to address concerns before they escalate.

Provider Failure

In recognition that care providers can also fail for reasons other than 'business failure' this guidance will also cover 'provider failure' which is defined for this purpose as:

"The inability to meet contractual obligations".

These obligations may be to DCC, but the definition extends to self-funders or people taking direct payments who have a contract of service with the provider. A provider has failed if it is no longer able to provide care reliably, safely, and consistently and / or support at the right level to the people for whom it is contracted to provide services.

5. Business failure of a provider in the CQC market oversight regime

Market Oversight aims to protect people using adult social care services from having their care interrupted where a large or specialist care provider is at risk of financial failure and must close one or more of its services. Where CQC assesses that this is likely it will notify the relevant local authorities where the affected service(s) deliver care so they can draw up specific contingency plans to preserve continuity of care. Local authorities have a legal duty to ensure people continue to have their care needs met if a provider stops being able to do so. https://www.cqc.org.uk/node/3691.

Care Providers will fall under the CQC regime where they are providing regulated services as follows:

Residential care criteria

For a residential care provider, they must have bed capacity:

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

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

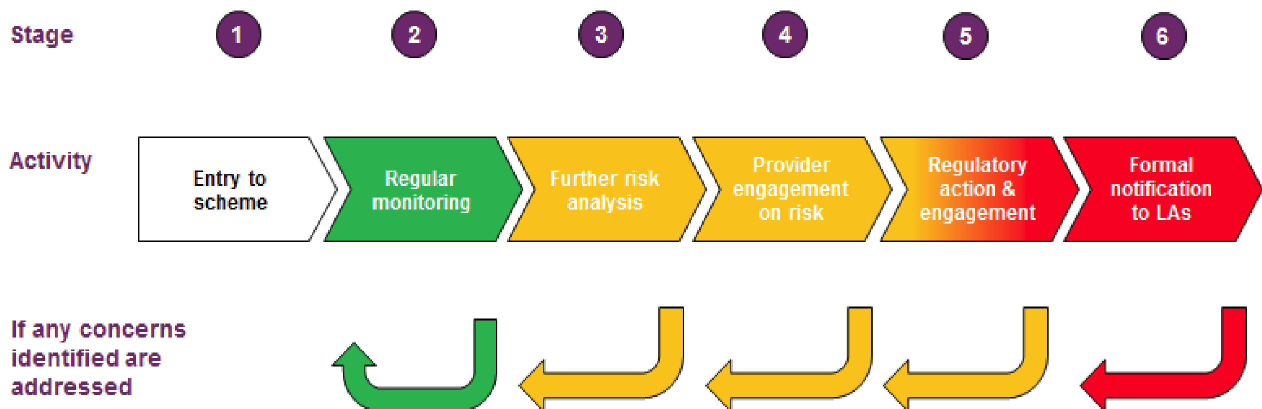
Non-residential care criteria

For non-residential care, they must:

a. provide at least 30,000 hours of care in a week anywhere in England (ie, significant size of provider); or
b. provide at least 2,000 people with care in a week anywhere in England (ie, significant scale regionally or nationally); or
c. provide at least 800 people with care in a week anywhere in England and the number of hours of care divided by the number of people provided care must be more than 30. For example, if 900 people receive care in a week then more than 27,000 hours of care must be provided in that week for the criteria to be satisfied (ie, a higher amount of provision).

CQC 12 May 2022

Market Oversight Model



Key
Indicates assessment of risk to financial sustainability
- **Green :** no cause for concern
- **Amber :** potential increase in risk
- **Amber/red:** increase in risk
- **Red:** risk clearly identified

There are three conditions that must be satisfied for CQC to trigger the duty to notify Local Authorities:

a. Business failure.
b. A registered provider is unable to carry on a regulated activity, by which we mean it is likely that a service will close, or a regulated activity will cease (which may require the Local Authority to need to step in and carry out its duty under s.48(2) of the Care Act 2014).

c. It is likely that both may happen and **b)** happens because of **a)**.

If the CQC is of the view that a provider is likely to become unable to continue with its activity because of business failure, DCC will work with the CQC to fulfil their temporary duty.

6. Business failure of a provider not in the CQC oversight regime

The providers outside the CQC oversight regime will in the main be those with small and medium size businesses.

The temporary duty on DCC to meet needs in the case of business failure applies regardless of whether the provider is in the market oversight regime. Despite the CQC having a market oversight responsibility, DCC has responsibility to ensure continuity of care in respect of business failure of all providers within its boundary.

7. Administration and other insolvency procedures

Business failure will usually involve an official being appointed, for example an Administrator, to oversee the insolvency proceedings. An Administrator represents the interests of the creditors of the provider that has failed and will try to rescue the company as a going concern. In these circumstances, the service will usually continue to be provided, and the exercise of DCC'S temporary duties may not be called for. DCC will not become involved in the commercial aspects of the insolvency but will cooperate with the Administrator if requested. DCC will support efforts to maintain service provision by, for example, not prematurely withdrawing people from the service that is affected or ceasing to commission that service.

8. Service interruptions other than business failure

The Care Act 2014 permits a local authority to meet needs which appear to it to be urgent. In this context, "urgent" takes its everyday meaning, and may be related to, for example, time, severity etc. This is likely to be the case in many situations where services are interrupted but business failure is not the cause.

This power can be exercised to meet urgent needs without having first conducted a needs assessment, financial assessment, or eligibility criteria determination. DCC can meet urgent needs regardless of whether the adult is ordinarily resident in Derby and will work closely with a host Authority to understand a person's needs to ensure safeguarding concerns, any future move and appropriate decision making are undertaken and managed. The power may also be used in the context of quality failings of a provider if that is causing people to have urgent needs.

DCC has a power to act to meet needs, but this doesn't mean that it must act. Whether or not to act is a collaborative decision between Operational, Safeguarding and Commissioning in line with delegated responsibilities and through a process of risk assessment.

Examples of service interruption that will require a decision to act include but is not limited to:

- where the provider cannot or will not meet its responsibilities.
- where the continued provision of care and support to those receiving services is in imminent jeopardy and there is no likelihood of returning to a “business as usual” situation in the immediate future, leading to urgent needs.
- where a care home closes, and residents have agreed to the provider’s plans to move the residents to a nearby care home that the provider also owns.
- where the authority judges that the needs of individuals are urgent.
- where the service closure is temporary (for example unforeseen absence of qualified staff).
- where the service closure is permanent (for example the home is to be sold on for use as a hotel).
- where the service closure is an emergency.
- where the service closure is planned.
- where a planned closure may be involved.

Where DCC becomes involved in ensuring needs continue to be met, that involvement could be short-lived (for example the giving of advice) or enduring over some months (for example overseeing the movement of residents following the closure of several homes owned by the same provider).

Acts of God (for example flooding) or complications with suppliers (for example a nursing agency refuses to continue to provide qualified staff) should not in themselves automatically be considered to trigger the use of the power. In all cases, the test is whether there is an urgent need to be met.

9. The need for contingency planning

DCC will continue to work with neighbouring local authorities to oversee providers that both utilise. This includes working together to conduct financial appraisals of small providers and working together to accommodate customers in the event of a large-scale provider failure. This will be included in the Directorate’s Business Continuity plans.

When a neighbouring local authority places a suspension on care home placements DCC will automatically suspend contracting with that Provider and send the details to the relevant social care team. If the suspension is with a domiciliary care provider DCC will look at what the issues are and whether they are consistent with the care provision for Derby City before determining if there should be a decision to suspend contracting.

10. Activation of the Managing Provider Failure Procedure

Trigger Criteria

The procedure will be activated if any of the following criteria is met:

- A decision to decommission care because of improvement measures not being met by the Provider and/or significant and widespread allegations of abuse that have been evidenced so leading to failure may be taken by DCC's Head of Commissioning and Market Management in conjunction with the Head of Safeguarding Adults and Professional Standards and the Service Director for Integration and Direct Services. A 'Final Concerns Response Meeting' will need to have been held before the decision is made and authorised. The formal decision to activate this Procedure will come from the same lead personnel, and the expectation is that DCC and, as appropriate, Health Leads will agree activation and work in partnership through the process.
- DCC is notified of the imminent business failure of a regulated care provider registered as operating in Derby City.
- DCC is advised of the immediate suspension, closure, and de-registration of a regulated care provider by the CQC e.g., on the grounds of health and safety or assessed risk to customers.
- DCC is notified of a major and immediate unplanned service interruption e.g., a significant fire or flood *and* where the care provider's own business continuity plan is unable or has failed to address the resulting service impact.

As soon as a failure notification is received or real risk of potential failure is identified, DCC's Head of Commissioning and Market Management, and the Service Director for Integration and Direct Services must be notified immediately by telephone with confirmation in writing (email).

Staff passing information to the 'Leads' above **must** ensure it has been received and 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.

The DCC leads will instruct appropriate Officers to verify the failure or potential failure with the CQC, and/or the Care Providers Owner, and determine what other relevant parties need to be contacted, by whom, and when.

Should the failure be related to the alleged abuse of one or more vulnerable adults, the DCC Head of Safeguarding Adults and Professional Standards must be notified and should ensure that Safeguarding Alerts are made in accordance with the *Adult Safeguarding Policy and Procedure.*

The DCC lead will immediately call a Provider Failure Management meeting to take place at the earliest practicable opportunity. In view of the potential implications for the health and well-being of customers, the relevant Officers will be required to treat the situation as demanding their personal involvement and very high priority. The meetings can be hosted in either face to face or virtually.

11. Potential Options for Alternative Service Provision

Potential options for alternative service provision may include:

- spot purchase from other Care Providers
- reserving services in other suitable locations
- temporary staffing, (for example via local Agencies)

- temporary management, (for example 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

It should not simply be assumed – especially in the case of a Provider operating several services, and/or where an Insolvency Practitioner is acting – that any payments DCC makes which are intended by DCC 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.

All transfers of customers between care providers should occur within normal working hours.

12. Support for Customers and their Families/Carers

It is paramount that customers and their families/carers are involved and supported appropriately throughout the escalation process and especially where there is risk of provider failure.

DCC, along with relevant partners in the process, will:

- carry out Safe and Well Checks for customers.
- provide information, advice, and guidance in relation to meeting individual social care and/or health needs.
- discuss the options available to customers if DCC feels there is a need to change providers to keep the customer safe and to maintain or improve their well being.
- keep customers and their families/carers as informed as necessary if concerns around their provider start to escalate – this will include what the risks may be to them when this happens and how DCC and its partners will work together to improve the situation.
- actively engage with customers and their families/carers to obtain feedback on their views and opinions regarding the care and support they have received.
- Listen to any worries that customers and/or their families/carers have throughout the escalation process and give support where needed to help alleviate these.

The above is not exhaustive and DCC will support and communicate on a basis that is appropriate to each situation.

13. Processes

The following processes are attached to this document:

Appendix 1
End to End Process for managing provider concerns through to Provider Failure Management

Appendix 1 Schedule A:
Process 1- Final Concerns Response Management

Appendix 1Schedule B:
Process 2 –Provider Failure Management

Appendix 2

Management Checklist for use as guidance

Document Control

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This document includes material derived from similar guidance prepared by Leicestershire County Council, Northamptonshire County Council and NHS Northamptonshire, NHS Nottingham, and Nottingham City Council whose assistance is gratefully acknowledged.

Appendix 1 to the Adult Social Care Managing Provider Concerns to Provider Failure Guidance

End To End Escalation Process: Provider Concerns to Provider Failure Management

Introduction

To ensure that there is a robust system in place to monitor and address concerns regarding a provider of care and support this 'end to end' process of escalation is designed to guide staff in this operation.

Responsibility and Accountability for Quality Assurance

The Quality and Monitoring Team (QMT) has responsibility and accountability for the Quality Assurance Process for:

- Regulated and LA/ICB contracted providers
- Regulated and non-LA/ICB contracted providers (e.g., organisations providing support to Direct Payment customers)
- Unregulated and LA contracted providers (Supported by Lead Commissioners)
- Unregulated and non-contracted providers (e.g., organisations providing support to Direct Payment customers) (Supported by Lead Commissioner)
- Out of area placements (Supported by Lead Commissioner))

across Adult Social Care.

Triggering the QMT Quality Assurance Process

Operational Teams
All Operational Teams will formally report concerns to the QMT on the following basis: • Where a concern has been identified the operational colleague will initially ***alert*** the QMT through Liquid Logic by providing a case note to the QMT Duty Tray outlining the nature of the concern(s) • The operational colleague has used their professional judgement and ensured that actions have been taken specifically to address support concerns around an individual which may include a 'Safe and Well Check' and/or • The operational colleague has observed or experienced a situation not necessarily directly in relation to the customer they have responsibility for but that raises concern and they have ensured that positive action has been taken to resolve the situation • The operational colleague will discuss the concern(s), as appropriate with their Service Manager, so that they are aware and can act accordingly if necessary

Safeguarding
Safeguarding colleagues will ensure that the following checklist has been covered as part of their process of alerting the QMT of provider concerns: • Circumstances have been shared in full with MASH • Decision made as to whether safeguarding criteria is met regarding the provider or individuals • Referral(s) to coroner and inform them that enquiries are underway • List of individual's subject to safeguarding collated and shared

- Enquiry Planning Meeting to be convened within MASH including decision with police around joint enquiries and intelligence sharing with partner agencies (for individuals and providers)
- Agreement sought for care records to be seized where necessary
- Resources identified and allocated to carry out enquiries

Customer Complaints or Whistleblowing
Where a customer, Staff Member or their representative makes a complaint about a provider outside of the Council's formal complaints process to the Safeguarding or an Operational Team (may be via the QMT) then the receiving team will: • Investigate the complaint and attempt to resolve between the provider and the customer within a fixed timescale • Communicate with the provider and the customer appropriate to the level of complaint • Alert the QMT as per normal practice and identify whether the complaint was resolved satisfactorily or not by the end of the fixed timescale The QMT on receiving an alert as above will: • Record the nature of the complaint and those which have been resolved satisfactorily • Record where complaints have not been resolved and take over management of the complaint as part of QMT Provider Quality Assurance for a fixed timescale • Decide to (de) escalate in line with QMT Quality Assurance and this guidance dependent on the outcome at the end of the fixed timescale • Communicate with the provider and the customer as appropriate

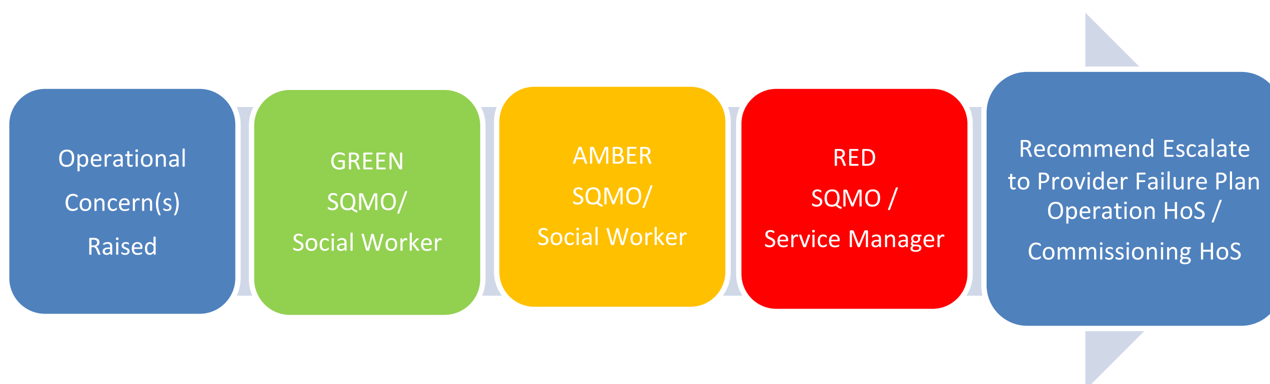
Adult Social Care (ASC) Finance Teams
The Finance Team will monitor and raise concerns with the Lead Commissioner for the market are regarding both short term and long terms risks to a provider's financial viability.

The relevant QMO will take the reported concern(s) and apply the QMT's RAG rated tool and confirm the RAG status of the Provider to the relevant social worker(s) and Senior Quality Monitoring Officer (SQMO).
The QMT's RAG status is as follows:

Red	CQC Notice of Proposal of Closure (NOP) Lack of sufficient evidence demonstrating ability to address high number of and/or serious Safeguarding alerts which are adversely impacting on customers well being High risk of closure i.e., financial pressures (possible need to move customers / find alternative services) Final contract breach notice CQC Rating of Inadequate and/or Warning Notices High level and/or seriousness of Safeguarding Notifications Suspension (including voluntary) Health and Safety Audit – scoring 50% or less Default Notice(s)/Enforcement(s) More than one contract breach notice Inadequate - The service is performing badly.

Amber	High risk of moving to Red (including soft intelligence) Contract breach notice Environmental Enforcement Notice(s) Derbyshire Fire and Rescue Enforcement Notice(s) Infection control risks Environmental Health Notice(s) Planning Enforcements Visit not undertaken within past 2 years (QMO) Safeguarding's / Whistle blows (not yet resolved) CQC inspection report – requires improvement No registered manager in place Concerns from GP, Fieldworkers, Healthcare Professionals Quality Audit undertaken and risks identified / provider not responding to actions Health and Safety Audit – scoring between 60% and 50% LA ¼ Return indicating High level of staff/manager turnover Contractual restrictions i.e., limit on number of new admissions - following suspension (3 and 6 month) Infection control risk Non return of signed individual contracts back to DCC Unresolved customer complaints Requires improvement - The service is not performing as well as expected.
Green	High risk of moving to Amber Monitoring visit undertaken within past 18 months; action plan outstanding but no significant concerns (QMO) Audit Undertaken and any actions have been addressed Nil concerns raised by GP, Fieldworkers, Healthcare Professionals Good - The service is performing well and meeting our expectations.

Escalation through the QMT process is as follows:



Functions

In undertaking the functions below the QMT will work with Operational and Safeguarding colleagues as they follow their processes to ensure movement within the escalation process is co-ordinated and managed effectively:

QMO	• Manage actions/improvement and communication to relevant colleagues and the Provider to AMBER level • Manage and communicate de-escalation between AMBER / GREEN levels • Notify senior QMO or Commissioning Delivery Hub Manager as appropriate of contract breaches Recommend escalation from AMBER to RED to Head of Adults Commissioning, Integration, and Market Development • /SQMO
Head of Adults Commissioning, Integration, and Market Development (delegated to Senior QMO in QMT in their absence)	• Agree recommendation to escalate from AMBER to RED status and undertake necessary management and communication to relevant colleagues. • Manage actions/improvement and communication to relevant colleagues at RED status • ***Recommend*** Provider suspension by report to Director of Integration & Direct Services • **Recommend** lifting Provider suspension by report to Director of Integration and Direct Services • Manage and communicate to relevant colleagues de-escalation between RED/AMBER status • Escalate from RED to PROVIDER FAILURE and communicate to relevant colleagues • Manage and/or contribute to Provider Failure Process arranging for any delegated staff input • Determine level and number of contract breaches and notify Head of Commissioning & Market Management as appropriate • Work in partnership with Head of Commissioning & Market Management and Operational HoS • SEE PROVIDER FAILURE Roles and Responsibilities
Head of Adults Commissioning, Integration, and Market Development	Oversee and work in partnership with the Head of Adults Commissioning, Integration, and Market Development • The Lead Commissioner for the market area and Operational HoS from RED status onwards until full resolution of the PROVIDER FAILURE PROCESS • On receipt of contract breach notification from Lead Commissioner for the market to liaise with Legal Services for advice on possible contract termination and if agreed instigate Process 1 Final Concerns Response Management • Notification to the Director of Integration and Direct Services with ***recommendation*** to activate PROVIDER FAILURE PROCESS

<u>Escalation to Provider Failure Process</u>

The Director in liaison with the Head of Integrated Commissioning and Operational HoS will use the following Trigger Criteria to activate:

i) A decision to decommission care because of improvement measures not being met by the Provider and/or significant and widespread allegations of abuse that have been evidenced and so leading to failure may be taken by DCC's Head of Commissioning in

conjunction with the Director of Integration and Direct Services. A 'Final Concerns Response Meeting' will need to have been held before the decision is made and authorised. The formal decision to activate this Procedure will come from the same lead personnel, and the expectation is that DCC and, as appropriate, Health Leads will agree activation and work in partnership through the process.

ii) DCC is notified of the imminent business failure of a regulated care provider registered as operating in Derby City

iii) DCC is advised of the immediate suspension, closure, and de-registration of a regulated care provider by the CQC e.g., on the grounds of health and safety or assessed risk to Customers.

iv) DCC is notified of a major and immediate unplanned service interruption e.g., a significant fire or flood *and* where the care provider's own business continuity plan is unable or has failed to address the resulting service impact.

The Director of Integration and Direct Services is responsible for the DECISION to ACTIVATE the Provider Failure PROCESSES.

Provider Failure Process

Where Trigger Criteria i) has been applied then PROCESS 1 (Schedule A) will be instigated. If the Provider fails at the end of PROCESS 1 then PROCESS 2 will be instigated. Where Trigger Criteria ii), iii) or iv) has been applied then PROCESS 2 (Schedule B) will be instigated. THIS IS PROVIDER FAILURE WHERE THERE ARE NO REMEDIAL OPTIONS AVAILABLE TO DCC TO SAVE THE PROVIDER IN ITS CURRENT STATE.

Appendix 1

Schedule A to the Adult Social Care Managing Provider Concerns to Provider Failure Guidance

Process 1

Final Concerns Response Management

Concerns Response Manager (CRM)
Convenes a meeting

Invited colleagues submit current actions and Provider progress to the CRM prior to the meeting date

Meeting takes place Chaired by the CRM:
- Current Action Plan
- Provider response
- Final Action Plan with short ABSOLUTE deadline

Each CRM Representative to bring final actions for Provider as

Safeguarding	**Operations** Social Worker Health Professional Police	**Health & Safety** Organisational Clinical	**Commissioning** DCC Quality Assurance Strategic Commissioning ICB	**CQC**	**Provider**

Meeting agrees:
- **Final Action Plan and Absolute Deadline for Completion**
- **CRM reps' responsibility to manage specific action progress in the Final Action Plan**
- **Follow up Final Concerns Response Meeting arrangements**

Meeting re-convenes:
- **Discuss Provider response**
- **Agree recommendation to escalate to Provider Failure Management or de-escalate**

CRM confirms in writing the recommendation decision to:
- **Meeting members**
- **DCC Service Director (s)**
- **DCC HoS Integrated Commissioning**

Roles and Responsibilities - Concerns Response Manager (CRM)
The following designations have the responsibility for overall management of the Final Concern(s) Management:

1	Head of Safeguarding Adults and Professional Standards or delegated Officer where *Safeguarding is the primary failure concern*
2	Head of Integrated Commissioning and Market Development or Lead Commissioner *for major failure concerns which present significant risk either due to complexity of service, vulnerability of customers, severity of concerns or size of provider*
3	Head of Adults Commissioning, Integration, and Market Development or Lead Commissioner *for providers who do not present significant corporate risk (as above)*

Concerns Management
The Concerns Response Manager has the following responsibilities:

1	Convene Concerns Response Meeting as soon as business/service failure notification
2	Develop an agreed action plan and allocate specific option actions to appropriate Concern Response Team members
3	Set clear timescales for action
4	Seek legal / HR advice as required and notify Communications
5	Keep Director and Heads of Service fully briefed (if CRM role has been delegated)
6	Communicate formally and in writing with the provider regarding key decisions and actions
7	Ensure all meetings / decisions recorded for audit purposes
8	Maintain logs for all requests, decisions, and actions

Concerns Response Team
The following are the key Concerns Response Team members and their responsibilities:

Role	**Safeguarding**
	• Ensure safety plans are in place alongside locality • Mobilise services to ensure risks are managed • Chair/lead the Safeguarding element at meetings • Co-ordinate a single or multiple Safeguarding enquiries • Work alongside partners specifically about Safeguarding concerns including criminal investigations

Role	**Operations**

Social Worker	• Enable customers to exercise choice and control • Support customers to maximise their well being • Ensure all eligible care and support needs are identified and appropriately met • Promote the safety of the customer and their carers • Uphold the rights of the customer including their right to make unwise decisions Responsible for care and support decision making where the customer requires this • Communicate with all individual service users and families as
Health Professional	Responsible for all health intervention decision making Ensure all identified health needs are appropriately met Communicate with all individual patients and families
Police	Responsible for managing allegations of criminal neglect Communication of outcomes from investigations/prosecutions
Note – the NHS will lead and co-ordinate all actions relating to fully funded NHS customers	

Role	**Health & Safety**
Organisational	• Provide feedback from audits and inspections undertaken with score/ ratings and outcomes for recommended actions • On behalf of the Council provide advice, guidance, and training support to the Provider • Carry out accident and incident investigations on behalf of the Council and feedback to this meeting
Clinical	• Support with the management of medication and provide the Council with information concerning provider health and safety compliance impact up on care provided to customers
Note – the NHS will lead and co-ordinate all actions relating to fully funded NHS customers	

Role	**Commissioning**
DCC Quality Monitoring	• Provide Quality Assurance Evidence • Update on relevant Action Plan(s) • Monitor service arrangements
Lead Commissioning (DCC and ICB)	• Secure appropriate continuity of care • Action and oversee required contractual arrangements • Monitor service arrangements • Maintain communication with the provider
Note – the NHS will lead and co-ordinate all actions relating to fully funded NHS customers	

Role	**CQC**
Inspector	• Monitor the service through updates with partner agencies or local CQC intelligence • Provide feedback on inspection activity and findings

Inspection Manager	• Inform partner agencies of any enforcement action being undertaken or inspection activity • Provide feedback to partner agencies regarding any decisions made by CQC in terms of the location or the provider

Role	**Administration**
Trained minute taker	• Organise meeting venues • Ensure the log and accurate records of all meetings and actions are maintained • Circulate copies of minutes and relevant paperwork as required

Appendix 1
Schedule B to the Adult Social Care Managing Provider Concerns to Provider Failure Guidance
Process 2
Provider Failure Management

Provider Failure Manager (PFM)
Calls meeting

The purpose of the meeting is to discuss and agree the options and action plan to ensure the safety and wellbeing of all customers receiving services from the Failed Provider

Each Representation below should be at an appropriate seniority level to make decisions in relation to agreeing options and taking responsibility for the implementation of specific actions/options

Operations	Health & Safety	Support Functions	CQC	Provider
Social Worker Health Professional Police Safeguarding	DCC Clinical	DCC Quality Assurance Strategic Commissioning Finance Officer(s) Communications Legal Business Administration		

Options:

- Spot purchase from other Care Providers
- Reserve services in other suitable locations
- Temporary staffing, (for example via local Agencies)
- Temporary management, (for example 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.

The meeting will agree:

- Options from the above list and/or alternatives not on the list but that can be realistically implemented
- Actions to progress the option(s)
- Actions to ensure the safety and well-being of customers
- Development and implementation of the Communications Plan
- Management of the Provider Failure End date
- Progress Meeting

Please refer to Appendix 2 of this document for a checklist to assist the process

PFM confirms the above in writing to:

- Meeting members
- Service Director (if PFM is delegated)

1 or more progress meetings will be called by the PFM dependent on the specifics needed to finalise individual Provider Failures.

Roles and Responsibilities - Provider Failure Manager (PFM)
The following designations have the responsibility for overall management:

1	Service Director Integration and Direct Services – can delegate responsibility to:
2	Head of Service – Safeguarding Adults and Professional Standards *where Safeguarding is the primary failure concern* OR
3	Head of Integrated Commissioning & Market Development *for major failure concerns which present significant risk either due to Vulnerability of customers, severity of concerns or size of provider*
4	Head of Adults Commissioning, Integration, and Market Development or Nominated Lead Commissioner for *providers who do not present significant corporate risk (as above)*

Provider Failure Management
The PFM has the following responsibilities:

1	Convene the Provider Failure Management Meeting as soon as the decision to activate Process 2 has been authorised by the Service Director for Integration and Direct Services
2	Develop an agreed action plan and allocate specific option actions to appropriate Provider Failure Management Meeting representatives
3	Set clear timescales for actions
4	Seek legal/HR advice as required and notify Communications
5	Keep Service Director(s) and other Heads of Service fully briefed
6	Communicate formally and in writing with the provider regarding key decisions and actions
7	Ensure all meetings / decisions are recorded for audit purposes
8	Maintain logs for all requests, decisions, and actions

Provider Failure Management Team
The following are the key Provider Failure Management Team members and their responsibilities:

ROLE	**Operations**
	Ensure the safety and wellbeing of customers through managing: • Reviews of individual care placements/packages • Transfer of individual placements/packages to alternative provision • Ongoing DOLS, Best Interest Assessments, Mental Capacity Assessments • Communication with all individual customers and families • Notification to other professionals and relevant health provision for individual customers
Note – the NHS will lead and co-ordinate all actions relating to fully funded NHS customers	

ROLE	**Health & Safety**
Organisational	• Provide feedback from audits and inspections undertaken with score/ ratings and outcomes for recommended actions • On behalf of the Council provide advice, guidance, and training support to the Provider

	• Carry out accident and incident investigations on behalf of the Council and feedback to this meeting • Advising the Council and provider of possible breaches in relation to health and safety • Support in the development of risk assessments to ensure safe transfer of the customers from one provider to another
Clinical	• Support with the management of medication and provide the Council with information concerning provider health and safety compliance impact up on care provided to customers
Note – the NHS will lead and co-ordinate all actions relating to fully funded NHS customers	

ROLE	**Support Functions**
DCC Quality Assurance	• Identify capacity with contracted Providers and liaise with/advise operational colleagues • Manage contract management processes
Strategic Commissioning	• Co-ordinate alternative placement solutions not managed by brokerage • Oversee options in relation to provider staffing/management • Work with Finance, HR and Legal, as appropriate, to ensure options are within legal frameworks • Maintain communication with the provider
Finance	Manage and co-ordinate the implementation of any financial options or associated financial actions required to facilitate other agreed options: • Explore temporary funding options • Oversee recharging process • Provide advice and guidance on enabling care provider staff to remain in post and deliver services until alternate arrangements are made
Communications	Develop and manage the Communications Plan across stakeholders: • DCC and Health staff • Customers and their families • Provider and their staff • Councillors • Press
Legal/HR	To provide advice in relation to the specific situation.
Note – the NHS will lead and co-ordinate all actions relating to fully funded NHS customers	

ROLE	**CQC**
Inspector	• Monitor the service through updates with partner agencies or local CQC Intelligence • Provide feedback on inspection activity and findings
Inspection Manager	• Inform partner agencies of any enforcement action being undertaken or inspection activity • Provide feedback to partner agencies regarding any decisions made by CQC in terms of the location or provider

ROLE	**Administration**

Trained Minute Taker	- To organise meeting venues - Ensure the log and accurate records of all meetings and actions are maintained - Circulate copies of minutes and relevant paperwork as required

Appendix 2 - Management Checklist (for use as guidance)

The following checklist provides a **framework for managing care provider failure.** ***Please note that this list is not exhaustive.*** The Final Concerns Response and Provider Failure Management Teams 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 where necessary, not all points will yet be applicable until the position clarifies.

Provider Concerns / Escalation / Provider Failure Report (Action Plan)

This is an end-to-end process checklist which culminates in action required to ameliorate the impact of provider failure, it is to be used when we start working with a provider where Provider Failure may happen because of the intervention. Where additional quality monitoring or suspension is the outcome of the concerns intervention not all of this checklist will need to be completed.

This Report provides a framework for managing care provider failure. **Please note that this list is not exhaustive.** You may therefore wish to add additional information into this report as necessary.

Date initiated:	
Name of Service(s):	
Name of Lead Officer	
Steering Group Members: (Confirm Chair)	

Contents

1	**Provider Failure Management Team**
2	**Initial work/clarification**
3	**Customers**
4	**Financial Responsibilities**
5	**Carers and ‘Significant Others’**
6	**Consultations/Information Management**
7	**Relocation (if decision is made to close)**
8	**Quality Assurance**
9	**Record Keeping**

Action Plan	
Key details and contacts (To be completed as soon as concerns received)	
Name/address of Provider (Derby Site)	
Name and Address of Head Office (if different)	
Date ICB/LA/CQC notified	
Brief description of situation (to be updated as and when necessary).	
Owner/company	
Manager/contact	
Administrator/contact	

No. of customers & funding organisations NOTE: Identifying funding for residents (ICB, LA, self-funders, etc.) can help to establish appropriate Joint Incident Steering Group (JISG) membership.	**Total**	**Residential**	**Fully Funded Continuing Healthcare**	**Funded Nursing Care**	**Self-funders**

	Action	**Responsibility (To be completed by the JISG)**			**Notes**
		DCC	**NHS**	**Provider**	
		Initials of responsible Officer			
1	**Provider Failure Management Team**				
1.1	Assemble team and plan necessary work				

1.2	Appoint Team Leader(s)				
2	**Initial work/clarification**				
2.1	Establish timescales for failure(s)				
2.2	Establish number of Customers affected, and User category, and who funds them				
2.3	Identify lead contact at Provider if not already recorded above				
2.4	Hold an initial meeting with Provider to discuss issues. Establish timescales / dates for ongoing dialogue with provider				
2.5	Work with provider to develop improvement / concerns Action Plan				
2.6	Develop initial risk logs and plans for customers				
2.8	Decide on next steps: Additional Quality Monitoring Suspension or Activate the full provider failure process				
2.9	Seek an up-to-date list of other Providers with potential capacity (liaise with CQC as necessary) and contact details of Staffing Agencies it would be acceptable to use				
2.10	Consult adjacent Local Authority officers as necessary				
2.11	Establish tasks and timescales and allocate them				
2.12	Allocate lead workers, (preferably based on site) and equipment & management support requirements				
2.13	Consider equipment issues: mattresses, furniture, adaptations, packing boxes etc. Who owns it? Can it be transferred?				
2.14	Arrange a meeting with Provider/Owners/other relevant parties				
2.15	Is there a Business Continuity Plan in place as part of the contractual arrangements? Is it still viable?				

2.16	Agree when, how and by whom Customers and Carers are informed of the need to change provider at an early stage (in a calm and stress-free manner)				
2.17	Ensure the Owner allows free and open access by professionals to the service over the relocation period				
2.18	Agree what 'need to know' information should be shared with other parties e.g. care professionals; GP; NHS urgent care lead; other potential Care Providers [***Note*** that even though a Provider may be considered 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 agreement specific information is not disclosed to third parties which might precipitate the business's final demise.				
2.19	Formal scripts to be developed with the lead Communications Officer for: - • staff working with customers and relatives • provider staff • press				
2.20	At the time of a potential failure, investigate the potential of staff or voluntary groups to facilitate customers/carers visiting other provision				
2.21	Identify key Care Provider Management staff to be involved				
2.22	Contact details of Care Provider Owner/Manager if not already recorded above				
2.23	Identify site(s) for offsite meetings for Management Team and Care staff if required				
2.24	Other agencies to be involved?				
2.25	NHS to follow incident reporting processes				

2.26	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				
2.27	Ensure all officers have considered the impact of the failure process upon other workstreams and escalated as necessary to line manager(s)				
2.28	Identify agency to provide an administrative lead to collate all records				
3	**Customers**				
3.1	Collect an accurate list of all customers and their needs - confirm numbers with provider. Consider special factors (i.e., ‘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 customers				
3.3	Check current Registration category				
3.4	Assess customers to identify possible change in need or category of care				
3.5	Check if any very frail people and those nearing end of life need exceptional arrangements				
3.6	Identify customers wishing to change provision / move sooner rather than later				
3.7	Identify customers who should be assessed early in the project work due to their pre-disposition to stress, anxiety, or complexity, or for other factors				
3.8	Two-stage Assessments of Customers 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 support transfer.				
3.10	Identify customers with active ‘Deprivation of Liberty’ (DOL) authorisations and ensure the provider as				

	Managing Authority refers all those who are DOLS -liable to the 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.				
3.11	Identify Customers with 'Health and Welfare Deputies', and those with 'Lasting Powers of Attorney' for Health and Welfare decisions, medication needs (GP's, Pharmacists) and ensure contact is made with the relevant parties.				
4	**Financial Responsibilities**				
4.1	Ensure managers can commit all resources to the failure process including financial as well as staffing				
4.2	Any Out of County funded Customers? Make external commissioners aware of situation, and confirm whether they wish the JISG to act on their behalf to relocate Customers				
4.3	Identify DCC-funded residents and identify any Section 117 MHA funded residents.				
4.4	Identify NHS-funded residents				
4.5	Identify whether there are any private self-funded Customers and who will take responsibility for their care. Check capacity and their representation *(see 3.8. above)*				
4.6	Identify any remaining Customers who are funded by the Department of Work and Pensions or have 'Preserved Rights'				
4.7	Check current Fee level being paid				
4.8	Investigate cost of potential new provision				
4.9	Take a legal view and response, on the period of contract payment/termination issues etc.				
4.10	Consider issues such as petty cash etc.				
4.11	Identify customers with Deputyship in relation to financial affairs, all Enduring Powers of Attorney and all those with				

	Lasting Powers of Attorney for Property & Affairs. Contact relevant parties and ensure records of their involvement are made, particularly in relation to any changed cost to new placements.				
5	**Carers and ‘Significant Others’**				
5.1	Ascertain the list of names, addresses and telephone numbers				
5.2	Identify Carers who may themselves have special factors to consider – own health, Out of Area etc				
5.3	Seek fullest involvement of relatives / ’significant others’ in the relocation process				
5.4	Consider necessity for commissioning advocacy for carers affected (but bear in mind resources implications before proceeding)				
5.5	Consider and where necessary undertake carers assessments				
6	**Consultations/Information Management**				
6.1	To ensure the process runs smoothly it is essential that all groups are consulted: • Customers • 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 the timescales are not exacerbated				
6.3	Ensure Residents meetings are arranged with appropriate levels of management representation				
6.4	Ensure Relatives meetings are arranged with appropriate 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 customers and adequate resource requirements to complete				
7.2	Check choice(s) of area/services available that are compatible with service user need/category with resident/carer				
7.3	Maximise resident/carer ability to make an informed choice about compatible area / services / Homes available, in adherence to the principles of the *Mental Capacity Act 2005*				
7.4	Are there friendships between customers 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, DCC and other local authority staff to ensure there are no concerns about the Care Provider				
7.7	Offer opportunity for customer/carer to view / visit / trial visit Care Provider				
7.8	Seek Care staff help to inform/visit potential provision with customer where applicable				
7.9	Decision by customer/carer on new provision and date to move				
7.10	Help of Care Staff to take or escort customer to potential new providers on placement?				
7.11	Arrange schedule transport to new provision in and out of county e.g., car / minibus / ambulance – identify cost and who pays				
7.12	Consideration of equipment issues, and arrangements for its transfer and installation *(see also 2.7 above)*				
7.13	Ensure customers 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 on their knowledge of customers to new providers, escorting, transporting etc				
7.15	Staff handover to new providers – verbal, electronic and written. 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. Find opportunities for current Care Staff to verbally discuss customers care needs summary with receiving Care Staff, where appropriate				
7.17	Maintain a log of decisions and movement of customers				
7.18	Move customers at their own pace / convenience as far as possible.				
7.19	Establish a programme of Social Worker / Nursing reviews and resource implications to ensure Customers well-being after the move. Establish a Team if required.				
7.20	Customer medications and treatment details to go with customers				
7.21	Particular attention to be made to ensure correct identification of relocated customers				
7.22	Any changes of GP and new provision to be recorded in all appropriate systems of all necessary organisations involved				
7.23	Placements made Out of County should be notified to the receiving NHS / Local Authority				
7.24	Provider Customer information / case files / summaries transfer with Customers 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 of change of Home				
7.27	Liaise closely with the DCC Commissioning Support Assistants and NHS Continuing Care Team (new contracts need to be issued, old contracts terminated)				
7.28	Consider whether moves should be arranged to coincide with the moving of other customers or spread over more than a week (if time is available)				
7.29	Consider the desirability of temporary/second moves				
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 identify good practice, lessons identified and further actions 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				
9.4	Customer’s outcomes should be recorded, particularly about their health and emotional well-being				
9.5	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 and Recommendations to be submitted to the relevant groups and management levels within each agency, including the Safeguarding Adults Board (SAB).				

10.3	Consideration of referral to the SAB should be included in the de-brief and review.				

OUTCOME

Action	**Outcome**	**Date**
Remedial work to be undertaken with Provider		
Provider Suspended - Remedial work to be undertaken with Provider		
Provider Failure		