CARE WITHIN THE HOME SERVICES:PACKAGE PURCHASE PROTOCOL & SERVICE DELIVERY REQUIREMENTS (Schedule 2)

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CARE WITHIN THE HOME SERVICES PACKAGE PURCHASE PROTOCOL & SERVICE DELIVERY REQUIREMENTS

1. Document Purpose

1.1 This document sets out the terms under which packages will be commissioned and governed under the Care within the Home services contract.

1.2 This service delivery requirements schedule forms part of the Contract Terms and Conditions (T&Cs) and should be read in conjunction with the 'Service Specification for Care within the Home Services' (Schedule 1).

1.3 This package purchase protocol is joint between Surrey County Council (SCC) and NHS Surrey Heartlands CCG who host the Surrey Continuing Healthcare team. The team is responsible for caring for people registered with GPs under both CCGs in Surrey which are NHS Surrey Heartlands CCG and NHS Frimley CCG (Surrey Heath & Farnham).

1.4 The term 'commissioned' refers to services purchased to meet the needs of individuals through providing good quality Care within the Home services.

1.5 Some services are jointly commissioned by SCC and the NHS, whilst other services are solely commissioned. The term 'commissioned' refers to either arrangement in this document and the term 'Commissioner' refers to staff from SCC Adult Social Care, NHS Continuing Healthcare and joint where applicable who require homecare services to be provided to a resident on their behalf.

1.6 The term 'assessor' refers to a representative of an organisation assessing the care needs of an individual receiving a package of care (POC). This can be SCC, the NHS or a care company acting on behalf of either SCC or NHS.

1.7 This contract covers the provision of services to an individual, and where relevant, carers, identified by the Commissioner as requiring CQC regulated home based care and support services.

1.8 This document sets out the business rules, processes and expected model of service delivery that applies to all Providers entering the Dynamic Purchasing System (DPS) to deliver Care within the Home services under this contract.

2. General Service Delivery Expectations

2.1 Details of the service being commissioned, and the standards and expectations for Providers can be found within the 'Service Specification for Care within the Home Services' (Schedule 1).

2.2 This section details the Commissioner's expectations of providers delivering Care within the Home Services for Surrey residents.

2.3 The Commissioner may purchase services from the Provider for an individual within the agreed delivery areas which are the 94 postcode areas in Surrey where

the Provider has been contracted to deliver services. (Please refer to Section 1 of the Delivery Areas and Price Guidance.)

2.4 To ensure residents can be supported based upon their needs, expectations and taking account of their strengths and personal circumstances, the Commissioner expects service to be available:

- Weekdays – Monday to Friday
- Saturday and Sundays
- Public and Bank Holidays inclusive of Christmas Day and Boxing Day
- Early morning 6-9am
- Morning 9-12 noon
- Afternoons 12 noon-5pm
- Evenings 5-11pm
- Nights 10pm-6am

2.5 There is an expectation that the provider will be able to pick up Packages of Care (POC) at these times throughout the whole of the delivery post code area(s) they are contracted to work within throughout the life of this contract.

2.6 The delivery of care across the whole post code area, and timings of calls, will form part of contract monitoring conversations and KPI reporting. Where a Provider is not responding to or accepting POC in a post code area, Commissioners will discuss this with the Provider and following review this could result in a provider being asked to consider delivery in another post code area or consolidate existing delivery areas.

2.7 It may be deemed necessary for a provider to cease being offered POC in a specific post code area to ensure Commissioners are consolidating work with providers actively operating in those post code areas at the time. This is also to reduce Information Governance risks in sharing information with Providers not wishing to work through the DPS in that post code area and not responding to POC.

2.8 The individual specific requirements for each POC shall be set out in the support plan written by the Surrey County Council adult social care team or in the care plan written by the NHS CHC clinical team and this will be shared with the Provider once they have been selected to provide the care.

2.9 The referral which is sent through e-brokerage (a web-based system that all Providers need to be signed up to under the DPS requirements) to Providers who have indicated they can deliver care to a resident in a postcode area. It will detail the support requirements of the individual for a Provider to make an informed decision about the POC and the needs of the individual(s) they are accepting. This information sharing process will remain under review to ensure we can improve this process when / if necessary.

2.10 The Provider must provide services without discriminating against an individual on the grounds of ethnic background, religion, disability, age, gender and sexual orientation. When providing the service, the provider shall consider any religious or cultural requirements.

2.11 Commissioners will support providers where staff experience discrimination of this nature when delivering care and support to residents.

2.12 The service type required will be clearly indicated to Providers through the e-brokerage referral. For example, where a POC is required for Home Based Care (HBC), CHC High needs, Live-in Care or HBC Carers Break, or where an individual is considered as having additional needs. This is to ensure individuals are supported by the most appropriate Provider who can support their health and wellbeing and reduce the likelihood of a breakdown in the delivery of the POC.

2.13 In some instances, representatives of the Commissioner may contact providers on the DPS directly. This will be, for example, to ensure a POC is picked up within the defined timeline, the package requires specific additional information not contained within the referral or where a POC would be better placed with a provider due to existing rounds and / or availability of staff.

2.14 The Provider will ensure that care/support staff are able to travel to individuals at the pre-agreed times and that they remain with the individual for the duration of the contracted visit in line with the individual's support plan. The Provider will also be responsible for timely communications with both the individual receiving care and the social work team where calls are late, cancelled or consistently over or under agreed commissioned delivery times.

2.15 The Commissioner will support providers to have flexibility with care delivery times where care delivery is not required at a specific time (i.e. for medication administration) but only if this is agreed with the individual and social worker. This will support Providers to manage rounds and valuable care hours through effective planning of delivery times.

2.16 If more than one Provider is contracted to deliver services to an individual the Providers are asked to work together to ensure continuity of care, and the provision of information to the other Provider(s). The Commissioner reserves the right to seek assurance that this is happening effectively.

2.17 It is the responsibility of the Provider to raise any concerns, complaints or risks (either perceived or real) regarding the delivery of care to an individual at the earliest opportunity through contacting the social work team, CHC placements team, brokerage team (where applicable) or commissioning relationship manager.

2.18 The Provider is expected to give a minimum of 14 days' notice to end a POC if they are unable to continue delivering care to an individual. This allows for the considered and safe transfer of care for an individual to another Provider.

2.19 The Provider will ensure that all vehicles it provides to care workers for use in the delivery of the services and/or if the care worker uses their own private vehicles to carry out the service that the vehicle has a current MOT and insurance cover for business use and that the care worker has a current valid driving licence.

3. The Referral Process

A referral shall be completed for the individual in accordance with the following procedure:

3.1 The assessor(s) will complete an assessment of the needs of the individual. This will include details of the specific care and/or support tasks that are required to be delivered by the provider on behalf of the commissioner to meet the specified outcomes. The postcode of the resident is detailed on the referral.

3.2 Where a POC is time critical or under exceptional circumstances Providers may be asked to accept a POC with all information available at the time pending, including written confirmation of care package requirements. An assessment and support plan will be completed as soon as possible by the social care practitioner or CHC placement team after the service commences and within a maximum of seven (7) working days.

3.3 All POC will be offered to providers via the e-brokerage system which all providers must be signed up to. Commissioners are committed to all POC being offered to DPS approved Providers through e-brokerage but in some instances by exception, it may be necessary for DPS Providers to be contacted directly outside of this process. These direct contacts will include, but not be limited to, instances such as a requirement for a time critical placement, an individual returning home with an existing Provider after planned hospital treatment or if there are specific considerations for that POC that require an exception to the standard process. Direct contacts will be made only to DPS approved Providers.

3.4 Requests for care from Commissioners will be submitted through e-brokerage seven days a week. Providers are expected to respond to requests for new packages from 8am to 6pm weekdays and 9am to 4pm at weekends and public holidays.

3.5 The Provider must respond via e-brokerage before the response deadline expires to indicate whether they accept or reject the package. In most cases, when submitted by a social care team or the CHC placements team an e-brokerage request will expire after 3 hours and after 1 hour for hospital discharges. This timescale may be shortened or lengthened as required by the Commissioner. Providers may be contacted directly by a Commissioner to facilitate changes to this process where necessary. Where details of future package requirements are known in advance, the commissioner will work with providers to arrange these with more notice, to support future planning of capacity.

3.6 Where the care package requested is for live-in care, the e-brokerage request will specify whether a replacement care worker is required to support the individual during the care worker break. The live-in care Provider is asked to indicate through their response whether they have capacity to meet the needs of the package requested.

3.7 The Commissioner will confirm through e-brokerage within forty-eight (48) hours from the deadline set for responses whether the Provider has been awarded

the POC or not. If the Provider receives no communication from the Commissioner within forty-eight (48) hours from the deadline set for responses, then the Provider is no longer obliged to hold the space on their rota.

3.8 Where a package is awarded, the Provider will receive an email notification through e-brokerage. The Commissioner will make contact via telephone or email to discuss the requirements and confirm commencement arrangements. Commissioners will email the individual's support plan/care plan and any further documentation required to the Provider.

3.9 Once awarded a POC, Providers are expected to commence within forty-eight (48) hours of the original request or within the timescales required by the Commissioner (see 3.5 for hospital discharges). Providers should only commence service(s) once confirmation is received in writing from the Commissioner.

3.10 Where a referral is made for a hospital discharge, the Commissioner expects the Provider to work towards the discharge being arranged for the same day where at all possible, including at weekends in line with the current hospital discharge policies which can be found on the Department of Health and Social care section of the Government website. The Provider is expected to work with other health and care partners in any assessment process post discharge. Providers will be expected to work with individuals to ultimately reduce their dependency on care and support where possible.

3.11 Commissioners will be assured of the ability of Providers to deliver good quality services to residents due to the robust evaluation criteria to be met in order to join the Care within the Home DPS. Ongoing contract management, quality assurance and provider oversight arrangements by Commissioners will also ensure that all Providers on the contract are suitably qualified to deliver Care within the Home services on behalf of Commissioners. Therefore, on occasions when Commissioners receive multiple positive responses to an individual referral, the final selection criteria for awarding the package will be competitive price. Exceptions, including those as set out in 3.3, are when;

- It is more appropriate for another provider to deliver the POC based upon existing activity such as rounds or presence in an area.
- A provider is better placed to meet the needs of that individual.
- The commissioners can offer multiple POC for instance where a provider has handed back a round.

4. Short Term Variances and Changes to Care Packages

4.1 To support a shift in culture away from time and task commissioning, and to ensure that strength-based approaches are followed consistently, a formal process must be followed to inform the Commissioner of a variance in a POC. Submission of Electronic Care Monitoring Data (ECM), as referenced within the specification, will ensure cases where variances are required, that these can be identified and reviewed quickly, helping Providers and Commissioners alike.

4.2 Variances in packages frequently occur and they can be for a wide variety of reasons, e.g. one-off instances such as a need to call an ambulance for a person. A variation does not always indicate a change in need and often reflects a short term, temporary need only.

4.3 For ASC funded packages,

4.3.1 If it is a planned one-off, isolated occasion the provider must inform the Commissioner with the reason for the variance and request agreement for the additional time spent with the individual. If authorised, reasons for the variation should be added on the relevant week via the comments in the provider portal when submitting the e-invoice for the service delivered

4.3.2 In keeping with the move away from time and task commissioning the Commissioner only expects to pay for one-off variances for periods of 30 minutes or more above the delivery of the originally commissioned call duration. The locality duty team or emergency duty team must be advised as soon possible.

4.3.3 Providers may be asked to submit two weeks of care records to evidence time delivered does not fall under what has been commissioned.

4.3.4 If a pattern of over or under delivery emerges the locality duty team must be notified, and a decision made around how best to proceed i.e. does the individual need to be re-assessed or if it is a small adjustment the support plan can be updated to reflect this.

4.3.5 For step-by-step guidance on variances and the process to follow please see Appendix 1 of this document.

4.4 For NHS Continuing Healthcare packages,

4.4.1 Where a Provider identifies a change in need requiring a permanent amendment to the existing care package the provider must contact the District Nurse (DN) / Hospice Clinical Nurse Specialist (CNS), involved in the individual's case to discuss the changes being requested.

4.4.2 If the DN/CNS agrees that the change in care package is required, they will complete and submit a package of care amendment form which is submitted to the CHC team for sign off.

4.4.3 Once the changes have been agreed the CHC Placements team will confirm these to the Provider and send them a new Individual Service User Placement agreement (ISUP) reflecting the new POC. NB Changes should not be implemented until the CHC Placements team has confirmed that they have been approved.

4.4.4 If the provider is unable to make contact with or receives no engagement from the individual's DN/CNS they can submit a request via email to the NHS Continuing Healthcare CHC Duty Team syheartlandsccg.chcdutynurses@nhs.net

4.4.5 Where a Provider has had to make a temporary change to care input at night or over a weekend the CHC Placements team should be advised of the change on the next working day so that adjustments can be made to facilitate payment for any additional input provided. The CHC Placements team can be contacted at syheartlandsccg.chcplacements@nhs.net

4.4.6 Where appropriate, the CHC Team may arrange an urgent review of the care package before approval is confirmed.

5. Review of Individual Support Plans (Surrey County Council Clients)

5.1 This section refers to the role of the social care teams in the review process which will be further referred to as social care teams.

5.2 Social care teams will review the individual's support plan as and when required. A review will take place around 6 weeks after a new POC has commenced and following that at least annually. Providers can request a review if they feel an individual's needs have changed and are encouraged to do so where they have been able to reduce an individual's care and support needs through strengths-based practices.

5.3 Social care teams will inform the Provider of the date of the review at least seven (7) days prior to the review being held. The provider shall notify the social care team of any issues, which it believes are pertinent to the review. In some extenuating circumstances, where reviews take place on the telephone, prior notice may not be given.

5.4 Social care teams will make a written copy of the review and the decisions/outcomes within seven (7) working days of the date of the review.

5.5 Information relevant to the Provider will be shared at that point. This may not be the complete review if the individual has shared information during the review of a confidential nature, or if it contains information about other Providers which does not need to be shared.

5.6 Social care teams can request the attendance of the provider's care/support staff at the review. In such circumstances the provider is permitted to invoice SCC the standard rate for a maximum of one hour to cover the staff member's loss of earnings. This is detailed further in the Pricing and Invoicing Protocol (Schedule 3). This payment will be made for the care worker(s) only and will not extend to management.

5.7 No changes shall be made to the support plan without the authority of the social care team or any authorised SCC representative. If the individual receiving support or any other individual requests a change to the support plan directly to the provider, the provider shall direct that individual to the social care team responsible for the care package.

5.8 In keeping with section 1.15 in the Care within the Home Service Specification (Schedule 1) SCC is committed to working more closely with providers through the life of the new DPS. As such, specifically for HBC, it is the ambition of the Commissioner that a shared partnership between the Commissioner and Provider(s) will develop whereby the Provider will undertake reviews, where appropriate and able to do so, of an individual's care and support. These reviews will be shared with the Commissioner and reviewed to ensure they meet the Care Act duty for a resident's care to be reviewed. This partnership will create more positive relationships and an ability to share skills, expertise and experience to the benefit of both parties particularly in terms of agreeing variances and changes to packages over time.

6. Review of Individual Care Plans (NHS Continuing Healthcare Clients)

6.1 Reviews of any individual care packages commissioned by the CHC team will be carried out by an NHS CHC assessor 6 weeks after commencement of the individual care package in the case of fast track cases, three (3) months after the commencement of non-fast track cases and annually thereafter.

6.2 The CHC Team may request the attendance of the Provider’s care/support staff delivering the services to the individual at the review. In such circumstances the Provider is permitted to invoice the CHC service the standard rate for a maximum of one hour to cover the staff member’s loss of earnings. This is detailed further in Schedule 2 (Pricing and Invoicing Schedule). This payment will be made for the care worker(s) only and will not extend to management.

6.3 The Provider may not make any changes to the support plan without the prior authority of the CHC placement team or any authorised CHC representative, whose decision shall be final. If the individual or carer requests a change to the support plan directly to the Provider, the Provider shall direct that individual to the CHC Placement Team

6.4 If an individual is admitted to hospital, it may be that the CHC placement team will authorise the Provider to allow the individual’s care worker to accompany the individual. This will need to be authorised by the CHC placement team in advance. In any event, the care worker will ensure that a complete handover is provided to the ambulance or hospital staff as appropriate.

7. Operational Service Delivery Expectations

7.1 Guidance on late and missed calls - The Commissioners view planned and timely visits to vulnerable people in their own homes as an important part of meeting individual needs, ensuring their wellbeing and demonstrating quality provision. It is clear that missed or late calls are not acceptable, as they leave individuals feeling anxious and forgotten and potentially at serious risk. The consequences of each missed or late call must be considered.

7.2 A missed call is where an individual has not received a visit where one is scheduled, and does not receive a visit before the next scheduled visit, and has not been contacted to rearrange the time of visit (e.g. visits are scheduled to take place three times a day and the first visit of the day does not take place and the first achieved visit is the scheduled second visit of the day.) The consequence of a missed call needs to be risk assessed according to the Commissioners safeguarding procedures. Any missed call should be communicated to the Commissioner as soon as practically possible, refer to 8.2 for more information. NB – A missed call is different to a cancelled call (see 7.5).

7.3 A late call is where an individual has not received a visit within 30 minutes of the scheduled time and has not been contacted to rearrange the time of visit.

7.4 A rescheduled call is when a call is delayed and the individual receiving care has agreed for the call to be delivered at a different time/ or the individual has requested it be delayed.

7.5 A cancelled call is when a call has been cancelled prior to the due time and the individual receiving care has agreed for the call to be cancelled/ or the individual has requested it be cancelled.

7.6 The Provider must phone, send a text message or use communication options in the ECM system to inform the service user and/or their family contacts if they are going to be late for their scheduled visit.

7.7 Call times should only vary if there has been prior agreement with the individual receiving support, and after the Commissioner has been notified.

7.8 If a visit cannot be delivered at the scheduled time the Commissioner expects the provider to ensure that the individual is contacted and advised of the delay by, at the latest, 15 minutes after the start of the scheduled time.

7.9 The Provider will only be paid for services delivered. The Provider should retain ECM records to evidence delivery of care for at least the previous month period. The only circumstances in which a Provider will be paid for non-delivery of a service is when either

- the commissioner gives less than 24 hours' notice that the care is no longer required or
- the individual / individual's family give less than 24 hours' notice that the care is not required.

7.10 The Provider must inform the Commissioner if there is a regular pattern of late cancellations either by the individual or the individual's family e.g. family takes individual out every Sunday for lunch. If the individual lacks capacity the individual's family/ carer should be contacted. The Provider must have a clear and auditable communication strategy in place to action this.

7.11 A prioritisation plan should be in place to manage occasions where calls need to be rescheduled or cancelled (e.g. in extreme weather). This should consider the vulnerability of individuals, the complexity of care needs and whether the visit is time

critical (e.g. medication). As part of this strategy, communication with individuals about changes is essential.

7.12 In the event of an unplanned absence the provider will invoice for the first scheduled visit but not for any subsequent planned visits.

7.13 The Commissioner has made reference to ECM within the service specification. Providers must use an ECM system to be able to capture this information and report on these as part of the KPI's for this contract.

8. Communication between the Commissioner and the Provider

8.1 Death of individual - In the event of the death of an individual the party receiving the first notification must inform the other relevant parties immediately and within twenty four (24) hours at the latest of their being aware of the death or as soon as reasonably possible.

8.2 Missed call - Should a call be missed the provider must report to the commissioners as soon as reasonably possible they become aware the call will be missed and in any event, within two (2) hours on a normal working day. A missed call will be looked at under safeguarding and considered a safeguarding concern. Providers must also provide a written summary within twenty-four (24) hours of the call being missed stating:

- Name of the Individual
- Purpose of the call
- Reasons why the call was missed
- What actions the provider took to mitigate the impact of the missed call
- Confirmation that the individual family member or carer was informed once the provider became aware the call would be missed

8.3 If the individual or a member of their family or carer was not informed before the call was scheduled to take place, the provider must confirm why they were not notified once the provider became aware the call would be missed.

8.4 Provider prevented from delivering service by the individual - In the event that the individual prevents the provider from delivering the service, the provider must inform the commissioner within twenty-four (24) hours. Where prevention from delivering care may put the individual at risk, for example where time critical medication is required, then this must be communicated as soon as possible during working hours to the social care duty team and outside working hours to the emergency duty team.

8.5 Planned absence - Each party shall ensure that they notify the other of any planned absence (e.g. planned respite or hospitalisation) of the individual within five (5) working days of becoming aware of such planned absence or as soon as reasonably possible

8.6 Unplanned absence - In the event of any unplanned absence of the individual (e.g. emergency hospitalisation) the party receiving notification will inform the other within twenty four (24) hours at the latest.

8.7 In the event of a hospital admission - The locality teams will communicate with a provider if they are made aware that an individual has been admitted to hospital. If the provider becomes aware that an individual has been admitted to hospital (as an emergency or for planned treatment) they are asked to inform the hospital social care team where possible or at the very least the social care team or the CHC Duty desk (details of which will be contained within the provider welcome pack and can be seen in Appendix 4 of the Service Specification (Schedule 1) . Attendance at A&E or a short-term ward does not equate to a formal admission to hospital. Care delivery should continue unless advised otherwise.

8.8 'Absence' for any reason other than death (e.g. hospital stay) – retention and resumption of service - In the event of the absence of the individual for any other reason (other than death) so that the provider is unable to deliver the services agreed with the commissioner, the commissioner may require the provider to retain the service for that individual during the period of absence. The commissioner will confirm this in writing to the provider (NB email is acceptable). The commissioner will not pay retainer fees for HBC.

8.9 Retained services - In the event that the service is retained the provider will be required to resume the service to the individual within twenty-four (24) hours of being informed of the requirement by the commissioner.

8.10 Hospital Discharge - In most instances when arranging care for an individual's hospital discharge, the commissioner will contact the provider who was supporting the individual when they were admitted to hospital. If the previous provider does not respond quickly or has not got capacity available, then the care will be sourced through e-brokerage. There may be additional instances where the existing provider is not approached, for example where an individual's needs have changed substantially, the existing package is very high cost or the individual requests a change in provider.

8.11 Absence where the individual is receiving live-in care

Instances of absence will be dealt with on a case-by-case basis with the needs of the individual informing decision making. Where the individual being cared for is admitted to hospital the care worker must advise the agency and, in most cases, seek alternative accommodation within 24 hours of admission. A discussion will take place between the commissioner and provider about whether the individual requires continuity of care to facilitate an effective discharge or support the individual with tasks whilst they are in hospital. The provider and locality team/CHC duty team should discuss whether they are requested to retain the service and whether a retainer fee is appropriate, ensuring time frames for any agreements are clear.

8.12 Within a shared household arrangement (as outlined in section 7.40 of Schedule 1, Service Specification) if one individual no longer requires care at home due to absence, including temporary absence for example hospital admission, the rate will revert to the individual 24 hour live-in care rate, including or excluding break

rate as required by the individual who will continue to receive care. Commissioners will update individual support plans to reflect this. In this instance a retainer for the absent individual referenced in 7.47 of Schedule 1, Service Specification, will not be required.

8.13 Should a situation arise where it is suspected that someone is at risk of abuse the Multi Agency Safeguarding Hub (MASH) should be contacted during office hours on 0300 470 9100, ascmash@surreycc.gov.uk.

8.14 Communication outside normal working hours - In the event that the provider needs to contact the commissioner outside normal working hours pursuant to any of the above paragraphs, please contact the following:

- For ASC funded packages - the SCC Emergency Duty Team on 01483 517898.
- For CHC funded packages – the duty desk who will pick it up on the next working day.

Refer to Useful contact details section in Appendix 4 of the Service Specification (Schedule 1).

9. Inability to provide a commissioned service (wholly or partially)

9.1 If the Provider is unable to provide all or any part of the scheduled commissioned service due to problems affecting the staffing of the service, the duty team, the CHC placement team or if after 5pm (for ASC clients), the emergency duty team should be notified immediately. The provider must follow their business continuity plan (BCP) in conjunction with adult social care or CHC. Please see the relevant business continuity provisions in the Service Specification (Schedule 1).

9.2 The provider is required to ensure that it has a BCP in place to ensure continued delivery of the service. Where such plans fail the Commissioner will be entitled to source the delivery of the service from elsewhere and reserves the right to recoup its costs in doing so, as detailed in the contract.

9.3 Service failure will be monitored and regular or persistent failure to provide the service shall constitute a breach of contract.

9.4 In the event of any form of service failure the processes within the SCC Care Provider Support and Intervention Protocol (details in Care within the Home Specification, Schedule 1) will be implemented. The commissioners as part of this protocol reserve the right to suspend purchasing new packages of care from a Provider. The Provider will be informed of the reasons for suspension in writing

10. Termination of an individual Care package

10.1 An individual care package shall terminate immediately if the individual ceases to require the service as a result of their death.

10.2 The individual care package shall terminate immediately if the individual ceases to require the service because of an unplanned temporary or permanent change in their circumstances e.g. admission to hospital or a care home. This applies unless you are asked to retain the package in writing as per section 8.8, and 8.11 for live-in care.

10.3 In the event of an unplanned change, including but not limited to any change resulting from a failure on the part of the Provider to deliver the service in accordance with the term of the contract and support plan or where the safety of the individual is at risk, termination of the individual care package shall take effect immediately.

10.4 The Commissioner has the right to terminate an individual care package at any time upon giving forty-eight (48) hours' notice in writing to the provider. The commissioner will communicate this to the individual impacted in this instance.

10.5 The Commissioner will work with the Provider to resolve any issues including, but not limited to, any requirement by the Commissioner that an individual care package be amended, prior to issuing notice but this clause will not prevent the right to terminate in clause 10.4.

10.6 The Provider is permitted to terminate an individual care package by giving fourteen (14) days' notice in writing to the Commissioner. This is to give adequate time for the Commissioner to source alternative care and reduce potential disruption to an individual's care. The option to terminate the individual care package can only be exercised where:

- Following a comprehensive joint review involving both the Commissioner and the Provider which will explore all methods of service delivery, it is apparent that the assessed needs of the individual have changed to a point where the care that is needed exceeds a level of service which the Provider is able to provide; or
- The individual or carer displays challenging behaviour or other behaviours which place the Provider's staff at risk, and which were not identified in the support plan as part of the risk assessment prior to commencement of the service. In such cases the Provider shall discuss the case with the Commissioner prior to issuing of the notice and shall make all reasonable endeavours to ensure that all alternative ways of delivery are explored prior to the issue of notice.
- The Provider is unable to deliver services in a defined postcode area, either wholly or in part. Reasons for the inability to deliver services in a postcode area must be put in writing to Commissioners and will be used by Commissioners when deciding to purchase any future packages of care from the provider.

10.7 After notice has been provided following the above steps, the Provider will be expected to advise the individual that notice has been given and inform the Commissioner once they have done so. Where the circumstances surrounding the notice make this communication difficult, it may be agreed for the Commissioner to contact the individual instead.

10.8 Where alternative care is sourced prior to the 14th day, the notice can end sooner.

10.9 If reason for notice is due to no longer delivering in the postcode area the Commissioner may remove the area from the provider's e-brokerage.

10.10 During any notice period given in accordance with this protocol the provider will be required to continue to provide services to the individual for the duration of the notice period.

10.11 The provider will co-operate with the commissioner and any new provider to ensure continuity of care for the Individual and that the individual's care is not compromised.

10.12 Where a provider terminates or threatens to terminate one or more individual care packages without reasonable justification or explanation the Commissioner shall have the right to set-off any liability, damage, loss, costs, charges and expenses incurred because of the provider's action in accordance with the provisions of the contract.

Appendix 1 Step-by-step guidance on the variation Process (Adult Social Care funded packages)

VARIATION 1: Planned (one-off, isolated occasion)

- Contact the locality duty team by email in advance of the planned variation (see Appendix 4 within Schedule 1 for contact details)
- Contact must outline the request for a variation along with the reason.
- Duty team will consider request, taking into account individual's needs and alternative provisions available and will confirm their decision in writing.
- Payment for variations will be made once confirmation is established via case notes by relevant locality team.
- Reasons for the variation should also be added on the relevant week via the comments in the provider portal when submitting the e-invoice for the service delivered.

VARIATION 2: Unplanned (additional care already delivered)

- Where a variation is required due to a call taking longer than planned, provider must make contact with the locality duty team or the emergency duty team if out of hours (see Appendix 4 within Schedule 1 for contact details) as soon as they are able by telephone and followed up in an email.
- The reason for the extended call and detail of the circumstances must be provided.
- Providers may be asked to submit two weeks' worth of care records to evidence time delivered is additional to the calls commissioned during this period.
- Duty team will consider request and confirm agreement in writing.
- If a pattern is emerging or the provider feels there is a permanent change, a review can be requested as noted in 5.2.
- Payment for variations will be made once confirmation is established via case notes by relevant locality team.
- Reasons for the variation should also be added on the relevant week via the comments in the provider portal when submitting the e-invoice for the service delivered.