NHS
North East and North Cumbria

Corporate	ICBP003 Choice and Equity Policy

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POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NESCU.comms@nhs.net

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1. Introduction

1.1 This policy describes the way in which Integrated Care Board (ICB) will commission care for people who have been assessed as eligible for fully funded NHS Continuing Healthcare. The policy describes the way in which ICB will commission care in a manner which reflects the choice and preferences of eligible individuals but balances the need for ICB to commission care that is safe and effective and makes the best use of available resources.

1.2 In developing this policy, ICB has had regard to the guidance set out in the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (July 2022 (revised), corrected July 2023) and is mindful of its obligations under the relevant legislation set out below.

1.3 The National Framework states that ICBs should take a strategic as well as an individual approach to fulfilling their NHS Continuing Healthcare commissioning responsibilities. The National Framework advises ICBs to consider commissioning NHS funded care from a wide range of providers, to secure high quality services that offer value for money.

1.4 Status

This policy is a corporate policy.

2 The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (July 2022 (revised), corrected July 2023)

2.1 The National Framework states:

"Where an individual is eligible for NHS Continuing Healthcare, the ICB is responsible for care planning, commissioning services and for case management. It is the responsibility of the ICB to plan strategically, specify outcomes and procure services, to manage demand and provider performance for all services that are required to meet the needs of all eligible individuals who qualify for NHS Continuing Healthcare, and for the healthcare part of a joint care package. The services commissioned must include on-going case management for all those entitled to NHS Continuing Healthcare, as well as for the NHS elements of joint packages, including review and/or reassessment of the individual's needs." (Paragraph 165).

Where a person qualifies for NHS Continuing Healthcare, the package to be provided is that which the ICB assesses is appropriate to meet all the individual's assessed health and associated care and support needs. The ICB has responsibility for ensuring this is the case and determining what the appropriate package should be. In doing so, the ICB should have due regard to the individual's wishes and preferred outcomes.

3 Definitions

'Continuing Care' - refers to care provided over an extended period to a person aged 18 or over, to meet physical and/or mental health needs which have arisen because of disability, accident, or illness.

'NHS Continuing Healthcare (or "CHC")' - refers to a package of continuing care that is commissioned (arranged and funded) by or on behalf of the NHS in accordance with Regulation 20 of The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended).

'The National Framework' – refers to The National Framework for NHS Continuing Healthcare and NHS funded Nursing Care (published by the Department of Health 2009) which provides the context for the commissioning of NHS Continuing Healthcare, providing clarity and consistency of decision-making regarding eligibility and setting out the systems and processes to be used by the NHS.
'**Eligible individual'** - shall within this Policy refer to an eligible individual who has been assessed by the commissioner under The National Framework to qualify to have their assessed health and social care needs met and fully funded by the NHS.
Funded Nursing Care (or "FNC") - FNC is a weekly sum paid by the NHS (via the responsible Integrated Care Board (ICB)) directly to the care home, as a contribution towards the cost of nursing care needs that are provided by a registered nurse employed by the care home.

4 Context

4.1 "NHS Continuing Healthcare" (CHC) means a package of continuing care arranged and funded solely by the NHS where the eligible individual has been found to have a 'primary health need' as set out in the National Framework. Such care is provided to an eligible individual aged 18 or over, to meet their health and associated social care needs that have arisen because of disability, accident, or illness. The actual services provided as part of that package should be seen in the wider context of best practice and service development for each client group. Eligibility places no limits on the settings in which the package of support can be offered or on the type of service delivery." (Definition's page 15)

4.2 This policy does not apply to packages of care for those under the age of 18, nor does it apply to the provision of aftercare services under s117 of the Mental Health Act. It only applies where individuals have been found to be eligible for Joint Funding or NHS CHC and applies only to the commissioning of that CHC provision.

5 The Provision of Services for People who are Eligible for NHS Continuing Healthcare

5.1 Many individuals who require Continuing Healthcare will receive it in a specialised environment. The treatments, care and equipment required to meet complex, intense and unpredictable health needs often depend on such environments for safe delivery, management, and clinical supervision. Specialised care, particularly for people with complex disabilities may only be provided in Specialist Care Homes (with or without nursing), which may sometimes be distant from the Individual's ordinary place of residence.

5.2. These factors mean that there is often a limited choice of clinically appropriate, safe, sustainable, and affordable packages of care.

5.3. ICBs commission in accordance with the NHS Constitution and the duties at s.14U (duty to promote Individual involvement) and 14V (duty to promote Individual choice) of the National Health Service Act 2006 ("the NHS Act"). The ICB fully recognises these obligations but must balance them against its other duties.

5.4. In commissioning CHC care, each ICB must have constant regard to its financial duties. In brief, section 223G of the NHS Act provides for payment to the ICB from the NHS Commissioning Board ("NHS England") in respect of each financial year, to allow the ICB to perform its functions. Section 223I provides that, in summary, each ICB must break even financially each financial year. In the case of Condliff v North Staffordshire Primary Care Trust [2011] EWHC 872 (Admin), the Court stressed the fundamental challenge for commissioners in allocating scarce resources to best serve the local population, whilst also having due regard to eligible individual rights and choices.

5.5. The ICB acknowledge that they must also have due regard to the rights of eligible individuals under Article 8 of the European Convention on Human Rights to respect for private and family life, and any interference with this right must be clearly justified as proportionate, in accordance with Gunter v Southwestern Staffordshire Primary Care Trust [2005].

5.6. The ICB must also have due regard to its equality duties, both under s.14T of the NHS Act (duty to reduce inequalities) and the Public Sector Equality Duty under s.149 of the Equality Act 2010 (duty to eliminate discrimination and advance equality of opportunity between persons with and without protected characteristics). The ICB is guided in balancing obligations as in the case of Condliff in which the Court held that a policy of allocating scarce resources on the strict basis of a comparative assessment of clinical need was intentionally non-discriminatory and did no more than apply the resources for the purpose for which they are provided without giving preferential treatment to one Individual over another on non-medical grounds (para. 36).

5.7. In the light of these constraints, ICB has developed this policy due to the need to balance personal choice and safety with the need to effectively use finite resources. It is also necessary to have a policy which supports consistent and equitable decision making about the commissioning of care regardless of the person's age, condition, or disability. These decisions need to provide transparency and fairness in the allocation of resources.

5.8 Application of this policy will ensure that decisions about care will:

- be person centred by fully involving the eligible individual and their family/representative possible.
- be robust, fair, consistent, and transparent
- be based on the objective assessment of the eligible individual's clinical need, safety, and best interests
- have regard to the safety and appropriateness of care to the eligible individual and staff involved in the delivery
- Implement the principles and processes of Personal Health Budgets (PHBs) and ensure availability of information and support to allow take up of all options related to PHBs
- consider the need for ICB to allocate its financial resources in the most cost-effective way
- support and offer choice to the greatest extent possible in view of the above factors

5.9 The ICB has a duty to commission care for an eligible individual with continuing healthcare needs to meet those assessed needs. An eligible individual or their family/representative cannot make a financial contribution to the cost of NHS Continuing Healthcare identified by ICB as required to meet the eligible individual's needs. However, an eligible individual has the right to decline NHS services and make their own private arrangements.

5.10 Access to NHS services depends upon clinical need, not ability to pay. The ICB is only obliged to commission care if it is identified as the responsible commissioner, in line with the guidance, Who Pays? Establishing the Responsible Commissioner (DHSC revised 2020) "With:"NHS England, Who Pays? Determining which NHS commissioner is responsible for commissioning healthcare services and making payments to providers (Version 4, July 2025; effective 1 August 2025). The ICB will not charge a fee or require a co-payment from any NHS Individual in relation to their assessed needs. The principle that NHS services remain free at the point of delivery has not changed and remains the statutory position under the NHS Act 2006. The ICB are not currently able to allow eligible individuals to top up payments into the package of care assessed as meeting the needs of the eligible individual under NHS Continuing

Healthcare and covered by the fee negotiated with the service provider (e.g. the care home) as part of the contract.

5.11 However, where a service provider offers additional services which are not required to meet the eligible individual's assessed needs under NHS Continuing Healthcare, the eligible individual may choose to arrange and pay for those services privately.
Eligible individuals (or third parties on their behalf) must not make any payment to "top up" or otherwise contribute towards the cost of the services that the ICB has assessed and commissioned to meet NHS Continuing Healthcare needs. Any privately purchased services must be clearly separable from the NHS-funded package (for example, optional lifestyle or comfort items) and must be covered by a separate agreement between the individual and the provider, with separate itemised invoicing, and must not affect access to, or the quality of, the NHS-funded care.

5.12 Examples of such services falling outside NHS provision include hairdressing, a bigger room, or a nicer view within a care home. Any additional services which are unrelated to the person's primary health needs will not be funded by the ICB as these are services over and above those which the service user has been assessed as reasonably requiring, and the NHS could not therefore reasonably be expected to fund those elements. In these circumstances the provider must be able to clearly separate the associated cost of these additional services. Any payments made by the individual (and/or his/her representative/s) under a contract with a care provider for services cannot relate to any services to be provided under the ICB contract with the care provider.

If the individual (and/or his/her representative/s) decides for any reason that the funding of the additional services is to be terminated, the ICB will not assume responsibility for funding any additional services.

5.13 Where an eligible individual advises that they wish to purchase additional private care or services the ICB will discuss the matter with the eligible individual to seek to identify the reasons for this. If the eligible individual advises that they have concerns that the existing care package is not sufficient or not appropriate to meet their needs the ICB will offer to review the care package to identify whether a different package would more appropriately meet the eligible individuals assessed needs.

5.14 The decision to purchase additional private care services will always be a voluntary one for the eligible individual concerned. The ICB will not require the eligible individual to purchase additional private care services as a condition of the provision or continued provision of NHS funded services to them.

5.15 Unless it is possible to separately identify and deliver the NHS funded elements of a service it will not usually be permissible for eligible individuals to pay for higher cost services and/or accommodation.

5.16 The ICB will not be held responsible for the payment of additional private care services if the individual is no longer able to afford them.

5.17 In instances where more than one clinically effective care option is available (e.g., a nursing home placement and a domiciliary care package at home) the total cost of each care package will be identified and assessed for their overall cost effectiveness as part of the decision-making process. While there is no set upper limit on the cost of care, the expectation is that the most cost-effective option will be commissioned that meets the eligible individual's assessed health needs and circumstances.

5.18 The cost comparison must be based on the genuine costs of alternative models. A comparison with the cost of supporting a person in a care home should be based on the actual costs that would be incurred in supporting a person with specific needs in the case and not on an assumed standard care home cost.

5.19 Any assessment of a care option should include the psychological and associated social care needs of the eligible individual and the impact on their home and family life, as well as the eligible individual's care needs. The outcome of this assessment will be considered in arriving at a decision.

5.20 The setting in which CHC is provided will be decided by the ICB. The ICB must take into consideration its wider resources, other commissioned services, and an equitable allocation of the same. However, this consideration will always be balanced against the factors set out above.

5.21 The ICB recognises that an individual's needs may change over time and there may be other changes that the ICB must take account of, including other demands on its budgets, technology changes or other factors that may change commissioning decisions related to the services that are reasonably required to meet the needs of an individual. The ICB has no legal mandate to review a social care service and cannot amend any care plan without consultation with the Local Authority therefore this will be completed in partnership by arranging a joint review by the ICB and the Local Authority. Consequently, any offer made by the ICB and/or any services that are commissioned by the ICB does not constitute any promise that the services will continue to be offered or commissioned in that manner in the future. Regular case reviews should be undertaken to reassess an individual's care needs and eligibility for NHS funded services and/or to determine what services should be offered or commissioned for an individual. The ICB reserves the right to reassess any package of health and/or social care services and/or an individual's CHC eligibility at any time and to amend care plans or any commissioned services in the light of any relevant circumstance

6. Continuing Healthcare Funded Care Home Placements

6.1 Where an eligible individual has been assessed as requiring placement within a care home, the ICB operates a preferred provider list, and the expectation is that eligible individuals requiring placement will have their needs met in one of these homes. The ICB will endeavour to provide a reasonable choice of placements

(generally three placements) and discuss the placements with the eligible individual and their family.

6.2 The individual may wish to move into a home outside of the preferred provider list, or their family/representative may wish to place the eligible individual in a home outside of the preferred provider list. If the fee for the bed is comparable to the fee agreed with the preferred provider and the ICB are satisfied with the Care Quality Commission (CQC) inspection reports, their own ICB internal Quality contract monitoring of the care home and that the home can meet the eligible individual's assessed care needs the ICB will consider this option.

6.3 The ICB will agree to fund the cost of a care home commissioned within the ICB's locality and look at reasonable costings for any out of area placements if the needs cannot be met within borough.

6.4. If needs cannot be met in the locality it is up to the ICB to source an alternative provision where needs can be met out of area. If the person wishes to choose a particular out of area provision which is more costly than the suitable out of area provision identified by the ICB then the ICB would seek clarity about whether the higher fees included additional or other services which went beyond those identified within the CHC package and, if so, the ICB would consider funding the core costs of care which related to CHC, allowing the eligible individual to contract separately with the care home for the additional or other services if they wished to do so.

6.5 The provider will only be able to invoice the ICBs for the core care costs and reasonable accommodation costs and will have to invoice the individual separately for the non-core care costs and extra accommodation costs. The invoices will detail what the ICB and eligible individual is being charged for.

6.6 If the provider refuses to provide appropriate clarification as to the basis upon which their fees are charged, or to contract on this basis, the ICB are unlikely to purchase the care at this home and the eligible individual will be advised that they will need to consider choosing a home from those commissioned within the ICB locality.

6.7 Where there is a conflict between a high-cost placement outside of the fee agreed with the local commissioned providers and personal choice the case will be referred and discussed through the ICBs preferred governance process.

6.8 In all cases NHS CHC assessments will not be undertaken in the acute hospital setting and the ICB will access the Discharge to Assess (D2A) pathways in place to enable the assessment to take place at the right time, in the right place, outside of hospital.

6.9 If the eligible individual is unwilling to accept any of the offers made by the ICB, the ICB will have fulfilled its duties to the eligible individual and is not required to take further steps to provide services to him or her. This may trigger a safeguarding alert as the ICB has a Duty of Care to make sure the individual and others are safe from harm.

6.10 If the eligible individual's representatives are delaying placement in a care setting due to non-availability of their first choice and the individual does not have the mental capacity to make decisions themselves, the ICB reserves the right to work with the multi-disciplinary team involved in the eligible individual's care and to make a best interest's decision on behalf of the individual to secure a prompt discharge.

7. Continuing Healthcare Funded Packages of Care at Home

7.1 **The ICB does not have the resources or facilities to provide either a 24-**hour registered nursing service or the equivalent of nursing/residential care provision in a person's own home. This level of care is unlikely to meet the necessity for cost effectiveness in comparison with other care settings which is a consideration that the ICB is legally bound to undertake. However, the ICBs will consider all requests for home care, on an eligible individual basis, having regard to assessed needs in accordance with the principles set out in the National Framework in every case.

7.2 The ICB will take account of the following issues before agreeing to commission a care package at home:

- where the eligible individual has been found to have a 'primary health need' as set out in the National Framework. Eligibility places no limits on the settings in which the package of support can be offered or on the type of service delivery and, in addition

- whether care can be delivered safely and without undue risk to the eligible individual. Safety will be determined by a written assessment of risk undertaken by an appropriately qualified professional in consultation with the eligible individual and/or their family. The risk assessment will include the availability of equipment, the appropriateness of the physical environment, potential adaptations, and the availability of appropriately trained care staff and/or other staff to deliver the care at the intensity and frequency required. Risks posed to carers or other members of the household (including children) will also be considered

- where equipment and/or assistive technology can be used to support the safe delivery of care at Home, it is expected that the eligible individual will accept this and use it appropriately.

- the acceptance by the ICB and each person involved in the eligible individual's care of any identified risks in providing care and the eligible individual's acceptance of the risks and potential consequences of receiving care at home. Where an identified risk can be minimised through actions by the eligible individual or their family and carers, those eligible individuals agree (and confirm their agreement in writing) to comply with the steps required to minimise such identified risk

- the eligible individual's GP agrees to provide primary care medical support, and the local provider of community services agrees to deliver the necessary community support.

- the suitability and availability of alternative care options

- the cost of providing the care at home in the context of cost effectiveness

- the relative costs of providing the package of care in line with the eligible individual's preference considered in line with the relative benefit to that eligible individual of doing so.

- the willingness and ability of family, friends, or informal carers to support elements of care where this is part of the care plan and the agreement of those persons to the care plan and a contingency plan if the family, friends, or informal carers are no longer able to care for the individual and meet those needs.

- the outcome of the Carers Assessment referral

- If the ICB does not agree with the current package of care, they inform the individual/family that they will pick up the funding on a temporary basis whilst working with them to commission the agreed package of care

7.3 Many eligible individuals wish to be cared for in their own homes rather than in a care home, especially in the terminal stages of an illness. Where an eligible individual or their family expresses such a desire, the ICB will support this choice wherever possible considering the factors set out in paragraphs 4 and 6 of this policy. Any consideration of a package of care at an eligible individual's home will be considered, even if subsequently discounted with documented rationale.

7.4 It may be necessary to pay more to meet an eligible individual's assessed needs in a way that does not discriminate against them but there is no right for an eligible individual's care to be provided at home and as such the ICB does not have to commission a home care package if it is more expensive than providing care in a residential setting (subject to a proper consideration of the factors as outlined above).

7.5 Home care packages that exceed the cost of a preferred care home placement would be carefully considered, with a full risk assessment undertaken.

7.6 Persons who need waking night care might generally be more appropriately cared for in a residential placement. The need for waking night care indicates a high level of supervision day and night.

7.7 Residential placements may be deemed more appropriate for persons who have complex and high levels of need. Residential placements benefit from direct oversight by registered professionals and the 24-hour monitoring of persons.

7.8 If the clinical need is for registered nurse direct supervision or intervention throughout the 24 hours the care would normally be expected to be provided within a nursing home placement. This would include the requirement for 1-2 hourly intervention/monitoring for turning, continence management, medication, feeding, manual handling, and other clinical interventions or for the management of significant cognitive impairment.

7.9 There are specific conditions or interventions that it may not be appropriate to manage in a home care setting. In each case a comprehensive risk assessment

should be completed to determine the most appropriate place for care to be provided.

7.10 Each assessment will consider the appropriateness of a home-based package of care, considering the range of factors in paragraph 7.2 and any others deemed appropriate by the ICB in an eligible individual case and underpinned by the principles in 5.2. Circumstances to be taken into consideration

7.11 The CHC Service will seek to take account of the wishes expressed by eligible individuals and their families when making decisions as to the location(s) of care packages and residential placements to be offered to satisfy the obligations of the ICBs to commission NHS Continuing Healthcare. The ICBs accept that many persons with complex medical conditions wish to remain in their own homes and to continue to live with their families, with a package of support provided to the person in their own homes. Where a person or their family expresses such a desire the NHS CHC Service will investigate to determine whether it is clinically feasible and cost effective to commission a sustainable package of Continuing Healthcare for a person in their own home.

7.12 Packages of care in a person's own home are bespoke in nature and thus can often be considerably more expensive for the ICBs than delivery of an equivalent package of services for a person in a care home. Such packages have the benefit of keeping a person in familiar surroundings and/or enabling a family to stay together. However, the ICB needs to act fairly to balance the resources spent on an eligible individual with those available to fund services to other persons.

7.13 The ICB has resolved that, in an exceptional case and to balance these different interests it may be prepared to support a clinically sustainable package of care which keeps a person in their own home provided the anticipated cost to the ICB is not ordinarily higher than the anticipated cost delivered in an alternative appropriate location such as a care home. The ICB will consider the cost comparison based on the genuine costs of alternative models. A comparison with the cost of supporting a person in a care home should be based on actual costs that would be incurred in supporting a person with the specific needs in the case and not on an assumed standard care cost.

7.14 In situations where there is a home care package (with family support) and the family are unable to provide the agreed support, in those circumstances the ICB would need to reassess the appropriateness of a home package.

7.15 Exceptional Circumstances

7.15.1 The ICB recognises that exceptional circumstances may require exceptional consideration but will retain its obligation to make best use of NHS resources to meet the needs of the whole population served. Where the package of care is defined as exceeding the normal level of expenditure or includes exceptional features then the case may be referred to a NENC ICB High-Cost Panel to consider the suggested package and any exceptional circumstances that are pertinent to the individual. As per paragraph 6.2 the ICB will pick up funding on a temporary basis whilst working on the agreed package of care

7.15.2 Exceptionality will be determined on a case-by-case basis and will require agreement by personnel at Director level or as determined by the Commissioner's Standing Rules and Financial Instruction.

7.15.3 Each assessment will consider the appropriateness of a home-based package of care, considering the range of factors in paragraphs 4 and 6 above.

7.15.4 The authorisation for the commissioning and funding of packages of care at home lies with the ICB. There will be a process for the authorisation of eligibility and the authorisation of care packages and placements.

7.15.5 Once a package of care at home has been agreed by the ICB, the eligible individual may be given a notional weekly personal health budget (PHB), which is the cost of the care package. Eligible individuals and their families may be able to have some flexibility in the delivery of the care (for example, times) if the eligible individual's assessed care needs are being met. If the weekly cost of the care increases, apart from a single period of up to two weeks to cover either an acute episode or for end-of-life care to prevent a hospital admission, the care package will be reviewed, and other options (for example a nursing home placement) will be explored following consideration of the issues outlined in paragraph 6.

7.15.6 NHS rules allow NHS Commissioners to offer eligible individuals the opportunity to have their own PHB in certain situations. Eligible individuals and those supporting them, will know exactly how much funding is available for their care and they will be able to agree with the ICB the best way to spend it to meet their assessed needs and to achieve agreed outcomes.

7.16 Review

7.16.1 The ICB will periodically review an eligible individual's needs within the context of CHC in line with the National Framework. This should be an initial three-month review, followed by a minimal of annual reviews (or following a change in circumstances) to ensure that the package of care still meets that eligible individual's needs at that time. The three-month and annual review

will be undertaken by the ICB whether an eligible individual is receiving care at home or in a care home.

7.16.2 Eligible individuals and their families need to be aware that there may be times where it will no longer be appropriate to commission or provide care at home. For example, deterioration in the person's condition may result in the need for clinical oversight and 24-hour monitoring.

7.16.3 In line with the ICB's duties to commission appropriate health services to meet an eligible individual's assessed needs, the ICB will commission packages of care at home when the factors outlined in section 6 and underpinned by those principles outlined in section 4 render it appropriate.

7.16.4 By reason of such reviews it will sometimes be apparent that an eligible individual's needs have changed and consequently it will be necessary to undergo a review of the appropriateness of any package of care at an eligible individual's home in line with the decision-making process as outlined at paragraphs 4 and 6.

7.16.5 Any package of care provided in an eligible individual's home must therefore remain appropriate in line with that decision-making process for it to be continued following the CHC review. Should it be considered inappropriate, the ICB will not continue to fund any such package and will revise its offer accordingly, with reference to section 6 above.

7.16.6 If a home care package is not considered appropriate on review, the offer of residential care as an alternative, in accordance with this policy will be a discharge of the ICB's duty to make a reasonable offer, and, if not accepted, the package can be withdrawn taking into account the ICB's Duty of Care to safeguard an individual see paragraph 5.9.

8. Right to Refuse

8.1 An eligible individual is not obliged to accept the ICB's offer of care. Where an eligible individual chooses not to accept a package, the ICB will take reasonable steps to inform the individual that:

8.1.1 the ICB is not required to make further offers to the individual or offer to fund care in a location of the individual's choice

8.1.2 the Local Authority may not assume responsibility to provide care to the individual as anyone who has been assessed as CHC eligible will have a primary health need and as such their needs are above what the Local Authority can legally provide. As such the Local Authority cannot legally provide care.

8.2 The ICB will have discharged its duty to eligible individuals by making an offer of a suitable CHC care package whether individuals choose to accept the offer.

8.3 For example, the ICB may discharge its duty by offering to commission a package of services for an eligible individual in one or more appropriate care settings, irrespective of whether this is the individual's preferred location.

8.4 If the ICB's offers of appropriate care packages are refused by the eligible individual or someone with legal authority to act on behalf of the individual, the ICB may have recourse to local Safeguarding Policies and Procedures and the Mental Capacity Act 2005, as appropriate.

8.5 Where an eligible individual exercise their right to refuse, the ICB will ask the individual or their representative(s) to sign a written statement confirming that they are choosing not to accept the offer of care provision and will consider paragraph 7.1.2.

8.6 Where an eligible individual refuses such care, they are entitled to re-engage with the ICB at any time, and, if they do so, the ICB will reconsider what offer should be made to that individual.

9. How Personal Health Budgets work

9.1 A personal health budget (PHB) is an amount of money to support a person's identified health and wellbeing needs planned and agreed between the person and the ICB team. The vision for PHBs is to enable people with long term conditions and disabilities to have greater choice, flexibility and control over the health care and support they receive. The ICB's PHB Policy should be referred to for more information and for a more detailed explanation of the various types of PHB available.

9.2 The budget set for an eligible individual will depend on their clinical and associated social care need and may be available for both care within an eligible individual's home and where care is provided within a residential setting. A PHB may only be spent on the services agreed between the eligible individual and their Care Co-ordinator in the care and support plan that will enable the eligible individual to meet their agreed health and wellbeing outcomes. For further information please see the ICB's PHB Policy.

9.3 Where a PHB is being agreed with an eligible individual, a support plan will be put into place which will include:

- issues of importance to the eligible individual
- changes to be achieved
- support to be provided to the eligible individual and how this will be managed
- how the budget will be used
- how the eligible individual will remain in control
- how the eligible individual will make it all happen

10. Fast Track

10.1 The eligibility criteria for NHS CHC for Fast Track applications are defined within the National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care. Care provision for individuals assessed on the Fast Track will be subject to the same principles as set out in the relevant sections in this policy dependant on needs.

10.2 In urgent situations however, where services may need to be commissioned very quickly there may not be time to apply choice as described above, however the NHS ICB team will take reasonable steps to work in partnership with the eligible individual and their family / representative in all cases.

10.3 Since Fast Tracked individuals are deemed to be near End of Life, the ICB will support the principle of individuals having the right to choose the setting for their end-of-life care, so long as the care meets the needs of the individual and is equitable.

10.4 Following a review, if the individual is deemed no longer eligible for NHS CHC the offer of care may be amended and / or referred to the Local Authority with the individual's agreement/consent in line with this Policy.

10.5 If following a review, the CHC Fast track is no longer applicable, the ICB will undertake a multidisciplinary team meeting comprising of professionals included in your current and potential future care to complete a Decision Support Tool to determine whether the eligible individual remains eligible for NHS Continuing Healthcare and if so the principles of The Choice and Equity policy will be part of the commissioning decision.

11. Capacity

11.1 The ICB will always consult directly with an eligible individual regarding choose their care arrangements. In accordance with the Mental Capacity Act 2005, it will assume that the eligible individual retains the necessary capacity to make these decisions unless demonstrated otherwise via a formal capacity assessment.

11.2 If a formal capacity assessment is identified as being required it is the responsibility of the ICB to ensure that this is undertaken.

11.3 If an eligible individual lacks the capacity to decide about choice of care setting, the ICB will follow the processes set out in the Mental Capacity Act 2005 to commission the most clinically and cost effective, safe care available based on an assessment of the person's best interests, having regard to the factors set out in paragraphs 4 and 6 above, having regard to the Act and associated Code of Practice.

11.4 In considering the appropriate care setting and to make a reasonable offer of care for an eligible individual, the ICB will consider issues that may arise in relation to:

- Any valid and applicable **Lasting Power of Attorney** that may have been made by the eligible individual.
- Any valid and applicable **Advance Decision** (also known as a "living will" or "Advance Directive") that may have been made by the eligible individual.
- Any financial planning made prior to becoming unwell to accommodate preferred place of care
- Any **Advance statement of wishes previously prepared by the eligible individual**

11.5 In the absence of any court appointed deputy or LPA, the ICB will make all decisions in the eligible individual's best interests in accordance with the Mental Capacity Act 2005 and the associated Code of Practice.

12. Review of NHS Funded Continuing Healthcare eligibility and care provision

12.1 The National Framework states that all eligible individuals should be reviewed no later than three months following the initial assessment and then annually as a minimum requirement to ensure that the package of care is still meeting the eligible individual's needs.

12.2 If an eligible individual is found to be not eligible for NHS Continuing Healthcare following a full MDT review and a residential placement is being funded by the ICB, then the ICB will only fund the Funded Nursing Care Contribution to the care placement (if the individual is assessed as eligible for FNC), rather than fully fund the placement.

12.3 On review, the eligible individual's condition may have improved or stabilised to such an extent that they no longer meet the criteria for NHS Continuing Healthcare. Consequently, the Individual may become the responsibility of the Local Authority (LA) who will assess their needs against the Care Act eligibility criteria. This means the individual may be charged for their care. If an individual has funds above the financial threshold, they have the right not to involve the local authority and they can arrange their own care if they wish to do so.

12.4 Where the individual remains eligible for NHS Continuing Healthcare, the review may result in an increase of decrease in care based on the assessed need of the eligible individual at that time. Where care is provided at home the factors in paragraph 6.2 will again be considered and an alternative care option may be agreed if this is appropriate.

12.5 In order to meet its duty to commission health services to meet an eligible individual's needs appropriately and safely, the ICB must be afforded access to complete its review of an eligible individual's CHC when that package is provided in an eligible individual's home. In circumstances where access is not facilitated and the ICB cannot satisfy itself as to the safety, appropriateness, or cost efficiency of the current package of care, this will leave no option other than to revise the offer of care to be provided in a location that would facilitate the proper review of an eligible individual's needs which can then, in turn, potentially prompt

an assessment process of where those needs ought to be met (in line with paragraphs 4.2 and 6.2 above).

13. Right of Appeal

13.1 If the individual wishes to challenge the package of care provided / offered by the ICB, any complaint should be made via the NHS Complaints Procedure.

14. Guidance

- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (July 2022 (revised), corrected July 2023) The NHS Continuing Healthcare (Responsibilities) Directions 2012
- Human Rights Act 1998
- Who Pays? Establishing the Responsible Commissioner (revised 2020)
- Care Act 2014
- Statutory guidance to support Local Authorities to implement the Care Act 2014
- The Care and Support and After Care (Choice of Accommodation) Regulations 2014

15. Implementation

15.1 This policy will be available to all Staff for use in relation to the specific function of the policy.

15.2 All directors and managers are responsible for ensuring that relevant staff within their own directorates and departments have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

16. Training Implications

The Executive Director will ensure that the necessary training or education needs, and methods required to implement the policy or procedure(s) are identified and resourced or built into the delivery planning process. This may include identification of external training providers or development of an internal training process.

17. Documentation

17.1 Other related policy documents

- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care – July 2022 (revised)
- The NHS Continuing Healthcare (Responsibilities) Directions 2012
- Who Pays? Establishing the Responsible Commissioner (revised 2020)
- The Care and Support and After Care (Choice of Accommodation) Regulations 2014

17.2 Legislation and statutory requirements

- Care Act 2014
- Human Rights Act 1998
- Statutory guidance to support Local Authorities to implement the Care Act 2014

17.3 Best practice recommendations

- Joint Working Principles between partner organisations
- A Commissioning Policy to support commissioning principles between partner organisations

18. Monitoring, Review and Archiving

18.1 **Monitoring**
The ICB will agree with the accountable Executive Director a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

18.2 **Review**

18.2.1 The ICB will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. **No policy or procedure will remain operational for a period exceeding three years without a review taking place.**

18.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The governing body will then consider the need to review the policy or procedure outside of the agreed timescale for revision

18.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director, and a revised

document may be issued. Review to the main body of the policy must always follow the original approval process.

18.3 Archiving

The ICB will ensure that archived copies of superseded policy documents are retained in accordance with the NHS Records Management Code of Practice 2021.

Schedule of Duties and Responsibilities

Through day-to-day work, employees are in the best position to recognise any specific fraud risks within their own areas of responsibility. They also have a duty to ensure that those risks, however large or small, are identified and eliminated. Where it is believed fraud, bribery or corruption could occur, or has occurred, this should be reported to the CFS or the chief finance officer immediately.

ICB Board	The ICB has the lead responsibility for NHS Continuing Healthcare and Complex Care in the ICB locality, there are also specific requirements for Local Authorities to cooperate and work in partnership with the ICB several key areas.
Local Authority	Local Authority staff have a responsibility to familiarise themselves with this policy and additional guidance for Local Authority staff contained in appendices. Local Authority staff have a responsibility to work in partnership with the ICB. Local Authority Operational staff should consult Integrated
Accountable Officer	The Accountable Officer (AO) is responsible for ensuring that the ICB discharges its statutory duties and functions, including ensuring that arrangements are in place for NHS Continuing Healthcare to be commissioned, delivered and governed in accordance with the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended) (which set out, among other matters, the NHS commissioning responsibilities now exercised by ICBs), the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, and any relevant NHS England
Chief Nurse	The Chief Nurse provides executive nursing leadership and clinical oversight for NHS Continuing Healthcare and Complex Care, including leadership of (or delegated oversight of) the Complex Care Team. The Chief Nurse will provide assurance that commissioning, care planning, case management and review processes are clinically safe, person-centred and compliant with the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care and with the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended) (which set out, among other matters, the NHS commissioning responsibilities now exercised by ICBs), together with any relevant NHS England guidance.

Local Resolution Panel Chair	The Independent CHC Panel Chair is responsible for ensuring that the local panel decision-making process is equitable and due process is followed as per the National Framework for the NHS Continuing Healthcare (July 2022 (revised), corrected July 2023) . The Chair's responsibilities include ensuring families and carers are given clear information about the panel procedures and decisions are communicated appropriately.
Heads of CHC (Delivery Units) and Case Managers	Have responsibility for supporting CHC staff to identify residents who may need additional observations. They should support staff to review submitted clinical documents to inform appropriate decision making around those people who may require additional care and supervision and signpost for additional support e.g. Dementia Outreach, Falls Clinic, etc. They also have a duty to ensure all staff and providers are aware of and comply with this policy.
Complex Care Team	All members of Complex Care Team have a responsibility to familiarise themselves with the content of the policy ensuring that all requests receive from providers for 1:1 have adhered strictly to the guidelines. Clinical staff should make sure that there is no mismatch with evidence submitted and the request.

Appendix A – Equality Impact Assessment

Equality Impact Assessment
Initial Screening Assessment (STEP 1)

As a public body organisation we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Debra Pease
Job Title: Head of All Age Continuing Care
Organisation: NECS

Title of the service/project or policy: Choice and Equity Policy

Is this a;
Strategy / Policy ☒ **Service Review** ☐ **Project** ☐
Other Click here to enter text.

What are the aim(s) and objectives of the service, project or policy:
This policy describes the way in which Integrated Care Board (ICB) will commission care for people who have been assessed as eligible for fully funded NHS Continuing Healthcare. The policy describes the way in which ICB will commission care in a manner which reflects the choice and preferences of eligible individuals but balances the need for ICB to commission care that is safe and effective and makes the best use of available resources

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff** ☒
- **Service User / Patients** ☒
- **Other Public Sector Organisations** ☒
- **Voluntary / Community groups / Trade Unions** ☐
- **Others, please specify** Click here to enter text.

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☐	☒
Has there been or likely to be any staff/patient/public concerns?	☐	☒
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could this piece of work affect the workforce or employment practices?	☐	☒
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☒

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

The purpose of this policy is to ensure the commissioning of care is equitable for all individuals requiring care within the borough and the same process is used for everyone regardless of characteristics therefore there is no detrimental impact on any equality group.

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☐	☐
Please provide the following caveat at the start of any written documentation: **"If you require this document in an alternative format such as easy read, large text, braille or an alternative language please contact (ENTER CONTACT DETAILS HERE)"**		
If any of the above have not been implemented, please state the reason: Click here to enter text.		

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Executive Committee	Approver	July 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

If you are not completing 'STEP 2 - Equality Impact Assessment' this screening document will need to be approved and published alongside your documentation.

Please send a copy of this screening documentation to: NECSU.Equality@nhs.net for audit purposes.

Appendix A – Equality Impact Assessment

Title
Choice and Equity Policy

Directorate
Nursing
Brief Description of the proposed change
Updated with any changes to legislation and guidance

Who will the project/service/policy/decision impact?	
Staff	☒
Service User / Patients	☒
Carers	☒
Other Public Sector Organisations	☒
Voluntary / Community groups / Trade Unions	☐
Others, please specify below:	☐

Integrated Impact Assessment Review Panel	
Members of the panel:	
Date:	

Equalities Impact

For each protected characteristics group, consider whether the proposed change has:

No Impact: **N,** Negative Impact: **N,** Neutral Impact: **Ne,** Positive Impact: **P,** Unknown: **U**

Impact	No Impact	Negative	Neutral	Positive	Unknown
Age	☐	☐	☒	☐	☐
Disability	☐	☐	☒	☐	☐
Gender Re-assignment	☐	☐	☒	☐	☐
Marriage/Civil Partnership	☐	☐	☒	☐	☐
Pregnancy and Maternity	☐	☐	☒	☐	☐
Race and ethnicity	☐	☐	☒	☐	☐
Religion or belief	☐	☐	☒	☐	☐
Sex	☐	☐	☒	☐	☐

Sexual Orientation	☐	☐	☒	☐	☐
Other (see appendix 6 and provide detail)	☐	☐	☐	☐	☐

Summarise the overall impact:

Overall, the proposed change is an update to reflect current legislation and national guidance and does not alter the policy intent or eligibility criteria. The impact is therefore expected to be neutral across protected characteristic groups, with potential positive impact through clearer, more consistent and transparent decision-making, supporting equitable access to NHS Continuing Healthcare commissioning decisions. No specific adverse impacts are anticipated for staff, service users/patients, carers, or partner organisations.

Summarise the evidence used to make the judgement:

Judgement was informed by a review of the updated policy content against the Equality Act 2010 protected characteristics and the Public Sector Equality Duty, together with consideration of the nature of the change (a refresh to reflect current legislation and national guidance, with no change to policy intent, eligibility criteria or decision-making thresholds). Consideration was also given to how the policy is implemented in practice (access routes, communication and reasonable adjustments) and any available learning from routine service feedback/complaints and case review/audit activity, with no evidence identified of disproportionate adverse impact arising from the proposed update.

If there are negative impacts; how might these be mitigated:

Health Inequalities Impact

For each listed group at risk of health inequalities, consider whether the proposed change has:

No Impact: **N,** Negative Impact: **N,** Neutral Impact: **Ne,** Positive Impact: **P,** Unknown: **U**

Impact	No Impact	Negative	Neutral	Positive	Unknown
CORE 20	☐	☐	☒	☐	☐
CORE 20 PLUS	☐	☐	☒	☐	☐
Health Inclusion Groups	☐	☐	☒	☐	☐
Combined Overall	☐	☐	☒	☐	☐

Summarise the overall impact:

Overall, the update is not expected to create or widen health inequalities as it does not change eligibility, access routes, or decision-making thresholds; it updates the policy to reflect current legislation and national guidance. The impact is therefore anticipated to be neutral across groups at higher risk of health inequalities, with potential positive impact through improved clarity and consistency of communication and processes, supporting fair access and timely decision-making for all individuals.

Summarise the evidence used to make the judgement:

Judgement was informed by reviewing the updated policy to confirm it does not change eligibility criteria, access routes, or decision-making thresholds and therefore is unlikely to have differential impact on groups at higher risk of health inequalities (including CORE20/CORE20PLUS populations and health inclusion groups). Consideration was also given to implementation factors that can influence inequality (communication, accessibility of information, reasonable adjustments and support for carers/advocates) and any available routine intelligence (service feedback/complaints, case review/audit learning), with no evidence identified that the policy refresh would worsen health inequality outcomes.

If there are negative impacts; how might these be mitigated:

Quality Impact Assessment

For each domain of quality, consider whether the proposal has:

No Impact: **N,** Negative Impact: **N,** Neutral Impact: **Ne,** Positive Impact: **P,** Unknown: **U**

Impact	No Impact	Negative	Neutral	Positive	Unknown
Patient Safety	☐	☐	☐	☐	☐
Clinical Effectiveness	☐	☐	☐	☐	☐
Patient Experience	☐	☐	☐	☐	☐
System/ Operational Impacts	☐	☐	☐	☐	☐
Combined Overall	☐	☐	☐	☐	☐

Summarise the overall impact:

Overall, the policy refresh is expected to have a neutral impact on quality because it does not change eligibility, clinical decision-making thresholds, or care delivery arrangements. There may be a positive impact through clearer and more consistent processes and communication, supporting a better patient and carer experience and more timely, transparent decision-making. No specific adverse impacts on patient safety, clinical effectiveness, patient experience, or system/operational delivery are anticipated as a result of the update.

Summarise the evidence used to make the judgement:

Judgement was informed by reviewing the updated policy to confirm it is a legislative/guidance refresh and does not change eligibility criteria, clinical pathways, decision-making thresholds, or care delivery arrangements. The potential impact was considered against the key quality domains (patient safety, clinical effectiveness, patient experience and system/operational delivery), with focus on whether any changes would introduce additional clinical risk, variation in practice, or barriers to timely, person-centred communication. Consideration was also given to relevant governance intelligence where available (incidents, complaints/PALS, case review and audit learning), with no evidence identified that the update would adversely affect quality.

If there are negative impacts; how might these be mitigated:

Overall Conclusion

Summarise the overall outcome of the screening tool, any key potential impacts identified, and any key mitigations, and tick the relevant score under each domain below.

Impact	No Impact	Negative	Neutral	Positive	Unknown
Equality	☐	☐	☒	☐	☐
Health Inequality	☐	☐	☒	☐	☐
Quality	☐	☐	☒	☐	☐
Combined Overall	☐	☐	☒	☐	☐

Any negative impact outcomes will need a full impact assessment.

Recommendation	Tick Applicable
Proceed	☒
More information needed	☐
Full Impact Assessment required	☐
Stop	☐

Any other key issues to record

Completion

Name and Job Title of the person completing the screening tool:	
Kirsty Freeman – Programme Lead	
Date:	13/4/2026

Authorisation

Name and Job Title of the Accountable Lead:	
Date:	

Appendix B

Implementation of Choice and Equity