NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Bedfordshire Luton and Milton Keynes Integrated Care Board

NHS Continuing Healthcare Commissioning Policy

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Draft v1.0	12-05-2025	AACC Quality & Assurance Manager	1st Draft
Final v1.0	04-08-2025	BLMK ICB Operational Group	The BLMK ICB Operational Group adopted the policy as approved.

Implementation Plan

Development and Consultation:	The following individuals were consulted and involved in the development of this document: ▪ Associate Director All Age Continuing Care ▪ Head of All Age Continuing Care ▪ All Age Continuing Care Quality & Assurance Manager ▪ Continuing Healthcare Operational Leads ▪ All Age Continuing Care Commissioning Manager ▪ Senior Contracts Manager ▪ Chief Nurse Officer
Dissemination:	Staff can access this document via the website and will be notified of new / revised versions via the staff briefing. This document will be included in the organisation's Publication Scheme in compliance with the Freedom of Information Act 2000.
Training:	The following training will be provided to make sure compliance with this document is understood: ▪ Dissemination training to all AACC Staff
Monitoring:	Monitoring and compliance of this document will be carried out via: ▪ See Section 6.13
Review:	The Document Owner will ensure this document is reviewed in accordance with the review date on page 2.
Equality, Diversity and Privacy:	Appendix 1 - Equality Impact Assessment Appendix 2 - Data Protection Impact Assessment
Associated Documents:	The following documents must be read in conjunction with this document: ▪ National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care July 2022 (Revised) ▪ Care Act 2014 ▪ Mental Capacity Act 2005 ▪ BLMK ICB NHS CCC Operational Policy ▪ BLMK ICB NHS CHC Operational Policy ▪ BLMK ICB CHC Dispute Policy ▪ BLMK ICB CHC Appeals Policy ▪ BLMK ICB Enhanced Observation Policy ▪ BLMK ICB Safeguarding Adults & Children Policy

References:	The following articles were accessed and used to inform the development of this document: • Who Pays? Determining which NHS commissioner is responsible for commissioning health care services and making payments to providers. Version 3 • Health & Safety at Work Act 1974 • The Equality Act 2010

Table of Contents

1.0 Introduction

1.1 NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB) aims to ensure robust governance through its formal written procedural documents, such as this document, which communicate standard organisational ways of working. These documents help clarify operational requirements and consistency within day-to-day practice. They can improve the quality of work, increase the successful achievement of objectives and support patient safety, quality and experience. The ICB aims to ensure its procedural documents are user friendly, up-to-date and easily accessible.

1.2 The ICB must design and implement procedural documents that meet the diverse needs of our service and workforce, ensuring that none is placed at a disadvantage over others, in accordance with the Equality Act 2010. The Equality Impact Assessment initial screening, which was used to determine the potential impact this policy might have with respect to the individual protected characteristics is incorporated at Appendix 1.

1.3 A Data Protection Impact Assessment is a process which helps assess privacy risks to individuals in the collection, use and disclosure of personal information. The Data Protection Impact Assessment initial screening, which was used to determine the potential impact this policy might have with respect to an individual's privacy is incorporated at Appendix 2.

1.4 This policy describes the way in which Bedfordshire, Luton and Milton Keynes (BLMK) ICB will commission the provision of care for individuals who have been assessed as eligible for NHS Continuing Healthcare (CHC) in accordance with The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2022), (the Framework).

1.5 The purpose of this policy is to provide clarity regarding the commissioning processes undertaken, ensuring that the process is person led; that equity, equality and risk is managed and that the ICB are able to demonstrate the most effective use of NHS resources.

2.0 Scope

2.1 This policy applies to all ICB staff members, including Ordinary Members of the Board of the ICB, involved in policy-making processes, whether permanent, temporary or contracted-in under a contract for service (either as an individual or through a third-party supplier, which may be a Local Authority (LA)).

2.2 This Policy applies as appropriate, to all Providers of healthcare to individuals identified to be the responsibility of the ICB via the CHC or associated Joint Funding processes.

2.3 This policy does not change the ICB's statutory responsibilities to comply to national standards and legislative duties, however it promotes consistency of decision making and transparency in how the ICB will comply with their obligations as commissioners

of NHS funded services as stated in the Department of Health, Choice Framework (2014) and the associated national policy in the delivery of healthcare.

2.4 The CHC eligibility process is not within the scope of this policy.

3.0 Definitions

3.1 *NHS Continuing Healthcare* - means a package of ongoing care that is arranged and funded solely by the National Health Service (NHS) where the individual has been assessed and found to have a 'primary health need'. Such care is provided to an individual aged 18 or over, to meet health and associated social care needs that have arisen as a result of disability, accident or illness. The actual services provided as part of the package should be seen in the wider context of best practice and service development for each client group. Eligibility for NHS CHC is not determined by the setting in which the package of support can be offered or by the type of service delivery.

3.2 *NHS Funded Nursing Care* - is the funding provided by the NHS to care homes with nursing to support the provision of nursing care by a registered nurse. Since 2007 NHS FNC has been based on a single band rate. In all cases individuals should be considered for eligibility for NHS CHC before a decision is reached about the need for NHS FNC.

3.3 *Social Care Needs* – There is not a legal definition of the term 'social care need' in the context of NHS CHC. However, the Care Act 2014 introduced National Eligibility Criteria for care and support to determine when an individual or their carer has eligible needs which the local authority must address, subject to means where appropriate. These criteria set out that an individual has eligible needs under the Care Act 2014 where these needs arise from (or relate to) a physical or mental impairment or illness which results in them being unable to achieve two or more of the following outcomes which is:

- managing and maintaining nutrition
- maintaining personal hygiene
- managing toilet needs
- being appropriately clothed
- being able to make use of the home safely
- maintaining a habitable home environment
- developing and maintaining family or other personal relationships
- accessing and engaging in work, training, education or volunteering
- making use of necessary facilities or services in the local community, including public transport and recreational facilities or services
- carrying out any caring responsibilities the adult has for a child

3.4 *Healthcare Needs* – are related to the treatment, control, or prevention of a disease, illness, injury or disability and the care or aftercare, by a professional, of a person with these needs.

3.5 *Fast Track Tool* – Should be used for individuals who need an urgent package of care, due to a rapidly deteriorating condition that may be entering the terminal phase.

3.6 *Care Packages* – suite of services (nursing, therapies, home care etc.) that are designed to match the assessed needs of an individual.

3.7 *Care Plan* – A personalised plan drawn up by a CHC Assessor to meet the needs of an individual, centred on the Decision Support Tool (DST) which establishes the health needs.

3.8 *Decision Support Tool* – a tool providing a framework used by clinicians to collate the multidisciplinary assessment of needs of an individual and apply the evidence in a single practical format in order to facilitate consistent, evidence-based decision-making regarding NHS CHC eligibility. The DST is not an assessment in itself.

3.9 *Case Manager* – CHC Assessor responsible for; drawing up a care and support plan; monitoring the needs of the individual receiving a care package and assessing the suitability of the package.

3.10 *Personal Health Budget* - In line with the NHS Long Term Plan (2019) ICBs are required to offer personal health budgets (PHBs) to people in receipt of CHC funding in order to give individuals better flexibility, choice and control over their care. A PHB helps people to get the services they need to achieve their agreed health and wellbeing outcomes (agreed between the individual and clinician). Financially, PHBs can be managed in a number of ways including:

- A notional budget held by the ICB commissioner
- A budget managed on the individual's behalf by a third party, and
- A payment directly to the individual (a 'healthcare direct payment').

3.11 *Reviews* - All individuals in receipt of CHC (including Fast Track, Joint funding and FNC) should be reviewed within three months after commencement and no less than annually thereafter. The purpose of this review is to ensure the care and support arrangements continue to meet the needs of the individual. Should, at any point, the health needs of the individual materially change, the ICB will consider re-assessing for both CHC eligibility and the care provision in line with the National Framework.

3.12 *Joint Funding* – Process for assessing and arranging a bespoke care package, where there are specific health needs identified beyond which the LA is able to provide in accordance with the Care Act 2014, and where there is not an NHS commissioned service to meet those needs. This could be funded solely by the ICB or a combined package of health and social care, jointly funded, following the exclusion of CHC.

4.0 Policy Statement

4.1 The ICB aims to provide an open and transparent decision-making process that balances individual care preferences with the need for the ICB to commission and manage the local demand for healthcare for all the people of BLMK in a safe and effective manner.

4.2 The ICB fully embrace equality and diversity, and the established NHS values and principles on equality and fairness, as set out in legal frameworks e.g. The NHS Constitution for England, Department of Health (2013) and the laws under the Equality Act 2010 together with the European Convention on Human Rights.

4.3 The ICB are obliged to meet the health and care needs of individuals who are eligible for CHC, in line with guidance, however, can have discretion as to the manner of provision of services as long as it meets the care requirements of the individual. Ensuring to exercise reasonable judgement to provide the most appropriate care within the resources available.

4.4 Care packages will be commissioned from a variety of sources, including but not limited to, care homes, domiciliary care providers and from Nurse-led providers, where a BLMK contract is in place for CHC provision. When a care package is commissioned by the ICB, where there is no agreement in place, a spot contract purchasing arrangement will be agreed in order to ensure that there are quality standards in place to meet the requirements of the provision of NHS services.

4.5 At all times the ICB will ensure the best use of NHS resources both locally and nationally commissioned, and provide a level of service that is sustainable, equitable (fair) to the health and wellbeing of the people of BLMK with a focus on improving consistency and quality of care where able.

4.6 The services commissioned will include on-going case management for all those entitled to CHC, as well as for the NHS elements of joint packages of care, including the assessment and review of individual patient needs.

4.7 As well as service contracts, BLMK ICB as commissioners are responsible for monitoring quality, access and patient experience within the context of provider performance.

4.8 The ICB takes a strategic as well as an individual approach to fulfilling its CHC commissioning responsibilities within the context of quality, innovation, prevention and productivity agendas.

4.9 The ICB has a duty to provide care to an individual with healthcare needs to meet those assessed needs. An individual cannot make a financial contribution to the cost of the provision of NHS healthcare. An individual, however, has the right to decline NHS services and funding and make their own private arrangements should they wish.

4.10 If an individual declines care packages offered by the ICB, they will not be prejudiced should they wish to take up an offer of NHS services at a later date, following a review of their needs as per CHC process, and this policy will be applied to such individuals in the same way as to all those newly eligible for CHC.

4.11 Each individual will have a commissioning support plan to ensure person centred care and decisions are made based on individual's needs.

4.12 While there is an expectation that individual choice is considered, it must not compromise overall service provision. The ICB accept this policy may at times limit individual preference in order to promote equitable and sustainable healthcare for all.

4.13 The ICB will primarily fund a package of care within established contractual agreements. Funding outside of average market value will only be applied following internal process and regulatory guidelines. (Appendix 3)

4.14 If an individual does not have the mental capacity to decide about the location of their commissioned care package and suitable placement, the ICB will comply with the requirements of the Mental Capacity Act, 2005. The ICB will commission the most safe and cost effective care available based on an assessment of the individual's needs in conjunction with the best interest representation. All decisions will be evidenced and carried out in consultation with any appointed advocate, Attorney under an Enduring Power of Attorney, Lasting Power of Attorney or a Court Appointed Deputy or the Court of Protection directly and family and/or friends will be consulted where appropriate under the terms of the Mental Capacity Act 2005. Where an individual does not have family or friends to support them, an Independent Mental Capacity Advocate may be consulted in line with the Mental Capacity Act, 2005.

4.15 Care will not be commissioned from those care providers where there are concerns raised about the quality of the care provided or where they are known not to meet the Care Quality Commission minimum standards for care homes. BLMK ICB will work in partnership with BLMK (Luton, Bedford Borough, Central Bedfordshire and Milton Keynes) Councils and other out of area LAs as required, to ensure the quality of care in care homes meets the required standards.

4.16 Where concerns about standards are raised, the owners of the care provision will be informed that commissioning arrangements for CHC funding will be suspended until improvements have been made to achieve the Care Quality Commission minimum standards of care and the quality standards within the CHC spot purchasing contract. Where care is already commissioned for individuals in a care setting, a risk assessment currently called 'care review' will be undertaken in partnership with the individual and their family to ensure appropriate controls are in place to assure the individual's safety and the quality of care provided, which may include commissioning an alternative package of care elsewhere.

4.17 In drawing up this policy, the ICB has had regard to the Human Rights Act 1998 and, in particular, the implications of placement for individuals in relation to their Article 8 rights.

5.0 Roles and Responsibilities

5.1 The following have specific responsibilities in relation to this policy.

5.2 The Board

The ICB's Board has a responsibility to scrutinise, review and approve this policy in conjunction with the overall aims of the ICB and its statutory obligations under the NHS Act (2006).

5.3 **Chief Executive**

The ICB has legal responsibilities under the NHS Act and Standing Rules Regulations (2012) to have regard to the Framework and exercise its functions in regard to NHS AACC. The Chief Executive for BLMK ICB has overall responsibility to ensure suitable governance arrangements are in place.

5.4 **Chief Nurse**

The Chief Nurse holds the Executive position for oversight of NHS AACC performance, strategic planning using NHS AACC intelligence for wider commissioning, contracting & procurement and financial authority.

5.5 **Associate Director All Age Continuing Care**
Responsible for the direct oversight of this policy's implementation and operation, including governance. Provides financial scrutiny and authority.

5.6 **AACC Department**

It is the duty of AACC staff to, work in partnership, with individuals who are eligible for CHC, in a person-centred approach and in a timely and consistent manner to ensure that individuals receive the care they require without unreasonable delays.

It is the responsibility of CHC staff to ensure the process for commissioning packages of care will be transparent, fair and equitable for the residents of BLMK.

It is the responsibility of CHC staff to adhere to the NHS Act to ensure the best use of public funds with value-based commissioning of care, in accordance with the Secretary of State for Health & Social Care's direction.

6.0 Processes and Procedures

6.1 Individual circumstances will be considered, it must be understood that it is usually not possible to replicate support services that would be available within in-patient NHS settings and nursing care facilities, and if this level of care is required, it would not usually be possible to care for the individual at home.

6.2 Following an individual's assessment has identified eligibility for CHC or an element of NHS-funded joint package of care, the CHC case manager will work with the individual and/or their carers and representatives to agree health and wellbeing outcomes and develop a care plan.

6.3 On completion of an agreed commissioning care support plan the CHC case manager and brokerage team will work to put the plan in place. This may result in the continuation of an already established package of care, as long as the perimeters of this policy are met.

6.4 Care Home Placements

6.4.1 Where an individual has been assessed as needing care in a care home environment, the role of the ICB is to identify and commission a suitable placement.

6.4.2 The ICB will endeavour to identify a choice of care home placements within the individual's preferred geographical area as far as possible, however this is dependent on the availability of care home vacancies, the ability of specific care homes to meet the individual's needs with the appropriate quality of care, and the care home's working within the ICBs contractual agreement.

6.4.3 In some circumstances, an individual may wish to live in a care home that has not been identified by the ICB. In these circumstances, as long as the care home is able to meet the individual's needs and the care home satisfies appropriate criteria set by the Care Quality Commission and local authority social services, the ICB will consider this option.

6.5 1:1 or Enhanced Observations in Care Homes

6.5.1 Where enhanced observations are requested, a separate policy which outlines the exceptions and requirements for 1:1 care is required ie the Enhanced observation policy and 1:1 protocol, must be adhered to in order to establish a need for 1:1.

6.5.2 Subsequently this care will be monitored on a regular basis to minimise deprivation of liberty and ensure it is effective in managing the needs of the individual, in line with the Enhanced observation policy.

6.6 Care at Home

6.6.1 Many individuals wish to be cared for in their own homes rather than in a residential or nursing care home. The ICB will always endeavour to support individuals' choices in regard to preferred place of care.

6.6.2 The ICB will consider funding packages of care at home providing care can be delivered safely, taking into account the risks to the individual, the staff or other members of the household (including children), and the level of risk that is acceptable to the individual. These are the factors to be considered:

- The individual's current and likely future needs documented in a person-centred support plan or care prescription.
- The individual's GP and community & mental health services agreement to provide clinical oversight and support.
- The suitability and availability of alternative care options.
- The absolute cost of the care and support required to meet the assessed needs and health and well-being outcomes, compared to the relative costs of providing the package of choice, both considered against the relative benefit of

each package to the individual.

- The psychological, social and physical impact on the individual.
- The willingness and ability of family, friends or informal carers to provide elements of care where this is part of the care plan and the agreement of those persons to the care plan.
- The provision of contingency if the care provider fails or is unable to get to the individual.

6.6.3 The ICB's decision will be balanced against the factors set out above. The option of a package of care at home should be considered, even if discounted, and the reasons for its unsuitability should be clearly documented and communicated to the individual.

6.6.4 The ICB consider that in some circumstances an individual's needs are most appropriately met within a care home setting. The general assumptions are set out below; however, the ICB will take into consideration all relevant circumstances to establish whether these assumptions can be displaced:

- Individual's whose health and care needs mean that they cannot be left without care and/or supervision for more than a short period of time during their waking hours. An example of short period of time would be a care worker using the bathroom or making a hot drink.
- The need for waking night care indicates a high level of supervision is required at night will be considered on an individual's health needs, risk and safety.
- Placements are generally deemed more appropriate for individuals who have highly complex health needs.
- Where there is a need for the presence of a Registered Nurse over a 24-hour continuous period, the ICB would only be expected to provide this within a care home with nursing environment.

Each assessment will consider the appropriateness of a home-based package of care, considering the range of factors and principles within this policy.

6.6.5 The expectation is that individuals who are eligible for CHC or NHS elements of joint packages of care and require care at home, will be offered a notional Personal Health Budget (PHB) by default.

6.6.6 People newly in receipt of CHC funding for home care packages will be introduced to the concept of PHBs before or during their 3-month CHC Review, depending on the individual's circumstances and preference. If they would like to investigate this option, based on the outcome of the individual's DST, an indicative budget will be discussed with them during an introductory meeting to explain the PHB process.

6.6.7 Support services will be provided to help people with direct payments, and support and advice will be provided for those wishing to employ personal assistants directly.

6.6.8 BLMK ICB will encourage this approach when an individual who was previously in receipt of a LA direct payment transfers to CHC to avoid unnecessary changes of provider or care package.

6.6.9 It is important to have a contractual agreement for carers working in a home setting whether under PHB or supplied by an agency. Contingency plans must be outlined in a support plan which is vital for each package agreed. These need to include suitable alternative arrangements, documented clearly after discussion with family /individual and professionals within the support plan.

6.6.10 When working in an individual's home, care workers do not have access to the full range of support services that are available within a hospital or nursing home environment, and in most cases, care workers will be working in isolation. If an individual care package at home is agreed, this must be acknowledged, and any implications identified and fully understood, with appropriate contingency plans where required.

6.6.11 When working in an individual's home the ICB expects mutual respect to be shown between care workers and individual's and family members. Care workers will respect the fact that the care environment is the individual's home and will be sensitive to that environment and its contents.

Care workers will not:

- consume the individual's food or drink without appropriate permission or invitation.
- use the individual's possessions e.g. computer or telephone without appropriate permission or invitation.
- use furniture or possessions in a way that the individual would not want.
- take responsibility for looking after any valuables on behalf of the individual.

6.6.12 Any loss of or damage to the individual's property should be immediately reported to the individual. In the event that care workers are responsible for damage or loss the provider will be responsible for compensating the individual.

6.6.13 The provider is responsible for ensuring a safe working environment for care workers. As part of the Risk Assessment, the provider will minimise and mitigate risks.

6.6.14 Where the individual's home compromises the ability to deliver safe and appropriate care the provider will report this to the ICB.

6.6.15 Individuals accepting care workers into their home must allow access to facilities in order to provide a safe environment for both the individual and care worker, in accordance with the Health & Safety at work Act 1974 and The Equality Act 2010.

6.6.16 On some occasions, there may be a delay in re-arranging a home care package due to availability, or the ICB may be unable to re-arrange a home care package. In these circumstances, rapid admission to a care home may be required to ensure care and safety is maintained.

6.6.17 There may also be occasions where home care providers or care workers are unable to get to an individual, for example, due to adverse weather or high level of staff sickness. The ICB are not usually able to obtain rapid access to additional homecare in these cases. When an individual decides to receive care in their home, these risks should be clearly explained to them, documented in the support plan, and considered as part of the decision-making process.

6.6.18 If an individual does not allow an alternative care arrangement to be put in place in the event of existing care arrangements breaking down, the ICB will follow safeguarding policy and the Mental Capacity Act (2005) to ensure the best interests of the individual are maintained, in line with the ICB's Safeguarding Adults & Children Policy.

6.6.19 Where care at home has irretrievably broken-down following mediation between all parties, as long as the conditions of this policy can still be met, the ICB will commission a replacement care package from a second provider. Should the second care package breakdown, the ICB will work to support the individual with meeting their needs however, where commissioning and delivery of care at home becomes unviable then the ICB will commission an appropriate care home or other appropriate provision that both meets their needs and satisfies the ICB criteria as set down in this policy.

6.6.20 If the placement offered is not acceptable to the individual receiving care, it may be appropriate to consider a PHB in the form of a Third-Party Budget or Direct Payment or may arrange to fund their own personal care package or alternative care home placement.

6.6.21 The above does not apply to situations where care providers have withdrawn from a package of care because they no longer provide a service in that geographical area, have ceased trading, have had restrictions placed on them by the Care Quality Commission, or where the ICB has decided to stop commissioning that care provider due to safeguarding or care quality concerns.

6.6.22 Where it has been identified by the ICB that the safety of its staff or those providing care is at risk, the ICB shall take the action it considers appropriate to remove or minimise the identified risk. Where this relates to the conduct of an individual or the home environment, the ICB will request that the individual and/or their representative take the necessary action to remove or minimise the risk. Harassment, bullying or abuse of care workers by an individual or their representatives will not be accepted, and the ICB will take any action necessary to protect its staff or its agents/contractors in line with the NHS stand on Zero Tolerance.

6.6.23 Where there is a continuing risk to the safety or wellbeing of ICB staff or its agents/contractors, the ICB retain the right to take any action considered necessary to remove or minimise the risk including withdrawal of the offer of care and support at home.

6.6.24 The ICB will consider commissioning respite care in the form of an interim care home placement, or a short-term increase in formal home care to provide a break for unpaid carers who are providing care to meet needs which would otherwise require formal, paid care to meet them.

6.7 People with existing care in place who become eligible for CHC

6.7.1 As part of the CHC process for any individual who is in a care home placement or has a home care package which does not meet the requirements of this policy, the individual needs to be informed about how this policy may affect decision making about the existing and future care commissioning. This will enable them to make an informed decision about whether they would like to accept a funded package of care or placement from the ICB should they be deemed eligible for CHC.

6.7.2 If an individual who is currently in receipt of care at home or in a care home becomes eligible for CHC, and the care home or care provider fee is in excess of what the ICB would expect to fund, the ICB would only continue to fund at the higher rate based on evidence of exceptional clinical reasons why the individual's needs could only be met in that specific placement or by that specific care provider (for example, if there is potential for significant detriment to the individual's health if moved.)

6.7.3 If an individual is found eligible for CHC and there is no evidence of exceptional clinical need the ICB will:

- Renegotiate fees with the current provider, however, if this is unsuccessful.
- Consider an alternative placement or care provider which can meet the individual's assessed needs.
- If alternative placements or care providers are offered and rejected, the ICB will consider that funding has been refused and the individual wishes to continue with his or her existing private arrangement with the care provider.

6.8 Funding arrangements for individuals receiving services outside of the ICB area

6.8.1 For individuals who are to receive services in a care home setting, the default position should be a home within BLMK ICB area, should be within the ICB's agreed commissioned rates

6.8.2 Where an individual's preference is to move outside of the ICB area or if an individual's healthcare needs would be best met in a location outside of BLMK and/or closer to family/friends, the cost should be set at rate that is comparable to the rate the local ICB would pay for equivalent care.

6.8.3 Where there is no appropriate provision available within the ICB area, the provider will be chosen based on the best value care available (the provider who provides the best level of care at a price which is sustainable).

6.8.4 If an individual wishes to re-locate to an area outside of BLMK, and live in their own home, BLMK ICB will cease to be the responsible commissioner for that individual, and any CHC package of care would be the responsibility of the receiving ICB. The current and receiving ICB should work together to ensure a smooth handover of commissioning responsibility. The responsible commissioner guidance should be consulted.

6.9 Changes in circumstance

6.9.1 Reviews of care provision could result in an increase or decrease in the care package required to meet those needs.

6.9.2 The provision of a package of care at home does not constitute a commitment by the ICB to fund the individual's care for life, or that the individual will always be cared for at home.

6.9.3 The individual and/or care providers should update the ICB if care needs reduce or increase so further assessment can be made to ensure the individual continues to receive the most clinically effective services and make effective use of NHS resources.

6.9.4 Where an individual who is currently receiving care at home has been assessed and their needs have changed, the ICBs will consider whether the current care provision remains appropriate, against the criteria within this policy and the safest and most economic option.

6.9.5 Following a review, where an amendment to a care package has been identified and the individual does not agree, then the Refusal of Funding process will apply.

6.9.6 Where a provider of care significantly increases their pricing and an alternative provider can deliver the same level of care for better value, the ICBs will consider a change in provider. During this process, the ICBs will ensure the individual is fully informed and case management is provided throughout this process.

6.10 Refusal of CHC Funding

6.10.1 The ICB will consider that it is a refusal of NHS services where the ICB have offered the individual what they consider to be an appropriate care package to meet the individual's assessed needs and this is not accepted by the individual or their representative who has Lasting power of attorney (LPA), including where the individual has requested a particular package of care and the ICB have taken a decision that the package will not be commissioned, but offered an alternative package of care.

6.10.2 Where there appears to be a refusal, the ICB will write to the individual with a final offer setting out the care packages that the ICB is willing to consider, and the consequences

of refusing a package of care or placement. In this letter the ICB will provide a period of no less than 14 days for confirmation of acceptance of a package.

6.10.3 If the individual is considered to be vulnerable, appropriate BLMK Safeguarding Adult policies will be applied.

6.11 Commissioning Disagreements

6.11.1 Whereby an individual is not satisfied with the choices offered to them or the commissioning decision made by the ICB, they may lodge a complaint in writing to the ICB.

6.11.2 Where the ICB, having applied the criteria set out in this policy, decides to place an individual in a care home as opposed to providing a home care package and the individual disagrees with this decision, the ICB will offer an appropriate interim placement taking account of the individual's safety as the over-riding factor. For these purposes, 'interim' refers to the time between the complaint being lodged and then considered by the ICB. Depending on the outcome of the complaint, such 'interim' placement may become permanent.

6.11.3 If, during the interim, the individual refuses the ICB offer of an interim placement pending the outcome of the complaint, they may arrange and fund their own package of care or placement within their chosen care home.

6.11.4 The ICB decision will be effective until the outcome of the complaint.

6.11.5 If the complaint is successful arrangements will then be made to revise the care package provided in consultation with the individual.

6.11.6 If the care home placement is still not acceptable to the individual, they may continue to arrange and fund their own package of care or placement.

6.11.7 Complaints should be sent via email to: blmkicb.contactus@nhs.net

6.12 Governance

6.12.1 The CHC case manager will complete an Individual Placement Agreement (IPA) for each care package, describing details of the bespoke package, to be used as record between the ICB and Provider of the cost of care package.

6.12.2 The IPA will be submitted through the ICB's brokerage process (appendix 3) for clinical and financial approval, to ensure appropriate governance.

6.13 Monitoring

6.13.1 Regular audit of commissioning will be undertaken by the ICB. Data will be provided to the Governing Body and appropriate learning developed.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Appendix 1 - Equality Impact Assessment Initial Screening

Please answer the questions against each of the protected characteristic and inclusion health groups. If there are significant impacts and issues identified a full Equality / Quality Impact Assessment (EQIA) must be undertaken. It is against the law to discriminate against someone because of these protected characteristics. For support and advice on undertaking EQIAs please contact: agcsu.equalities@nhs.net

Name of Policy:	Continuing Healthcare Commissioning Policy
Date of assessment:	05/06/2025
Screening undertaken by:	AACC Quality & Assurance Manager

Protected characteristic and inclusion health groups. Find out more about the Equality Act 2010, which provides the legal framework to tackle disadvantage and discrimination: https://www.equalityhumanrights.com/en/equality-act/protected-characteristics	Could the policy create a disadvantage for some groups in application or access? (Give brief summary)	If Yes - are there any mechanisms already in place to mitigate the potential adverse impacts identified? If not, please detail additional actions that could help. If this is not possible, please explain why
Age A person belonging to a particular age (for example 32 year olds) or range of ages (for example 18 to 30 year olds).	No	
Disability A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.	No	
Gender reassignment The process of transitioning from one gender to another.	No	
Marriage and civil partnership Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'.	No	
Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against	No	

maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.		
Race Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins.	No	
Religion or belief Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	No	
Sex A man or a woman.	No	
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex, to both sexes or none.	No	
Carers Individuals within the ICB which may have carer responsibilities.	No	
Please summarise the improvements which this policy offers compared to the previous version or position.		
This is a new policy and it describes the way in which Bedfordshire, Luton and Milton Keynes (BLMK) ICB will commission the provision of care for individuals who have been assessed as eligible for NHS Continuing Healthcare (CHC) in accordance with The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2022)		
Has potential disadvantage for some groups been identified which require mitigation?		
~~Yes~~ / No – (If there are significant impacts and issues identified a full Equality / Quality Impact Assessment (EQIA) must be undertaken.)		

Appendix 2 - Data Protection Impact Assessment Initial Screening

Data protection is the fair and proper use of information about people. Before completing this form, please refer to the Data Protection Impact Assessment (DPIA) Guidance in the Information Governance (IG) section on the staff Intranet or contact the Data Protection Officer for support via blmkccg.ig@nhs.net

A DPIA is a process to help you identify and minimise the data protection risks. You must do a DPIA for processing that is likely to result in a high risk to individuals. You can use our screening checklist below to help you decide when to do one. If you have answered 'Yes' to any of the 10 screening questions, you must then carry out a full DPIA using the Stage 2 form, which is also available on the Intranet in the IG section.

Name of Policy:	Continuing Healthcare Commissioning Policy
Date of assessment:	05/06/2025
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Stage 1 – DPIA form **please answer 'Yes' or 'No'**

1.	**Will the policy result in the processing of personal identifiable information / data?** This includes information about living or deceased individuals, including their name, address postcode, email address, telephone number, payroll number etc.	~~Yes~~ / No
2.	**Will the policy result in the processing of sensitive information / data?** This includes for living or deceased individuals, including their physical health, mental health, sexuality, sexual orientation, religious belief, National Insurance No., political interest etc.	~~Yes~~ / No
3.	**Will the policy involve the sharing of identifiers which are unique to an individual or household?** e.g., Hospital Number, NHS Number, National Insurance Number, Payroll Number etc.	~~Yes~~ / No
4.	**Will the policy result in the processing of pseudonymised information by organisations who have the key / ability to reidentify the information?** **Pseudonymised data -** where all identifiers have been removed and replaced with alternative identifiers that do not identify any individual. Re-identification can only be achieved with knowledge of the re-identification key. **Anonymised data -** data where all identifiers have been removed and data left does not identify any patients. Re-identification is remotely possible, but very unlikely.	~~Yes~~ / No
5.	**Will the policy result in organisations or people having access to information they do not currently have access to?**	~~Yes~~ / No
6.	**Will the policy result in an organisation using information it already holds or has access to, but for a different purpose?**	~~Yes~~ / No
7.	**Does the policy result in the use of technology which might be perceived as being privacy intruding?** e.g., biometrics, facial recognition, CCTV, audio recording etc.	~~Yes~~ / No
8.	**Will the policy result in decisions being made or action being taken against individuals in ways which could have a significant impact on them?** Including profiling and automated decision making. (This is automated processing of personal data to evaluate certain things about an individual i.e., diagnosis and then making a decision solely by automated means - without any human involvement)	~~Yes~~ / No
9.	**Will the policy result in the collection of additional information about individuals in addition to what is already collected / held?**	~~Yes~~ / No
10.	**Will the policy require individuals to be contacted in ways which they may not be aware of and may find intrusive?** e.g., personal email, text message etc.	~~Yes~~ / No

Appendix 3 - Continuing Healthcare Standard Operating Procedure For Individual Placement Agreement (IPA)

Objective	For BLMK Continuing Healthcare (CHC) Team to complete Individual Placement Agreements (IPA) to be used as record between the ICB and Provider of the service user's cost of care package
Scope	This process is to be used by the CHC team to detail the agreed price for the delivery of service, by the provider, to the service user, and authorised by the ICB. The IPA can either describe which care package the service user is receiving (and which agreed price therefore applies) regardless of place of care or, if necessary, describe a bespoke package or equipment and price. This includes all service users eligible for CHC, Fast Track and Joint-funded packages of care.
Responsibilities	**ALL CHC Team** • To ensure Service Users confidentiality is maintained in accordance with GDPR regulations. • To apply Conflict of Interests regulations. • To ensure appropriate application of NHS funding to individualised care. **ICB Executive (individual to be determined at time of requirement)** • To authorise the financial commitment agreement on behalf of the ICB above £4,500 per week. • Overall oversight and scrutiny of CHC packages **AD CHC** • To authorise the financial commitment agreement on behalf of the ICB up to £4,500 per week. **Head of CHC** • To quality monitor content of financial rationale and apply financial scrutiny • To authorise the financial commitment agreement on behalf of the ICB for IPAs up to £2,500 per week **CHC Commissioning & Transformation Manager** • To quality monitor content of financial rationale and apply financial scrutiny **CHC Operational Lead** • To quality monitor content of financial & clinical rationale and apply financial scrutiny • To authorise the financial commitment agreement on behalf of the ICB for IPAs up to £1,500 per week **CHC Clinical Team Leader** • To quality monitor content of clinical rationale • To complete IPA, detailing care package required based on assessment and personalisation discussion with service user/representative. **CHC Assessor** • To complete IPA, detailing care package required based on assessment

	and personalisation discussion with service user/representative. • To record details of established care provider and costs of package when adopting, where applicable **CHC Admin** • Complete financial rationale on IPA, liaising with provider to confirm details and negotiating costs where applicable • Quality check IPA • Add contract to database **CHS Brokerage** • To Source care providers suitable for requirements as indicated in clincal rationale/care plan (using preferred provider list in first instance) • Ensure provider is registered under CQC and no concerns noted. • Complete financial rationale on IPA, liaising with provider to confirm details and negotiating costs where applicable • Quality check IPA • Add contract to database **IPA Panel** • Consisting of CHC Head of Service, Operational Lead, Commissioning & Transformation Manager, Development Practitioner • To be held twice weekly • To provide clinial and financial scrutiny to complex care packages.
Process	**Following MDT assessment/review, receipt of Fast-track or request to change package of care from appropriate clinician.** 1. Assessor creates eIPA on database, completing clinical rationale to indicate care required (see guidance) 2. Clinical Team Leader reviews clinical rationale to verify requested package is appropriate to meet individuals needs. **Things to be considered during Clinical approval. (not exhaustive)** • Are all clinical needs met by the suggested POC • Are there any specialist skills required? If so how are these being addressed by suggested POC • Is single-handed/double-handed required for moving and handling. • Are length of visits appropriate? • Is the client going to be safe with the suggested POC • Are there more appropriate alternatives – balance with client's choice. Consider MCA/BI • Is 1:1, 2:1 required? If so, why? What interventions are being administered?

	• Waking nights? If so, why? What interventions are being administered and frequency? Would sleeping or live-in be option? • Is client attending day services/school? If so what is/isn't required during this time? • What is the role/input of family or others. If sitting service/respite required who is this for and why do they need it? Has NOK had a carers assessment? • Are double-up visits required? Why 3. eIPA moves to CHC admin/CHS depending on appropriate route for sourcing and completion of financial details. 4. Operational Lead reviews both clincal and financial details and approves if appropriate. Option to reject if not appropriate or discuss at IPA panel. **Things to be considered during financial approval.** • Are all clinical approval considerations answered? • Is the cost within expected range for POC? Consider hourly rate for domiciliary care and tier rate for care home. • Is breakdown of care package clear and does cost reflect this correctly? • Has any negotiation of casts been done? • Should there be a temporary approval? What action is required and who has this been assigned to? • Does this need to be discussed at IPA Panel? 5. eIPA to progress through levels of financial authorisation dependent on cost. 6. CHC admin/CHS quality checks eIPA and generates contract for sending to provider. 7. Provider accepts contract. **N.B No package of care is to commence prior to the completion of the above process and financial authorisation is approved.**
High Cost/Complex Care Packages	High cost packages requiring Exec sign off and complex cases to be presented at the weekly 'High Cost/Complex Case Discussion' meeting held by BLMK ICB Chief Nurse. A rationale for expenditure with explanation of work to reduce cost and overview of the preferred provider will be presented to the Chief Nurse. Cases agreed will be reviewed further to reduction or on going requirement for high cost by at the weekly discussion. All discussions will be recorded on the patient record held on My Care Bank.
Validation date	06 Sept 2024
Review period	1 year
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