NHS
Nottingham and Nottinghamshire
Integrated Care Board

Continuing Healthcare and Joint Packages of Care (Adults) Commissioning Policy

March 2024 – September 2025

CONTROL RECORD				
Reference COM-005	**Version** 2.1	**Status** Final	**Author** Assistant Director of Nursing and Quality (CHC) **Sponsor** Chief Nurse **Team** Nursing and Quality	
Title	Continuing Healthcare and Joint Packages of Care (Adults) Commissioning Policy			
Amendments	Content within Appendix A has been updated from 14 days to 3 days			
Purpose	To ensure the quality of care delivered within the limitations of the Integrated Care Board's available financial resources and to support consistency and equity of access to services for all individuals assessed as eligible for NHS Continuing Healthcare, Funded Nursing Care or a health contribution to a joint package including s117 after-care contributions.			
Superseded Documents	Continuing Healthcare (Adults and Children) Policy v2.0			
Audience	All ICB staff, CHC service delivery staff, eligible individuals and their representatives			
Consulted with	None			
Equality Impact Assessment	Completed - see Section 28			
Approving Body	Strategic Planning and Integration Committee		**Date approved**	March 2024
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Contents

1. Introduction

1.1. NHS Continuing Healthcare ("CHC") 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' as set out in this National Framework. 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.

1.2. This policy applies to the NHS Nottingham and Nottinghamshire Integrated Care Board, hereafter referred to as "the ICB".

1.3. The NHS exists to serve the needs of all but also has a statutory duty to financially break even (National Health Service Act 2006). ICBs have a responsibility to provide health benefits for the whole of their population, whilst commissioning appropriate care to meet the clinical needs of individual patients.

1.4. This policy covers those individuals for whom the ICB is the responsible commissioner and eligible for funding in accordance with the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2022 and any subsequent updates).

1.5. This policy relates to people who have been assessed as eligible for:

- CHC;
- Joint funded packages of health and social care including the health contribution to s117 after-care; and
- Funded Nursing Care ("FNC")

1.6. The ICB has established this commissioning policy to ensure the best use of NHS resources, providing a level of service that is sustainable and equitable (fair) to the health and well-being of the people within the ICB footprint.

2. Purpose

2.1. The purpose of this policy is to ensure that high-quality, cost-effective care is delivered, and to support consistency and equity of access to services for individuals assessed as eligible for CHC, a health contribution to a joint package of health and social care (including s117 after-care) or FNC.

2.2. All NHS organisations have a duty to operate within its financial framework which must be considered in addition to the Human Rights Act. The ICB also has an obligation of equality under the Public Sector Equality Duty ("PSED") of the Equality Act 2010.

2.3. This policy should be read in conjunction with the National Framework for Continuing Healthcare and NHS Funded Nursing Care.

2.4. The principles of this policy apply to the provision of Personal Health Budgets ("PHB"). All individuals who are eligible for CHC and have home based care, have a right to have a PHB if they wish to do so. However they can also choose not to have the option of a PHB and still have the care they require commissioned by the ICB. All guidance in relation to PHBs and integrated budgets (for joint funded support) can be found in the ICB's PHB guidance.

3. Scope

3.1. This policy applies to all ICB staff, CHC delivery team staff and individuals in receipt of NHS funding plus their representatives.

4. Roles and Responsibilities

Roles	Responsibilities
Directors	Directors have overall accountability for all aspects of an individual's safety within the ICB and to ensure appropriate care is delivered. The ICB's Directors are responsible for the implementation of all relevant policies and arrangements within their areas of control and to lead their managers and staff in proactive and effective risk management.
Chief Nurse	The Chief Nurse leads on CHC and has a consultative and advisory role in clinical and operational aspects within the team. The Chief Nurse ensures that the ICB has met its responsibilities as set out in the National Health Service Regulations 2012.
Assistant Director, Heads of CHC, Lead CHC Nurse and Case Managers	Responsible for ensuring that the CHC team work to the National Framework and the ICB's policies related to CHC and for ensuring the delivery of best possible health and well-being outcomes, as well as working to promote equality, and achieving this with the best use of available resources.
CHC Delivery Unit staff	All members of CHC delivery teams have a responsibility to familiarise themselves with the contents of the Policy.

5. Principles

5.1. When commissioning services for people, we will prioritise the achievement of outcomes, and value for money, over purely the level of choice available.

5.2. The funding made available to support an individual will be determined by the most cost-effective care package that meets the individual's assessed needs, based on the local care market, the availability of local care providers and the cost of community based and residential or nursing care.

5.3. All individuals living at home will have their care delivered through person-centred care and a care and support plan ("CASP") will be developed reflecting clear outcomes aiming to maximise independence and control over their health and care outcomes. The care can be funded via a PHB, either notional, third party or via a direct payment. This will be discussed with the individual and/or their family to ensure the most suitable option.

5.4. The ICB has obligations of equality under the Public Sector Equality Duty (PSED) and a duty to operate within its financial framework which must be considered in addition the Human Rights Act.

5.5. The ICB also has a responsibility to promote a comprehensive health service on behalf of the Secretary of State and to offer individual choice but within the constraints of the resources available to it.

5.6. The balance between cost and individual choice should be applied consistently and equitably across all individuals eligible for CHC thus this policy sets out the principles which will be applied to all decisions.

5.7. It is the responsibility of the NHS to make reasonable offers of services to individuals eligible for CHC to meet their assessed needs. If offers of reasonable services are made to individuals to meet their assessed needs and refused, the ICB has discharged its legal duty to those individuals.

5.8. The ICB will always aim to integrate commissioning with partners across the Integrated Care System ("ICS").

6. Safer Patients, Safer Cultures and Safer Systems

6.1. The ICB is continuously working to improve patient safety. Patient safety will always remain paramount in planning a care package and will not be compromised.

6.2. The ICB will only commission packages of care provided where the care can be delivered safely without undue risk to the individual, the staff or other members of the household (if a domiciliary package) and the level of risk is acceptable to the individual with capacity. If the individual lacks capacity to make a decision regarding

risk, the ICB's policy on decision-making under the Mental Capacity Act 2005 must be followed.

6.3. It is vital that the person-centred CASP and any undertaken assessments capture the complexity of the individual's needs, providing the necessary evidence that the needs are of such a level which warrants the requested care package. This will enable the ICB to better understand, better commission and effectively manage the needs of individuals within the population they serve.

6.4. For assessed needs to be approved by the ICB, they must be identified and detailed in the person centred CASP and must be:

- **Lawful**: The proposed package of care should be legitimately within the scope of the funds and resources that will be used. The package of care must be lawful and regulatory requirements relating to specific measures proposed must be addressed.

- **Effective**: The proposals must meet the person's assessed eligible needs and support the person's independence, health and well-being. A risk assessment must be carried out and any risks identified that might jeopardise the effectiveness of the plan or threaten the safety or well-being of the person or others must be addressed. The proposals must make effective use of the funds and resources available in accordance with the principle of best value.

- **Affordable:** All costs have been identified and can realistically be met within the budget. In deciding whether the support plan is affordable it must show that it is within the indicative budget or, if the indicative budget is exceeded, a clear and reasoned explanation is provided to justify the additional spend.

- **Appropriate:** The CASP should not include the purchase of items or services that are inappropriate for the NHS to fund or that would bring the NHS into disrepute. The CASP must have clear and strong links to a health or social care outcome.

6.5. There may be circumstances where concerns are raised about the quality of care from a provider. Where necessary, the ICB will instruct the case managers to work with individuals and their families to commission an alternative package of care whilst care quality concerns are investigated.

6.6. In all cases, the ICB will ensure individuals are worked with to ensure that the CASP and care provision is managed on an individual basis and responsive to their changing needs and circumstances.

6.7. The ICB is committed to ensuring that a high quality, person-centred approach is at the heart of everything it does, whilst remaining focused on safe and effective care.

7. Assessment and Decision-Making

7.1. The process of assessment and decision making should be person-centred. This means ensuring the individual, their perception of their support needs, and their preferred models of support are at the heart of the assessment and care planning process.

7.2. When deciding on how their needs are met, the individual's wishes and expectations of how and where the care is delivered should be documented and taken into account, along with the risks of different types of provision and access to resources (National Framework).

7.3. The need to balance individual choice alongside safety and value for money means the ICB has to ensure consistent decision-making providing transparency so that decisions are:

- Person-centred;
- Robust, fair, consistent and transparent;
- Based on objective assessment of the individual's clinical need, safety and best interests;
- Have regard for the safety and appropriateness of care to the individual and those involved in care delivery;
- Involve the individual and their appointed representative wherever this is possible and appropriate;
- Take into account the need for the ICB to allocate resources in the most cost effective way;
- Support choice to the greatest extent possible in the light of the above factors.

7.4. The PHB Guidance details the particulars and specifics of individualised personalised care supported by an individual's CASP.

8. Commissioning Packages of Care

8.1. For individuals in receipt of CHC, the package of care to be provided will be assessed by the ICB to meet all of the individual's assessed health needs and associated care and support needs. It is the ICB's responsibility to determine what this appropriate package should be, involving the wishes of the individual and their family in every step where possible.

8.2. For joint packages of care, the ICB will meet the costs of the part of the package which have been agreed as a health funded responsibility.

8.3. For individuals who are in receipt of FNC, the ICB will commission and fund this element of the care package until on review it is determined that they no longer have

any need for registered nursing care, or they are no longer resident in a care home that provides registered nursing care, or they become eligible for CHC.

8.4. The ICB has a legal duty to commission services for assessed needs as determined in the care plans and CHC assessment. The CHC assessment and the Decision Support Tool ("DST") are enhanced by the person centred CASP.

8.5. The ICB is obliged to meet the health and care needs of individuals who are eligible for CHC. The package of care will be commissioned in the individual's best interests. However, guidance does not prescribe the type of healthcare required to meet the need. The ICB has discretion as to the manner of the provision of CHC services and must exercise reasonable judgment to provide the most appropriate, cost-effective care.

8.6. The ICB will offer a level of resource to meet the individual's assessed care needs in the most cost effective and appropriate way.

8.7. Whilst there is provision for consideration of exceptional circumstances in relation to all of the matters listed below the ICB does not routinely fund the following:

- Care at home when a risk assessment identifies risks that cannot be safely managed in the community.
- Care at home when the person requires 24-hour oversight by a registered nurse or registered Mental Health Nurse due to their health needs.
- When a person has night time care needs which can be managed by universal health services in the community.
- Care at home when there are repeated admissions into hospital as a result of the person's risks or needs and that they are unable to manage at home.
- Ongoing payment for care packages where the person is in hospital. For providers with NHS contracts care will be funded in line with the provisions of the current contract. After these time periods the ICB can suspend the care package and cease funding. Each case should be discussed by the ICB and the provider and an agreement made regarding the continuation of the package and any retainer funding if it is expected that the individual will be discharged with the same care package.
- 24-hour one-to-one care in a nursing home setting as this may indicate the current setting is not suitable and the patient may need to move to an alternative care setting.
- Cases where the provision of care at home is significantly more expensive than the cost for care that meets assessed needs for that individual in a care home setting.
- The cost of rent, food and utility bills. This is in line with the National Framework.

8.8. The ICB will only fund packages detailed above in exceptional circumstances, taking into account the following considerations:

- Likely impact on the individual of any potential move, including psychological and emotional impact.
- Suitability and/or availability of alternative arrangements.
- Risks involved to the individual and others.
- The individual's rights and those of their family and other carers.
- Whether there are any creative alternatives available to enable the best use of resources available and to enable the individual's choice to be realised.
- The ICB's obligation in relation to equality and the PSED.
- If the weekly cost of care increases, the care package will be reviewed to ensure high quality and cost-effective care is given. Other options (for example, a placement in a care home) may be explored. This excludes single periods of cost increase to cover an acute episode and end of life care where the individual is in the terminal stage and hospital admission can be prevented.

8.9. Where a person, in receipt of CHC funding, needs to be away from their normal residence to receive NHS approved and funded treatment, through either ICB commissioned services or as approved by the Individual Funding Requests (IFR) Panel, the ICB will continue to fund the usual commissioned care package so that carers may accompany the individual for the treatment. In addition, the ICB will fund reasonable quoted costs for the carer accommodation and carer mileage costs within the United Kingdom. This is for a maximum period of three weeks in a financial year. A request for more than three weeks would be reviewed by the ICB at the Complex Care Quality Assurance (CCQA) panel and a response returned to the patient and or family once a decision is made. Reasonable accommodation costs are considered to be equivalent to budget hotel prices for the area. Mileage costs are capped at 45p per mile. Train fares will be funded if the total cost is equivalent or less than mileage costs. Ferry crossings or flights to Northern Ireland or other UK islands will be at the lowest price sourced.

8.10. When funding for carer accommodation and carer travel costs are approved, the ICB will set a ceiling price on the cost in line with the original quote received with the request. Any subsequent changes to arrangements which incur a higher cost will only be funded up to the original price approved.

8.11. The ICB will not fund carer accommodation, mileage or other travel costs for any treatment, whether NHS approved or otherwise, being delivered outside of the United Kingdom. The ICB will not fund carer accommodation, mileage or other travel costs for any treatment that has not been approved by the NHS, either through ICB commissioned services or through the IFR Panel.

8.12. NHS funding cannot be used to fund a person's and/or their family's holiday. Where a person wishes to go on holiday and take their employed personal assistant (PA) or staff from a commissioned provider, they must formally request this through their CHC Case Manager to the ICB. The ICB will pay for the staff for the current hours of support that are already agreed in the care and support plan.

The ICB will not cover the following costs:

- Flights for the person, their family or staff.
- Hire vehicles.
- Food and beverages for the person, their family or staff.
- Any other request which is not directly related to a person's health and well-being.

The ICB can:

- Cover the additional cost of carer accommodation; and
- Reimburse mileage at 45p per mile where a carer is expected to use their own vehicle to provide care and support to a person on their holiday. This excludes fuel costs outside of the UK.

Funding for holiday support may be requested for up to a maximum of 3 weeks per financial year.

8.13. The ICB will require additional assurance, for example with complex care packages where:

- The cost of care exceeds £2,500.00 per week;
- The case is contentious irrespective of its cost – such cases are defined as those that fall outside the scope of this policy or where there is significant concern or complexity around the package of care and funding requested; or
- The provision of a PHB to support care at home is significantly more than the cost of care in a residential setting.

These packages will be managed through the Complex Care & Quality Assurance Panel ("CCQA").

8.14. The CCQA Panel process aims to ensure that these requests are considered in a fair and transparent way, with decisions based on the best available evidence and in accordance with the ICB's commissioning policies.

When considering a request, in addition to the principles outlined in section 5 of this policy the Panel will also ensure that decisions:

- Comply with relevant national policies or local policies and priorities that have been adopted by the ICB concerning specific conditions or treatments;
- Are based on the available evidence concerning the clinical and cost effectiveness of the proposed care package or placement;
- Address any contractual, CQC or safeguarding issues; and

- Are taken without undue delay; a pragmatic approach may need to be taken when dealing with urgent requests i.e. where a delay in reaching a decision to fund adversely affects the clinical outcome.

9. One-to-One (1:1) in Care Homes

9.1. The ICB has established guidance on one-to-one (1:1) Provision for NHS Continuing Healthcare residents in Care Homes, see Appendix A.

The purpose is to:

- Implement the 1:1 pathway across all care homes commissioned to provide services for CHC eligible residents;
- Ensure that providers have accessed NHS universal services prior to requesting 1:1;
- Ensure all requests for 1:1 in a care home adhere to the NHS Continuing Healthcare National Framework which stipulates the elements of a good multidisciplinary assessment of needs; and
- 1:1 funding will not be paid when the individual is in hospital unless the member of staff is present at hospital and prior approval has been gained from the ICB.

10. Fast Track

10.1. Fast Track CHC is where an individual has a rapidly deteriorating condition and the condition may be entering a terminal phase. This enables a referral to be made by an appropriate clinician for “fast tracking” for immediate provision of CHC. The ICB has developed guidance on Fast Track CHC which is included in this policy at Appendix B.

10.2. Where an individual already has a social care funded or a self-funded package in place and is then made eligible for fast track CHC, the ICB will fund such packages up to a maximum hourly rate of £30.00. Where the provider’s rates are over £30.00 then each case will be considered by the ICB taking account of the following:

- Are the family and person comfortable with a change in provider?
- How long has the current package been in place?
- Can family members provide any support?
- Can the current provider meet the persons health needs?
- Would the family prefer a personal health budget?
- Could a mixed package work?

10.3. Where a family select a care home that is outside the ICB area, then the ICB will fund the care home at the host ICB’s contracted rate.

10.4. After review, where an individual is no longer eligible for CHC, then a notice period will be given to the patient and the provider.

11. Respite/Carers Breaks

11.1. Respite is an interim short-term arrangement for carers which provides relief from their caring duties.

11.2. The ICB will fund a maximum of 42 nights for respite in any continuous 12-month period.

11.3. Requests for respite which surpasses the allocated 42 nights per annum will not be classified as respite and will trigger a package review to determine the appropriateness of the package of care in meeting the individual's clinically assessed needs and the level of support which is required.

11.4. Anyone in receipt of CHC or a joint package of care is not eligible for NHS carer's breaks from Nottinghamshire County Council. In such cases any funding for carer's breaks need to be discussed as part of the CHC or joint package of care review.

12. Transport And Fuel

The ICB will only pay for the individual's assessed needs or services as outlined and agreed in their person-centred CASP.

12.1. Unless there are evidenced exceptional circumstances, funding for transport will not be authorised for those individuals with a Motability Scheme[1] or on a Higher Mobility Allowance. In exceptional circumstances, there will need to be a full understanding of each individual's circumstances and which costs are being met by the Motability Scheme, Department of Work and Pensions and any other government funding.

13. Equipment

13.1. In line with the National Framework, equipment should be available to recipients of CHC. The ICB has an Integrated Community Equipment Loans Service (ICELs) which will provide the majority of equipment required to people living in their own homes. ICELs has a policy to stipulate when equipment can be loaned to a care home and this policy is included within the ICB's contract with care homes. Reference should be made to this policy where equipment is required for an NHS funded care home resident.

13.2. Some individuals in receipt CHC will require bespoke equipment to meet specific assessed needs. The ICB is responsible for arranging assessment for and provision of such equipment. This includes responsibility for any essential servicing and repair that might be required.

[1] (https://www.motability.co.uk/about/how-the-scheme-works/how-your-vehicle-can-be-used/)

13.3. Where specialist medical equipment is required and this is not available from ICELs the ICB has developed guidance at Appendix C of this document.

14. Day Care Centres

14.1. It is expected that Care Home weekly fees will cover the individual's entertainment and activities provided within the care home setting as part of their contractual obligations and their duty of care to residents. The ICB will not commission extra-curricular activities for Care Home residents to attend day centres unless in exceptional circumstances.

14.2. For individuals living in their own home day care provision will be considered as part of an overall package of care within the CASP.

15. Joint Packages of Care

15.1. In some cases where a person does not demonstrate a primary health need, the ICB may still commission a package of care with the local authority in which the ICB accepts responsibility for meeting the identified health needs in that package. In such cases this policy applies to the health element of that funding.

15.2. In the exceptional circumstance that a joint package of care has been agreed for a placement in a nursing home, clear evidence is needed about what health input is being provided beyond the FNC element of the package (especially if it is a standard placement rate) and any agreement will include the cost of FNC. FNC will not be provided in residential packages as there is no nursing oversight provided by the home.

15.3. A joint package of care will be agreed based on the level of care input which is commissioned by each organisation and the ICB will fund the tasks/interventions which are beyond the powers of the local authority to provide. The ICB will not fund therapies in a care home (e.g. physiotherapy/ occupational therapies at additional charges) which be accessed via core NHS services through usual referral pathways.

15.4. Appendix D sets out the ICB's principles around funding of joint packages of care with the local authorities.

16. Self-Funders who become eligible for NHS Continuing Healthcare

16.1. If an individual who is self-funding a home care package or care home placement becomes eligible for CHC and the current cost is in excess of the ICB's contracted prices, the provider and the individual must be informed that the ICB would only continue to fund at the higher rate based on evidence of exceptional clinical

reasons. This would include reasoning as to why the individual's needs could only be met in that specific placement or by that specific agency.

16.2. If an individual who is self-funding a home care package using the services of self-employed carers/personal assistants, becomes eligible for CHC, the individual must be informed that the ICB would only continue to fund those carers/personal assistants if the individual or their representative becomes an employer meaning all carers/personal assistants are classed as employees.

16.3. In all cases, the principles around what care is commissioned will be in line with the principles detailed in Section 5 of this policy.

16.4. In the event that an individual, who was previously funded by social services, becomes eligible for CHC, the ICB will apply the same principles as for other individuals. Namely, that the ICB has a duty to consider the best use of resources for their population, whilst meeting the healthcare needs of an individual. The ICB will seek to provide care with the least disruption to the individual.

17. Funding Arrangements for Individuals receiving Services outside the ICB area

17.1. For individuals who are to receive services outside the local ICB area, but where Nottingham and Nottinghamshire ICB is the responsible commissioner, the principles outlined in this policy will continue to apply. Nottingham and Nottinghamshire ICB will provide funding in line with the host ICB's contracted pricing arrangements.

18. Private Funding of Care

18.1. The decision to purchase private care services should always be a voluntary one and not imposed upon individuals. The ICB does not permit individuals or their representatives to 'top-up' the cost of placements, accommodation and packages of care where the funding is for an assessed need. This is in line with the NHS Constitution which affirms that individuals should never be charged for their NHS care or be allowed to pay towards an NHS service (except where specific legislation is in place to allow this) as this would contravene the founding principles and legislation of the NHS.

18.2. Individuals cannot top-up funds for higher cost services and/or higher cost accommodation or placement if it is considered part of their assessed needs and package of care. The only alternative would be for the individual to fund the entirety of their own package.

18.3. Where top-up funding is to meet an individual's preference and not to meet an assessed healthcare need, for example hairdressing, aromatherapy, beauty

treatments, entertainment, a larger room or one with a view, there should be a clear separation between the care provided by CHC to meet an assessed need and the choice which has been made by the individual. The care provider is expected to issue a contract to the individual which clearly sets out the privately funded element.

18.4. If an individual would like care that is not an assessed need they are able to fund this privately.

19. Mental Capacity

19.1. If an individual is assessed as lacking the mental capacity to decide about the type and location of their commissioned care package and/or suitable placement, the ICB will comply with the requirements of the Mental Capacity Act 2005. The ICB will commission care that is based on the key principles of the Mental Capacity Act (2005, amended 2019) and that is the most cost effective and safe care available based on an assessment of the individual's needs in conjunction with an assessment of their best interest.

All decisions will be evidenced and carried out in consultation with any appointed advocate, A Lasting Power of Attorney or an enduring power of attorney which has been registered with the office of the public guardian or a Court Appointed Deputy or, if appropriate in any given case, the Court of Protection directly. Family members will also be consulted under the terms of the Mental Capacity Act 2005 (amended 2019). Where an individual does not have family or friends to represent them, an Independent Mental Capacity Advocate will be appointed.

20. Reviews

20.1. All individuals in receipt of NHS funding will be reviewed to ensure that the care plan continues to meet the individual's needs, the package of care that they are receiving remains appropriate, the PHB is being managed appropriately and whether or not the individual still has continuing healthcare needs.

20.2. For CHC funding, this review is carried out in line with the NHS Continuing Healthcare National Service Framework.

20.3. Reviews may need to take place sooner or more frequently if the ICB becomes aware that the health needs of the individual have changed significantly or if it becomes apparent that the care plan is not being followed or expected health outcomes are not being met.

20.4. The individual and 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 to ensure effective use of NHS resources.

20.5. In the event that a review of an individual establishes that their condition has improved or stabilised to such an extent that they no longer meet the eligibility

criteria for CHC, the ICB will no longer be required to fund their care. Such decisions will take account of well managed needs in accordance with the National Framework for CHC

20.6. The ICB will provide written notice of cessation of funding to the individual and the local authority from the date of the ICB's decision. The notice period is 14 days for patients registered in Bassetlaw and 28 days for patients registered in Nottingham and Nottinghamshire.[2] Any on-going package of care that is needed may qualify for funding by social services, subject to assessment, or the cost of any package of care may need to be met by the individual themselves. The transition of commissioning responsibility should be seamless, and the individual will be notified of any proposed changes to funding involved when appropriate.

21. Individual Dissatisfaction with Package Offer

21.1. Where an individual is not satisfied with the choices offered to them or believes that because of exceptional circumstances some or all of the principles in this policy are not applicable in their case, they may submit a complaint in writing to the ICB. Exceptionality is determined on a case-by-case basis and will require a clear clinical rationale and agreement by the CCQA Panel.

21.2. Where the ICB, having applied the criteria set out in this policy, decides to fund care which is not agreed by the recipient (either because of type, volume or location of care) and the individual makes a complaint against this decision, the ICB will offer an appropriate interim offer taking account of the individual's safety as the over-riding factor. For these purposes, "interim" refers to the time between the complaint being received and then considered and communicated by the ICB.

21.3. The ICB's original decision regarding the complaint will be effective until the outcome of the complaint. If the complaint is successful, arrangements will then be made to revise the care package provided in consultation with the individual.

21.4. If, during the interim, the individual refuses the ICB's offer of an interim placement, they may arrange and fund their own package of care. If the ICB's original decision is upheld, the ICB will again offer the individual an appropriate care package that meets the criteria set out in this policy and their assessed needs, in line with the previous package of care. If the care package is still not acceptable to the individual, they may continue to arrange and fund their own package of care or placement.

21.5. If the original care package offer proposed by the ICB is upheld, the individual will be advised of their right to complain to the Parliamentary and Health Service Ombudsman.

[2] Work to align the notice periods is under discussion

22. Article 8 of the Human Rights Act

22.1. The Human Rights Act means an individual can take action in the UK courts if their human rights have been breached. However, Article 8 of the Human Rights Act is a qualified right; this means rights can be restricted in specific situations. To prove objective justification for qualification of the right, the aim must be a real objective consideration and not in itself discriminatory. For example, ensuring the health and safety of others would be a legitimate aim. Other examples of legitimate aim include the protection of other people's rights, the health, safety and welfare of individuals, running an efficient service, etc.

23. Equality and Diversity Statement

23.1 The ICB pays due regard to the requirements of the PSED of the Equality Act 2010 in policy development and implementation as a commissioner and provider of services as well as an employer.

23.2 The ICB is committed to ensuring that the way we provide services to the public and the experiences of our staff does not discriminate against any individuals or groups on the basis of their age, disability, gender identity (trans, non-binary), marriage or civil partnership status, pregnancy or maternity, race, religion or belief, gender or sexual orientation.

23.3 The ICB is committed to ensuring that its activities also consider the disadvantages that some people in our diverse population experience when accessing health services. Such disadvantaged groups include people experiencing economic and social deprivation, carers, refugees and asylum seekers, people who are homeless, workers in stigmatised occupations, people who are geographically isolated, Gypsies, Roma and Travellers.

23.4 As an employer, the ICB is committed to promoting equality of opportunity in recruitment, training and career progression and to valuing and increasing diversity within our workforce.

23.5 To help ensure that these commitments are embedded in the ICB's day-to-day working practices, an Equality Impact Assessment has been completed for, and is included in this policy.

24. Communication, Monitoring and Review

24.1. The ICB will establish effective arrangements for communicating the requirements of this policy and will provide guidance and support to line management in relation to their responsibilities.

24.2. This policy will be audited as to effectiveness of ensuring choice and equity in the delivery of CHC across the ICB.

24.3. This policy will be reviewed every three years, or if there are changes in national guidance on individual choice or CHC and will be approved by the ICB Strategic Planning and Integration Committee.

24.4. An audit of cases will be undertaken on an annual basis by the Head of Continuing Healthcare/Lead CHC Nurse – this will check that the CHC process has been followed in terms of verification of decision, issue of decision letter to the patient and the commissioned care package is line with this policy and has been approved as per the ICB delegated limits. Corrective action will be taken where necessary. The audit findings will be presented to the Assistant Director of Nursing and Quality and the Deputy Chief Nurse.

24.5. Any individual who has queries regarding the content of this Policy, or has difficulty understanding how this relates to their role, should contact the ICB's Continuing Healthcare Team via email: nnicb-nn.chcteam@nhs.net

25. Staff Training

25.1 Awareness of this policy will be proactively undertaken throughout the ICB and ongoing support will be provided to individuals to enable them to discharge their responsibilities. The core training that all CHC staff will undertake in addition to mandatory training will be personalised care training including PHBs. The assessment teams will undertake CHC specific training including the NHSE CHC e-learning.

26. Interaction with other Policies

26.1. The policy should be read in conjunction with the National Framework for Continuing Healthcare and NHS Funded Nursing Care (2022).

27. References

- ICB Commissioning Strategy: Commissioning Strategy 2020-2022
- ICB Financial Strategy: Financial Strategy 2019-20 to 2023-34
- ICB Safeguarding Policy: QUAL-001 Safeguarding Policy (inc LAC, PREVENT and Safeguarding Training Strategy) v2 (kinstacdn.com)
- Equality, Diversity and Inclusion (EDI) Policy 2020-2023 Equality Diversity and Inclusion Policy (nottsccg.nhs.uk)
- Delayed Discharges Directions: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784710/Delayed_Discharges__Continuing_Care__Directions_2013.pdf and https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784711/Delayed_Discharges__Continuing_Care___Amendment__Directions_2018.pdf

- Direct Payment: https://www.england.nhs.uk/wp-content/uploads/2017/06/guid-dirct-paymnt.pdf
- Carers' Breaks and Respite Care: https://www.nhs.uk/conditions/social-care-and-support-guide/support-and-benefits-for-carers/carer-breaks-and-respite-care/
- NHS Funded Nursing Care Practice Guidance NHS-funded nursing care practice guidance - GOV.UK (www.gov.uk)
- Human Rights Act 1998, Citizens Advice Bureau & Equality and Human Rights Commission: https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty
- Mental Capacity Act 2005: www.legislation.gov.uk/ukpga/2005/9/contents
- Motability Scheme: https://www.motability.co.uk/about/how-the-scheme-works/how-your-vehicle-can-be-used/
- National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care: https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-careNational framework for NHS continuing healthcare and NHS-funded nursing care - GOV.UK (www.gov.uk)
- NHS Choices Framework (2019): https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs
- NHS Constitution: https://www.gov.uk/government/publications/the-nhs-constitution-for-england
- Patient Safety Strategy: https://improvement.nhs.uk/resources/patient-safety-strategy/

28. Equality Impact Assessment

Overall Impact on: **Equality, Inclusion and Human Rights**	**Neutral**

Name of Policy, Process, Strategy or Service Change	Continuing Healthcare and Joint Packages of Care (Adults) Commissioning Policy
Date of Completion	8 February 2024
EIA Responsible Person Include name, job role and contact details.	Jane Godden, Head of Continuing Healthcare Email: nnicb-nn.chcteam@nhs.net
EIA Group Include the name and position of all members of the EIA Group.	Nicola Ryan, Deputy Chief Nurse Sally Dore, Assistant Director of Nursing Heather Woods, CHC Lead Nurse
Summary of Evidence Provide an overview of any evidence (both internal and external) that you utilised to formulate the EIA. E.g., other policies, Acts, patient feedback, etc.	• Equality Act 2010 (inc. the PSED) • Human Rights Act 1998 • Mental Health Act 1983 • Gender Recognition Act 2004 • Mental Capacity Act 2005 (inc. DOLS) • Down Syndrome Act 2022 • Children's Act 1989 and 2004 (where applicable) • Sexual Orientation Monitoring Standard, NHS England/ LGBT Foundation (Sexual Orientation Monitoring - Full Specification)

	What are **the actual, expected or potential positive impacts** of the policy, process, strategy or service change?	What are the **actual, expected or potential negative impacts** of the policy, process, strategy or service change?	What **actions have been taken** to address the actual or potential **positive and negative impacts** of the policy, process, strategy or service change?	What, if any**, additional actions should be considered** to ensure the policy, process, strategy or service change is as inclusive as possible? Include the **name and contact details** of the person responsible for the actions.	**Impact Score**
Age	A person-centred approach will achieve better outcomes by promoting health, well-being and independence through choice and control. This policy will include people 18 years and over.	The policy is for adults aged 18 years and old. Anyone aged under 18 years is covered by the Children and Young People's CHC Policy. There is no consideration for the transition of the care of young people into adult services.		None.	**2**
Disability[1] (Including: mental, physical, learning, intellectual and neurodivergent)	A person-centred approach will achieve better outcomes by promoting health, well-being and independence through choice and control. Adults with a disability who meet the criteria for adult continuing care will receive the care and support they have been clinically	A personalised approach may not always be achieved due to controls within the ICB's available resources. There is a potential impact on adults who do not have capacity to make decisions and choices about their care.	The ICB will support an individual's communication needs by providing an interpreter and or easy read, large print or recordings to ensure the person is provided with the information they require to be fully		**2**

	assessed for to meet their level of disability. Adult assessors are fully trained in use of the Mental Capacity Act and will work with fellow professionals and families to make best interest decisions where required. The ICB will work with individuals and their families and support networks to find the most appropriate way to meet identified needs. The ICB will be responsive to changing needs and circumstances.	The policy may impact on people with physical or learning disabilities when the person's preference is for a package of care at home which is high cost due to complexity and intensity of needs. There is an expectation that CHC Case Managers will ensure that those people who have specific communication needs and will make this available in time for any DST assessment/ meetings with the individual, family and carers. This should not cause delays.	involved in the care and support planning process.		
Gender[2] (Including: trans, non-binary and gender reassignment)	Decisions regarding how care is delivered will be based on their needs, and the individual's gender identity is not a determinant of whether they receive care.	The Policy does not make allowances for individual choice regarding the gender of the caregiver, and requires a clinical reason for challenging the delivery of care. The gender identity of the individual is not considered in the macro or individualised planning of CHC services.	None	None	**2**

Marriage and Civil Partnership	Whilst the Policy does not specifically mention marriage and civil partnership, it does discuss "family" in relation to decision-making. The next of kin of all individuals will be included wherever possible, and consent is given or it's in their best interests, in the planning and decisions regarding care.	There are no perceived negative impacts for this protected characteristic.	None	None	**3**
Pregnancy and Maternity Status	Whilst the Policy does not specifically mention pregnancy and maternity, it does discuss "family" concerning decision-making. In the application of the policy, the ICB and providers should work together to ensure the best care package for the individual.	There are no actual or expected negative impacts on the characteristic of Pregnancy and Maternity Status.	None	None	**3**
Race[3]	The ICB will endeavour to meet all cultural needs of individuals, recognising personal choice. Part of the care and support planning process will recognise cultural sensitivities. Interpreters and information in other languages will be provided upon request.	The Policy does not specifically mention cultural considerations as part of the assessment and planning process to enable a person-centred approach to care delivery. The Policy is applicable equally across all areas of Nottingham and Nottinghamshire, that	Mechanisms are in place via the Communications and Engagement Team to provide information in a range of languages, and in a range of accessible formats.	None	**2**

		individual and community needs are not given full consideration.			
Religion and Belief[4]	Part of the care planning process considers religious needs and preferences, taking into account the personalised approach.	The Policy does not specifically mention religious or belief impacts when undertaking the assessment and planning process to enable a person-centred approach to care delivery. The Policy is applicable equally across all areas of Nottingham and Nottinghamshire, that individual and community needs are not given full consideration.	A personalised approach is offered through individual choice and control within the ICB's available resources. The ICB will work with patients and families to find the most appropriate way to meet identified needs.	None	**2**
Sex[5]	Decisions regarding how care is delivered will be based on their needs, and the individual's sex is not a determinant of whether they receive care. Sometimes individuals may want to choose the sex of their carers, and this will be accommodated whenever possible.	There are no actual or expected negative impacts on the characteristic of Sex.	None	None	**3**

Sexual Orientation[6]	Decisions regarding how care is delivered will be based on their needs, and the individual's sexual orientation is not a determinant of whether they receive care.	There is a potential negative impact on people whose sexual orientation is lesbian, gay, bi, or any other sexual orientation other than heterosexual/ straight. The sexual orientation of individual's is not considered in the macro or individualised planning of CHC services. A lack of patient Sexual Orientation Monitoring means these inequalities and related specific patient needs are often not acknowledged or addressed in mainstream service provision.	None	None	**1**
Human Rights[7]	The care and support planning process will have due regard to the Human Rights Act 1998, with specific due regard to Articles 2, 3, 5, 8, and 14.	There are no actual or expected negative impacts on the characteristic of Human Rights	None	Support from ICB Safeguarding Team to access the Court of protection as required.	**3**
Community Cohesion and **Social Inclusion**[8]	During the care and support planning process, individuals are given the opportunity to explore methods to assist them with accessing the local community and activities. If the individual chooses to receive their CHC care package via a personal	There are no actual or expected negative impacts on the characteristic of Community Cohesion and Social Inclusion.	None	None	**4**

	health budget it allows more creative solutions to remove any barriers that may have prevented community access previously.				
Safeguarding[9] (Including: adults, children, Looked After Children and adults at risk or who lack capacity)	Care givers/ professionals will undertake Safeguarding and Capacity Training in accordance with best practices.		The ICB will work with fellow professionals and families to make best interest decisions where required.	Support from the ICB safeguarding team	**3**
Other Groups at Risk[10] of Stigmatisation, Discrimination or Disadvantage	It is recognised that Nottingham and Nottinghamshire communities are diverse in their makeup, and therefore, children and young people from a diverse range of backgrounds, family structures, and identities will likely access CHC services.	The policy may not always support the recognition of structural barriers to how the most vulnerable access inclusive care services.	None	None	**2**

Additional Narrative		

Provide additional evidence and narrative about the positive, negative, and neutral impacts of the proposal on the equality, inclusion and human rights elements detailed above.
 	
You should consider:
• Three elements of Quality (safety, experience and effectiveness)
• Intersectionality
• Impact of COVID-19
• Access to Services
  ○ Physical
  ○ Written communication
  ○ Verbal communication
• Digital Poverty
• Safeguarding
• Dignity and Respect
• Person-centred Care
	Here you should add additional detail or explanation around the positive, negative, and neutral impact of the proposals on the above protected characteristic and health inclusion groups. To address this, you should consider the barriers to accessing or using the service, including the mitigations to respond to these.
	
	People entitled to CHC will have a positive impact on unpaid and family carers by ensuring the cared for individual has the right care and support at home or in the community. By using a person-centred approach and involving unpaid and family carers in the care and support planning process, it will help address and support the mental health and well-being of those informal carers by planning for the right level of support for the cared for person.
	
	The provision of a CHC package will likely positively impact not only the individual but also their wider family and support network.
		4

Positive Impact	Neutral Impact	Negative Impact	Undetermined Impact	Equality Impact Score Total	
56 to 50	**49 to 36**	**35 to 22**	**21 to 14**		**36**

Positive	Neutral	Negative	Undetermined
4	**3**	**2**	**1**

1. **Disability** refers to anyone who has: "…a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities…" (Equality Act 2010 definition). This includes, but is not limited to: mental health conditions, learning disabilities, intellectual disabilities, neurodivergent conditions (such as dyslexia, dyspraxia and dyscalculia), autism, many physical conditions (including HIV, AIDS and cancer), and communication difficulties (including d/Deaf and blind people).

2. **Gender**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: "A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex."

3. **Race**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: A person's colour, nationality, or ethnic or national origins. This also includes people whose first spoken language is not English, and/or those who have a limited understanding of written and spoken English due to English not being their first language.

4. **Religion and Belief**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: Religion means any religion and a reference to religion includes a reference to a lack of religion. Belief means any religious or philosophical belief and a reference to belief includes a reference to a lack of belief.

5. **Sex**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: A reference to a person who has a particular protected characteristic and is a reference to a man or to a woman.

6. **Sexual Orientation**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: Sexual orientation means a person's sexual orientation towards persons of the same sex, persons of the opposite sex or persons of either sex.

7. The **Human Rights Act 1998** sets out the fundamental areas that everyone and every organisation must adhere to. In relation to health and care, the most commonly applicable of the Articles within the Human Rights Act 1998 include: Article 2 Right to Life, Article 5 Right to Liberty and Security, Article 8 Right to Respect of Private and Family Life, and Article 9 Freedom of Thought, Conscience and Religion.

8. **Community Cohesion** is having a shared sense of belonging for all groups in society. It relies on criteria such as: the presence of a shared vision, inclusion of those with diverse backgrounds, equal opportunity, and supportive relationships between individuals. **Social Inclusion** is defined as the process of improving the terms of participation in society, particularly for people who are disadvantaged, through enhancing opportunities, access to resources, voice and respect for rights (United Nations definition). For the EQIA process, we should note any positive or negative impacts on certain groups being excluded or not included within a community or societal area. For example, people who are homeless, those from different socioeconomic groups, people of colour or those from certain age groups.

9. **Safeguarding** means: "…protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility" (NHS England definition). Those most in need of protection are children, looked after children, and adults at risk (such as those receiving care, those under a DoLS or LPS Order, and those with a mental, intellectual or physical disability). In addition to the ten types of abuse set out in the Health and Care Act 2022, this section of the EQIA should also consider PREVENT, radicalisation and counterterrorism.

10. **Other Groups** refers to anyone else that could be positively or negatively impacted by the policy, process, strategy or service change. This could include, but is not limited to: carers, refugees and asylum seekers, people who are homeless, gypsy, Roma and traveller communities, people living with an addiction (e.g., alcohol, drugs or gambling), people experiencing social or economic deprivation, and people in stigmatised occupations (e.g., sex workers).

Appendix A

Guidance for 1:1 Provision for NHS CHC residents in Care Homes

1. Introduction

1.1. This applies to all care homes and NHS Continuing healthcare staff when requesting one-to-one observations within the adult NHS Continuing Healthcare services in Nottingham and Nottinghamshire ICB.

1.2. In addition to the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care July 2022 (Revised), this policy will serve as a framework to support the decision-making process as to whether additional levels of One-to-One observations should be commissioned by Nottingham and Nottinghamshire ICB as part of a resident's care package within a care home.

1.3. The primary aim of one-to-one observations is to ensure the resident's safety following an appropriate clinical and risk assessment. This type of observation is highly restrictive and should not be regarded as part of a routine practice - rather, it must be based on the resident's current assessed clinical needs. Care homes are encouraged to employ the least intrusive method of observations where possible.

1.4. For the purpose of this policy, one-to-one observation shall mean:

1.5. "One designated healthcare staff member who is knowledgeable and trained about the resident's care plans and risk assessments, assigned to one resident for attentive continuous observations during a set period of time each day. The healthcare member of staff must have immediate access to the resident at all times and ensure the resident is always kept within arms' length and eyesight."

1.6. The assigned resident becomes the member of staff's sole responsibility for the duration of the prescribed one-to-one observational hours therefore no other resident shall be assigned to that member of staff during that period. Care homes should make arrangements for interim cover when the member of staff providing one-to-one observations has a break, etc.

1.7. The Department of Health advocates a culture whereby care providers should use restrictive interventions such as one-to-one only as a last resort and for the shortest possible time (Positive and Proactive Care: reducing the need for restrictive interventions, 2014).

2. Scope

2.1. This appendix applies to all care homes commissioned by the ICB to look after eligible NHS CHC residents and their representatives, CHC staff and CHC Case Managers.

3. Definitions

3.1. **One-to-one observations (1:1):** Attentive continuous observations during a set period of time each day. For the purpose of this policy one-to-one observations shall hitherto be referred to as 1:1.

3.2. **Observation Levels**: NICE Guidelines 10 (2015) describes four levels of observation:

- **Level 1 - Low level intermittent observation:** This is the minimum level of observation for all residents in resident areas. Staff should know the location of all residents in their area, but residents need not be kept in sight. Residents subject to general observations will normally have been assessed as being a low risk to themselves or others. Their location and safety will be checked at a minimum of hourly intervals.

- **Level 2 - High level intermittent observation**: Usually used if a resident is at risk of becoming violent or aggressive but does not represent an immediate risk. The frequency of observation is once every 15–30 minutes. This means that the resident's location and safety must be visibly checked at specified intervals and recorded in the Care Plan.

- **Level 3 - Continuous observation**: Usually used when a resident presents an immediate threat and needs to be kept within eyesight or at arm's length of a designated 1:1 healthcare staff, with immediate access to other members of staff if needed.

- **Level 4 - Multi-professional continuous observation:** Usually used when a resident is at the highest risk of harming themselves or others and needs to be kept within eyesight of two or three staff members and at arm's- length of at least one staff member.

  For the purpose of this policy and its accompanying documents, the Nottingham and Nottinghamshire ICB will only consider funding for levels 3 or 4 one-to-one.

4. Process

4.1. The 1:1 pathway (appendix 1) **must** be followed by all care homes requesting level 3 or level 4 1:1 support for residents. The ICBs will authorise 1:1 **only** where there is a **clearly documented clinical rationale which is evidenced and supported by appropriate risk assessments.**

4.2. All 1:1 requests **must be emailed** to the resident's CHC Case Manager and be accompanied by relevant resident care plans, risk assessments and records, etc. which clinically evidences the need for level 3 or level 4 one-to-one.

4.3. In line with the Caldicott Principles, care homes should ensure that Resident Identifiable Data is only shared with appropriate people.

4.4. The Request must state the hours of the 1:1 request and intended length of time the 1:1 is needed for. Care homes should also state what clinical or therapeutic interventions have been undertaken prior to requesting 1:1.

4.5. Residents with a falls history or assessed as high risk of falls will not be approved for 1:1 funding by the ICB as care homes are expected to utilise assistive technology, multifactorial assessments and interventions to abate any associated falls risk. This is in line with NICE Clinical Guidelines 2013 [CG161 2013].

4.6. For residents receiving Band C or D funding as per the CHC care homes contract pricing schedule, these rates are inclusive of 2 hrs 1:1 per day. This will, therefore, be deducted from any payment. i.e., 12 hours per day approved 10 hours would be paid.

4.7. The ICB expects each resident to have dedicated time with staff during the day during personal care, mealtimes or other interventions. The ICB will approve a maximum of 22 hours 1:1 per day.

4.8. Upon receipt of the documentation outlined above, the CHC Case Manager can authorise 1:1 for a maximum of 12 hours per day for 3 days and advise the ICB within 24 hours so this can be recorded on the database for invoice purposes.

4.9. 1:1s must be reviewed and documented three times daily (AM, PM, EVE and when needs change) by the care home. Care Logs must be sent to the CHC Case Manager when seeking a further extension beyond an initial 1:1 approved date.

4.10. In the first instance, the ICB will only approve additional funding for level 3 or level 4 one-to-one for a maximum of 3 days before review. This review should be conducted face to face and only in exceptional circumstances by telephone.

4.11. The ICB will approve 1:1 in a care home for a maximum of up to 6 months (8 weekly extensions). After 6 months alternative provision or commissioning arrangements may be sought.

4.12. Care Homes must ensure that healthcare staff who provide1:1 support are rostered in as **additional** support specifically for the provision of 1:1 *(refer to 1.5 above)*. Therefore, they do not count as part of the core healthcare staff on floor duty for looked after residents. In the event of the home using external healthcare agencies to provide1:1 support, these agencies must be Care Quality Commission (CQC) registered and compliant. It is expected that if any registered nurses are employed by care homes, that they are registered with the Nursing and Midwifery Council (NMC) and have a valid pin.

4.13. The hourly rate for level 3 or 4 1:1 will be set by the ICBs on an annual basis; care homes must always obtain approval in email or writing from the CHC Case Manager before implementing level 3 or level 4 1:1. **The ICB will not fund care for which there is no agreed, evidenced clinical rationale and where the 1:1 pathway has not been followed.**

4.14. To facilitate payment, copies of 1:1 charts, care plans and any other additional validation information must be provided upon request including staff timesheets and daily staff rotas.

4.15. Requests from family members/representatives to initiate or continue 1:1 where there is no clinical rationale will not be authorised and invoices will not be paid. Families, however, are at liberty to make private contractual arrangement with the care home for interventions and care outside of the assessed clinical need as indicated within the resident's care plan. It must not, however, include any core services/costs funded under contract by the ICB.

4.16. 1:1 observations should only be in place as an interim measure for the least amount of time clinically, after all steps and interventions taken to reduce the risk of harm to the resident and others has failed.

5 Out of Hours 1:1 Request

5.1. All requests made for 1:1 outside of the ICBs' operational hours (Monday to Friday, 9:00 – 17:00) **must** follow the 1:1 pathway.

5.2. Care homes have a statutory duty to ensure residents' safety balanced by appropriate staffing levels. It is expected that if, after following the 1:1 pathway, clinical assessments evidence the need for level 3 or level 4 1:1 observations outside of the ICBs' working hours, a care home is to implement 1:1 as an interim measure for the wellbeing of its residents.

5.3. The onus is on care homes to provide ICBs with the **clinical rationale** and **clinical evidence** which supports the need for 1:1 so the ICBs are able to retrospectively approve the 1:1 request on the following working day facilitating payment.

5.4. The ICB will **not** approve a 1:1 for which there is no **evidenced** clinical rationale and where the 1:1 pathway has not been followed.

6. Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

6.1 The Mental Capacity Act places responsibility on organisations to protect an individual's right to liberty and to undertake certain procedures where they are or need to deprive an individual of their liberty. These procedures are known as Deprivation of Liberty Safeguards (DOLS).

6.2 If an individual is assessed as lacking mental capacity to make decisions in relation to their care and support needs, any act undertaken for, or any decision made on behalf of that person, must be made in their best interest. The Mental Capacity Act sets out a checklist of factors to be considered when undertaking best interest decisions. The two-stage capacity assessment (as outlined in the MCA 2005 Code of Practice) must be completed in relation to the specific decision in order to evidence that the individual lacks the capacity to make that decision. The decision can then be made in their best interest and following the guidance in the MCA Code of Practice Chapter 5 (2005).

6.3 1:1 must be set at the least restrictive level for the least amount of time within the least restrictive environment. General observations (level 1 as per section 3.2) will be the presumed level of 1:1 required. Justification through assessment will be required to move up (or down) the levels in response to the resident's condition. It is essential that any change in requirement is communicated effectively, and the situation managed sensitively and effectively.

6.4 If an organisation, through assessment, deems it necessary to place one or a number of restrictions on an individual for their own safety or the safety of others, or the required level of 1:1 requires restrictions to the individual's liberty, then DoLS will need to be considered if the individual lacks capacity to make decisions about the implementation of those restrictions. The MCA applies to people aged 16 years and over and who are assessed to lack capacity to make decisions commonly (but not exclusively) around residency and their care and support needs. A DoLS Authorisation will apply to those aged 18 years and over and are deprived of their liberty in a managing authority such as a care home or hospital.

6.5 In situations where residents without capacity are supervised as part of their 1:1 observations in the confinement of a room or separated from all other people other than members of staff, it may be interpreted as seclusion. A clear rationale for seclusion must be identified and documented in the resident's notes. If a DoLS standard authorisation is in place, then consideration must be made to contacting the best interest assessor if and when restrictions and restraints are required so the authorisation can be amended.

7. Audit

7.1 The ICB will regularly check 1:1 care is being provided in line with the commissioned package and may request evidence that appropriate staff members are in place to provide the 1:1 care.

7.2 The ICB will cease 1:1 payment immediately if 1:1 care is not in place when checks are made. These cases will be investigated individually and further action may be taken.

All 1:1 requests and accompanying documents must be emailed to:

1. **For Greater Notts, send to: NCP.continuingcarenotts@nhs.net**
2. **For Mid Notts, send to: nnicb-nn.midnottschc@nhs.net**
3. **For Bassetlaw nnicb-bassetlaw.chc-office@nhs.net**

Evidence or requests for residents on D2A funding can also be sent directly to: nnicb-nn.onetoone@nhs.net

Appendix B

Fast Track Guidance

1. Introduction

1.1 The aim of the Fast-track pathway is to ensure individuals with a rapidly deteriorating condition, that may be entering a terminal phase of life, are supported in their preferred place of care as quickly as possible. The ICB has responsibility for the commissioning and funding of appropriate care until a decision on longer term NHS continuing health care (CHC) eligibility is made. This care at the end of life often requires packages to be implemented rapidly. There is additional opportunity to offer a Fast-track package via a Personal Health Budget (PHB).

1.2 This section of the Nottingham and Nottinghamshire ICB CHC Adult commissioning policy provides guidance on how the Fast-track process will be managed to meet the expectations of individuals, relatives and carers.

2. Fast-track Referral Process

2.1 A referral for a Fast-track can only be made by an appropriate clinician who should be knowledgeable about the individual's health needs, diagnosis, treatment or care and be able to provide an assessment of why the individual meets the Fast-Track Pathway Tool criteria-Appropriate clinicians include the following:

- GP
- Specialist Palliative Nurses
- Hospital Consultant
- District Nurse/Community Matron.
- Clinicians employed in voluntary and independent sector organisations that have a specialist role in end-of-life needs, e.g. hospices

Step 1	Identify the person meets the following referral criteria: - • The individual has a rapidly deteriorating condition and may be entering a terminal phase
Step 2	Complete the Fast-track Referral Form ensuring: - • You provide the information clarifying why you deem this individual to have a rapidly deteriorating condition and entering the terminal phase • You have indicated the prognosis of the individual • You have indicated that the person/family are aware and have consented to the referral and information sharing • You have advised the person/family of the review which will take place within 8 weeks

	• You have identified the person's preferred place of care, and the care required • You have completed the forms including equality monitoring • You have provided your name and contact details • You have identified any care the person is currently receiving either NHS, social care or private care
Step 3	Email the FastTrack referral form and Health Needs Assessment to the relevant ICB Continuing Healthcare Team for the locality

3. Fast-track Provision

3.1 **Care Homes** – when a person is Fast-tracked who is currently living in a nursing or residential placement the following needs to be considered: -

- Is this the person's choice for end of life (EOL) care?
- Is the current care home placement able to meet the individual's needs?
- If needs cannot be met where does the individual want to move to?
- Can a new placement meet their needs?
- Is it in the Best Interest of the individual to move to another home?
- For care in residential homes how often will a co-ordinated overview by Community services will be undertaken
- Will the District Nurse team be able to support if in a residential home/Supported Living placement?

Nursing Homes to be sourced by the family, if it's the persons wishes and they are in the community at the point of referral utilising the Nottingham and Nottinghamshire ICB AQP approved Nursing Home list.

3.2 **Homecare** - when a person is Fast-tracked who wants to remain in their own home the following needs to be considered: -

- Home circumstances i.e. Who they live with and the environment, space for equipment and staff?
- What equipment will be required to support them at home? - can this be obtained? is there storage space?
- What care are family and friends able to provide and for how long?
- What care will be provided by Universal Services?
- What are the immediate needs as the Fast-track care package commences?
- For care at home how often will a co-ordinated overview by Community services be undertaken?
- What may be their ongoing needs as their condition deteriorates?
- What care do they currently receive? Is this enough?

4. Homecare Packages

4.1 Home care packages will be sourced utilising the Nottingham and

Nottinghamshire ICB AQP framework. The referral request will identify a recommended package of care. The Fast-track teams will review and source appropriate support.

4.2 The homecare package should be person centred and discussed with the individual/family based on need and whether any risks in delivery can be managed safely and cost effectively in the home.

4.3 Packages need to be personalised, the Fast-track CHC teams will require evidence of the person's needs and the discussion with the person and their family to indicate the recommended package of care. This evidence will be sourced via the referral documents. Depending on presenting condition, it is anticipated that the initial home care packages procured will be regular but less intensive, however, these may increase as health need increases during the End-of-Life process. **Packages will be commissioned at a maximum of 2 calls per day with 1 or 2 carers dependent on need with up to 2 nights (if required).** Night care should be sourced via local provision where available i.e., Nottinghamshire Hospice. The package of care could be calculated in hours per week and offered to the person as a personal health budget to give them more choice and control of the hours they require to meet their needs

4.4 Packages are flexible and additional visits can be commissioned if needs are clearly identified and evidenced.

5. Requests for additional Ad hoc Support

5.1 There may be occasions when a single episode of additional support is required to enable a carer to attend an appointment or to respond to other commitments. These requests will be considered on an individual basis; however, one episode of care will not normally exceed a 3-hour time frame per person per week.
In addition, requests for respite care whilst on the Fast-track pathway will be considered on an individual basis. Respite care should be provided in a placement registered to provide nursing care.

6. Universal Services

6.1 All Fast-track individuals should have clinical oversight of their package by an appropriate healthcare professional, this includes people that are at home or in the Hospice. This will be the relevant community nursing team with GP support.

7. Fast-track individuals who move Out of Area

7.1 It is recognised that some people on the Fast-track pathway will move outside of the Nottingham and Nottinghamshire ICB area either due to clinical need or due to family/individual choice. When the move out of area is due to clinical need the clinician recommending the placement will be required to demonstrate that no

other local service is able to meet those health needs. The evidence needs to be presented to the ICB for confirmation of funding for the out of area placement. When the move out of area is at the request of the family/individual even where their clinical needs can be met within locally provided services the ICB will fund the cost of a nursing home based on the host ICB fast track CHC rates.

8. Review of Fast-track Pathway

8.1 The Fast-track Pathway for everyone should be reviewed at 8 weeks. As per guidance a review should be completed using the Decision Support Tool (DST) and a multi-disciplinary approach taken to review eligibility.

8.2 The DST will follow the ICB CHC process as per the CHC Policy. Needs and prognosis can change and as such eligibility for health funding may also change.

8.3 Any changes to eligibility will be advised in writing to the person, family and relevant local authority with a 28 day notice period.

8.4 If it is deemed that End of Life is imminent, as indicated by the criteria below, then the review may be delayed and the person deemed to continue to have a Primary Health Need (PHN) such that the completion of a full DST would be unnecessary. Examples are:

- Have a syringe driver in place
- No longer eating or drinking or taking very minimal amounts of fluids
- Life expectancy can be measured in days

9. Package Costs

9.1 The contracted care home rate for Fast-track packages is aligned to the contracted Band B rate. Home care rates for Fast-track packages are the Adult Home Care AQP rates for the ICB.

9.2 Packages may already be in place at the time of referral, these may be funded by the person and their family or via the Local Authority. The ICB will fund packages at the contracted rate for new referrals, where a package is already in place the ICB will honour rates under £30ph. Where provider's rates are over £30ph each case will be discussed individually with the following questions considered.

- Are the family and person comfortable with a change in providers?
- How long has the current package been in place?
- Can family members provide any support?
- Can the current providers meet the persons health needs?
- Would the family prefer a personal health budget?
- Could a mixed package work?

Appendix C

Funding for Equipment

This guidance has been developed to manage requests received by the CHC Team for funding equipment for individuals who are eligible for CHC or joint funding.

The provision of community equipment falls within the remit of ICELS (Integrated Community Equipment Loan Service). All requests for community equipment should be directed to ICELS by contacting the team via icesteam@nottscc.gov.uk in the first instance who will give guidance and support.

However, ICELS will not fund certain medical/nursing type items, usually the higher end medical/nursing aids to support the management of 'life threatening conditions. These are items which are often complex, address a 24 hour need and are usually looked after via the acute hospital MESU arrangements such as

- Cough Assist Machines
- Vibrating Vests
- Nebulisers
- Suction Machines
- Heated Dehumidifiers
- Drip stands/trolleys

Any requests for respiratory equipment, e.g. Cough Assists, Nippys, should be directed to the Respiratory Services at the relevant acute hospital – the majority of such requests will be dealt with by this service. For Nottingham University Hospitals contact: Complexventilationteam@nuh.nhs.uk

Any other request for such medical items can be made by the CHC Case Manager to the CHC Team by contacting the team on nnicb-nn.chcteam@nhs.net with a completed "Change of Package" form giving details of who the equipment is for (must be eligible for CHC/joint funding), rationale for the requirement of the equipment, details of who will be responsible for purchasing the equipment, owning the equipment, responsibility for servicing and repairs and responsibility for training the carers to use the equipment. The request should also be accompanied by a minimum of two up-to-date quotes.

Once a request has been received the CHC team will escalate through the appropriate approval channels for authorisation.

All equipment will normally be purchased by the Provider (i.e., the acute or community trust) who will own the equipment. The initial purchase should include a warranty to cover maintenance and servicing. The ICB will reimburse costs to the Provider for the purchase and warranty costs on receipt of an invoice. For an individual living at home

with a PHB, provision for servicing and repairs following expiry of the warranty should be included in the budget and documented in the care and support plan, along with details regarding training for using the equipment.

The CHC Case Manager will be responsible for arranging training for the individual's care team to use the equipment. Any practitioner who provides the training will be accountable for the appropriateness of the training and ensuring that the person who does the work is able to do it to the required standard.

There may be exceptional circumstances when the ICB would purchase the equipment i.e. when a patient is being discharged from an out of area hospital. In this case the equipment would be purchased through Arden and GEM Commissioning and Support Unit and the quotation should include a warranty within the purchase price. The ICB will be responsible for arranging the required servicing (at the necessary intervals) and any repairs. Therefore, if possible, the ICB should arrange for MESU to carry out the servicing and arrange the relevant service visits/recalls.

Longer term it is anticipated that the ICB will come to an arrangement with ICELs to purchase medical type equipment and loan the items to individuals, thus responsibility for servicing and repairs to sit with ICELs.

Appendix D

Principles - Jointly Funded Packages of Health and Social Care and s117 Aftercare

(to be reviewed April 2024 and annually thereafter)

1. When joint funding for any case is agreed the health funded share of the package should be that which meets the health needs of the patient as agreed by the relevant Panel. Where percentage splits have been agreed, the split must not be automatically applied to care package changes where new services or elements are added without the agreement of the ICB. With the exception of s117 aftercare, any 30% packages will not be approved and instead the elements of health care will be funded, for example PEG, Stoma, complex catheters etc.

2. When the nursing component equivalent to FNC forms part of an adult joint funded placement, the FNC contribution is included as part of the total package to which the % split is applied. This is illustrated as below (simplified figures):

Local Authority care home rate	£800
Funded nursing care	£200
Total	£1000

Funding split agreed at Panel 50/50
Adult social care pays £800 to the care home
ICB pays £200 (FNC) direct to the care home, and the balance of £300 is re-charged by Adult Social Care to health

3. If the responsible ICB for a previously assessed patient changes, it is expected that the inheriting ICB should honour the existing funding arrangement until the service user is re-assessed at the previously agreed review date, agreement is obtained between the two ICBs involved and the Local Authority have notification of any changes.

4. The most recent 'Responsible Commissioner – Who Pays' guidance will be followed to determine the responsible ICB and funding responsibilities. Changes in the guidance will be adhered to as and when these occur.

5. Nottinghamshire County Council and Nottingham City Council finance will submit a joint funded recharge schedule on a quarterly basis to the ICB.

6. Each quarter, the Local Authorities and ICB will agree a mutually acceptable timescale for the issue and return of the recharge schedule. Work will take

place to simplify the structure / process in order to support a more timely turnaround.

7. At year end (March) the Council Finance and ICB Finance will agree the amounts that need to be included in the previous years' accounts to ensure that we reconcile entries in the Whole of Government accounts and other reporting. This will not prejudice what is owed or recharged to partners. Following year end, the usual quarterly schedule will be sent to Health for agreement as per normal practice.

8. The Local Authority will inform the ICB, by email, of all changes to care packages other than annual inflationary uplifts (see paragraph 12 below). Changes include increases and decreases to care packages. The Local Authority will inform the ICB of any package increases prior to the event. Any emergency changes should be communicated to the ICB the next working day.

9. The ICB will respond by email to accept or query the change within 5 working days of notification of the change.

10. The ICB will not accept backdated requests for increases in care. The increase will be implemented from the date of receipt of the request.

11. For adult cases, once a change to care package costs has been agreed by both parties the Local Authority will aim to send an ACM33 (County Council) or Agreement (City Council) to the ICB within 28 days of the date of the email agreement. The ICB will check, sign or query the ACM/Agreement, responding to the Local Authority within 28 working days of receipt.

12. Where a change has been agreed via email and the corresponding recharge accepted but a dual signed ACM/Agreement is outstanding, this will not be defined as a financial risk for declaration by the Councils.

13. Annual inflationary uplifts – the Local Authority will provide the ICB with copies of the committee reports which state the annual inflationary uplifts by service type. Where the uplift is automatically applied in the system, the Local Authority will provide the ICB with an uplift spreadsheet separate to the re-charge schedule which details all annual uplifts, in line with Committee approved increases and regardless of the percentage agreed, before the end of Q1. Where the uplifts are subject to individual review, e.g. Direct Payments and those with shared support (such as Supported Living), these will be shared with the ICB as soon as possible following the review. The backdating of these is not expected to be prior to the current financial year. In normal circumstances the uplifts are applied from the beginning of a financial year but for some services the uplift may be applied in year.

14. The ICB will share the ICB's approved annual inflationary uplift report with the Local Authorities.

15. If any in year uplifts are agreed in excess of LA committee/ICB approved percentages and the ICB is not involved in the provider negotiations then the ICB will only contribute the previously agreed existing weekly amount and will not contribute the same percentage split to the new package total.
E.g. £1000 pw package 50/50 split, if the LA agree to a 20% rate uplift without ICB consultation the ICB will continue to pay £500pw.

16. If the ICB has been involved in the consultation it will only uplift the health contribution by the ICB pre-approved rate uplift e.g. for 23/24, a maximum of 5.5%

17. Direct Payments – Local Authorities administer annual audits of the DP accounts of service users. Where a recoup is made and the service user is jointly funded the Local Authority will calculate the share of the recoup due to the ICB. This will be based upon the period to which the recoup relates, the period the service user was joint funded and the funding split(s) applicable during this time. The cost of providing the audit will be shared pro-rated to the recoup relating to the ICB (i.e. the cost is expected to be no more than 50% but often less as not all service users audited will be in receipt of joint funding). The cost will be netted off the payment to the ICB. Any net recoup owed to the ICB will be netted off future schedules.

18. Periods of notice for changes in adult funding are shown in sub-Appendix 1.

19. Where current packages are reviewed with the outcome of a decrease in need for the service user, the Local Authority will calculate the amount due back to the ICB and return it by way of a reversal on a subsequent schedule. This refund should be the calculated back to the date of the reduction and split according to the original joint funding agreement.

20. If a package or elements of a package are found to have ceased and the Local Authority has already received payment from the ICB then the Local Authority will calculate the amount due back to the ICB and return it by way of a reversal on a subsequent schedule once the Local Authority is in receipt of the funds from the provider. Calculation of the amount due to the ICB will consider statutory contract notice periods (some of which are specific to the provider), redundancy payments and other factors required to be observed. This also applies to joint direct payment agreements, whereby health will receive the net amount of any recoups made by the Local Authority, based on the original joint funding agreement.

21. The Local Authority is holding the financial risk and administrative burden of these packages. Due to the Local Authority recharging in arrears, a monthly payment on account from the ICB to the Local Authority will be agreed and reviewed at least annually at the start of each financial year in line with estimated spend.

22. The schedule at sub-Appendix 2 should be provided to the Local Authority on a weekly basis for adult package starts, ceases, changes to funding streams, and any Fast Track decisions. This will avoid any duplication in payments made to service users or providers.

Section 28b

23. Any jointly funded packages commissioned by the ICB and recharged to the Local Authority, will only be initiated in exceptional circumstances, where the Local Authority are unable to commission directly with the provider and by panel agreement.

24. All of the above applies in reverse, except where stated below:
    - Paragraph 19 (payments on account) does not apply for S28b recharging.

Sub-Appendix 1

Start and End of NHS Funding Matrix

This matrix indicates when NHS funding should start or end and is compliant with the National Framework for NHS Continuing Healthcare & NHS Funded Nursing Care.

	TO NONE	**TO FNC**	**TO JOINT FUNDING**	**TO CHC**	**TO FAST TRACK**
FROM NONE	X	ICB decision date*	Panel decision date **	ICB decision date*	FT approval date
FROM FNC	ICB decision date	X	Panel decision date **	ICB decision date*	FT approval date
FROM JOINT FUNDING	ICB decision date	ICB decision date	Panel decision date where there is a change to the joint funding	ICB decision date*	FT approval date
FROM CHC and FAST TRACK	28 days' notice from date notified of ICB decision (Former Nottingham and Nottinghamshire CCG) 14 days' notice (Former Bassetlaw CCG)	28 days' notice from date notified of ICB decision (Former Nottingham and Nottinghamshire CCG) 14 days' notice (Former Bassetlaw CCG)	28 days' notice from date notified of ICB decision date – separate discussion to be held at panel re JF (Former Nottingham and Nottinghamshire CCG) 14 days' notice (Former Bassetlaw CCG)	X	X

Key

*Day 29 following receipt of Checklist or ICB decision date whichever is earlier.

** In the case of joint funding (excluding S117), the recharge to health will only commence from the date joint funding was agreed at panel, unless the Panel decision is made within 2 weeks of the ICB decision date, i.e. at the first available Panel meeting after ICB verification of the MDT recommendation.

Notes

Where a case is subject to the NHS CHC Disputes Resolution Protocol any CHC funding shall commence from the original ICB decision date or day 29 (for CHC funded). This does not apply to joint funded packages of care.

Sub-Appendix 2

Nottinghamshire County Council

NHS Nottingham and Nottinghamshire

Patient	Date of Birth	Review Type (FNC, CHC, JF, S117/D2A)	Recommendation	DST(✓)	Breach Date (re: 28 days/42 days D2A)	Quality Premium (n/a for S117/D2A)		Comments	ICB Sign Off	
						Decision	Under 28 days?		Date	Initials