NHS
Central East
Integrated Care Board

Central East ICB All Aged Commissioned Care Equity and Choice Policy

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1. Introduction

1.1 Central East Integrated Care Board is responsible for arranging and commissioning a range of NHS-funded continuing care and bespoke care arrangements for people for whom it is the responsible commissioner. This policy sets out how the ICB will commission equitable, safe and effective care for adults eligible for NHS Continuing Healthcare (CHC), children and young people with continuing care needs, people receiving health-funded discharge to assess or interim arrangements, and people receiving other ICB-commissioned care packages where this policy is expressly applied.

1.2 The policy provides a transparent framework for commissioning decisions. It does not determine eligibility for adult CHC, Children and Young People's Continuing Care (CYPCC), NHS-funded Nursing Care, joint funding or any other statutory service. It must be read alongside the relevant national frameworks, legislation, statutory guidance, local operational procedures and any scheme of delegation that applies to the specific care arrangement.

2. Purpose and Scope

2.1 The purpose of this policy is to support consistent, lawful and accountable commissioning decisions across adult CHC, CYPCC and other relevant ICB-commissioned care arrangements. It balances individual choice, personalisation, the child or young person's voice, family circumstances and continuity of care with the ICB's duty to commission safe and effective care, manage risk, and use NHS resources fairly and sustainably for the whole population.

- Ensure decisions are person-led, fair, transparent and evidence-based.
- Clarify how the ICB will consider choice, placement, care at home, Personal Health Budgets, additional services, refusals of funding, exceptional circumstances and out-of-area arrangements.

- Set out reasonable safeguards for safety, quality, value for money, equality, human rights, mental capacity, information governance and dispute resolution.
- Support timely decision-making and avoid unnecessary delays to hospital discharge or commencement of appropriate care.

2.2 The scope of the policy applies to all Central East ICB staff and any organisation or individual acting on behalf of the ICB in relation to adult CHC commissioning, CYPCC commissioning, health-funded discharge to assess pathways, NHS elements of joint funded packages, and other bespoke ICB-commissioned care arrangements where the ICB is commissioning care to meet assessed health or associated care needs. scope.

2.3 Eligibility decision-making for adult CHC, CYPCC, Local Authority charging decisions, education provision, EHCP statutory processes and provider contractual disputes that are not about an individual's care package are outside the scope of this policy. However, the policy should be read alongside local CHC and CYPCC operating procedures, Personal Health Budget policy, children's safeguarding procedures, SEND and transition arrangements, joint funding and disputes policies, safeguarding policies, complaints processes and provider contract arrangements.

Individual Funding Requests (IFRs), and other funding decisions made under the ICB's Inclusion arrangements, are outside the scope of this policy and must be considered through the relevant separate ICB policy and governance process. This policy must not be used as an alternative route to establish CHC or CYPCC eligibility or to secure NHS funding where the applicable eligibility criteria are not met.

3. Definitions

3.1 NHS Continuing Healthcare (CHC): a package of ongoing care arranged and funded solely by the NHS for an adult assessed as having a primary health need.

NHS-funded Nursing Care (FNC): funding paid by the NHS to care homes with nursing to support registered nursing care for eligible individuals.

3.2 Children and Young People's Continuing Care (CYPCC): a package of additional health support for a child or young person aged 0 to 17 whose complex health needs cannot be met by existing universal or specialist health services alone. CYPCC is distinct from adult NHS Continuing Healthcare and does not create automatic eligibility for adult CHC from age 18.

3.3 Other ICB-commissioned care arrangement: a bespoke NHS-funded arrangement commissioned by the ICB to meet assessed health or associated care needs outside routine universal or specialist services, including interim health-funded care, jointly funded arrangements, complex care packages, urgent end of life support, or other packages agreed through ICB governance.

3.4 Personal Health Budget (PHB): an amount of money to support agreed health and well-being outcomes. It may be held notionally by the ICB, managed by a third party, paid as a direct payment, or delivered through a combination of these options.

3.5 Joint funding: a jointly arranged health and social care package for a person who is not eligible for CHC but has specific health needs requiring a joint approach that cannot be met solely through existing NHS-commissioned services or by the Local Authority alone.

3.6 Individual: the person receiving, or being considered for, a commissioned package of care. For children and young people, this includes the child or young person, their parent or person with parental responsibility, and others involved in their care as appropriate. For adults, it includes, where appropriate, their representative, attorney, deputy, advocate, family member or carer.

3.7 Individual Funding Request (IFR): a request for NHS funding considered through the ICB's separate Inclusion / IFR arrangements where the relevant criteria for that process apply. IFR decisions are distinct from AACC commissioning decisions and from approval of exceptional or non-standard packages for individuals who already fall within an agreed AACC commissioning route.

4. Policy Statement

4.1 The ICB has a statutory responsibility to meet the reasonable requirements of people for whom it has responsibility and it will therefore commission a reasonable package of care to meet assessed healthcare needs. It has discretion as to the manner in which those services are commissioned and provided.

4.2 The ICB will consider the individual's needs, preferences and personal circumstances, but individual choice must be balanced with safety, clinical effectiveness, quality, market availability, affordability, equity and sustainability.

4.3 Commissioning decisions must be based on objective assessment of need, safety, best interests where relevant, and the proper use of NHS resources.

4.4 The ICB will not normally commission care that cannot be delivered safely, lawfully, sustainably, or within appropriate quality standards.

4.5 Where a preferred option is not commissioned, the ICB will explain the reasons and identify an appropriate alternative capable of meeting assessed needs.

4.6 The ICB will consider equality, diversity, health inequalities, human rights, reasonable adjustments and accessibility throughout the decision-making process.

4.7 NHS care is free at the point of delivery. Individuals cannot top up or contribute towards care required to meet assessed NHS healthcare needs. Individuals can, however, purchase care that is over and above that which they are assessed as requiring provided always that this is divisible from NHS care.

4.8 Financial thresholds, standard rates and delegated approval limits are governance mechanisms only and must not replace individual assessment of need or operate as automatic caps on funding.

4.9 For children and young people, decisions must take account of welfare, safeguarding, parental responsibility, the child or young person's voice, family circumstances, education and SEND interfaces, transition planning and the need for multi-agency working.

4.10 Decisions must demonstrate that assessed eligible needs can be met safely and effectively, that viable alternatives have been considered, and that the selected option represents fair, equitable and sustainable use of NHS resources across the population.

4.11 Choice & Equity informs the identification of an appropriate commissioning option based on assessed need, individual circumstances, safety, quality, equality, available options and appropriate use of NHS resources. The proposed commissioning decision must then receive the clinical/operational, quality/commissioning and finance/value-for-money assurance required under the ICB's current AACC financial approval arrangements. Formal authorisation must be made by the officer holding the appropriate delegated authority.

5. Roles and Responsibilities

5.1 The ICB Board or delegated committee is responsible for approving this policy and seeking assurance that appropriate all-age governance is in place across adult CHC, CYPCC and other relevant ICB-commissioned care arrangements.

5.2 The Chief Executive has overall accountability for ensuring that the ICB discharges its statutory responsibilities.

5.3 The Executive Chief Nurse or delegated executive lead has senior oversight of CHC quality, safety, performance, assurance and escalation arrangements.

5.4 The relevant all-age continuing care, CHC, CYPCC or commissioned care senior leadership team is responsible for implementation, operational oversight, audit, learning, and ensuring that staff understand and apply the policy consistently within their area of responsibility.

5.5 CHC practitioners, case managers, assessors, brokerage and commissioning staff are responsible for working with individuals and their representatives, documenting care and support planning, evidencing rationale for commissioning decisions, escalating concerns, and ensuring decisions are fair, transparent and timely.

5.6 Contracting, procurement, quality and safeguarding teams support the CHC team to assure provider suitability, quality, safety, contractual compliance and market sustainability.

5.7 Relevant operational and clinical leads are responsible for confirming that the proposed package is proportionate to assessed need, that the clinical and operational rationale is clearly documented and that material clinical or operational risks have been identified and addressed.

5.8 Quality, commissioning, contracting and safeguarding functions must provide proportionate assurance that the proposed provider and commissioning arrangement are safe, suitable, contractually appropriate and capable of meeting assessed needs.

5.9 Finance and/or the relevant delegated financial decision-maker is responsible for providing proportionate financial assurance, including scrutiny of cost, rates, alternative options and value for money and for ensuring that formal authorisation is exercised within the current approved Scheme of Delegation and AACC Financial Approval Framework.

5.10 Assurance and financial authorisation are related but distinct. Participation in a panel or assurance discussion does not confer financial authority beyond an individual's formally delegated limit.

5.11 All decision-makers must declare and manage actual, potential or perceived conflicts of interest in accordance with ICB policy.

6. Processes and Procedures

6.1 Commissioning Care & Support

Following confirmation of eligibility or agreement to an ICB-commissioned care arrangement, the ICB will work with the individual, the child or young person and their family where relevant, and appropriate professionals to identify health and wellbeing outcomes and develop a care and support plan.

Care may be commissioned through care homes, care homes with nursing, domiciliary care, nurse-led providers, Personal Health Budgets, third party arrangements, equipment, assistive technology, or other appropriate arrangements. The ICB will usually only commission from providers with appropriate registration, quality assurance and contractual arrangements in place.

No package of care may commence until the appropriate clinical/operational, quality/commissioning, financial/value-for-money assurance has been completed and the package has been authorised by the appropriate delegated decision-maker in accordance with the current approved ICB Scheme of Delegation and AACC Financial Approval Framework. Where urgent interim arrangements are necessary to protect safety, these must be authorised through the agreed urgent approval route and subject to the required retrospective assurance and review.

6.2 Care Home Placements

Where an individual has been assessed as requiring care in a care home environment, the ICB will identify and commission a suitable placement able to meet assessed needs safely and effectively.

- The ICB will endeavour to offer choice within the individual's preferred geographical area, subject to provider availability, the ability to meet assessed needs, quality status, acceptance of the ICB rate, and clinical urgency.
- Where Fast Track funding applies, the priority is securing services quickly and choice may therefore be more limited.
- The ICB will agree to a reasonable weekly fee it considers sufficient to meet the assessed needs. It will not normally commission a placement where the provider will not accept the agreed rate save in exceptional circumstances, where it is satisfied on the available evidence that the proposed package is necessary to meet the individual's assessed needs safely effectively, that no suitable alternative is available at the agreed rate. Any exception must be supported by a documented clinical and commissioning rationale, with consideration of alternatives, with an assessment of quality, safety, equality and value for money with approval through the applicable scheme of delegation and financial authorisation process.
- The ICB will not commission new placements with providers whose CQC registration is suspended or cancelled, where admissions are embargoed, or where safeguarding or quality concerns mean that the provider is not considered suitable to meet the person's assessed needs.
- Where an individual prefers a care home not identified by the ICB (including out of area), the ICB may consider this if the provider can meet assessed needs, meets quality requirements, and the fee is comparable or otherwise justified through an agreed exceptional circumstances process.

6.3 Fast Track and urgent end of life packages

Where an individual is eligible through the Fast Track pathway, the priority is to arrange an appropriate package of care without delay. The urgency of the individual's condition may mean that fewer choices are available than in non-urgent cases.

- Fast Track packages must still be safe, clinically appropriate and capable of meeting assessed needs. The ICB will consider individual and family preferences wherever practicable, but the need to implement care rapidly may limit the range of providers, settings or options that can reasonably be offered.
- Where urgent interim arrangements are required, the rationale, risks, provider availability and review arrangements must be documented. Fast Track arrangements must be reviewed in line with national guidance and local operational procedures.

6.4 Funded packages of care at home

The ICB recognises that many people wish to be cared for at home. A home care package will be considered, if appropriate, and the reasons for any decision not to commission care at home will be documented and communicated to the individual.

A package of care at home will be considered where care can be delivered safely, lawfully, sustainably and cost effectively, taking account of the risks to the individual, care workers, informal carers, children and other household members.

- Factors to be considered include current and likely future needs; GP, community and mental health service support; suitability of the home environment; staffing availability and training; equipment and assistive technology; contingency arrangements; relative cost and benefit of alternative options; impact on the individual and family; and the willingness and ability of informal carers to provide agreed elements of support.
- It is usually not possible to replicate the full range of support available in hospital, care home or nursing home settings. Where constant supervision, waking night care, frequent interventions, 24-hour registered nurse presence, or highly specialist interventions are required, a care home or care home with nursing may be the more appropriate setting.
- Care workers in a home environment must have a safe place to work. Individuals and representatives are expected to permit reasonable access to facilities necessary for safe care delivery. Providers must report environmental or behavioural risks that compromise safe care.
- Harassment, bullying or abuse of care workers, ICB staff, providers or contractors will not be accepted. Where risks cannot be mitigated, the ICB may withdraw the offer of care at home and commission an alternative safe package or placement.
- Contingency plans must be agreed before a home care package begins. These should address provider failure, staff sickness, adverse weather, equipment failure, escalation arrangements, and what will happen if care at home breaks down.

6.5 Home versus care home decision framework

Where there is a material difference between the individual's preferred option and the package or placement the ICB proposes to commission, the decision must be supported by a documented comparison of options.

The documented comparison must include assessed needs, safety and environmental risks, staffing requirements, availability of market provision, informal carer contribution, contingency arrangements, equality and accessibility considerations, Mental Capacity Act and best interests' considerations where relevant, Article 8 considerations, relative cost, and the clinical benefit of each viable option.

The completed decision framework must be retained on the individual's record and used to support explanation of the decision, including any review, complaint or appeal received.

6.6 Personal Health Budgets

Where an adult is eligible for CHC and requires care at home, the default offer is a notional Personal Health Budget unless there is a clear reason why this is not appropriate. Adults eligible for CHC, including those eligible through the Fast Track route, have a legal right to have a Personal Health Budget, although the urgency of Fast Track arrangements may affect whether this is the most practical option. For children and young people, personal health budgets may be considered in line with the CYPCC framework, local PHB policy, parental responsibility, safeguarding and the agreed care and support plan.

Options available for the delivery of a PHB are:

- A notional budget is held by the ICB and used to commission services on the individual's behalf.
- A third-party budget is managed by an independent organisation that purchases support on behalf of the individual.
- A direct payment is paid to the individual or their representative, who uses it to purchase agreed support in line with the care and support plan. Direct payments require formal agreement, appropriate records, review and monitoring.
- PHBs must be affordable within the overall CHC budget and must be used only to meet agreed health and well-being outcomes. Budget holders must not top up the agreed NHS care package from personal resources. If the agreed budget is considered insufficient, the individual may request a review.

All PHBs must be delivered and managed in accordance with the PHB Policy. Until a single Central East ICB Personal Health Budget policy is approved, the relevant existing legacy-area PHB policies and operational arrangements will continue to apply. Once a Central East ICB-wide PHB policy is approved, that policy will supersede the relevant legacy arrangements. PHBs must at all times be managed in accordance with the PHB policy and operational arrangements applicable at the time.

6.7 Additional services and financial contributions

The ICB will fund reasonable care costs to meet assessed healthcare needs. Individuals must not be asked to contribute to, or top up, the cost of NHS care needed to meet those assessed needs.

Where a care home provider offers optional services unrelated to assessed healthcare needs, such as hairdressing, a preferred room without assessed clinical need, additional hospitality, or other amenities, the individual may choose to purchase these separately. Any such arrangement must be clearly separate from the NHS contract and must not affect the provider's ability to meet assessed needs if the individual stops paying for the additional service. Where a person chooses to purchase additional care at home this must be unrelated to assessment healthcare needs and must be clearly distinguishable.

The ICB accepts no liability for an individual's failure to pay for optional additional services.

6.8 Provider failure and market disruption

Where a provider is unable to continue delivering services, withdraws from a package, ceases trading, experiences significant staffing failure, is subject to regulatory restriction, or is no longer considered safe or suitable, the ICB may make immediate interim commissioning arrangements to maintain continuity of care and protect safety.

In urgent circumstances, the ICB may commission an alternative provider, interim placement or other temporary arrangement while a longer-term decision is made. The individual and representatives must be informed as soon as practicable, and the rationale, risks and review date must be documented.

Provider failure or withdrawal is distinct from refusal of funding by an individual. The refusal process must not be applied where a package breakdown as a result of provider market failure, safeguarding, regulatory action or an ICB decision to stop using a provider because of quality concerns.

6.9 Changes in circumstances

All care packages remain subject to review. A package of care at home, placement, PHB or provider arrangement must not be understood as a commitment to fund that arrangement for life or to maintain care in a particular setting indefinitely.

- If an individual no longer meets CHC eligibility following reassessment, the ICB will no longer be required to fund the package. The ICB will provide written notice, work with the Local Authority where relevant, and seek a seamless transition.
- Where needs increase, decrease, stabilise or change, the ICB will consider whether existing care remains appropriate, safe and cost effective.
- Where a provider significantly increases fees and an alternative provider can meet the same needs safely and effectively at better value, the ICB may consider a change of provider, while keeping the individual informed and providing case management support.

6.10 Exceptional circumstances and complex/non-standard care

Exceptional circumstances are compelling individual factors that may justify commissioning an option that would not ordinarily be selected under standard commissioning arrangements. Exceptionality must be considered case by case and must not be inferred solely from cost.

The rationale must be supported by relevant evidence, which may include assessed need, clinical risk, safety, equality or human rights considerations, safeguarding, family circumstances, absence of viable alternatives, provider availability and the relative benefit of the proposed option.

The ICB may seek independent clinical, commissioning, legal or other specialist advice where necessary.

Where an exceptional or non-standard package falls within AACC's commissioning responsibilities, it must be considered through the appropriate AACC assurance and delegated approval route. This is distinct from an Individual Funding Request, which must follow the ICB's separate Inclusion / IFR process.

6.11 Assurance, delegated approval and complex/high-risk governance

The ICB will maintain an approved Scheme of Delegation and AACC Financial Approval Framework setting out the financial authority and escalation arrangements applicable to commissioned-care packages. The specific approval limits in force at any time are governed by those arrangements and are not reproduced within this policy.

Commissioning recommendations must receive proportionate assurance across three domains before formal authorisation:

Operational / Clinical assurance – confirming that assessed need is understood, the proposed package is clinically and operationally appropriate, material risks are identified, and an appropriate review plan is in place.

Quality / Commissioning assurance – confirming that the proposed provider and arrangement are safe, suitable and commissionable, including relevant quality, safeguarding, contractual and market considerations and compliance with the principles of this Choice & Equity Policy.

Finance / Value-for-Money assurance – confirming that package costs and rates are understood, appropriate challenge has taken place, viable alternatives have been considered, relevant joint-funding arrangements are clear, and the appropriate delegated financial authority has been identified.

Routine packages should be approved through normal delegated arrangements where the required assurance is complete. Packages exceeding applicable delegated authority, falling outside agreed commissioning parameters, or presenting material clinical, quality, operational, financial or other complexity should receive the additional scrutiny and/or escalation required under the current AACC governance arrangements before formal approval by the appropriate delegated officer.

Formal approval must be made by an officer holding the appropriate delegated authority. Assurance obtained through a panel or multidisciplinary discussion does not itself confer financial authority beyond the approver's delegated limit.

Approval records must provide a sufficient audit trail, including the assessed need, recommended option, individual preference where relevant, viable alternatives considered, provider quality position, current and proposed cost where applicable, clinical rationale, relevant Choice & Equity considerations, material risks, reason for additional scrutiny or escalation where applicable, decision and rationale, approving officer, any conditions or time limitation, and review date.

Urgent or interim packages may follow the agreed expedited approval arrangements where delay would create unacceptable risk. Any retrospective approval required under the AACC Financial Approval Framework must be completed and documented within the prescribed timescale.

Where the cost or configuration of an existing package changes materially, the ICB must reassess whether the arrangement continues to meet assessed need safely and effectively, whether alternative arrangements should be considered and whether the change requires further assurance or approval under the current AACC Financial Approval Framework. Short-term changes required for an acute episode or urgent end-of-life care should be managed proportionately through the applicable urgent arrangements.

6.12 Refusal of adult NHS Continuing Healthcare funding

This section applies specifically to adult NHS Continuing Healthcare. The ICB will consider that there has been a refusal of adult NHS services where it has offered a package or placement that it reasonably considers appropriate to meet assessed needs and the offer is not accepted by the adult individual or a legally authorised representative.

- Where refusal appears to apply, the ICB will write to the individual or representative with a final offer, setting out the package or placement the ICB is willing to commission and the consequences of refusing it. The letter will allow no less than 14 days for confirmation of acceptance.
- If there is no response within the stated period, the ICB will issue written notice confirming that NHS funding will cease on a specified date no earlier than 28 days from the date of the notice.
- Where the individual lacks capacity, and they or their representative refuse the care package on offer, then consideration must be given to the need to refer the matter to the Court of Protection Decisions must be made in the person's best interests in accordance with the Mental Capacity Act 2005. Where there is a dispute about the location or level of care, steps must be taken to resolve this locally but where this cannot be resolved, the ICB must form a clear view around the available options, reach a decision and then seek Court authority to place someone somewhere, if this is against their will.
- If the individual is vulnerable, safeguarding policies must be followed. Refusal of a particular offer must be distinguished from a complaint or appeal about the commissioning decision and steps must always be taken to seek to discuss concerns and address these in person wherever possible.
- For children and young people, refusal, disagreement or non-acceptance of a proposed package must not be treated as an adult CHC refusal process. The ICB must consider parental responsibility, the child or young person's wishes and feelings, safeguarding, best interests or welfare considerations, and must use the relevant CYPCC review, dispute, safeguarding or legal escalation routes.

6.13 Existing care arrangements and self-funders who become eligible

Where an individual already has a care home placement or home care package that may not comply with this policy, a decision must be made around whether to notify the individual about how CHC eligibility may affect future commissioning decisions.

If an existing provider or placement costs more than the ICB would usually fund, the ICB will only continue funding at the higher rate where there is evidence of as to why the individual's needs can only be met by that provider or in that placement. Where there is no such evidence, the ICB may renegotiate fees, identify an alternative provider or placement able to meet assessed needs, and apply the refusal process if reasonable alternatives are rejected.

6.14 Out of placements and transfers

The default position for a care home placement would be a suitable placement within the Central East ICB area, where available and appropriate. Where an individual wishes to move outside the ICB area, or where needs are best met closer to family or in another area, the ICB will consider the request subject to clinical suitability, safety, cost, provider quality, responsible commissioner rules and market availability.

Where an individual moves out of area to live in their own home, commissioning responsibility may be transferred to the receiving ICB in line with responsible commissioner guidance. The current and receiving ICBs must work together to ensure safe handover and minimise disruption.

6.15 Health-funded discharge to assess and interim arrangements

Assessment of longer-term care needs should usually take place when the individual has reached the point of recovery where an accurate assessment can be made. CHC assessment should not delay safe hospital discharge.

Where interim health-funded support is appropriate because a person is highly likely to be eligible for CHC, the principles of this policy apply. If a home care package cannot be implemented immediately, the individual may be transferred to an appropriate interim setting while arrangements are made, where this is safe and clinically appropriate.

6.16 Mental capacity, best interests and deprivation of liberty

Where there is reason to believe an individual may lack capacity to decide about their care setting or commissioned package, the ICB must comply with the Mental Capacity Act 2005. Capacity is decision-specific and time-specific.

The ICB must either carry out its own capacity assessment or commission a capacity assessment to determine whether the person understands the decisions to be made regarding residence and care.

Where an individual lacks capacity, the ICB will commission the safe and cost-effective package that meets assessed needs, in consultation with best interests' representatives, attorneys, deputies, advocates, family and friends as appropriate. If no appropriate family or friends are available, an Independent Mental Capacity Advocate may be considered where the statutory criteria are met.

The ICB will consider independent advocacy support where an individual would otherwise have substantial difficulty participating in decisions regarding care planning, commissioning, reviews, complaints or appeals.

Where restrictions amount to a deprivation of liberty, the relevant Deprivation of Liberty Safeguards or Court of Protection process must be followed.

Where significant unresolved disagreement exists regarding residence, care arrangements, restrictions or best interests, legal advice and referral to the Court of Protection must be considered.

6.17 Children, young people, parental responsibility and welfare

For children and young people, commissioning decisions must be informed by the child or young person's assessed health needs, wishes and feelings, age and understanding, parental responsibility, family circumstances, safeguarding duties, continuity of education and the interfaces with Local Authority children's services and SEND arrangements.

Parents or those with parental responsibility must be involved in care planning unless there is a lawful reason not to do so. The child or young person must be supported to participate in a way that is appropriate to their communication needs, age, understanding and preferences.

Where there is disagreement about a child or young person's package, the ICB must seek multi-agency resolution at the earliest stage, including children's safeguarding, Local Authority, education and legal advice where appropriate. The Mental Capacity Act process does not apply to children under 16.

Where a CYPCC package is being considered, the ICB must ensure that assessment, planning and review are informed by a multi-agency understanding of the child or young person's needs. This needs to include relevant health professionals and, where appropriate, children's social care, education/SEND services, community providers, the child or young person, parents or those with parental responsibility, and other people involved in their care.

Commissioning decisions for children and young people needs to be outcome-focused and consider health, development, welfare, family life, education, participation, communication, independence, emotional wellbeing and continuity of care. The rationale for the agreed package must explain how the commissioned support contributes to the child or young person's assessed outcomes and why the arrangement is safe, proportionate and sustainable.

6.18 Joint funding and inter-agency disputes

Where an individual is not eligible for CHC but has specific health needs that are not met through existing NHS commissioned services, FNC, or by the Local Authority acting alone, joint funding may be considered. Joint funding decisions must be objective, evidence-based and centred on need, not cost.

- Joint funding must not be used to address a commissioning gap in a universal NHS service. Where such a service should meet the need but is unavailable or not delivering, that must be escalated to the relevant provider/service and not treated as a joint funding case.
- If the proposed NHS contribution to a joint package exceeds 50% of the overall care and support, the MDT must consider whether CHC eligibility requires further review. Exceptions may be considered on a case-by-case basis.
- Joint funding arrangements must identify the lead organisation, funding split, provider arrangements, review schedule, and process for resolving disagreement.
- During disputes between statutory bodies, individuals must not be left without appropriate support. Existing arrangements must continue wherever required to maintain safety while the dispute is resolved save in exceptional circumstances.
- Disputes must be resolved collaboratively, in a timely way, using evidence available at the time of the decision, with escalation through agreed senior management and external arbitration only where necessary.

6.19 Review of care arrangements

All individuals in receipt of CHC should have a review within three months of the package commencing and at least annually thereafter, or sooner if needs change. High-cost or complex packages may require earlier or more frequent review.

Reviews must consider whether the care package continues to meet assessed needs, remains safe and effective, is the least restrictive appropriate option, represents appropriate use of NHS resources, and remains compliant with this policy. The individual, representatives, providers and relevant professionals should be involved as appropriate.

CYPCC packages must be reviewed in line with the National Framework for Children and Young People's Care and local procedures. Reviews must take account of changes in health need, development, family circumstances, safeguarding, education/SEND arrangements, provider capacity, transition planning and whether the package continues to meet agreed outcomes safely and effectively.

6.20 CYPCC review process

Where a child or young person, parent or person with parental responsibility is dissatisfied with a CYPCC commissioning decision or considers that the agreed package no longer meets assessed needs or outcomes, they may request a review through the ICB's CYPCC process. The ICB must provide clear, accessible information about how to request a review, the relevant contact details, expected timescales and the support or advocacy available.

The review must be child- and family-centred and informed by an up-to-date multi-agency understanding of health needs, agreed outcomes, the child or young person's wishes and feelings, parental responsibility, family circumstances, safeguarding, education and SEND arrangements, provider information and transition planning where relevant. The ICB must reconsider the decision and care package using evidence available at the time of review, seeking further assessment or professional advice where required.

The outcome must be communicated in writing and in an accessible format, setting out the evidence considered, the decision and rationale, any changes to provision, implementation and review arrangements, and the route for further challenge. Where disagreement remains, the ICB should seek timely local resolution through the relevant CYPCC senior clinical or commissioning route and multi-agency partners. A complaint may then be made through the ICB complaints process, and once local resolution has been exhausted the individual must be advised of the relevant external escalation route, including the Parliamentary and Health Service Ombudsman where applicable. Existing support must wherever possible continue where necessary to maintain safety while the review or dispute is resolved, unless a change is required to protect the child or young person's welfare.

6.21 Equality, health inequalities and reasonable adjustments

In applying this policy, the ICB will have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations between people having due regard to protected characteristics.

Reasonable adjustments must be considered and documented where needed to support individuals to engage with care planning, commissioning decisions, appeals and complaints. This includes adjustments relating to communication, language, advocacy, digital access, disability, trauma, health literacy, culture, cognition, sensory needs and physical accessibility.

The ICB will comply with the Accessible Information Standard (DAPB1605), including the identification, recording, flagging, sharing, meeting and review of individuals' information and communication needs.

The emotional and psychological impact of care commissioning decisions must be acknowledged, particularly for people experiencing communication barriers, trauma, discrimination or social disadvantage. Staff must provide information in accessible formats and avoid information overload wherever possible.

6.22 Safeguarding and Care Act section 42 duties

Where abuse, neglect, self-neglect, organisational abuse, domestic abuse, financial abuse or other safeguarding concerns are suspected, staff must follow local safeguarding procedures and make referrals or enquiries in accordance with statutory duties, including section 42 of the Care Act 2014 where the criteria are met.

Safeguarding considerations must be documented in commissioning decisions where relevant, including risks to the individual, informal carers, children or other household members, care workers, ICB staff and provider staff. Safeguarding processes do not remove the need to meet assessed eligible health needs, but they may affect the setting, provider or contingency arrangements that can be safely commissioned.

6.23 Data protection, information sharing and records

Personal information must be processed fairly, lawfully and transparently in accordance with UK data protection legislation, Caldicott principles and ICB information governance requirements.

Information relevant to CHC, joint funding and commissioning decisions may include assessments, reviews, DSTs, support plans, verification outcomes, joint funding templates, care provider information, complaints, safeguarding information and financial approvals. Personal identifiable information must only be shared with relevant people where there is a lawful basis for doing so.

6.24 Monitoring, audit and review

The CHC senior leadership team will monitor implementation through case review, audit, complaints and appeals, safeguarding concerns, provider quality intelligence, financial approvals, complex case panels, feedback from individuals and representatives, and learning from disputes or external review.

Monitoring must include choice outcome trends, Personal Health Budget uptake, refused preferences, out-of-area placements, equality impacts by protected characteristic, deprivation and geography, inclusion health groups, complaints relating to choice or equity, and any evidence of unwarranted variation.

Monitoring of the financial approval / assurance process may also consider, where data are available, volumes and values of escalated packages, reasons for escalation, approval outcomes, incomplete or deferred submissions, urgent / retrospective approvals, material package increases, 1:1 or enhanced-care arrangements, compliance with review conditions and any evidence of unwarranted variation between localities.
The policy will be reviewed every two years, or sooner if required by legislative change, national guidance, case law, organisational change, serious incident learning, audit findings, or repeated escalation of disputes.

6.25 Departures from this policy and exceptional approval

Any proposed departure from this policy must be considered through the exceptional circumstances or senior approval process. The reason for departure, alternatives considered, clinical rationale, equality and human rights implications, financial impact, risk mitigation and review arrangements must be documented.

A departure from this policy in one case does not create an entitlement or precedent for other cases. Comparable cases should, however, be considered to support fairness and consistency.

6.26 Transition from children and young people's services to adult CHC

Where a young person is approaching adulthood and may require adult NHS Continuing Healthcare, transition planning must begin in line with national guidance and local transition arrangements. CYPCC and adult CHC are distinct frameworks; receipt of CYPCC before age 18 does not automatically mean the young person will be eligible for adult CHC. The ICB should work with children's services, adult CHC, Local Authorities, education, SEND services, providers, the young person and their representatives to support planned, person-centred transition.

Transition decisions must consider continuity of care, family impact, education or employment arrangements, EHCP interfaces, mental capacity from age 16 where relevant, best interests, safeguarding, provider suitability, clear communication and contingency planning before the young person's 18th birthday.

For young people receiving CYPCC who may require adult services, transition planning must start early enough to avoid gaps in provision and must include a clear timeline for assessment, decision-making, communication, funding responsibility, provider handover and contingency planning. Planning must be coordinated with the young person, family, children's services, adult CHC, Local Authority partners, education/SEND services and providers.

This policy does not determine education provision or remove statutory responsibilities relating to Education, Health and Care Plans. Where health provision contributes to assessed education, health or care outcomes, the ICB must work with education and Local Authority partners to support coordinated planning, clear responsibility, and timely resolution of any disagreement.

6.27 Transition from legacy commissioning policies

On the effective date of this policy, it will become the Central East ICB framework for Choice & Equity decisions within its stated scope. Existing legacy-area policies and procedures will continue only where expressly required for an operational area not yet harmonised, including Personal Health Budget arrangements where applicable.

Existing commissioned-care packages will not require automatic reconsideration solely because this policy has come into effect. They will be considered against this policy at the next appropriate review, or earlier where there is a material change in need, package configuration, provider arrangement, risk or cost.

The implementation plan must identify which legacy policies are superseded, which transitional arrangements remain temporarily in force, and the date from which this policy applies to new commissioning decisions.

6.28 Associated documents and references

- National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, July 2022.
- Framework for Children and Young People's Continuing Care, January 2016.
- Hospital Discharge and Community Support Guidance.
- Constitution for England.
- Choice Framework.

- Mental Capacity Act 2005.
- Rights Act 1998.
- Equality Act 2010.
- Care Act 2014.
- Health and Care Act 2022.
- Protection Act 2018 and UK GDPR.
- Who Pays? Determining which NHS commissioner is responsible for commissioning healthcare services and making payments to providers.
- Health Care Services (Provider Selection Regime) Regulations 2023 and associated statutory guidance.
- CHC operational policy, joint funding policy, disputes policy, safeguarding policy, complaints policy, enhanced observation policy, PHB policy, and relevant contracting/procurement procedures.

7. Statutory and National Guidance

Legal status and policy hierarchy

7.1 This policy has been developed with reference to the following statutory and national guidance:

This policy must be applied in accordance with the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, the National Framework for Children and Young People's Continuing Care, relevant legislation, statutory guidance, case law and national policy. Where any provision of this policy conflicts with those requirements, the statutory requirement or national guidance shall prevail.

The policy supports consistent decision-making but does not fetter the ICB's discretion. Each case must be considered on its own facts, with decisions based on assessed need, safety, clinical effectiveness, equality, mental capacity, human rights, value for money and the efficient use of NHS resources.

The ICB will consider the individual's right to respect for private and family life under Article 8 of the Human Rights Act 1998 when making commissioning decisions. This consideration will be balanced against safety, clinical effectiveness, provider quality, lawful delivery of care and the need to use NHS resources fairly and sustainably.

Where the ICB departs from an individual's preferred option, the rationale must be clearly documented and communicated, including the alternatives considered and why the commissioned option is considered appropriate to meet assessed needs.

The ICB may decline or withdraw a direct payment where statutory exclusions apply, where the proposed arrangement cannot safely or lawfully meet assessed needs, where safeguarding or financial governance risks cannot be mitigated, or where the direct payment is not being used in accordance with the agreed care and support plan.

Direct payments and third-party budgets must be used only for services and support agreed in the care and support plan. Budget holders must keep appropriate records and cooperate with monitoring and

review requirements. Expenditure outside the agreed plan will not be funded by the ICB unless it has been reviewed and approved in advance.

At individual level, CHC care arrangements should be reviewed within three months of commencement and at least annually thereafter. Reviews should be brought forward following a significant change in need, hospital admission, safeguarding concern, provider failure, package breakdown, material cost increase, change in accommodation, or where the individual, representative, provider or professional raises evidence that the current package may no longer be appropriate.

Accessibility Statement

This policy is available in alternative formats upon request, including large print, Braille and translated versions, to ensure accessibility for all staff and stakeholders.

Implementation Plan

Development and Consultation: The policy should be subject to appropriate engagement with adult CHC, CYPCC, safeguarding, quality, contracting, finance, information governance, equality, complaints, Local Authority, provider, children's services, SEND and patient/family representative stakeholders before final approval.
Dissemination: The approved policy should be published on the ICB policy repository and communicated to all relevant CHC, CYPCC, commissioning, brokerage, quality, safeguarding, contracting, finance and complaints teams.
Training: Staff applying the policy should receive briefing or training on assessed need, choice, equity, PHBs, refusal of adult CHC funding, CYPCC-specific requirements, equality, safeguarding, Mental Capacity Act interface, documentation standards and escalation routes.
Monitoring: Implementation should be monitored through audit, complex case panels, complaints, appeals, safeguarding learning, equality impact monitoring, PHB uptake, high-cost package approvals, out-of-area placements and review compliance.
Review: The policy should be reviewed every two years, or sooner if required by changes in legislation, national guidance, case law, organisational arrangements, audit findings, complaints, safeguarding learning or operational risk.
Equality, Diversity, and Privacy: The EQIA and DPIA screening should be completed before final approval, with advice from equality and information governance leads where required.
Associated Documents: Local CHC operational procedures, CYPCC procedures, PHB policy, joint funding policy, disputes policy, safeguarding policy, complaints policy, procurement/contracting procedures and scheme of delegation.
References: National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care; National Framework for Children and Young People's Continuing Care; relevant legislation and statutory guidance.

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Appendix 1: Equality Impact Assessment

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

Name of Policy:	All Age ICB Commissioned Continuing Care Choice and Equity Policy
Date of assessment:	dd-mm-yyyy
Screening undertaken by:	<insert name and role>

Protected characteristic and inclusion health groups. **Find out more about the Equality Act 2010, which provides the legal framework to tackle disadvantage and discrimination:** https://www.equalityhumanrights.com/en/equality-act/protected-characteristics	**Could the policy create a disadvantage for some groups in application or access?** **The policy should not create disadvantage**	**If Yes - are there any mechanisms already in place to mitigate the potential adverse impacts identified?** **If not, please detail additional actions that could help.** **If this is not possible, please explain why**
Age A person belonging to a particular age (for example 32 year olds) or range of ages (for example 18 to 30 year olds).	Older people may be more likely to be eligible for CHC and may face barriers to challenging decisions.	Provide accessible information, involve representatives where appropriate, and avoid assumptions about ability or preference.
Disability A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.	Disabled people may be more likely to be affected and may require adjustments to engage fully.	Consider communication, cognition, sensory accessibility, physical access, advocacy, capacity and autonomy.
Gender reassignment The process of transitioning from one gender to another.	Care planning may involve sensitive personal information, identity, family roles and confidentiality.	Use the individual's name, pronouns and identity respectfully, protect confidentiality, and consider privacy, dignity and consent.
Marriage and civil partnership Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'.	No specific disadvantage has been identified. Commissioning decisions should recognise spouses and civil partners where they are involved in care planning, representation, family circumstances or informal support, while	

	avoiding assumptions about relationship status or family role.	
Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.	No specific disadvantage has been identified. Where relevant, care planning should take account of pregnancy, postnatal recovery, breastfeeding, parental responsibility, caring responsibilities, safeguarding and the impact of commissioned care arrangements on the parent and child.	
Race Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins.	Preferences about care setting, family role, gender of carers, language and cultural practice may influence care planning.	Offer interpretation, consider cultural and religious needs where clinically and operationally appropriate, and document how preferences have been balanced with assessed need and safety.
Religion or belief Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	Preferences about care setting, family role, gender of carers, language and cultural practice may influence care planning.	Offer interpretation, consider cultural and religious needs where clinically and operationally appropriate, and document how preferences have been balanced with assessed need and safety.
Sex A man or a woman.	Care planning may involve sensitive personal information, identity, family roles and confidentiality.	Use the individual's name, pronouns and identity respectfully, protect confidentiality, and consider privacy, dignity and consent.
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex, to both sexes or none.	Care planning may involve sensitive personal information, identity, family roles and confidentiality.	Use the individual's name, pronouns and identity respectfully, protect confidentiality, and consider privacy, dignity and consent.
Carers Individuals within the ICB which may have carer responsibilities.	The policy may rely on informal carers only where they are willing and able to provide agreed support.	Do not assume informal care. Document consent, role, contingency arrangements and carer impact.

Please summarise the improvements which this policy offers compared to the previous version or position.

This policy improves the previous position by setting out an all-age approach across adult CHC, CYPCC and other relevant ICB-commissioned care arrangements. It strengthens transparency, consistency and equity in commissioning decisions by requiring individual assessment, documented rationale, reasonable adjustments, accessible information, advocacy where appropriate, safeguarding consideration, carer impact assessment, Personal Health Budget consideration, review arrangements and escalation for exceptional or complex cases.

Has potential disadvantage for some groups been identified which require mitigation?

Yes - potential differential impact has been identified for some groups, with mitigations built into the policy.

Potential disadvantage or differential impact may arise for some groups because the policy affects people with complex health needs, disabled people, children and young people, older people, carers and people who require accessible communication, advocacy, cultural or religious consideration, reasonable adjustments, safeguarding support or family involvement. The policy includes mitigations through person-centred assessment, accessible information, reasonable adjustments, advocacy, Mental Capacity Act and best interests processes, safeguarding duties, carer consideration, documented decision-making, review, complaints and escalation routes. No unmitigated adverse impact has been identified from the policy as drafted.

Appendix 2: Data Protection Impact Assessment

Screening questions to determine if a full DPIA is required. Guidance on handling personal and sensitive data.

Data protection is the fair and proper use of information about people. Before completing this form, please refer to the Data Protection Impact Assessment (DPIA) Guidance in the Information Governance (IG) section on the staff Intranet or contact the Data Protection Officer for support via ***(insert email address once confirmed)***

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

Name of Policy:	All Age ICB Commissioned Continuing Care Choice and Equity Policy
Date of assessment:	dd-mm-yyyy
Screening undertaken by:	<insert name and role>

Stage 1 – DPIA form **please answer 'Yes' or 'No'**

1. Will the policy result in the processing of personal identifiable information / data? This includes information about living or deceased individuals, including their name, address postcode, email address, telephone number, payroll number etc.	Yes
2. Will the policy result in the processing of sensitive information / data? This includes for living or deceased individuals, including their physical health, mental health, sexuality, sexual orientation, religious belief, National Insurance No., political interest etc.	Yes
3. Will the policy involve the sharing of identifiers which are unique to an individual or household? e.g., Hospital Number, NHS Number, National Insurance Number, Payroll Number etc.	Yes
4. Will the policy result in the processing of pseudonymised information by organisations who have the key / ability to reidentify the information?	No

Pseudonymised data - where all identifiers have been removed and replaced with alternative identifiers that do not identify any individual. Re-identification can only be achieved with knowledge of the re-identification key. **Anonymised data -** data where all identifiers have been removed and data left does not identify any patients. Re-identification is remotely possible, but very unlikely.	
5. Will the policy result in organisations or people having access to information they do not currently have access to?	No
6. Will the policy result in an organisation using information it already holds or has access to, but for a different purpose?	No
7. Does the policy result in the use of technology which might be perceived as being privacy intruding? e.g., biometrics, facial recognition, CCTV, audio recording etc.	No
8. Will the policy result in decisions being made or action being taken against individuals in ways which could have a significant impact on them? Including profiling and automated decision making. (This is automated processing of personal data to evaluate certain things about an individual i.e., diagnosis and then making a decision solely by automated means - without any human involvement)	Yes
9. Will the policy result in the collection of additional information about individuals in addition to what is already collected / held?	No
10. Will the policy require individuals to be contacted in ways which they may not be aware of and may find intrusive? e.g., personal email, text message etc.	No

DPIA screening note: Although this policy does not create a new clinical system, its application involves processing personal identifiable and special category health and care information, including NHS numbers, assessments, care plans, safeguarding information, provider information and commissioning decisions that may significantly affect individuals. A full DPIA or information governance review should therefore be completed before final approval, with advice from the Data Protection Officer or IG lead.

Appendix 3: Commissioning Decision Checklist and Process Flow

This appendix provides a practical process checklist to support consistent, defensible and person-centred commissioning decisions under this policy. It should be used alongside the main policy sections on assessed need, choice, equity, safety, provider suitability, Personal Health Budgets, value for money, exceptional circumstances, approval, communication and review.

Appendix 3: Commissioning Decision Checklist | Part 1

START

↓

Confirm the applicable route: adult CHC, CYPCC, FNC, joint funding, discharge to assess, interim care or other ICB-commissioned arrangement

↓

Document assessed needs, outcomes, preferences, communication needs and representative views

↓

Child or young person?

If yes → Apply CYPCC processes: parental responsibility, child or young person's voice, welfare, safeguarding, family circumstances, education/SEND and transition planning where relevant

If no / not applicable, continue down

↓

Part 1 confirms route, assessed need, preferences, CYPCC-specific factors, capacity and equality considerations.

Appendix 3: Commissioning Decision Checklist | Part 1 continued

Consider mental capacity, best interests, advocacy and deprivation of liberty requirements where relevant

↓

Identify equality, health inequality, accessibility, reasonable adjustment and accessible information needs

Continue to Part 2 once these considerations are complete.

Appendix 3: Commissioning Decision Checklist | Part 2

CONTINUED FROM PART 1

↓

Record safeguarding risks and risk mitigations

↓

Check provider ability to meet needs, quality intelligence, CQC status, safeguarding position and contractual suitability

↓

Care at home required?

If yes → Assess whether home care can be delivered safely, lawfully and sustainably, including environment, workforce, equipment, informal carer role and contingency arrangements

If no / not applicable, continue down

↓

Part 2 covers risk, provider checks, PHB options and value for money.

Appendix 3: Commissioning Decision Checklist | Part 2 continued

Offer or consider Personal Health Budget options where applicable, or record clear reasons where not appropriate

↓

Compare viable options, including safety, quality, clinical effectiveness, equality, least restriction, provider availability, cost and value for money

Continue to Part 3 once these checks are complete.

Appendix 3: Commissioning Decision Checklist | Part 3

CONTINUED FROM PART 2

↓

↓

Exceptional circumstances?

If yes →

Record the exceptional clinical, safety, equality, human rights or safeguarding rationale and escalate through the agreed senior approval route

If no / not applicable, continue down

↓

Part 3 covers exceptionality, approvals, written decision and review date.

Appendix 3: Commissioning Decision Checklist | Part 3 continued

Complete the required AACC assurance and approval process

↓

1. Operational / Clinical assurance
Confirm assessed need, package rationale, clinical / operational risks and review arrangements.

↓

2. Quality / Commissioning assurance
Confirm provider suitability, quality / safeguarding position, commissioning route, viable alternatives and Choice & Equity compliance.

↓

3. Finance / Value-for-Money assurance
Confirm cost, rate, alternatives, financial challenge, joint-funding position where relevant and required delegated authority.

↓

Within routine delegated authority and no additional scrutiny / escalation required?

↓	↓
Yes	**No**

	Additional scrutiny and/or escalation through the appropriate AACC governance route
↓	↓
↓	**Where senior escalation is required**, the case should be presented decision-ready, with the required assurance completed wherever possible, a clear recommendation from the preceding stage, the reason for escalation identified, and any remaining decision or material risk clearly stated.
↓	↓
Formal approval by appropriate delegated officer	
↓	
Commission Put the agreed package in place with the provider/ arrangement.	
↓	
Record and communicate the commissioning decision, rationale, alternatives considered, review route and complaints or appeal route in writing	
↓	
Set review date and monitoring arrangements, including earlier review triggers	

Checklist summary

Use this editable table as a quick reference to support completion of the commissioning decision record.

No.	Checklist point	Complete
1	Assessed needs, applicable framework or commissioning route, and health/wellbeing outcomes documented.	☐
2	Individual preferences and representative views recorded.	☐
3	For children and young people, parental responsibility, child or young person's voice, family circumstances, education/SEND interface and safeguarding considered.	☐
4	Mental capacity and best interests considered where relevant.	☐
5	Equality, accessibility and reasonable adjustments considered.	☐
6	Safeguarding risks and risk mitigations recorded.	☐
7	Provider quality, CQC status and contractual suitability checked.	☐
8	Care at home risks, environment, staffing, equipment and contingency assessed.	☐
9	PHB options offered or reasons recorded.	☐
10	Cost, alternative options and value for money considered.	☐
11	Exceptional circumstances rationale recorded where applicable.	☐
12	Operational / clinical assurance completed and documented.	☐
13	Quality / commissioning assurance completed, including provider suitability and relevant quality / safeguarding considerations	☐
14	Finance / value-for-money assurance completed, including costs, rates and viable alternatives.	☐
15	Appropriate delegated authority identified, reason for any additional scrutiny / escalation documented, and any required escalation completed.	☐
16	Formal approval, decision-maker, rationale and any conditions recorded.	☐
17	Decision and relevant review / complaint / challenge route communicated appropriately.	☐
18	Review date and any earlier review / step-down triggers recorded.	☐

Appendix 3: Commissioning Decision Checklist and Process Flow