NHS
Birmingham and Solihull
Clinical Commissioning Group

Equality Analysis

(Health Inequalities, Human Rights, Social Value)

BIRMINGHAM AND SOLIHULL CCG PERSONAL HEALTH BUDGET POLICY

Before completing this equality analysis it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

1. Background

EA Title	Birmingham and Solihull CCG Personal Health Budget Policy		
EA Author	Anil Garcia	**Team**	Personalised Commissioning Team
Date Started	28th Dec 2018	**Date Completed**	1st Jan 2019
EA Version	V0.2	**Reviewed by E&D**	Yes

What are the intended outcomes of this work? Include outline of objectives and function aims

A personal health budget can be defined as – an amount of money to support the identified healthcare and wellbeing needs of an individual, which planned and agreed between the individual, or their nominee/representative, and the local CCG. At the centre of a PHB is the care and support plan. This plan helps people to identify their health and wellbeing goals, together with their Care Co-ordinator, set out how the budget will be spent to enable them to reach their goals and keep healthy and safe.

The introduction of Personal Health Budgets (PHBs) is one of a range of national policies designed to improve personalisation, choice and empowerment in the delivery of healthcare.

Personalisation is fundamentally about better lives, not just services or packages of care. It means working with people, carers and families to deliver better outcomes for all, and ensuring that the person is at the centre of their care. The move towards personalisation in healthcare, as well as social care and Continuing Healthcare, is not focused on changing systems and processes, or allocating funding, but centred on making the necessary changes to ensure people have greater independence, enhanced wellbeing and the choice and control over the way their care is delivered.

Birmingham and Solihull CCG are strongly committed to this approach and this document sets out how PHBs will be delivered locally. In doing so, Birmingham and Solihull CCG will follow all national guidance.

The purpose of this policy is to describe how the CCG will implement, monitor and manage Personal Health Budgets within the local area.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

The eligibility criteria described below is based on the – "National Health Service (Direct Payments) Regulations 2013 as amended by the National Health Service (Direct Payments) (Amendment) Regulations 2013":

- A person receiving NHS continuing healthcare or children's continuing care. These individuals already have a right to receive a PHB;
- People with Learning Disabilities and Autism
- People at the end of life – in receipt of end of life care
- Wheelchair users (From 2017 the Wheelchair Voucher scheme will be replaced by a Personal Wheelchair Budget);

- People who need high cost, longer term rehabilitation e.g. people with acquired brain injury, spinal injury or mental health recovery (including Section 117 aftercare).

There are no exclusions by diagnosis or by virtue of mental capacity.

Generally, people living in permanent residential care (such as a nursing home or residential home) are not eligible for a PHB, although there could be elements of their care which may be eligible as they are not in a position to exercise the level of choice required over the way in which the services are being delivered.

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	Working Groups	Clinical Experts
Government mandate to NHS England 2016/17		
Shared Planning Guidance 2016/17-2020/21		
National framework for NHS continuing healthcare and NHS funded nursing care		
High quality care for all: the operating framework for the NHS in England 2009/10		

3. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

Age: Describe age related impact and evidence. This can include safeguarding, consent and welfare issues:

Age	Birmingham	Solihull	BSol	England
All Usual Residents:	1073045	206674	1279719	53012456
Age 0 to 4	7.63%	5.59%	7.30%	6.26%
Age 5 to 7	4.28%	3.43%	4.15%	3.45%
Age 8 to 9	2.65%	2.23%	2.58%	2.16%
Age 10 to 14	6.86%	6.34%	6.78%	5.81%
Age 15	1.38%	1.36%	1.37%	1.23%
Age 16 to 17	2.74%	2.82%	2.76%	2.48%
Age 18 to 19	3.36%	2.31%	3.19%	2.59%
Age 20 to 24	8.75%	5.50%	8.23%	6.78%
Age 25 to 29	7.98%	5.16%	7.52%	6.89%
Age 30 to 44	20.75%	18.59%	20.40%	20.64%

3. Impact and Evidence:

Age 45 to 59	16.40%	20.81%	17.12%	17.71%
Age 60 to 64	4.33%	6.69%	4.71%	5.98%
Age 65 to 74	6.53%	9.90%	7.08%	8.59%
Age 75 to 84	4.57%	6.60%	4.90%	5.52%
Age 85 to 89	1.18%	1.75%	1.27%	1.46%
Age 90+	0.60%	0.91%	0.65%	0.76%
Mean Age	35	41		39
Median Age	32	42		39

- Birmingham has a younger population with 66% under 45 years and 17% in the 20-29 age group. 13% of the population is over 65 years old and is set to remain stable with many retirees continuing to move out of the City. The health needs of young people show that they have a relatively unhealthy start in life. The health of children in Birmingham is worse than England overall. This is reflected in a high level of infant mortality, low birth weight babies and high childhood obesity rates. Birmingham's teenage conception rate is one of the highest in the country.

- Conversely, Solihull is characterised by its older population. Between 1995 and 2015 the population aged 65 and over increased from 16% to 21% of the total so that there are now 9,200 more residents aged 65 to 84 years and 3,500 more aged 85 years and over than 20 years ago. Population projections based on the 2014 population estimates indicate the relative ageing of the Solihull population will continue and by 2033 those aged 65 and over will account for one in four of the borough population, with those aged 85+ numbering nearly 12,000 (5% of total). The growth in the numbers of those aged 85 and over represents a significant and growing challenge in terms of health and social care.

Eligibility or 'right to have' a personal health budget applies both to adults and young adults who are eligible for NHS Continuing Healthcare, and children in receipt of continuing care.

The CCG will work with the Local Authority, should any safeguarding concerns arise, in respect of an individual receiving a PHB. These will be investigated accordingly.

PHB's have the potential to have a positive impact on all ages groups and those in receipt of end of life care.

No negative impact identified in implementation of this policy with regards to the protected characteristic of age.

Disability: Describe disability related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/ learning disabilities, cognitive impairments:

BSol local demographics

The 2011 Census asked residents about their health, the data below shows the figures for the local area for those residents who stated that they had 'Bad or Very Bad Health' by age band:

3. Impact and Evidence:

Bad or Very Bad Health	Number	%	Age 0 to 15	Age 16 to 49	Age 50 to 64	Age 65+
BSol	82,529	6.45%	0.94%	3.46%	11.89%	19.76%

The Census also asked if residents had a long term health condition, and if so how much it limited their day to day activities:

	All	Age 0 to 15	Age 16 to 24	Age 25 to 34	Age 35 to 49	Age 50 to 64	Age 65 to 74	Age 75 to 84	Age 85+
BSol – Long-Term Health Problem									
Day to day activities limited a lot	8.70%	1.91%	2.23%	3.02%	6.41%	13.44%	20.95%	34.72%	57.24%
Day to day activities limited a little	9.34%	2.56%	3.43%	4.60%	8.08%	14.78%	24.06%	31.04%	28.40%
Day to day activities not limited	81.95 %	95.53 %	94.34 %	92.38 %	85.51 %	71.78%	54.99%	34.24%	14.35%

According to census data across Birmingham and Solihull as a whole 8.7% of the population have a disability that limits their day to day activities a lot, compared to 8.3% for England. When you look at activities limited a little, the figure for Birmingham and Solihull (9.34%) is broadly the same as England at 9.3%.

PHB and Disabilities

A personal health budget is an amount of money and a plan to use it, agreed between an individual and their health care professional(s). It is a way of enabling disabled people and those with long-term health needs to have greater choice, flexibility and control over the health and care support they receive.

Long term health and complex health needs

It is likely that many recipients of personal health budgets to have long term and complex health needs, often in conjunction with needs traditionally covered by social care services. These will include significant numbers of people who are disabled. Many will also be older people. Disabled people are expected to benefit. Personal health budgets will give people greater control over their care, allowing them to choose the services that best suit their needs. The evidence from the social care IBs pilots suggest that both people with physical disabilities and people with learning disabilities benefited from the additional control given by personal budgets

Mental Health Needs

Personal health budgets fit well with the recovery-focussed approach to mental health services. The recovery model aims to move beyond symptom and risk management to supporting people to re-establish meaningful lives with their mental health condition. It means looking beyond medical treatment to consider wider issues such as housing, employment and relationships. It also depends on services being able to develop individually tailored approaches, personal health budgets and integrated personal budgets could be beneficial to people receiving ‘after care’ through section 117 of the Mental Health Act 1983.

3. Impact and Evidence:

Section 117 after-care services include healthcare, social care and employment services, supported accommodation, and services to meet people's social, cultural and spiritual needs – as long as the needs arise from, or are related to, the person's mental condition, and helps reduce the risk of their mental condition getting worse. A personal health budget or integrated personal budget would provide individuals receiving after-care with a tailored approach that is right for them, which will empower them, and provide them with a supportive mechanism that can help them to re-establish meaningful lives with their mental health condition.

Learning Disabilities and Autism

Evidence suggests that for these individuals, a model of personalised care is beneficial to their health and care. Early learning from the personal health budget pilot sites and the implementation of personal budgets in social care showed that personalised care and support could lead to better outcomes for marginalised groups and people with complex needs, including people with learning disabilities, autism, or both.

The Social Care Institute for Excellence also found that for people with a learning disability, autism or both, personal budgets and personalised care and support can make a significant difference. They found that families and carers can benefit when the individual has choice and control over their care and wellbeing, and that budgets can improve life for this group, and can help prevent some individuals from going into residential care as adults (https://www.scie.org.uk/personalisation/specificgroups/learning-disability).

The aim of the Personal Health Budget is to enable people to define and agree the support they need to meet their identified health and social care needs, this is done regardless of diagnosis.

No reference is made with the policy of meeting the communication needs of service users (particularly in relation to the Care Co-Ordinator role and the compilation of the care and support plan).

No negative impact identified in implementation of this policy with regards to the protected characteristic of disability.

Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment:

There is a lack of good quality statistical data regarding trans people in the UK. Current estimates indicate that some 650,000 people are "likely to be gender incongruent to some degree"
Research evidence indicates that trans people experience fear and discrimination when accessing health services.

No negative impact identified in implementation of this policy with regards to the protected characteristic of gender reassignment.

Marriage and civil partnership: Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part-time working, and caring responsibilities:

No negative impact identified in implementation of this policy with regards to the protected characteristic of marriage and civil partnership.

3. Impact and Evidence:

Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities:

No negative impact identified in implementation of this policy with regards to the protected characteristic of pregnancy and maternity.

Race: Describe race related impact and evidence**.** This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers:

BSol local demographics:

Race %	B'ham	Solihull	Bsol
White British	53.14%	85.76%	58.40%
White Irish	2.05%	1.90%	2.02%
Gypsy/Irish Traveller	0.04%	0.03%	0.03%
White Other	2.70%	1.45%	2.49%
White & Black Caribbean	2.30%	1.16%	2.11%
White & Black African	0.30%	0.12%	0.27%
White & Asian	1.04%	0.56%	0.96%
Other Mixed	0.79%	0.29%	0.70%
Asian Indian	6.02%	3.43%	5.60%
Asian Pakistani	13.48%	1.65%	11.56%
Asian Bangladeshi	3.03%	0.31%	2.59%
Asian Chinese	1.18%	0.44%	1.06%
Asian Other	2.90%	0.73%	2.55%
Black African	2.79%	0.41%	2.41%
Black Caribbean	4.44%	0.93%	3.87%
Black Other	1.75%	0.22%	1.49%
Arab	1.02%	0.17%	0.88%
Other	1.02%	0.42%	0.91%

Birmingham is characterised by its ethnic diversity with a Black and Minority Ethnic (BAME) profile of around 42% and a range of languages spoken. Around 22% of Birmingham's residents are born overseas and 15% of the population is classified as having a main language other than English. There is a recognised link between poor health outcomes and English language needs. Wards with the highest number of recent migrants (arriving between 2001 and 2011) were Ladywood 73%, followed by Nechells (59.5%) and Harborne (50.7%).

In Solihull, the BAME population has more than doubled since the 2001 Census and now represents nearly 11% of the total population. On this basis the borough is less diverse than England as a whole (and significantly less so than Birmingham), but with BAME groups representing a relatively higher proportion of young people in Solihull (over 17% of those aged 15 and under) this representation is set to increase. The largest BAME group in Solihull is Asian or Asian British with over 13,500 residents (6.6% of the total population or 60% of all BAME residents), followed by mixed race (4,400), and Black

3. Impact and Evidence:

or Black British (3,200). 15,386 (7.4%) Solihull residents were born outside of the UK, which proportionally is much lower than the England (13.8%). Of those born outside of the UK 70% have been resident in the UK for 10 years or more, this shows that immigration has been a less significant feature of Solihull's demography than many other parts of the country.

No reference is made with the policy of meeting the language needs of service users (particularly in relation to the Care Co-Ordinator role and the compilation of the care and support plan).

No negative impact identified in implementation of this policy with regards to the protected characteristic of race.

Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues:

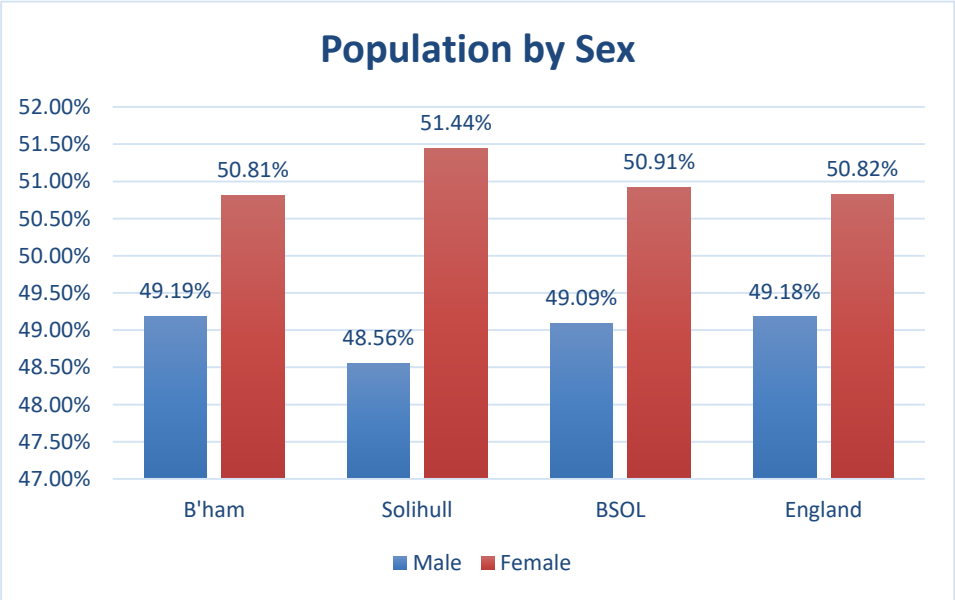
BSol local demographics

Christianity is the largest religion in Birmingham however at 46.1% this is lower than that of England as a whole which is 59.4%. Birmingham has more Muslims (21.8%), Sikhs (3%) and Hindus (2.1%) than England (5%, 0.8% and 1.5% respectively).
The majority of Solihull residents describe themselves as Christian (65.6%), with no religion the 2nd largest group (21.4%). There are significantly more Muslims (+3,610, 221%), Sikhs (+1,938, 124%) and Hindus (+1,834, 99%) than in 2001. The majority of Solihull Muslims and Hindus live in the Urban West of the Borough and therefore are local to the Solihull site. Sikh communities are more dispersed across the Borough.

No negative impact identified in implementation of this policy with regards to the protected characteristic of religion or belief.

Sex: Describe any impact and evidence on men and women. This could include access to services and employment:

BSol local demographics



3. Impact and Evidence:

Birmingham has a slightly higher number of women 545,239 (50.8%) than men 527,806 (49.2%) this reflects the picture for England as a whole. Life expectancy for men is 77.6 years compared to a national average of 79.4 years, for women it is 82.2 years compared to a national average of 83.1 years. Birmingham has a gap in life expectancy between the most deprived and least deprived areas of 7.4 years for men and 4.9 years for women.

In Solihull it is slightly different, where again women are in the majority but by a higher figure than for that of Birmingham and England (51.4%). Life expectancy in Solihull is higher than the national average; however, the gap ranges by up to nearly 10 years between the best and worst wards. Life expectancy is 80.3 years for men and 84.8 years for women.

Men tend to have a higher prevalence of long-term conditions than women, and there is evidence to suggest that men are less effective at managing their condition, especially those from lower socioeconomic groups. Helping people, especially men, to manage their care better, through giving them more control over some of the money that is spent on their care, could therefore help to redress this imbalance.

In contrast, the burden of caring for those with long-term conditions and related falls more upon women than men. Part of the aim of personal health budgets is to give people more control over the care they receive, hence tailoring it to their needs and preferences. This may mean that recipients of personal health budgets become less reliant on their informal carers, as the state is providing more of the services that they need. This could therefore help to reduce this impact that falls mainly upon women.

No negative impact identified in implementation of this policy with regards to the protected characteristic of sex.

Sexual orientation: Describe any impact and evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers:

According to ONS, in 2015, 1.7% of the UK population identified themselves as lesbian, gay or bisexual (LGB). More males (2.0%) than females (1.5%) identified themselves as LGB in 2015. Of the population aged 16 to 24, there were 3.3% identifying themselves as LGB, the largest percentage within any age group in 2015.

At present, there is limited evidence to indicate likely differences in benefits based upon an individual's sexual orientation. There is evidence available that people from different sexual orientation backgrounds access health and social care differently and experience different levels of satisfaction, and especially that people may not be willing to divulge their sexual orientation due to fear of discrimination. However, there is currently little reason to believe that the introduction of personal health budgets will exacerbate this. In fact, it is possible that personal health budgets will serve to improve satisfaction for these groups, as the indirect effects of personalisation increase NHS response to individual preferences.

No negative impact identified in implementation of this policy with regards to the protected characteristic of sexual orientation.

3. Impact and Evidence:

Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities:

The 2011 Census indicated that 107,380 people in Birmingham provide unpaid care (10% of usual resident population). Of those who provided unpaid care over 26% provided 50 or more hours a week. There are nearly 21,000 carers in Solihull equating to 10.5% of the total population, higher than the national average of 9.9%. This correlates with the larger 65+years population in Solihull
The burden of caring for those with long-term conditions often falls more upon women than men. Part of the aim of personal health budgets is to give people more control over the care they receive, hence tailoring it to their needs and preferences. This may mean that recipients of personal health budgets become less reliant on their informal carers, as the state is providing more of the services that they need. This could therefore help to reduce this impact that falls mainly upon women.

Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive)

No groups are excluded however a personal health budget cannot be used to pay for:

- alcohol, tobacco, gambling or debt repayment, or anything that is illegal.
- A personal health budget cannot be used to buy emergency care – for example if someone in receipt of a personal health budget had an accident, they would go to A&E like everyone else.
- A personal health budget also cannot buy primary care services such as seeing a GP or buying medication.

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	The purpose of the PHB is to promote individualised packages of care designed and developed between both patient and staff.
Is there any impact for groups or communities living in particular geographical areas?	n/a	
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	n/a	

How will you ensure the proposals reduce health inequalities?

Meeting needs

(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/697825/personal-health-budgets-and-integrated-personal-health-budgets-consultation.pdf)

Evidence from the evaluation of the personal health budget pilot programme, showed that personal health budgets can support a move from unplanned, emergency care to planned care, and that they are cost effective in comparison to conventional services. It also found that people with the highest levels of need experienced similar or improved outcomes when using a personal health budget. The use of personal health budgets was also associated with a significant improvement in the care-related quality of life and psychological wellbeing of individual's. Additional information can be found at; https://www.phbe.org.uk/index-phbe.php.

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	There are no exclusions based on protected characteristics. This policy governs the process of administering PHBs across BSol CCG. The eligibility criteria is nationally determined and relates to clinical health needs.
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	The CCG will work with the Local Authority, should any safeguarding concerns arise, in respect of an individual receiving a PHB. These will be investigated accordingly.
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	Equitable across all areas – Meeting needs in an individualised and personalised way.
	How will this affect a person's right to freedom of thought, conscience and religion?	Meets individual needs though shared decision making and care and support planning.
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	The Personal Health Budget is mutually discussed and agreed following the development of a care and support plan. Appeals process includes an opportunity to review results.
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	Meets individual needs though shared decision making and care and support planning. Personalised care and support planning is at the heart of making personal health budgets work well. A personalised care and support plan helps people to identify their health and wellbeing goals, together with their local NHS team, and sets out how the budget will be spent to enable them to reach their goals and keep healthy and safe
Right to **Life**	Will or could it affect someone's right to life? How?	Positive impact as a result of enabling greater personal control
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	N/A

6. Social Value

Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.

Marmot Policy Objective	What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?
Enable all people to have control over their lives and maximise their capabilities	Positive impact as a result of enabling greater personal control; at the centre of a PHB is the care and support plan. This plan helps people to identify their health and wellbeing goals, together with their Care Coordinator, set out how the budget will be spent to enable them to reach their goals and keep healthy and safe.
Create fair employment and good work for all	By virtue of their choice to employ personal assistants (PAs), many individuals become automatically bound by employment regulations. The Care Co-ordinator is responsible for helping to ensure that good practice is followed in PA employment, including a pension. The CCG funds this within the cost of employing the PA.
Create and develop health and sustainable places and communities	N/A
Strengthen the role and impact of ill-health prevention	The PHB process meets individual needs though shared decision making and individualised care and support planning. Evidence suggests that there is greater compliance with therapies and treatments where shared decision making is in place

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	Protected Characteristic/ Group/ Community	Date
NHSE Programme of pilots and test bed activities		2015-2019
Local Integrated Personal Commissioning activities		2016-2019

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

NHSE National user survey will inform the evolution of the national PHB offering, in addition BSol CCG will be undertaking an evaluation of PHB experiences across staff and patients. This will start in February 2019

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

Implementation of personal health budgets has the potential to meet patient's health and wellbeing needs in a way in which:

- Improves personalisation;
- Increases choice and control
- Empowers individuals

Some population groups are more likely to benefit (though this is based on their clinical need – no individuals are excluded based on their protected characteristic(s)) for example, people with a Learning Disability or Mental Health condition; Wheelchair users and people in receipt of end of life care.

The policy includes a requirement to undertake equality monitoring of the application process and a commitment to publish results within the CCG's Annual Equality and Diversity Report.

No negative impacts evidenced to date. The PHB process requires greater collaboration between staff and clients in the identification of individual needs and requirements.

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

Recommendations:

Equality Monitoring
That the equality monitoring of the PHB applications is extended to all applications and not limited to successful PHB applications.

Meeting Language and Communication Needs
Consideration is given to how the language and communication needs of patients (and their carers) will be met (particularly by the Care Coordinator) in developing and reviewing the care and support plan.

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

The contract is currently managed by MLCSU who are responsible for performance and quality manage the delivery of PHBs

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):

No procurement activity involved with this policy.

12. Publication

How will you share the findings of the Equality Analysis?

This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages. All Equality Analysis should be recommended for publication unless they are deemed to contain sensitive information.

Policy will go to the Policy Sub Group in Feb 2019 and from there it will be published on the CCG website.

Following approval all finalised Equality Analysis should be sent to the Communications and Engagement team for publication: bsol.comms@nhs.net

13. Sign Off

The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality Diversity and Inclusion or the Manager for Equality Diversity and Inclusion prior to approval from the delegated committee

	Name	Date
Quality Assured By:	M K Dunne	3/1/19
Which Committee will be considering the findings and signing off the EA?	Clinical Policy Sub Group	Feb 2019
Minute number (to be inserted following presentation to committee)		

Please send to Balvinder Everitt or Michelle Dunne, Equality, Diversity and Inclusion for Quality Assurance.

Once you have committee sign off, please send to Caroline Higgs, Communications & Engagement Team for publication: bsol.comms@nhs.net