

NHS Birmingham & Solihull Clinical Commissioning Group

Children and Young Peoples Policy for Continuing Care

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1. Introduction

The Department of Health published its National Framework Children and Young People's Continuing Care in 2016, setting out guidance for partners in Health, Education and Social Care.

2. Policy Statement & Scope

This document aims to clarify the respective roles and responsibilities of those services and to provide an objective, transparent process that will deliver timely and consistent decisions regarding the funding of care packages for children and young people who have specific health needs that meet the NHS Continuing Care criteria.

The Continuing Care for Children and Young people process covers children from birth up to the age of 18. Post 18 years of age, the NHS Continuing Healthcare framework applies and uses different criteria.

The Children and Young People's National Framework does not give guidance on the content or funding of the actual package of continuing care. Local children's and young people continuing care decision-making should be based on the assessed needs of the individual child or young person. The application of the National children's continuing care Framework will ensure that:

- a) children, young people and their families are actively engaged in the continuing care process;
- b) the continuing care process is co-ordinated and consistent between organisations; and
- c) health, education and social care practitioners, including those working in the independent and third sectors, and the public, understand the continuing care process.

3. Equality Statement

3.1 The general equality duty requires public authorities (such as the CCG) to have due regard to the aims of the general equality duty when making decisions and setting policies. To do this, it is necessary for the organisation to understand the potential impact of its decision making on different people. This can help to identify practical steps to tackle any negative impacts or discrimination, and to advance equality.

3.2 The CCG endeavours to challenge discrimination, promote equality and respect human rights and aims to design and implement policies, services and measures that meet the diverse needs of our population, patients and workforce, ensuring that non are placed at a disadvantage.

4. Equality Analysis

4.1 The CCG undertakes an Equality Analysis of policies, strategies, service design and other relevant activities to assess the impact of decision making against:

- The nine protected characteristics (age, disability, ethnic origin, sex, sexual orientation, gender reassignment, religion and belief, marriage or civil partnership, pregnancy or maternity status);
- Other groups or communities known to suffer disadvantage, such as the homeless, carers, migrants and sex workers;
- Human Rights
- Known health inequalities.

This analysis also explores the potential to support the Social Value Act.

4.2 An equality analysis of this policy was undertaken in November 2018 and is attached as **Appendix 1** to this policy.

5. Aims

The operational policy aims to:

- a. Set out a continuing care process for the Birmingham and Solihull health, social care and education economy that follows the principles and approach of the National Framework but also makes sense in the local context and;
- b. Ensure a joint, consistent and transparent approach to assessing care needs and commissioning and providing services in the light of those needs;
- c. Provide local practitioners with the knowledge and tools to follow the process;
- d. Set out transition arrangements from child to adult services in relation to continuing care arrangements;
- e. Clarify the remit, membership and working practices of the Children and Young People's Continuing Care Panel;
- f. Clarify funding responsibilities
- g. Set out an appeals process;
- h. Set out a robust process for resolving disputes between agencies.

The key trigger for entry to the children's continuing care pathway is the recognition that the child or young person in question has complex health needs above and beyond the level that universal and specialist health services are currently commissioned to meet. The level and nature of local health commissioning varies across the country and it is important therefore to recognise that there is no standard.

The processes described in this policy apply to children and young people eligible for children's continuing care and other funding streams. They should also be followed when considering whether to refer a young person for assessment for continuing healthcare (CHC). Unlike CHC, continuing care eligibility can be determined in the same meeting as the care package is determined, and by the same people.

The need for this guidance is also required to alleviate confusion about when to seek an assessment for adult continuing healthcare and how this is done. The guidance is also necessary to establish reasonable expectations on the part of patients, families and practitioners on the extent of provision likely to be available if they are eligible for an episode of adult continuing healthcare.

6. Responsibilities

5.1 Leadership and accountability.

Each CCG is the lead and Accountable Body, for ensuring that children in their local population are assessed for their continuing care needs and for providing a package of care that meets those needs

5.2 Governing Body

The CCG Governing Body takes the ultimate responsibility for this policy. They do this primarily through the Accountable Officer who must ensure that:

- they discharge their duties as required by CCG standing rules in relation to children and young peoples' continuing care
- the CCG complies with the requirements of this policy and the related primary and associated legislation. This includes their role as the assumed Body that takes responsibility for Continuing Care (CC)
- there is effective implementation of this policy by appropriate teams
- there is appropriate resources (staff and finance) in place to deliver the requirements of this policy
- there is open channels of communication between the commissioning teams for CC and Governing Body in relation to Continuing Care for Children and Young People as outlined in the National Framework.

5.3 The CCG Chief Nurse with responsibility for Children and Young Peoples' Continuing Care must ensure that:

- quality assurance in relation to Continuing Care is a regular Agenda item at the Quality and Safety Meeting
- the Children's Continuing Care Panel works to its Term of reference in relation to quality, and it feeds back any concerns with regard to continuing care to the appropriate Governance Group.

5.4 The CCG Chief Finance officer with responsibility for continuing care must ensure that:

- procedures for receiving financial assurance in relation to Continuing Care is in place and is a regular Agenda item at the Finance and Planning Meeting.

5.5 The CHC Team work on behalf of the CCGs and is based at Birmingham and Solihull CCG. They must ensure that:

- They have a named linked to continuing care

- There are links across the SEND/ Transforming Care and Future in Minds agendas
- They work in collaboration with the children's commissioners to identify where there are insufficient commissioned services for children and young people across Birmingham and Solihull to meet current demand thus ensuring the need for continuing care funding is only in exceptional cases

5.6 The Continuing Care Clinical Lead works on behalf of the CCGs and is based at BSol CCG. They must ensure that:

- They enact this policy and ensure that the procedures associated with it are followed.
- They authorise packages of care that are safe, meet the needs of the child or young person and are affordable whilst providing value for money
- They act as the conduit for the continuing care process and verification of the recommendation from the CYP Continuing care team
- That there is adequate resource to transact this policy
- Information regarding performance in relation to continuing care is related to the board

5.7 The MLCSU CHC and continuing care service must ensure that they:

- Practice to reflect the requirements of this policy
- Ensure there is a workforce with skillset to meet all cohorts of CYP that may require a continuing care assessment.
- Manage children's continuing care assessments across the BSol health economy
- Support the development of the children's continuing care assessments process including regular review and updating of standard operating procedures (sops)
- Contribute to developing, collating and presenting KPIs
- Undertake data analysis to monitor and drive service change and improvement
- Support the children's continuing care panel process and children's continuing care team in panel preparation, panel meetings, and the documentation of the decisions as required
- Draft reports for CCGs and senior management
- Undertake regular review, maintenance and update of children's continuing care referral list
- Quality assure children's continuing care documentation including support plans, risk assessments, agendas, minutes, letters
- Develop a strong network of professional relationships with both internal and external stakeholders
- Source and liaise with services, training organisations and voluntary organisations to enable the patients the control over how their care is delivered with quality and safety outcomes balanced with the patient's choices and need for flexibility.

- Participate in relevant internal and external working groups including the local authorities, the voluntary sector, provider organisations and user led organisations
- Plan and maintain business objectives and activity in relation to the roll out of children's continuing care assessments
- Robust systems (policies, procedures and financial management) are in place to monitor the activity and spend on children's continuing care.
- Act as a conduit for providers should there be a case discussed that requires continuing care.

5.8 Continuing Care Co-ordinator

The co-ordinator must ensure that they:

- Act as the lead for the assessment phase of the continuing care process.
- Transact and/or co-ordinate the assessments in relation to continuing care
- Undertake any training (formal or informal) as required in relation to children continuing care
- Ensure all assessments obtain evidence that a child has a continuing care need.
- Collate the relevant information including the assessments and DST
- Present recommendations of eligibility to commissioners.
- Present recommendations regarding packages of care to commissioners
- Undertake DSTs as part of the Multi-Disciplinary Team
- Act in accordance with this policy

The co-ordinator is responsible for arranging the MDT and ensuring that all parties, including social care and education are represented at the meeting.

They are independent to the child or young person's care and ensure that the MDT meets the requirements laid down in the continuing care framework. They will ensure that the evidence is available to support the chosen domains in the DST and the recommendation made by the MDT.

The co-ordinator acts as the single point of contact with whom professionals can liaise with if they wish to discuss a child or young person with possible continuing care needs.

5.9 Health assessor

The nominated children and young people's health assessor is likely going to be attached to the community, acute or mental health services provider.

They must be a health practitioner with relevant skills and competencies to undertake children's health needs assessments and they must know the child and their circumstances.

The health assessor will Undertake the health assessment relating to any child or young adult who may be eligible for continuing care or complex care. They must ensure that:

- The support evidence for the DST is available
- They contribute to the DSTs as part of the Multi-Disciplinary Team
- They act in accordance with this policy

5.10 The Multi Disciplinary Team

'Multidisciplinary team' (MDT) has many meanings but in the context of this policy the 'multidisciplinary team' is defined as:

- I. one professional who is from a healthcare profession and one person who is responsible for assessing individuals for community care services under section 47 of the National Health Service and Community Care Act 1990
or
- II. one professional who is from a healthcare profession and one person who is from education'
or
- III. one professional who is from a healthcare profession and one person who is responsible for assessing individuals for community care services under section 47 of the National Health Service and Community Care Act 1990 and one person who is from education'.
- IV. Or two professionals from differing disciplines within healthcare

The MDT must ensure that

- As a minimum requirement the MDT comprises of two professionals from different professions, (it is clear that the MDT should usually include all three health and social care professionals,
- They are knowledgeable about the individual's health, social care and educational needs.
- The DST is completed whilst ensuring all the appropriate evidence is cited
- The recommendation of eligibility is made to the CCG.
- At the same time as making a recommendation regarding eligibility that they should also offer a recommendation to the care package required.

7. Definitions

6.1 Mainstream or Universal Health and Care Services.

These are services that are provided by the NHS and have already been commissioned by CCGs or NHSE. They consist of, but not limited to, Primary Care (GP, Practice Nurses, Dental), Acute (Hospital services) and Community Services (community children's nurses, CAMHs, physiotherapy, occupational health, and SALT). All these services are free at the point of delivery. The key priorities in mainstream services are to change attitudes and improve skills in detection assessment and treatment of health needs.

6.2 Section 117 aftercare of the Mental Health Act

Section 117 of the Mental Health Act requires clinical commissioning groups and local authorities, in co-operation with voluntary agencies, to provide or arrange for the

provision of after-care to particular patients detained in hospital for treatment who then cease to be detained. This includes those detained under section 3, 37, 45A, 47 or 48 of the Act. It includes patients granted leave of absence under section 17 and patients going on community treatment orders (CTOs). It applies to people of all ages, including children and young people.

After-care services mean services which have the purposes of meeting a need arising from or related to the patient's mental disorder and reducing the risk of a deterioration of the child or young persons' mental condition (and, accordingly, reducing the risk of the patient requiring admission to hospital again for treatment for mental disorder. Their ultimate aim is to maintain patients in the community, with as few restrictions as are necessary, wherever possible.

6.3 Special Educational Needs and Disability (SEND)

Children and young people with special educational needs (SEN) all have learning difficulties or disabilities that make it harder for them to learn than most children and young people of the same age. These children and young people may need extra or different help to others.

The 0-25 SEND Code of Practice sets out 4 areas of SEN:

- Communicating and interaction
- Cognition and learning
- Social, emotional and mental health difficulties
- Sensory and/or physical needs

Some children and young people may have SEN that covers more than one of these areas.

6.4 Children and Young People Care, Education and Treatment Reviews

The aim of a Care, Education and Treatment review CETR is to facilitate a person-centred approach to ensure the treatment and support needs of the child or young person with learning disability and/or autism and their families are met and any barriers to progress are challenged and overcome. A CETR is intended to:

- support families and people with learning disabilities and/or autism in being listened to and being equal partners in their own care and treatment pathway
- prevent people with learning disabilities and/or autism being admitted unnecessarily into inpatient Learning Disability and Mental Health hospital beds
- ensure any admission is supported by a clear rationale of planned assessment and treatment with measurable outcomes
- ensure all parties work together with the person and their family to support discharge into the community (or to a less restrictive setting) at the earliest opportunity

- support a constructive and person-centred process of challenge to current care and treatment plans where necessary
- identify barriers to progress and to make clear and constructive recommendations for how these could be overcome.

6.5 Personal Health Budgets

As first outlined in the NHS Operating Framework 11/12 the Government is committed to delivering care, support and treatment to service users in a more personalised way. This is consistent with the wider Aiming High for Disabled Children and with the Every Disabled Child Matters charters which the Clinical Commissioning Groups and Local Authority have signed up to. Achievement of this has been proposed through developing Personal Health Budgets for individuals eligible for continuing care funding who, since October 2014, have a Right to Have (a Personal Health Budget) which will facilitate:

- Greater integration between health, education and social care at the level of the individual
- Greater level of patient choice and control than currently exists
- Greater independence
- Improved working relationships between Clinical Commissioning Groups, Social Care, Provider organisations and 3rd Sector organisations
- Increased personalisation
- Increased use of patients managing their conditions themselves with a corresponding decrease in unnecessary use of primary and secondary care services
- Decrease in unnecessary use of social care
- Improved transition and self-directed support at an earlier stage in line with adult services
- Embedded, localised, inclusive and person-centred approach to transition planning.

The CCG works towards delivery of a Personal Health Budget for every child or young person in receipt of continuing care, who wants one, in line with national implementation.

7. Policy/Procedure

7.1 Continuing Care and complex care

The Department of Health published the revised National Framework for Children and Young People's Continuing Care in January 2016¹ (hereafter referred to as 'the National Framework'), setting out guidance for CCGs and partners in Social Care and Education, in light of the Children and Families Act 2014 and national good practice in delivering Children's Continuing Care. This framework aims to clarify the respective roles and responsibilities of those services and to provide an objective, transparent

¹ <https://www.gov.uk/government/publications/children-and-young-peoples-continuing-care-national-framework>

process that will deliver timely and consistent decisions regarding the funding of care packages for children and young people who have specific health needs that meet Continuing Care criteria.

The Continuing Care process for children and young people applies from birth to the age of 17. Once an individual turns 18 years old the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (DH, 2018)² applies, which has different criteria.

The National Framework of Children's Continuing Care does not give guidance on the content or funding of packages of continuing care and local decision making should be based on the assessed needs of the individual child or young person. Applying the National Framework locally will ensure that:

- Children, young people and their families are actively engaged in the continuing care process;
- The continuing care process is coordinated and consistent between organisations
- Health, education and social care practitioners and the public understand the continuing care process.

Since April 2014 any individual eligible for NHS Continuing Healthcare or Continuing Care for children have the 'right to have' a personal health budget. This 'right to have' will be reflected in the CCG's Personal Health Budgets Policy (in development).

7.1.1 Identification

Children and young people needing a continuing care assessment will, in many cases, already be well known to local services. Most will be known to children's health services. Some children who have disabilities may have a social worker and regular multi-disciplinary meetings. Some will be identified due to increasing needs or changes in family circumstances and will require re-assessments.

A child or young person should be considered for continuing care assessment when it is recognised that they have health needs **that cannot be met by mainstream services alone**. This may be in conjunction with social care and/or education needs. The referral process should be led by the lead professional for the child or young person. If there is no lead professional, then the process may be led by any health, social care or education professional working with the child or young person.

7.1.2 Referral

Prior to a referral, professionals may contact the Continuing Care Nurses at MLCSU for advice on whether or not the child is likely to meet the threshold for funding from the NHS. If a child or young person is eligible for section 117 funding, this should be explored first before any referral for continuing care funding is made.

² <https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care>

The BSOL pathway for Children and Young People's Continuing Care in in **Appendix 2**.

To make a referral for continuing care funding, the referrer should submit a completed pre assessment checklist (with integral consent form) to the referrals email mlcsu.bsolreferrals@nhs.net

The continuing care team will log the referral, including the date of receipt, in order to support planning and scheduling of cases coming to panel and in monitoring timescales for completion of the process.

The case will then be allocated to a Continuing Care Co-ordinator. The co-ordinator will check the completeness of the information provided, including the range of universal and specialist health services currently being provided and seek further information from the referrer if necessary.

The co-ordinator will also meet the child and family/carer, introduce themselves and explain the process, although this may not always be possible if the child is Looked After. In these circumstances the co-ordinator will seek guidance from the child's social worker about the appropriateness of engaging the parents.

The co-ordinator will be responsible for identifying the information, communication support and language interpreting needs and will make necessary arrangements to ensure principles of the accessible information standard are implemented.

7.1.2.1 Referrals that do not meet the threshold for a full DST.

In the light of the information provided with the pre-assessment checklist the co-ordinator will assess the appropriateness of the referral with the aim of appropriately diverting those referrals, which will not meet the threshold for continuing care.

These referrals will be forwarded onto the appropriate pathway following discussion and agreement with the referrer.

These other pathways include:

- a) Self-referral to universal or targeted services
- b) Referral to the relevant health service for health need.
- c) Referral to social care
- d) Referral to voluntary sector organisations

The coordinator will write to the child, young person and their family to inform them that either:

- a) their referral for additional services will be considered by the BSol CCGs in partnership with the Local Authority under the National Framework for Continuing care, or
- b) their referral is not appropriate for continuing care explaining the reasons why.

The co-ordinator will inform the referrer of the outcome of the referral.

7.1.3 Continuing Care Assessment

For all appropriate continuing care referrals, continuing care co-ordinator will lead the process for completing the assessment section of the BSoI Continuing Care Decision Support Tool, Assessment and Recommendation Form – this contains the decision support tool and will require obtaining and collating health, social and education reports and assessments, as appropriate.

7.1.3.1 Health assessment –

This will be led by the continuing care coordinator. Where the child or young person is already known to another health professional, it may be appropriate for the continuing care coordinator will ask that person to support the completion of a health assessment. In addition to specific health factors, the health assessment also includes the preferences and view of the child or young person and their family and social factors.

In other cases the continuing care coordinator should complete the health assessment. This should be rare as the Framework requires that the assessment be undertaken by someone who knows the child/young person and their circumstance.

The continuing care co-ordinator should contact other health professionals involved with the child or young person such as paediatricians, therapists and specialist nurses to obtain any existing reports and assessments of relevance to the continuing care process.

7.1.3.2 Social care assessment –

If the child or young person already has a social worker, then the continuing care coordinator should request a social care assessment from that person. If there is no social worker and the social information obtained as part of the health assessment identifies that the child's needs require assessment by other agencies then a core assessment should be completed and sent to the relevant social worker by the health assessor or co-ordinator, for a social care assessment to be undertaken.

7.1.3.3 Education assessment, including the EHC plan (where available)

This should be requested if continuing care is being considered to support a child with complex health needs in school.

7.1.4 The Continuing Care Decision Support Tool, Assessment and Recommendation Form

The continuing care coordinator will then populate the assessment form summarising and bringing together health, social and education assessments.

The assessment section of the Proforma covers the four areas in line with the National Framework. However, the aim is not to unnecessarily duplicate information and to streamline the process as far as possible.

Area 1 – preferences and view of child or young person and their family – this can be a summary of information provided in the health or social care assessments, cross referenced to the relevant assessments.

Area 2 – holistic assessment – a summary of the overall family situation and needs, referencing the assessments and reports that give the details

Area 3 – needs and risks. Again a summary with cross-referencing to the relevant reports and assessments for the specific evidence

Area 4 - is the Decision Support Tool for completion and scoring.

Every effort must be made to streamline the information gathering and assessment process, with referrers gathering as much relevant information as possible to assist in the initial screening and decision-making.

Where a child is going through transition from Children to Adult Services, the Continuing Care Decision Support Tool, Assessment and Recommendation Form will be used to inform the assessment process and will be shared with relevant agencies.

7.1.5 The Decision Support Tool

The Continuing Care Decision Support tool must be completed as part of the assessment. This takes care to ensure that a specific need is not duplicated in two separate domains. The level of need in a single domain may not on its own indicate that a child/young person has a continuing care need but will contribute to a picture of overall care needs across all domains. Assessors should consider the level of need identified in all care domains in order to gain the overall picture.

A child or young person is likely to have continuing care needs if assessed as having a severe or priority level of need in at least one domain of care, or a high level of need in three domains of care.

The level of need in a single domain may not on its own indicate that a child or young person has a continuing care need, but will contribute to a picture of overall care needs across all domains. Levels of need are relative to each other as well as to those in other care domains. It is not possible to equate a number of incidences of one level with a number of incidences of another level, eg needs assessed as 'moderate' in two domains are the equivalent of one 'high' level of need. In presenting recommendations to a multi-agency forum, nominated children and young people's health assessors should consider the level of need identified in **all** care domains in order to gain the overall picture.

7.1.6 The Multi Disciplinary Team (MDT)

In order to complete the assessment process, a MDT will be convened by the continuing care co-ordinator to include the health assessor and social care and special education representation if involved. Where other professionals such as therapists are

closely involved with the child or young person it may be appropriate to invite them to the meeting as well. The meeting will be chaired by the continuing care co-ordinator.

The meeting must discuss the assessments and complete the DST and confirm whether the child or young person has continuing care needs. A child is likely to have continuing care needs if assessed as having a severe or priority level of need in at least one domain of care, or a high level of need in three domains of care.

The assessment of the level of need must recognise that where a child or young person requires constant supervision or care which is largely provided by family members, there will be a need for professional support to allow the family time off from their caring responsibilities, and this may require a social care assessment, and agreement, between the CCG and the local authority or Children's Trust, of the respective contribution.

7.1.7 The Recommendation

The recommendation must be needs-based and about eligibility for continuing care funding.

Care options should be considered once a decision regarding eligibility has been made. The MDT can only recommend what the care package needs to contain to meet the needs of the child or young person and not specifically the provider of said care.

For children and young people assessed as having continuing care needs then the MDT should agree options for meeting these care needs, taking full account of the family's views and preferences, the assessment information and the range of services that are currently in place and available to the child or young person in Birmingham and Solihull

The package could include, the community nursing team, CAMHs, direct payments, services specially commissioned for the child or young person from the statutory or independent sectors, hospice services, respite for the parents and carers or specialist equipment.

Recommendations for community support packages should take account of local criteria for access to services and thresholds for the level of service provision for example the number of nights per month for residential overnight breaks.

All cases will then go forward to the Panel for an agreement decision regarding whether Continuing Care thresholds are met and any package of care being proposed

For cases not passing the continuing care threshold, or being found entitled to extra contribution from the NHS to their care the meeting should still make recommendations and then refer on (if appropriate) to ensure a smooth transition through the pathways. Depending on the needs and the recommendations made, onward referral would be to:

- (i) Universal or targeted services accessed via self-referral or GP referral
- (ii) Partnership services including short breaks
- (iii) Children with Disabilities team
- (iv) Relevant mainstream health service.

The recommendation section of the Continuing Care Decision Support Tool, Assessment and Recommendation Form should be completed by the Continuing Care Co-ordinator. The Coordinator will share the recommendations with the child and family prior to the Panel and note their views.

7.2 Decision-Making

The Children and Young People's Continuing Care panel (CYP CC panel) is the multi-agency decision making forum for determining the eligibility of qualifying children and young people for continuing care funding and making decisions regarding community support packages for continuing care.

The Children's Continuing Care co-ordinator will attend the panel to present the case and the MDT recommendation. The Panel should have copies of the completed sections Continuing Care Decision Support Tool, Assessment and Recommendation Form, with all the reports and assessments used. The co-ordinator should present the proposed community support package of care and if the family has a preference for a PHB

At the Panel meeting a completed record of decisions regarding eligibility for a continuing care package and the community support package agreed.

7.2.1 Process if a child is not eligible for CC funding.

If the continuing care threshold is not passed, then it is expected that the child or young person's needs would be primarily met by existing universal or specialist services. Where cases are below but close to the continuing care threshold these may, because of special circumstances, be considered by the panel to have health care needs that cannot be met through commissioned services by the panel.

Following presentation of the case at the panel by the continuing care co-ordinator the panel can recommend complex care funding, where it feels the needs of the child or young person will not or cannot be met through a locally commissioned provision.

7.2.2 Informing.

Following the decision, the Continuing Care co-ordinator should write to the child or young person and their family. The letter should be sent within 5 days of the decision being made and:

- a) Explain what has been agreed, and, as relevant, the name of the case manager overseeing implementation of the community support package, the next steps and likely time-frames for implementation;

- b) Explain the review process, noting that community support packages are not permanent and may change as needs change;
- c) Provide information should the recipient wish to complain about any aspect of the process or to appeal against the decision made.
- d) Closedown timeframes for complaints

7.3 Fast Track Pathway for End of Life (EoL) and Crisis care

Children or young people who meet the criteria for children's palliative care nursing services and whose needs can be met through that service should receive that service first. They do not need to go through the continuing care process.

If the child or young person has needs that cannot be met by the available service, then a fast-track continuing care process should be followed.

Children and young people with a rapidly deteriorating condition which may be entering a terminal phase will require fast tracking for immediate provision of continuing care. Where possible, the Lead Professional will complete a full assessment and present the report with recommendations and costed out options to the continuing care co-ordinator.

A referral should be made using the appropriate CYP fast track form, including a health needs plan and a copy of the advanced care plan. The co-ordinator will assess the information and present the case verbally to the Person with Delegated Responsibility for the CCG responsible for the child or young person, including the recommendations for a community support package. It should take no longer than 2 working days for a Fast Track application for EoL to be agreed.

For all other children and young people who enter a crisis phase, and especially those where the care package has broken down and an immediate decision is required. The CCC will discuss the case with the Senior Commissioner in the CCG who will then agree a care package with other agency commissioners where required. It is recognised that this is outside of the usual process and therefore the relevant documentation including DST and recommendations should be collected after the decision to fund has been made and the case should be presented at the next available panel. The panel should make a further decision now they have all the available evidence whether to authorise the continued support to the care package or decide that the child or young person is not eligible for a health contribution to their care.

7.4 Care Packages

The CSU brokerage team will take the lead in arranging or commissioning the agreed community support package. Ideally this would be done in conjunction with local authority teams.

The community/primary care health provider (this will either be from the Children's community nursing service, CAMHS, LD CAMHS or the GP) will be responsible for

overseeing delivery of the community support package and will provide on-going case management.

7.5 Timescales

The pathway should aim for a decision to be given to the child or young person and their family within 6 weeks (30 working days). However, given the complexity and variety of needs which a CCG may be assessing, there should be scope for flexibility – where it is not contrary to the best interests of the child or young person. For example, if an assessment is being made pending a child's discharge from hospital which is not planned for several months, other assessments may be reasonably given priority. In cases of very complex needs, there may be a number of professionals involved.

For the Children's Continuing Care Panel, the Continuing Care co-ordinator should forward the completed documentation to the administrator as outlined in the terms of reference. The panel will meet every month and letters confirming decisions will be sent out within 5 working days of the panel.

7.6 Review(s)

The Continuing Care co-ordinator will be responsible for leading reviews.

The first review should be three months after the continuing care package of care is in place and thereafter annually unless circumstances indicate the need for an earlier review or the family request a review.

The purpose of the review is to ensure that the community support or placement package continues to be appropriate to the care needs and to deliver the desired outcomes. The review should include the provider to ensure that the services being delivered meet specifications, including quality standards and amount of provision.

Eligibility for continuing care funding should be considered at least annually for all cases and the DST should be updated to inform this decision.

Reviews must be objective, fair and transparent and fully involve the child or young person and their family. However, they should not be unnecessarily burdensome and it will be for the Continuing Care Co-ordinator, in discussion with the health assessor and case manager, to determine the extent to which any new assessments or re-scoring of the DST is necessary.

If the Continuing Care Co-ordinator determines that there have been no substantive changes to the care needs, the community support package continues to be appropriate for the needs and the child or young person and their family are satisfied with the provision, then the Continuing Care Co-ordinator should complete BSol Continuing Care Review Form and present this to panel.

If only minor changes to the package are indicated, then a full re-assessment need not be undertaken although the case will need to be presented to the Children's

Continuing Care Panel by the assessor to agree the changes. However, the Panel may request a full re-assessment before making a decision.

If the care needs have changed and/or the community support package is no longer fully appropriate or is not meeting the expressed needs of the family, then a full review is required. BSol Continuing Care Decision Support Tool, Assessment and Recommendation Form should be completed and the case presented to the appropriate Panel.

Reviews should be responsive to changes in a child or young person's fundamental need, as there will be cases where successful management of a condition has permanently reduced or removed an ongoing need. The responsibility to commission care is not indefinite as needs may change and this should be made clear to the child or young person and their family. Equally, commissioners must guard against making changes to a package of care, where the child or young person's underlying needs have not changed. Transparency of process and involvement of the child/young person and their family will be essential to maintain the fairness and consistency of the review.

In instances where transition back into universal or specialist health services is appropriate, the child or young person and their family should be supported through the transition.

7.6.1 Fast track reviews

If the child or young person is still alive the CCC will review the package of care at 4 weeks for appropriateness.

If the child or young person is still alive after 12 weeks the CCC will arrange for a full eligibility assessment for CC funding assessment to be undertaken using the BSol Continuing Care Decision Support Tool, Assessment and Recommendation Form.

7.7 Appeals

If the child or young person or their family or carer wish to pursue concerns about the continuing care process or about the decision itself, then the matter should be dealt with through BSOL CCG NHS complaints procedure.

7.8 Disputes

At times when disputes may arise between the statutory bodies where funding for a package cannot be agreed, the case will be referred to a joint senior team of Health, Local Authority and GPs. Cases will be presented for resolution.

The Continuing Care Panel has responsibility for agreeing whether or not a child or young person has continuing care needs and the funding arrangements for packages of continuing care in the community. It is expected that in all but the most exceptional circumstances the Panel will be able to resolve any disputes regarding the scoring of the DST or funding arrangements.

In exceptional circumstances when agreement cannot be reached, the case should be referred to Managing Director of the CCG and respective Local Authority Director, who will act as a disputes panel.

Within 10 working days, they will consider the case and reach a decision in relation to the dispute.

Should it be considered necessary, the Disputes panel may refer cases to an independent assessor (who would normally be a Children's continuing care lead from another area, with experience in providing independent assessments). Their recommendations will be considered by the disputes panel before a final decision is made

8 Transition

The processes for referral and assessment are determined nationally and should be followed in every circumstance. Where local policies are referred to, these contain details of any exceptional circumstances that may apply.

8.1.1 Key ages

- **By age 14:** Young people likely to be eligible for adult CHC should be identified by children's continuing care teams (and others) and adult CHC team notified about them
- **By age 16:** Formal referral to adult CHC for screening for possible eligibility via adult Checklist
- **By age 17:** Eligibility for adult CHC should be determined in principle by relevant CCG (using adult process of MDT assessment and completion of adult Decision Support Tool)
- **18th birthday** Eligibility for adult CHC comes into effect

8.1.2 Relationship between Children's and Adults Continuing Healthcare

The legislation and the respective responsibilities of the NHS, social care and other services are different in children's and adult services.

The terms 'continuing care' (in relation to children's services) and 'NHS continuing healthcare' (in relation to adults) also have different meanings. It is important that young people and their families are helped to understand this difference and its implications from the start of transition planning. Section 1.1 of the National Framework for Children and Young People's Continuing Care explains the differences between the continuing care for children and NHS continuing healthcare for adults.

Eligibility for children's continuing healthcare should not be taken as indicating any likelihood of eligibility for adult continuing healthcare.

An episode of adult continuing healthcare cannot commence until a patient's 18th birthday.

9 Monitoring/Compliance

9.1 Monitoring will be through the MLCSU contract, with monthly reports including KPIs and reporting requirements being monitored through the monthly MLCSU CHC and Continuing Care contract and quality review meeting (CQRM).

10 Related Policies

10.1 The following CCG policies are relevant: -

- Personal health budget Policy (in development)
- Continuing healthcare Policy (in development)

10.2 All CCG policies are published online and can be found at: -

<https://www.birminghamandsolihullccg.nhs.uk/about-us/publications/policies>

11. Relevant Legislation/Guidance

Health and Social Care Act 2014

National Health Service Act 2006

Children and Young People's Act 2008

<http://www.legislation.gov.uk/ukpga/2008/23/contents>

Equality Act 2010

Who Pays? Establishing the responsible commissioner guidance -

<https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf>

Securing better health for children and young people through world class commissioning Working Together to Safeguard Children 2010

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/276500/promoting_health_of_looked_after_children.pdf

Safeguarding Disabled Children: Practice Guidance

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190544/00374-2009DOM-EN.pdf

SEND Code of Practice 0- 25 years

<https://www.gov.uk/government/publications/send-code-of-practice-0-to-25>

Children and Families Act 2014

http://www.legislation.gov.uk/ukpga/2014/6/pdfs/ukpga_20140006_en.pdf

National Framework for Continuing care for Children and Young People 2016

<https://www.gov.uk/government/publications/children-and-young-peoples-continuing-care-national-framework>

From the Pond to the Sea CQC 2014

https://www.cqc.org.uk/sites/default/files/CQC_Transition%20Report.pdf

RCN (2013) - Response of the Royal College of Nursing to the Francis Report (PDF 640.7 KB)

Lost in transition: Moving young people between child and adult health services.

RCN 2013

https://www2.rcn.org.uk/_data/assets/pdf_file/0010/157879/003227_WEB.pdf

Transition from children's to adults' services for young people using health or social care services NICE 2016 <https://www.nice.org.uk/guidance/ng43>

12 Appendices

12.1 Equality analysis

Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Children and Young People's Continuing Care

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	Children and Young People's Continuing Care		
EA Author	Maria Kidd	Team	Nursing - CHC
Date Started	5 th November 2018	Date Completed	17 th November 2018
EA Version	V0.2	Reviewed by E&D	17 th November 2018
What are the intended outcomes of this work? Include outline of objectives and function aims			
<p>The National Framework for Children and Young People's Continuing Care (DH 2016) provides guidance for clinical commissioning groups (CCGs) when assessing the needs of children and young people whose complex needs cannot be met by universal or specialist health services. Use of the framework establishes where a package of additional health support may be needed to meet these needs, which may arise from a disability, accident or illness.</p> <p>Continuing Care (CC) eligible service users are likely to have a range of individual care and support needs relating to:</p> <ul style="list-style-type: none"> • diagnosed or an undiagnosed congenital condition • a physical disability and/or restricted mobility • life limiting conditions • end of life • profound and multiple learning disabilities • autistic spectrum disorder • complex and enduring mental health needs • progressive neurological condition, such as motor neurone disease • attention and conduct disorders • the presentation of behaviours that can challenge services • rare / genetic conditions <p>The policy aims to provide guidance and processes for the implementation of the National Framework for Children and Young People's Continuing Care. It clarifies the respective roles and responsibilities of those services and to provide an objective, transparent process that will deliver timely and consistent decisions regarding the funding of care packages for children and young people who have specific health needs that meet the NHS Continuing Care criteria.</p> <p>The service specification sets out the requirements for the provision of packages of care funded by Continuing Care. The service specification will form part of the contract that the CSU (on behalf of the CCG) will hold with the care provider. This will be delivered by providers that are registered with CQC to deliver home care.</p>			
Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.			

Patients - Children & Young People's aged 0-18 who are eligible for Continuing Care. (Post 18 years of age, the NHS Continuing Healthcare framework applies and uses different criteria)

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
National Framework for Children & Young People's Continuing Care	CYP continuing care operational group.	Rachel Yeates – Community Matron – Paediatrics – UHB Michele Brooks - Regional Strategic Lead for Children and Young People's Continuing Care Debbie Baxter- Senior CHC Clinical Lead Joyce Bowler – Interim CHC & continuing care project lead Maria Kidd – Clinical lead CYPO continuing care
	CHC Provider contracts meeting	Jazzi Chopra-Povall - Senior Clinical Quality Assurance Lead - CHC & Domiciliary

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:

The National Framework for Children & Young People's Continuing Care is for Children and Young People aged 0-18.

3. Impact and Evidence:

A continuing care package will be required when a child or young person has needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone.

Some children and young people (up to their 18th birthday), may have very complex health needs. These may be the result of congenital conditions, long-term or life-limiting or life-threatening conditions, disability, or the after-effects of serious illness or injury.

These needs may be so complex, that they cannot be met by the services which are routinely available from GP practices, hospitals or in the community commissioned by clinical commissioning groups (CCGs) or NHS England. A package of additional health support may be needed. This additional package of care has come to be known as continuing care.

Continuing care is not needed by children or young people whose needs can be met appropriately through existing universal or specialist services through a case management approach.

These are the population projections for 0-18 years old for Birmingham and Solihull CCG.

Age Group	Base Year	Projection Year		Population Change			
				2014-2020		2014-2030	
	2014	2020	2030	number	percent	number	percent
0 to 18	250,347	261,749	277,453	11,401	4.55%	27,105	10.83%

There are currently 118 Children and Young People in receipt of Continuing Care across BSOL CCG.

Separate arrangements exist for adults in the National Framework for Continuing Healthcare.

The policy is inclusive in its principles with no individual being treated differently on the basis of condition, diagnosis, age etc. The assessment process is designed to establish an individual's overall level of need and whether or not the child or young person in question has complex health needs above and beyond the level that universal and specialist health services are currently commissioned to meet.

Within the policy provision and guidance is included on Transition (from children and young adults to adults Continuing Healthcare) and also a Fast Track Pathway for End of life and Crisis care.

3. Impact and Evidence:

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:

The policy/service specification relates to Children and Young People who have serious healthcare needs, the vast majority of whom will be disabled within the definition of the Equality Act 2010. In the Equality Act a disability means a physical or a mental condition which has a substantial and long-term impact on your ability to do normal day to day activities. Within the service specification eligible service users are likely to have a range of individual care and support needs relating to:

- diagnosed or an undiagnosed congenital condition
- a physical disability and/or restricted mobility
- life limiting conditions
- end of life
- profound and multiple learning disabilities
- autistic spectrum disorder
- complex and enduring mental health needs
- progressive neurological condition, such as motor neurone disease
- attention and conduct disorders
- the presentation of behaviours that can challenge services
- rare/genetic conditions

Note the list is indicative and is not exhaustive.

Unlike the framework for adults, the Children and Young People's Continuing Care Framework requires a joint, consistent approach in particular, where a child or young person has a special educational need or disability (SEND), which will often be the case, then CCGs and local authorities should endeavour to coordinate the assessment and agreement of the package of continuing care, as part of the process to develop the child's Education, Health and Care plan.

The policy is inclusive in its principles with no individual being treated differently on the basis of condition, diagnosis, disability etc. the assessment process is designed to establish an individual's overall level of need and whether or not the child or young person in question has complex health needs above and beyond the level that universal and specialist health services are currently commissioned to meet.

There is no perceived difference in the benefits they will received from this policy based on their disability.

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

3. Impact and Evidence:

No impact identified.

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 impact identified.

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

No impact identified.

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

No adverse impact. There are some health conditions leading to disability which are more prevalent in certain racial groups. These CYP are able to access continuing care providing they meet the criteria.

The policy is inclusive in its principles with no individual being treated differently on the basis of condition, diagnosis, race etc. the assessment process is designed to establish an individual's overall level of need and whether or not the child or young person in question has complex health needs above and beyond the level that universal and specialist health services are currently commissioned to meet.

There is no perceived difference in the benefits they will received from this policy based on their 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:

The service specification section 3.1 page 5 highlights cultural considerations as a care principle when caring for families and their children.

Staff are expected to have training in diversity, death and dying dignity and privacy (section 4.7 page 17).

The policy is inclusive in its principles with no individual being treated differently on the basis of condition, diagnosis, religion etc. the assessment process is designed to establish an individual's overall level of need and whether or not the child or young person in question has complex health needs above and beyond the level that universal and specialist health services are currently commissioned to meet.

3. Impact and Evidence:

There is no perceived difference in the benefits they will received from this policy based on their religion.

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

Within the current caseload there are 52 males and 66 females.

The policy is inclusive in its principles with no individual being treated differently on the basis of condition, diagnosis, sex etc. the assessment process is designed to establish an individual's overall level of need and whether or not the child or young person in question has complex health needs above and beyond the level that universal and specialist health services are currently commissioned to meet.

There is no perceived difference in the benefits they will received from this policy based on their gender.

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:

The outcomes describe CYP expressing individuality. The policy is inclusive in its principles with no individual being treated differently on the basis of condition, diagnosis, sexual orientation etc. the assessment process is designed to establish an individual's overall level of need and whether or not the child or young person in question has complex health needs above and beyond the level that universal and specialist health services are currently commissioned to meet.

There is no perceived difference in the benefits they will received from this policy based on their sexual orientation.

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

Effective implementation for the policy and service specification should benefit families and carers, enabling them to have the optimal support in caring for their child

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)

Looked after children would be considered and have their needs met in line with other children and young people.

3. Impact and Evidence:

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	
Is there any impact for groups or communities living in particular geographical areas?	No	
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	No	
<p>How will you ensure the proposals reduce health inequalities? There will be training for health, social care and education providers to raise awareness of the National Framework and the associated policy, which should ensure that all CYP who may be eligible for continuing care are identified.</p>		

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?	The implementation of the policy should ensure that the CYP entitled to this services should receive it.
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 service specification is explicit in requiring the service to provide equality of opportunity and protection, dignity and respect.
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?	The service specification is explicit in requiring the service to provide equality of opportunity and protection, dignity and respect. Additionally the service should provide a personalised and responsive service.
	How will this affect a person’s right to freedom of thought, conscience and religion?	The service specification requires the provider to meet the religious, cultural and spiritual needs and wishes of service users.
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 service specification is explicit in requiring the service to provide equality of opportunity and protection, dignity and respect.

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?	The policy statement includes a requirement that children, young people and their families are actively engaged in the continuing care process. The service specification requires the service provider to provide care and support that enables autonomy and independence.
Right to Life	Will or could it affect someone's right to life? How?	Specific measures are included within the policy for children or young people who meet the criteria for children's palliative care nursing services and whose needs cannot be met by available services for a fast-track continuing care process to be followed.
Right to Liberty	Will or could someone be deprived of their liberty? How?	Deprivation of Liberty (DOLs) will be considered for those YP over 16 years

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	One of the locally defined outcomes is to promote independence, identity and sense of value for CYP.
Create fair employment and good work for all	No
Create and develop health and sustainable places and communities	No
Strengthen the role and impact of ill-health prevention	The implementation of this policy and service specification should optimise the health of the eligible CYP

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
Consultation with clinical experts (for the policy)	Via the CYP CC operational group	25.10.18

Consultation with clinical experts (for the service specification)	Meeting with CCG CHC team and the provider contracts meeting	13.9.18 and 8.12.18
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):		
<p>Modifications made to the service specification and policy following feedback from clinical experts. The policy was modified to make the processes clearer eg the (Fast Track process).</p> <p>The service specification was amended in defined outcomes to ensure that this reflected the clinical needs related to Children and Young People, rather than adults. In addition, the staff requirements section was amended to ensure all quality requirements were addressed.</p>		

8. Summary of Analysis

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

Implementation of the National Framework for Children and Young People's Continuing Care which is not condition specific or dependent on diagnosis, will mean that individuals will be assessed across a range of care domains set out in the Decision Support Tool for NHS Continuing Healthcare. If found eligible, the care package commissioned for that individual will be bespoke to that individual's needs.

Use of the Decision Support Tool should result in an overall picture of the individuals needs that captures their nature, and their complexity, intensity and/or unpredictability and thus the quality and/or quantity (including continuity) of care required to meet the individual's needs.

Having considered the purpose of the policy and service specification in the context of the EA the main protected characteristic the implementation of the policy and service specification will have an impact on is CYP with a disability. This should be a positive benefit as it should enable those children who are eligible for continuing care to be identified more readily and to access the service they are entitled to through a fair and equitable process.

The policy and service specification are inclusive in its principles with no individual being treated differently on the basis of condition, diagnosis, protected characteristic. The assessment process is designed to establish an individual's overall level of need and whether or not a 'primary health need' exists.

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.

Changes

The references to equality legislation both within the Policy and Service Specification are amended to reflect current legislation.

Recommendation

Service Specification – strengthen the Communication area of the ‘needs and outcomes’ table to be more explicit on the need for acting upon the Accessible Information Standard.

Recommendation

There should be no discrimination on the grounds of protected characteristics. BSol CCG is responsible for ensuring that discrimination does not occur and should use effective auditing to monitor this matter. It is recommended that this is achieved through the use of equality monitoring data to identify and address variations. Use of an equality monitoring for will assist the CCG to identify whether individuals from different groups are accessing the service on an equitable basis.

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):

Reporting requirements:

- Accessible Information Standard – provider will need to demonstrate an understanding of the standard and be able to provide examples of reasonable adjustments made to meet the information and communication needs of service users and their carers. This will be included in the contract and reported annually.
- Translation/Interpreting Service provision – provider will need to demonstrate how they will meet the language needs of service users and their carers.
- Service User and Carer feedback – monitoring of feedback on experience of the service.
- Staff equality/cultural competency training.
- Equality monitoring results and analysis.

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):

There is procurement of the CHC and CYP CC End-to End procurement for which a separate EA has been completed.

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.

Once the EA has been ratified by the Clinical Policy Group (4th January 2019) it will then be posted on the CCG website

Following ratification 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 and Diversity, Senior Manager for Assurance and Compliance or Equality and Human Rights Manager **and** signed-off by a delegated committee

	Name	Date
Quality Assured By:	<i>M K Dunne</i>	17 th November 2018
Which Committee will be considering the findings and signing off the EA?	Clinical Policy Group	4 th January 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

12.2 Pathway for Children and Young People's continuing care

Pathway for Children and Young People's Continuing Care
It is essential that any consideration for the Continuing Care service to become involved is performed via a Multi-Disciplinary Team meeting in the first instance

