Quality and Equality Impact Assessment (QEIA)

Leeds Health and Care Partnership, QEIA template version 2.5, September 2024

To be completed with support from Quality, Equality and Engagement leads. Email for all correspondence: wyicb-leeds.qualityteam@nhs.net

Complete all sections (see instructions / comments and consider Impact Matrix in appendix).

Assessment Completion	Name	Role	Date	Email
Scheme Lead	[Removed for publication]	Senior Programme Leader	29/05/2024	[Removed for publication]
Programme Lead sign off	[Removed for publication]	Associate Director		[Removed for publication]

A. Scheme Name	Linking Leeds contract renewal
Type of change	Adjust existing (15% contract reduction)
ICB	Leeds

B: Summary of change

Briefly describe the proposed change to the service, why it is being proposed, the expected outcomes and intended benefits, including to patients, the public and ICB finances. Describe in terms of aims; objectives, links to the ICB's strategic plans and other projects, partnership arrangements, and policies (national and regional). Please also include the expected implementation date (or any key dates we need to be aware of).

Context setting

The key context for interpreting the 15% contract reduction and this QEIA is that due to the introduction of the Primary Care Network (PCN) employed link workers, the size of the social prescribing workforce in Leeds has doubled since 2019.

Despite this doubling in size and owing to local agency in PCN employing link workers, the distribution and models of delivery of social prescribers across Leeds are variable. This raises a question mark over equity of offer, and whether the Leeds social prescribing offer is proportionate to need. The wider subject of equity of access is beyond the scope of this current QEIA, however, the panel should be aware that a significant amount of activity is taking place system-wide with PCN clinical directors, PCNs themselves, and the social prescribing steering group to define how we will progress towards a more equitable offer to social prescribing in Leeds. This activity will inform a newly designed service specification for Linking Leeds ready for April 2025.

In summary, the QEIA presented here is based on the current Linking Leeds contract, their current organisational structure, and the immediate impact of a 15% contract reduction between September 2024, and the end of March 2025. The transformation work is currently taking place to ready the service specification for April 2025 is likely to form aspects of the mitigating action within this QEIA.

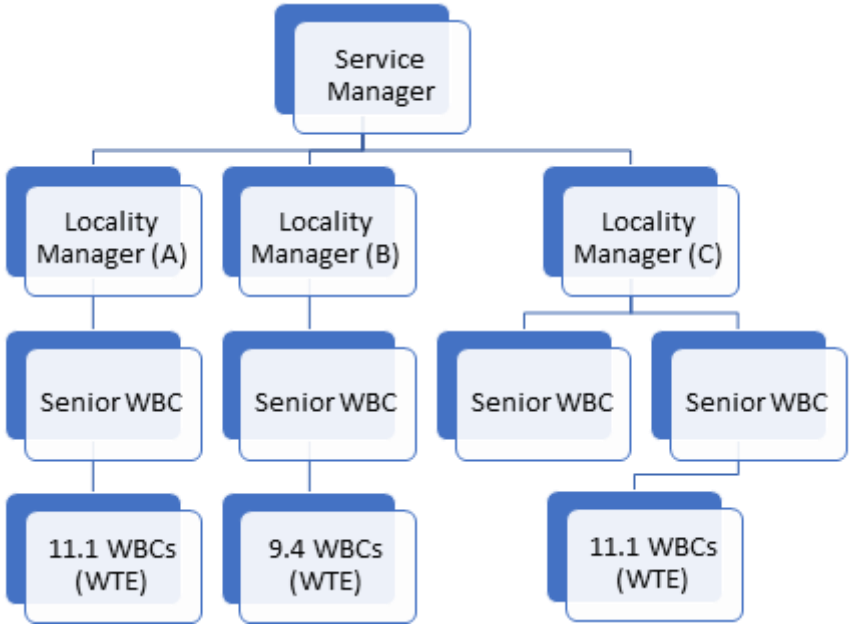
Background

The Linking Leeds service has been subject to review due to the significant financial challenge that the NHS Integrated Care Board (ICB) in Leeds and the wider health and care partnership continues to work through. The review was initiated as the service is in its final review of contract delivery before renewal and the social prescribing landscape has changed significantly with the aforementioned introduction of the Primary Care link workers roles funded via the NHS England (NHSE) GP contract. With this in mind, the opportunity has been taken to review the contract and realise financial savings.

Linking Leeds is the ICB-funded social prescribing service in Leeds which began in 2019 for five years (three years plus one, plus one). Linking Leeds is a collaborative of seven third sector providers with a contract value of £1.68m:

- Community Links
- Barca
- Better Leeds Communities
- Feel Good Factor
- Leeds Mind
- Age UK
- Leeds Irish Health and Homes

The service is structured across three localities and has a presence and connection with all PCNs across Leeds. The service offers a tiered service to its users; signposting, holistic support (8 x 1.25 hours appointments) and extended holistic support (12 x 1.25 hours appointments). The service structure can be seen in the image below.



Activity Levels

Table 1 details the mean yearly referral data for Linking Leeds (LL). Standard deviation is presented to highlight variance across time. As per the section above, the service offers a three-tiered service. Our current data indicates that 23% of users require signposting, 39% holistic support, and 38% extended holistic support. The yearly activity data has been broken down into these percentages and presented in the right-hand column. Please note, 26% of referrals are not 'onboarded' either due to inappropriate referral, the client expresses a wish not to pursue, or the client not responding to the Linking Leeds outreach.

Referral Data			**Tier of service delivered**		
	Mean	**Standard Deviation**	**Signpost**	**Holistic**	**Extended Holistic**
Q1	1574	129	267	453	444
Q2	1459	36	248	420	411
Q3	1375	88	234	396	386
Q4	1362	291	232	393	383
Year	5769	128	982	1632	1621

Table 1 (above): Yearly activity data for Linking Leeds expressed as mean and SD. Standard deviation is a method to show the variation around the mean value. Tier of service delivered accounts for 26% of referrals not 'onboarded'. Data is lifted from 2021 - 2023.

Tier one service consists of a one-hour signposting conversation. Tier two holistic service consists of weekly one-to-one appointments for up to eight weeks, each appointment lasting 75 minutes. Tier three extended holistic service consists of weekly one-to-one appointments for up to 12 weeks each lasting 75 minutes.

Accounting for the numbers in referral per year, the percentage of referrals not onboarded, and the three-tiered service with varying durations, the average Wellbeing Coordinator (WBC) hours spent per client = 10.

Geographical coverage

Figure 2 (below) highlights the coverage of Linking Leeds as per their 3-locality model with each PCN denoted within these localities. The current model covers the full city.

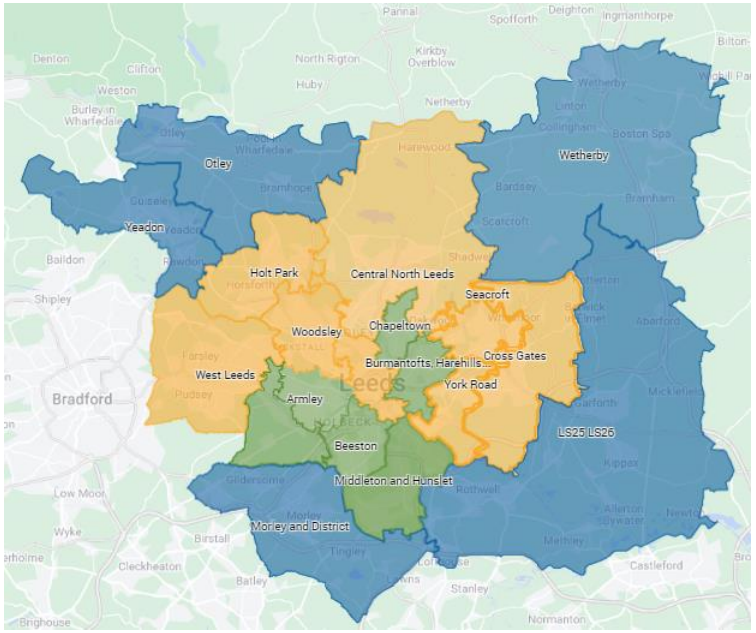


Table 2 shows the number of Whole Time Equivalents (WTE) Linking Leeds Wellbeing Coordinators per PCN. In addition, the figure details the total population size per PCN, the size and percentage of the population residing in the Indices of Multiple Deprivation 1 (IMD1) and the number of LL WBCs and PCN Link Workers combined in a PCN. The table is ordered from highest referring PCN footprint, to lowest. The total (based on LDM figures) of referrals per PCN since LL inception in 2019 can be found in the righthand column.

PCN	Number of Linking Leeds WBCs	Total population of PCN	Total population in IMD1	Percentage of population in IMD1	Average deprivation score of PCN	Number of social prescribers (LL and PCN) per PCN IMD1 population	Total number of referrals since 2019
Burmantofts, Harehills and Richmond Hill	2.5	87043	60351	69%	1	3800	4828
LS25 / LS26	2.4	74490	466	1%	8	55	4582
Seacroft	2.2	35923	19406	54%	2	4043	3677
Chapeltown	2	27317	8550	31%	5	1975	3666
Beeston	2.5	47287	27568	58%	1	3543	3623
Middleton and Hunslet	2	32882	20506	62%	1	3487	3126
West Leeds	1.8	69979	9154	13%	5	2007	2884
Woodsley	1.9	81511	11010	14%	5	1271	2346
York Road	1	32581	19556	60%	1	6519	2154
Cross Gates	1.7	29386	8012	27%	5	2504	2308
Central North Leeds	2	67148	8632	13%	7	1328	2138
Bramley, Wortley and Middleton	0.75	32856	12980	40%	3	7417	2013
Morley and District	1.9	63793	2579	4%	6	661	1673
Armley	1	35438	19211	54%	1	2596	1481
Yeadon	0.6	37552	172	0%	8	108	1477
Holt Park	1.9	34790	3133	9%	7	639	1156
Otley	1.8	28552	180	1%	8	64	1124
Wetherby	2.5	35195	95	0%	10	29	1056
Leeds Student Medical Practice and The Light	0.5	48524	2565	5%	5	337	508

Table 2: number of Linking Leeds Wellbeing Coordinators. Table details how these are distributed across Leeds PCN's by IMD decile.

Outcomes

The value that Linking Leeds provides the system is evidenced in the early themes coming from the evaluation (due to be finalised by the end of April), and their quarterly reporting data. This data indicates that the service is delivering positive outcomes for service users. These positive outcomes are quantified in the improvement in the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS - a valid and reliable person-reported outcome measure) from baseline to outcome. Figure 2 shows that these positive person-reported outcomes hold true across IMD deciles 1-8, and across age range of 16-60.

Figure 3: mental and emotional well-being change from baseline for Linking Leeds service users by IMD decile.

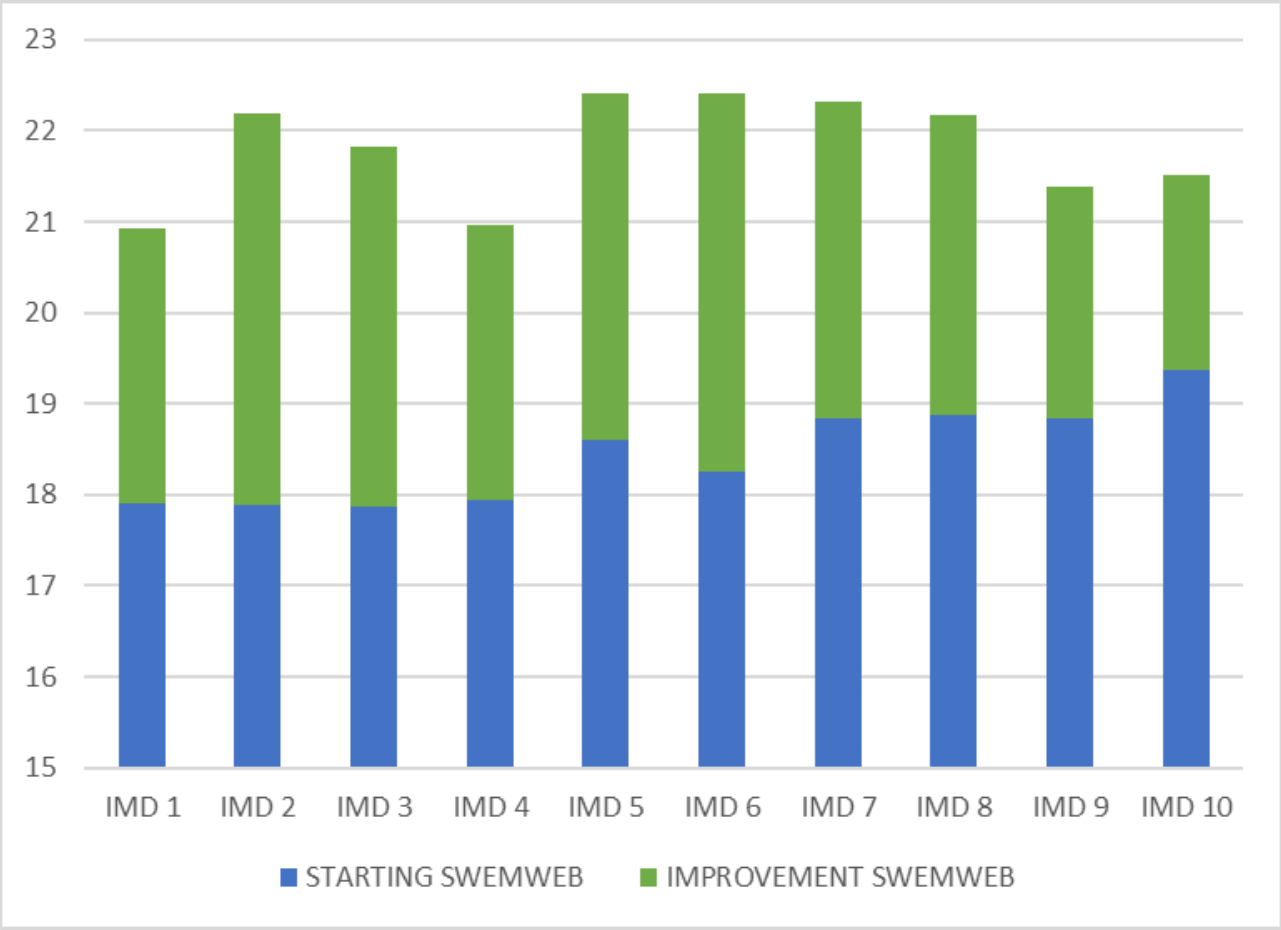


Figure 4: mental and emotional well-being change from baseline for Linking Leeds service users by age.

In addition to the above findings and informed by the goals of the Healthy Leeds Plan, data is presented on the impact of the Linking Leeds service on subsequent service utilisation. We therefore took a cohort approach and analysed service utilisation across a 12-month period pre and post-support from Linking Leeds. We ran a logistic regression analysis (https://www.statisticssolutions.com/free-resources/directory-of-statistical-analyses/what-is-logistic-regression/) across three key touch points between service and service user: GP appointments, emergency department attendance, and mental health referral. Table 4 below evidences these findings across the first four years following the implementation of Linking Leeds.

Service	Activity numbers 12-month pre	Activity numbers 12-month post	Odds Ratio	Risk Ratio (confidence interval)	Interpretation
GP	82439	47987	0.08	0.71 (0.68, 0.74)	92% probability of needing fewer GP appointments
Emergency Department	7981	6490	0.58	0.84 (0.81, 0.87)	41% probability of less Emergency Department (ED) attendance
Mental Health Referral	9505	8044	0.61	0.86 (0.82, 0.89)	38% probability of fewer mental health referrals and appointments

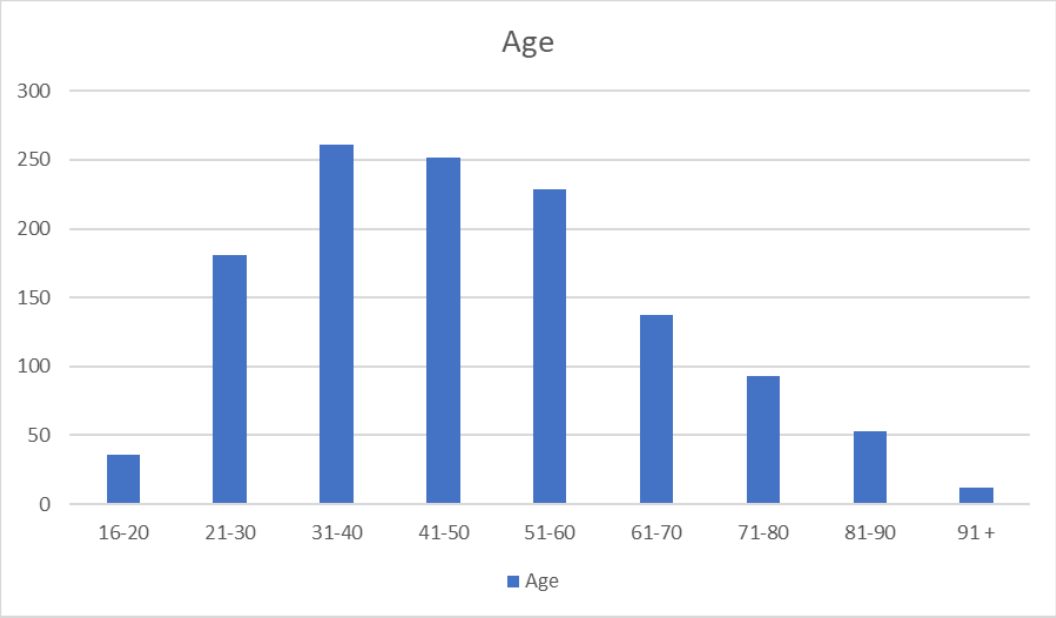
Table 4: Analysis of service utilisation pre and post-Linking Leeds support. Data taken from the Leeds Data Model. Analysis at individual level pre and post-Linking Leeds support and aggregated across four years from 2019.

In order of prevalence, the below table details the percentage of service users by population segment. This data can be used to bring further insight to the above-mentioned service figures.

Population segment	Proportion of service users
Long-term conditions	46.62%
Frailty	16.51%
Mostly healthy	14.63%
Serious mental illness	10.66%
Adult cancer	5.42%
Maternity	2.56%
Learning Disability and Autism	2.25%
End of Life	0.49%

Below details further demographic data to give an indicator of the populations and cohorts accessing Linking Leeds. This following data is lifted as an example from the most recent quarterly report.

Age Range



Age range

Age range	Number
16 – 20	34
21 – 30	176
31 – 40	261
41 – 50	250
51 – 60	226
61 – 70	138
71 – 80	92
81 – 90	51
Over 91	10

Ethnicity

Ethnicity	Percentage
White & Black Caribbean	1.4%
Other Mixed	1.6%
Other White	6.9%
Pakistani or British Pakistani	2.8%
White & Asian	0.6%
White & Black African	1.4%
Indian or British Indian	1.5%
Irish	1.4%
Other	4.3%
Other Asian	3.5%
Other Black	2.5%
African	3.4%
Bangladeshi or British Bangladeshi	0.4%
British or Mixed British	53.7%
Caribbean	1.3%
Chinese	0.2%
Not stated	30.5%

Gender

Gender	Percentage
Female	64.8%
Male	33.2%
Prefer not to say	0.7%
Non-binary	0.7%
Unable to answer	0%
Transgender	0.2%
Genderfluid	0.3%

Sexuality

Sexuality	Percentage
Heterosexual	87.6%
Asked but declined	2.5%
Bisexual	4.2%
Male Homosexual	0.5%
Female Homosexual	1.3%
Other sexual orientation not listed	1.2%
Asked but unsure	1.5%
Asked but declined	3.6%

Service Impact:

The reduction in the financial envelope and thus reduction in client-facing hours is estimated to result in approximately 2009 more GP appointments, 87 more ED attendances, and 50 more mental health-related referrals per year.

C. Service change details – (Involvement and equality checklist)

To be completed in conjunction with:

- Quality Manager: [Removed for publication]
- Equality Lead: [Removed for publication]
- Involvement Manager: [Removed for publication]

Questions (please describe the impact in each section)	Yes / No
1. Could the project change the way a service is currently provided or delivered? It may change the scale at which it Is being delivered. Service spec is currently being redesigned based on the new financial envelope and to mitigate any identified risk.	**Yes**
2. Could the project directly affect the services received by patients, carers, and families? – is it likely to specifically affect patients from protected or other groups? See appendix for more detail. It may reduce the yearly numbers of people able to be seen by Linking Leeds as capacity may reduce and increase wait times. The Service specification is currently being redesigned based on the new financial envelope and to mitigate any identified risk.	**Yes**
3. Could the project directly affect staff? For example, would staff need to work differently / could it change working patterns, location etc.? Is it likely to specifically affect staff from protected groups? Yes, it is likely that the workforce structure may need to change to account for the reduced financial envelope. This may mean some positions are removed from the structure.	**Yes**
4. Does the project build on feedback received from patients, carers, and families, including patient experience? What feedback and include links if available. Yes, firstly the service was designed with a significant amount of public engagement and co-production in 2018. To continue this thread, we ensure that patient voice is included in the quarterly reports from Linking Leeds. This feedback indicates there is high satisfaction with the service. In addition, the SWEMWEBS used to infer the impact of the service is a person-reported outcome measure – that being a self-reported measure of their well-being.	**Yes**

D: To be completed in conjunction with the involvement and equality lead

Insert comments in each section as required	Yes / No
Involvement activity required? Recommended activity relating to the proposed 15% reduction in contract value would largely comprise communications with stakeholders including patients / service users, and staff – please see below.	**No**

Insert comments in each section as required	Yes / No
Formal consultation activity required?	**No**
Full Equality Impact Assessment (EIA) required? The information and evidence included within this QEIA provide proportionate and reasonable assurance with respect of equality, equity and health inequalities in relation to the reduction in contract value (15%), potential impacts / risks and subsequent mitigating actions. We have noted that the remodelling of social prescribing across Leeds place will require a full / comprehensive Equality Impact Assessment (EIA), in addition to a QEIA, both of which should be initiated at the start of the re-modelling programme / project process and therefore inform decisions about the future social prescribing offer / model across Leeds.	**No**
Communication activity required (patients or staff)? The service receives high satisfaction feedback rates, so people like the service and find it helpful - any change, or rumour of a change, could have the potential to cause some concern about what's changing. Recommended communications at this point should include: • Informing people about what's happening and why. • Providing a point of contact, or a link to some FAQs on the website page to explain what's happening. This offers an opportunity to keep people in the loop, especially with a service redesign on the horizon, so that engagement is part of an ongoing conversation rather than just one-off events. So, the communications could potentially do several things – use existing patient feedback to show the benefits of and celebrate the service to date, explain the need to 'remodel' right now – reduce duplication, increase what people have told us works well, address areas which need improvement and ensuring best value for the Leeds pound, etc., etc.… and anticipating the redesign of the service from April next year, with an initial heads up about us wanting to involve people in the redesign plans.	**Yes**

E. Data Protection Impact Assessment (DPIA)

A DPIA is carried out to identify and minimise data protection risks when personal data is going to be used and processed as part of new processes, systems, or technologies.

Question	Yes / No
Does this project / decision involve a new use of personal data, a change of process or a significant change in the way in which personal data is handled? If yes, please email the IG Team at; wyicb-leeds.dpo@nhs.net for Leeds ICB or wyicb-wak.informationgovernance@nhs.net for the wider West Yorkshire ICB, to complete the screening form.	**No**

F. Evidence used in this assessment

List any evidence which has been used to inform the development of this proposal for example, any national guidance (e.g. NICE, Care Quality Commission, Department of Health, Royal Colleges), regional or local strategies, data analysis (e.g. performance data), engagement / consultation with partner agencies, interest groups, or patients.

Where applicable, state 'N/A' (not applicable) in boxes where no evidence exists, 'Not yet collected' where information has not yet been collected or delete where appropriate.

Evidence Source	Details
Research and guidance (local, regional, national)	Published report on the current (2022) evidence base for the effectiveness and impact of social prescribing in the UK: https://socialprescribingacademy.org.uk/resources/a-growing-evidence-base/ Understanding the effectiveness and mechanisms of a social prescribing service published in the British Medical Council Health Services Research Journal: https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3437-7

Evidence Source	Details
	A scoping review of the evidence base relating to the impact of social prescribing (2019) published in the British Journal of General Practice: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6301369/ Guidance commentary on social prescribing from the Office of Health Improvement and Disparities (2022): https://www.gov.uk/government/publications/social-prescribing-applying-all-our-health/social-prescribing-applying-all-our-health
Service delivery data such as who receives services	Quarterly review of the service since its inception. In addition, a recent evaluation of the service is in its final phase of completion before publication.
Consultation / engagement	Public engagement took place in 2018 and received over 600 responses from people in Leeds: https://webarchive.nationalarchives.gov.uk/ukgwa/20220902102616/https://www.leedsccg.nhs.uk/get-involved/your-views/social-prescribing/
Experience of care intelligence, knowledge, and insight (complaints, compliments, PALS, National and Local Surveys, Friends and Family Test, consultation outcomes)	Quarterly report includes case studies, client feedback, client exit survey, and person-reported outcome measures (i.e. a self-reported measure of wellbeing). The most recent collection of case studies, client feedback, and client exit survey is detailed in the appendix.
Other	

G. Impact Assessment: Quality, Equality, Health Inequalities, Safeguarding

What is the potential impact on quality of the proposed change? Outline the expected outcomes and who is intended to benefit.

Include all potential impacts (positive, negative, or neutral).

For negative impacts, list the action that will be taken in mitigation. See guidance notes in the appendix.

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
1. Patient Safety	A 15% reduction in funding poses a low / moderate risk to patient safety. Each client receives (on average) 10 hours' worth of one-to-one intervention from Linking Leeds staff. Current total of client-facing hours from the service: 38706 (3871 clients per year) Estimate client-facing hours with 15% reduction in finance: 31414 (3141 clients per year) The current model addresses many preventable harms including:	**-4 – Unlikely / Minor**	Trial the reduction in one-to-one client contact time from 1.25 hours, to 1 hour. This would mean the average 1:1 intervention time spent with clients would be 9 hours = 3490 clients per year. This could mitigate the reduction in service capacity by 349 people per annum.

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	• Mental health (Self-harm, stigma, low self-esteem, Suicidal ideation,) • Isolation (physical, digital, cultural and language barriers) • Financial barriers to health (food, heating etc) • Motivational barriers to health (low self-esteem, lack of engagement, distrust in the system) The low / moderate to risk to Patient Safety is reported below across the current tiered service offer: • Light touch clients: The potential loss of approx. 5400 client facing hours would increase wait times, impacting how the service's ability to provide timely initial assessment and light touch signposting. Social prescribing is often at its most effective when it is 'early intervention'. The ability to		

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	provide ‘quick fix’ interventions will be reduced. • Holistic and extended holistic: The reduction in client facing hours would result in either reduced client numbers or reduced time in service. N.B. those service users who benefit from the holistic or extended holistic are those with the greater complex needs. • Reduced client numbers would have a low / moderate impact on holistic and extended holistic users – the proposed 15% reduction in finance is predicted reduce client facing hours by 14% so we would be able to service 14% less clients. This risk is due relating to reduced capacity and therefore waiting times may increase There is evidence that this offer for PCN’s is highly variable in the model of service delivery and the numbers		

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	of link works providing said service. People with social needs that are impacting their mental and physical health may find the Leeds social prescribing offer less accessible.		
2. Experience of care	A 15% reduction in funding poses a low / moderate risk to experience of care. Data analysis has shown that after engagement with Linking Leeds clients are 92% probability of needed less GP appointments. The reductions in GP presentations therefore frees up GP capacity for Leeds residents with higher clinical need. There are also associated reductions on the chance of an emergency department (ED) presentation (41% lower odds) and on the chance of a Mental Health referral (38% lower odds). These statistics evidence three key strengths of the Linking Leeds service:	**-4 – Unlikely / Minor**	Trial the reduction in one-to-one client contact time from 1.25 hours, to 1 hour. This would mean the average one-to-one intervention time spent with clients would be 9 hours = 3490 clients per year. This could mitigate the reduction in service capacity by 349 people per annum and hypothesised to speed up client through put thus minimising wait times. This change would require sound evaluation framework around it

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	1. Takes an upstream preventative approach to bio-psychosocial health. 2. It frees vital capacity for those with higher clinical need. 3. It reduces pressures across other parts of the sector, predominantly by reducing physical and financial demand on other Primary Care services. Risk waiting times – A 15% budget cut could increase wait times and have an adverse impact at both Service and System wide levels. Longer wait times may leave our clients underlying problems unaddressed, leaving them at higher risk of presenting to their GP or ED to seek resolution and at a higher risk of negative impact on their mental health, social health, and wellbeing.		(including a pragmatic number qualitative and quantitative metrics) to understand the impact of this change.

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3. Clinical Effectiveness	A 15% reduction in funding poses a low / moderate risk to clinical effectiveness. There is little or no evidence to tangibly estimate the impact on clinical effectiveness of the service following a 15% reduction, and it must be stressed that this isn't a clinical intervention. The reduction is likely to lead to a reduction in client-facing hours, meaning if demand for the service is maintained, the wait times will increase. It is the impact of wait times for a social prescribing service that is unknown. There is no current evidence base for the impact of wait times for social prescribing services. However, parallels may be drawn with impact of wait times for Improving Access to Psychological Therapies (IAPT) services. Evidence from a recent study in the Lancet (Clarke et al., 2018) investigated outcomes attributed to mental health services. Findings indicate that mean	**-9 – Possible / Moderate**	Trial the reduction in one-to-one client contact time from 1.25 hours, to 1 hour. This would mean the average one-to-one intervention time spent with clients would be 9 hours = 3490 clients per year. This could mitigate the reduction in service capacity by 349 people per annum and is hypothesised to speed up client throughput thus minimising wait times. This could save approximately 698 GP appointments, 35 ED attendances, and 34 mental health related referrals.

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	waiting time to enter treatment were negatively associated with reliable recovery rates. This was compounded by the social deprivation of a locality. That being, longer waiting times for common mental health illness services in areas of severe deprivation were associated with worse mental health related outcomes. To compound this, evidence from the recent Leeds social prescribing evaluation indicates that the social prescribing offer from PCN-employed link workers is significantly variable in both model and scale of delivery and warrants its own focus to promote a more equitable offer for social prescribing across the city. Using the data presented earlier in the paper, we estimate that the reduction in client-facing hours and therefore client throughput will result in approximately 2009		

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
	more GP appointments, 87 more ED attendances, and 50 more mental health related referrals per year.		
4. Equality	15% reduction in the capacity of Linking Leeds social prescribing service would likely have a low / moderate equality impact on equality. Below is a breakdown of how various groups may be affected: 1. Vulnerable and Marginalised Groups Vulnerable definition, lifted from the Office of Health Improvement and Disparities. “Being vulnerable is defined as being in need of special care, support, or protection because of age, disability, risk of abuse or neglect.” • Low-Income Individuals: These service users often rely on social prescribing to access services that they might not otherwise engage with, such as welfare, citizens advice, housing advice, mental	**-9 – Possible / Moderate**	To address and mitigate these potential equality impacts, the following measures can be implemented: 1. Targeted Support Programs • Develop Specific Initiatives: Create targeted programs for the most affected groups, such as low-income families, older adults (over 65), ethnically diverse communities, and disabled people. Aim to ensure these programs are well-publicised, feasible and accessible.

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
	health support, social activities, and community resources. A reduction in capacity could present a barrier to people from lower IMD deciles accessing crucial support, exacerbating poverty and associated health issues. • Older adults (over the age of 65) frequently use social prescribing to combat isolation and live well with long-term conditions. Reduced service offers from Linking Leeds could lead to increased loneliness and deteriorating health, particularly among those without strong support networks.		2. Community Partnerships and Outreach • Strengthen Local Care Partnerships network of support: Partner with local organisations within localities that work with vulnerable and marginalised communities. Work in partnership to enhance outreach efforts to ensure these groups are aware of and can access available resources. • Mobile and Remote Services: Utilise mobile units and remote services to reach individuals who might have difficulty accessing traditional social prescribing services.

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
	2. People with common mental health illness • Mental Health Support: Social prescribing often provides vital mental health support through community resources and activities. Reducing capacity could lead to longer wait times to access the service. 3. Ethnically diverse communities • Data capture that accurately and sensitively describes ethnicity is currently lacking. However, access to culturally appropriate services is a key function of Linking Leeds. Social prescribing can link individuals to culturally appropriate services and community groups. Reducing this capacity might disproportionately affect ethnically diverse communities that benefit from		3. Enhanced Data Collection and Analysis • Continue to monitor impact: Collect and analyse data on who uses the Linking Leeds social prescribing services and who is affected by capacity reductions. Use this data to identify gaps and address inequalities proactively. • Feedback Mechanisms: Implement more focused and robust feedback mechanisms to understand the needs and experiences of service users from different demographic groups. 4. Policy and Advocacy

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
	tailored support, potentially leading to increased health disparities.		• Advocate for Funding: Advocate for sustained and consistent funding for social prescribing services, emphasising the importance of these services for equality and health equity.
	4. Disabled people Accessibility to Services: People with disabilities are more likely to face greater barriers in accessing services without the help of social prescribing who provide advocacy support, and which often facilitates connections to accessible community resources and support groups.		• Policy Development: Work with system leaders to develop policies that protect and prioritise funding and resources for vulnerable and marginalised groups. 5. Education and Awareness • Raise Awareness: Educate healthcare providers, community leaders, and the public about the importance of social prescribing and its role in promoting health equity.

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
			• Training for Providers: Provide training for healthcare providers on the specific needs of diverse populations and how to address these through social prescribing. 6. Integrated Care Approaches within LCP's. • Holistic Support Models: Promote integrated support models that combine bio-psycho-social support, ensuring that patients receive comprehensive support that addresses both health and social needs from a range of support providers. • Integration with PCNs and non-clinical PCN roles: Ensure close collaboration between

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
			social prescribing services and locality-based health and care services to provide seamless support for individuals.
5. Safeguarding		**0**	
6. Workforce	A 15% reduction in funding poses a high risk to the workforce. 1. Staff morale. There is evidence to show that the service performs well – a key driver of this has been high levels of staff morale, engagement, and agency. There have, however, been significant pressures on staff over the last 12 months, starting with a restructure in June 2023. It's worth noting that the restructure took place in the absence of a Service Manager which amplified the pressures on the wider management	**-12 – Likely / Moderate**	1. Review and evaluate the current service offer of support for their staff. 2. Integration with PCN's and ARRS roles: Ensure close collaboration between social prescribing services and locality-based health and care services to provide seamless support for individuals and making best use of system assets.

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
	Team, most notably the Locality Managers (two of the three have now left the service). The pressure around the June 2023 restructure has been followed directly by uncertainty around the recommissioning of the Service. Service leader's feedback that there is still a high element of residual 'change fatigue' after the last restructure. A 15% budget cut comes with a second round of uncertainty around job security and job descriptions. This will have a measurable impact on morale and retention which risks cascading into performance on both an employee and service level. 2. The reduction in funding arrives at a time when the complexity and challenge in client needs are increasing – there is		3. Strengthen Local Care Partnerships network of support: Partner with local organisations within localities. Work in partnership to enhance and maximise collective efforts to ensure we are harnessing all available resources. 4. Reduce client face hours to 1 hour from 1.25 hours which is predicted to improve throughput and wait times.

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
	evidence to support this with data suggesting that 40% of our clients require our extended holistic support, from 21% in 2020. The WBCs already feel that their job is rapidly becoming more demanding and more challenging and will be compounded by higher caseloads, and longer wait times.		
7. Health inequalities	A 15% reduction in funding poses a low / moderate risk to health inequalities. The person-level impact of the Linking Leeds service is evidenced above. The impact data has been cut by age, sex, ethnicity, IMD decile and PCN footprint. Evaluation indicates that the service has a positive impact on mental and emotional wellbeing, and this holds true (albeit to varying magnitudes) across these demographic descriptors.	**-9 – Possible / Moderate**	1. Targeted Support Programs • Develop Specific Initiatives: Create targeted programs for the most affected groups, such as low-income families, the elderly, ethnic minorities, and those with disabilities. Ensure these programs are well-publicised, feasible and easily accessible. 2. Community Partnerships and Outreach

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
	This indicates that the Linking Leeds offer is making a meaningful contribution to our efforts in tackling health inequalities. A 15% reduction in funding and therefore reduction in client-facing hours will reduce the number of clients 'throughput' – i.e. the number of people accessing the service per annum. Therefore, the number of people improving their mental and emotional wellbeing per annum will decrease.		• Strengthen Local Care Partnerships network of support: Partner with local organisations within localities that serve vulnerable and marginalized communities. Work in partnership to enhance outreach efforts to ensure these groups are aware of and can access available resources. Strengthen integration with PCNs and PCN non-clinical roles: Ensure close collaboration between social prescribing services and locality-based health and care services to provide seamless support for individuals and make best use of system assets.

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
8. Sustainability		**0**	
9. Other			

H. Action Plan

Describe the action that will be taken to mitigate negative impacts.

Identified impact	**What action will you take to mitigate the impact?**	**How will you measure impact / monitor progress?** (Include all identified positive and negative impacts. Measurement may be an existing or new quality indicator / KPI)	**Timescale** (When will mitigating action be completed?)	**Lead** (Person responsible for implementing mitigating action)
Reduction in client throughput (less	1. Reduce client-facing time from 75 mins to 60 mins.	1. Client throughput figures; outcome measures; experience measures (all	1. Change will be enacted from 1 September 2024 and will continue to	1. [Removed for publication] / [Removed for publication] (Linking

Identified impact	**What action will you take to mitigate the impact?**	**How will you measure impact / monitor progress?** (Include all identified positive and negative impacts. Measurement may be an existing or new quality indicator / KPI)	**Timescale** (When will mitigating action be completed?)	**Lead** (Person responsible for implementing mitigating action)
numbers of people seen per annum)	2. Integration with PCNs and non-clinical PCN roles: Ensure close collaboration between social prescribing services and locality-based health and care services to provide seamless support for individuals. 3. Targeted / proactive support: Create targeted programs for the most affected groups, Aim to ensure these programs are well-publicised, feasible and accessible. A pilot in York Road LCP is being developed.	currently captured in quarterly reports so will be able to track change across time). 2. TBC. No published metric to capture this well. The Evidence and Evaluation team will advise on developing a one-question Likert scale to be completed by partners across localities. 3. TBC. No published metric to capture this well. Evidence and Evaluation team will advise on developing a one-question Likert scale to be completed by partners across localities	March 2025 for evaluation. 2. This is a development mitigation that will start immediately with no end date but will continually be reviewed in monthly and quarterly meetings. 3. Pilot in York Road LCP will be developed and implemented by December 2024.	Leeds Service Manager) 2. [Removed for publication] / [Removed for publication] 3. [Removed for publication] / [Removed for publication] / [Removed for publication]
Negative impact on staff morale	1. Review and evaluate the current service offer of support for their staff. All staff to have had a one-to-	1. Staff feedback to be included in the monthly and quarterly monitoring process. All staff to have	1. Implemented immediately. All staff to have one-to-one	

Identified impact	**What action will you take to mitigate the impact?**	**How will you measure impact / monitor progress?** (Include all identified positive and negative impacts. Measurement may be an existing or new quality indicator / KPI)	**Timescale** (When will mitigating action be completed?)	**Lead** (Person responsible for implementing mitigating action)
	one conversation about their support needs by their line manager. 2. Integration with PCNs and non-clinical PCN roles: Ensure close collaboration between social prescribing services and locality-based health and care services to provide seamless support for individuals. 3. Targeted / proactive support: Create targeted programs for the most affected groups, aim to ensure these programs are well-publicised, feasible and accessible. A pilot in York Road LCP is being developed.	had a one-to-one conversation with their line manager to discuss routes to support. 2. TBC. No published metric to capture this well. Evidence and Evaluation team will advise on developing a one-question Likert scale to be completed by partners across localities. 3. TBC. No published metric to capture this well. Evidence and Evaluation team will advise on developing a one-question Likert scale to be completed by partners across localities.	conversations by December 2024. 2. This is a development mitigation that will start immediately with no end date but will continually be reviewed in monthly and quarterly meetings. 3. Pilot in York Road LCP will be developed and implemented by December 2024.	
Increasing caseload at a time when individual case	1. Reduce client-facing time from 75 mins to 60 mins.	1. Client throughput figures; outcome measures; experience measures (all	1. Change will be enacted from 1 September 2024 and will continue to	

Identified impact	**What action will you take to mitigate the impact?**	**How will you measure impact / monitor progress?** (Include all identified positive and negative impacts. Measurement may be an existing or new quality indicator / KPI)	**Timescale** (When will mitigating action be completed?)	**Lead** (Person responsible for implementing mitigating action)
complexity is also increasing.	2. Integration with PCNs and non-clinical PCN roles: Ensure close collaboration between social prescribing services and locality-based health and care services to provide seamless support for individuals. 3. Targeted / proactive support: Create targeted programs for the most affected groups, aim to ensure these programs are well-publicised, feasible and accessible. A pilot in York Road LCP is being developed.	currently captured in quarterly reports so will be able to track change across time). 2. TBC. No published metric to capture this well. Evidence and Evaluation team will advise on developing a one-question Likert scale to be completed by partners across localities. 3. TBC. No published metric to capture this well. Evidence and Evaluation team will advise on developing a one-question Likert scale to be completed by partners across localities.	March 2025 for evaluation. 2. This is a development mitigation that will start immediately with no end date but will continually be reviewed in monthly and quarterly meetings. 3. Pilot in York Road LCP will be developed and implemented by December 2024.	
Reduced client throughput and potential increase in wait times presents	1. Targeted Support Programs: Create targeted programs for the most affected groups. Ensure	1. TBC. No published metric to capture this well. Evidence and Evaluation team will advise on	1. Pilot in York Road LCP will be developed and implemented by December 2024.	1. [Removed for publication] / [Removed for publication] /

Identified impact	**What action will you take to mitigate the impact?**	**How will you measure impact / monitor progress?** (Include all identified positive and negative impacts. Measurement may be an existing or new quality indicator / KPI)	**Timescale** (When will mitigating action be completed?)	**Lead** (Person responsible for implementing mitigating action)
an additional access barrier for those already experiencing health inequalities.	these programs are well-publicised, feasible and easily accessible. A pilot in York Road LCP is being developed. 2. Community Partnerships and Outreach: Strengthen Local Care Partnerships network of support: Partner with local organisations within localities that serve vulnerable and marginalized communities. Work in partnership to enhance outreach efforts to ensure these groups are aware of and can access available resources. 3. Strengthen integration with PCNs and PCN non-clinical roles: Ensure close collaboration between social prescribing services and locality-based health	developing a one-question Likert scale to be completed by partners across localities. 2. TBC. No published metric to capture this well. Evidence and Evaluation team will advise on developing a one-question Likert scale to be completed by partners across localities. 3. Continue to monitor service access figures cut by age, sex, ethnicity, IMD, and PCN / LCP footprint.	2. This is a development mitigation that will start immediately with no end date but will continually be reviewed in monthly and quarterly meetings.	[Removed for publication] 2. [Removed for publication] / [Removed for publication] / [Removed for publication] / [Removed for publication] / [Removed for publication]

Identified impact	What action will you take to mitigate the impact?	How will you measure impact / monitor progress? (Include all identified positive and negative impacts. Measurement may be an existing or new quality indicator / KPI)	Timescale (When will mitigating action be completed?)	Lead (Person responsible for implementing mitigating action)
	and care services to provide seamless support for individuals and make the best use of system assets.			

I. Monitoring & review; Implementation of action plan and proposal

The action plan should be monitored regularly to ensure:

a. actions required to mitigate negative impacts are undertaken.
b. KPIs / quality indicators are measured in a timely manner so positive and negative impacts can be evaluated during implementation / the period of service delivery.

Outcome: Once the proposal has been implemented, the actual impacts will need to be evaluated and a judgement made as to whether the intended outcomes of the proposal were achieved (Section H to be completed as agreed following implementation)

Implementation: State who will monitor / review	Name of individual, group or committee	Role	Frequency
a. that actions to mitigate negative impacts have been taken.	a. [Removed for publication]	Senior Programme Leader	Monthly (informal), Quarterly (Formal)
b. the quality indicators during the period of service delivery. State the frequency of monitoring (e.g. Recovery Group Monthly, QSC Quarterly, J. Bloggs, Project Manager Unplanned Care Monthly	b. [Removed for publication]	Senior Programme Leader	Monthly (informal), Quarterly (Formal)

Outcome	Name of individual, group or committee	Role	Date
Who will review the proposal once the change has been implemented to determine what the actual impacts were?	Healthy Adults Population Board / Social Prescribing Steering Group	N/A	March 2025

J. Summary of the QEIA

Provide a brief summary of the results of the QEIA, e.g. highlight positive and negative potential impacts; indicate if any impacts can be mitigated. Taking this into account, state what the overall expected impact will be of the proposed change.

The QEIA and summary statement must be reviewed by a member of the Quality Team and include next steps.

Impact:

- Reduction in client throughput (less numbers of people seen per annum)
- Negative impact on staff morale
- Increasing caseload at a time when individual case complexity is also increasing.
- Reduced client throughput and potential increase in wait time presents an additional access barrier for those already experiencing health inequalities.

Action:

- Trial the reduction in client-facing time from 75 mins to 60 mins.
- Integration with PCNs and non-clinical PCN roles: Ensure close collaboration between social prescribing services and locality-based health and care services to provide seamless support for individuals.
- Targeted / proactive support: Create targeted programs for the most affected groups, aim to ensure these programs are well-publicised, feasible and accessible. A pilot in York Road LCP is being developed.

The mitigating actions within this QEIA are the medium between minimising the impact of fewer client-facing staff and maintaining the current client experience that evidence informs us improves outcomes for people and the system.

K: For Team use only

1. Reference	XX /
2. Form completed by (names and roles)	
3. Quality Review completed by:	Name: [Removed for publication] Date: Initial Review – 28.05.2024 Second Review – 05.06.2024
4. Equality review completed by:	Name: [Removed for publication] Date: Initial Review – 28.05.2024 Second Review – 05.06.2024
5. Date form / scheme agreed for governance	Review at panel assurance meeting: 13.06.2024
6. Proposed review date (6 months post implementation date)	
7. Notes	

L: Likely financial impact of the change (and / or level of risk to the ICB)

Level of risk to the ICB
Low
Medium
High

M: Approval to proceed

Approval to proceed	Name / Role	Yes / No	Date
PMO / PI / Director			
Proposed 6-month review date (post implementation)	To be agreed with Pathway Integration / Programme or scheme lead		

N: Review

To be completed following implementation only.

1. Review completed by	
2. Date of Review	
3. Scheme start date	

4. Were the proposed mitigations effective? (If not why not, and what further actions have been taken to mitigate?)

5. Is there any intelligence / service user feedback following the change of the service? If yes, where is this being shared and have any necessary actions been taken because of this feedback?

6. Overall conclusion Please provide brief feedback of scheme, i.e. its function, what went well and what didn't.

7. What are the next steps following the completion of the review? i.e. Future plans, further involvement / consultation required?

Appendix A: Impact Matrix

This matrix is included to help your thinking and determine the level of impact on each area.

Likelihood

Score	Likelihood	Regularity
0	Not applicable	
1	Rare	Not expected to occur for years, will occur in exceptional circumstances.
2	Unlikely	Expected to occur at least annually. Unlikely to occur…
3	Possible	Expected to occur at least monthly. Reasonable chance of…
4	Likely	Expected to occur at least weekly. Likely to occur.
5	Almost certain	Expected to occur at least daily. More likely to occur than not.

Scoring matrix

- **Opportunity**: 5 to 0
- **Consequence**: -1 to - 5

Likelihood	5	4	3	2	1	0	-1	-2	-3	-4	-5
5	**25**	**20**	**15**	**10**	**5**	**0**	**-5**	**-10**	**-15**	**-20**	**-25**
4	**20**	**16**	**12**	**8**	**4**	**0**	**-4**	**-8**	**-12**	**-16**	**-20**
3	**15**	**12**	**9**	**6**	**3**	**0**	**-3**	**-6**	**-9**	**-12**	**-15**
2	**10**	**8**	**6**	**4**	**2**	**0**	**-2**	**-4**	**-6**	**-8**	**-10**
1	**5**	**4**	**3**	**2**	**1**	**0**	**-1**	**-2**	**-3**	**-4**	**-5**

Category
Opportunity
Low – moderate risk
High risk

Opportunity and consequence

Impact	Score	Rating	The proposed change is anticipated to lead to the following level of opportunity and / or consequence
Positive	5	Excellence	Multiple enhanced benefits including excellent improvement in access, experience and / our outcomes for all patients, families, and carers. Outstanding reduction in health inequalities by narrowing the gap in access, experience and / or outcomes between people with protected characteristics and the general population. Leading to consistently improvement standards of experience and an enhancement of public confidence, significant improvements to performance and an improved and sustainable workforce.
	4	Major	Major benefits leading to long-term improvements and access, experience and / our outcomes for people with this protected characteristic. Major reduction in health inequalities by narrowing the gap in access, experience and / our outcomes between people with this protected characteristic and the general population. Benefits include improvements in management of patients with long-term effects and compliance with national standards.
	3	Moderate	Moderate benefits requiring professional intervention with moderate improvement in access, experience and / or outcomes for people with this protected characteristic. Moderate reduction in health inequalities by narrowing the gap in access, experience and / or outcomes between people with this protected characteristic and the general population.
	2	Minor	Minor improvement in access, experience and / or outcomes for people with this protected characteristic. Minor reduction in health inequalities by narrowing the gap in access, experience and / or outcomes between people with this protected characteristic and the general population.
	1	Negligible	Minimal benefit requiring no / minimal intervention or treatment. Negligible improvements in access, experience and / or outcomes for people with this protected characteristic. Negligible reduction in health inequalities by narrowing the gap in access, experience and / or outcomes between people with this protected characteristic and the general population.
Neutral	0	Neutral	No effect either positive or negative.

Impact	Score	Rating	The proposed change is anticipated to lead to the following level of opportunity and / or consequence
Negative	-1	Negligible	Negligible negative impact on access, experience and / or outcomes for people with this protected characteristic. Negligible increase in health inequalities by widening the gap in access, experience and / or outcomes between people with this protected characteristic and the general population. Potential to result in minimal injury requiring no / minimal intervention or treatment, peripheral element of treatment, suboptimal and / or informal complaint / inquiry.
	-2	Minor	Minor negative impact on access, experience and / our outcomes for people with this protected characteristic. Minor increase in health inequalities by widening the gap in access, experience and / or outcomes between people with this protected characteristic and the general population. Potential to result in minor injury or illness, requiring minor intervention and overall treatment suboptimal.
	-3	Moderate	Moderate negative impact on access ,experience and / or outcomes for people with this protected characteristic. Moderate increase in health inequalities by widening the gap in access, experience and / or outcomes between people with this protected characteristic and the general population. Potential to result in moderate injury requiring professional intervention.
	-4	Major	Major negative impact on access, experience and / or outcomes for people with this protected characteristic. Major increase in health inequalities by widening the gap in access, experience and / or outcomes between people with this protected characteristic and the general population. Potential to lead to major injury, leading to long-term incapacity / disability.
	-5	Catastrophic	Catastrophic negative impact on access, experience and / or outcomes for people with this protected characteristic. Catastrophic increase in health inequalities by widening the gap in access, experience and / or outcomes between people with this protected characteristic and the general population.

Impact	Score	Rating	The proposed change is anticipated to lead to the following level of opportunity and / or consequence
			Potential to result in incident leading to death, multiple permanent injuries or irreversible health effectis, an event which impacts on a large number of patients, totally unacceptable level of effectiveness or treatment, gross failure of experience and does not meet required standards.

Appendix B: Guidance notes on completing the impacts section G

Domain	Consider
1. Patient Safety	• Safe environment. • Preventable harm. • Reliability of safety systems. • Systems and processes to prevent healthcare acquired infection. • Clinical workforce capability and appropriate training and skills. • Provider's meeting CQC Essential Standards.
2. Experience of care	• Respect for person-centred values, preferences, and expressed needs, including cultural issues; the dignity, privacy, and independence of service users; quality-of-life issues; and shared decision making. • Coordination and integration of care across the health and social care system. • Information, communication, and education on clinical status, progress, prognosis, and processes of care to facilitate autonomy, self-care, and health promotion. • Physical comfort including pain management, help with activities of daily living, and clean and comfortable surroundings. • Emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families, and their finances. • Co-produce with the population and service users as the default position for project design. • Use what we know from insight and feedback in project design and be explicit in the expected outcomes for experience of care improvements. • Involvement of family and friends, on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as caregivers.

	• Transition and continuity as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions. • Access to care e.g., time spent waiting for admission, time between admission and placement in an in-patient setting, waiting time for an appointment or visit in the out-patient, primary care or social care setting. [Adapted from the NHS Patient Experience Framework, DoH 2011] revised in: https://www.england.nhs.uk/wp-content/uploads/2021/04/nhsi-patient-experience-improvement-framework.pdf
3. Clinical Effectiveness	• Implementation of evidence-based practice (NICE, pathways, royal colleges etc.). • Clinical leadership. • Care delivered in most clinically and cost-effective setting. • Variations in care. • The quality of information collected and the systems for monitoring clinical quality. • Locally agreed care pathways. • Clinical engagement. • Elimination of inefficiency and waste. • Service innovation. • Reliability and responsiveness. • Accelerating adoption and diffusion of innovation and care pathway improvement. • Preventing people dying prematurely. • Enhancing quality of life. • Helping people recover from episodes of ill health or following injury.
4. Equality	In order to answer section C and G4 the groups that need consideration are (use the links for more information): • **Age**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/age-discrimination • **Disability**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/disability-discrimination • **Gender reassignment**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/gender-reassignment-discrimination • **Pregnancy and maternity**: https://www.equalityhumanrights.com/en/our-work/managing-pregnancy-and-maternity-workplace • **Race**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/race-discrimination

	• **Religion or belief**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/religion-or-belief-discrimination • **Sex**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/sex-discrimination • **Sexual orientation**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/sexual-orientation-discrimination Other groups would include, but not be limited to, people who are: • Carers. • Homeless. • Living in poverty. • Asylum seekers / refugees. • In stigmatised occupations (e.g. sex workers). • Problem substance use. • Geographically isolated (e.g. rural). • People surviving abuse.
8. Safeguarding	• Will this impact on the duty to safeguard children, young people, and adults at risk? • Will this have an impact on Human Rights – for example any increased restrictions on their liberty?
9. Workforce	• Staffing levels. • Morale. • Workload. • Sustainability of service due to workforce changes (Attach key documents where appropriate).
10. Health Inequalities	• Health status, for example, life expectancy. • access to care, for example, availability of given services. • behavioural risks to health, for example, smoking rates. • wider determinants of health, for example, quality of housing.
11. Sustainability	See: https://www.bma.org.uk/media/3464/bma-climate-change-and-sustainability-paper-october-2020.pdf Climate change poses a major threat to our health as well as our planet. The environment is changing, that change is accelerating, and this has direct and immediate consequences for our patients, the public and the NHS. Also consider; technology, pharmaceuticals, transport, supply/purchasing, waste, building / sites, and impact of carbon emissions.

	Visit Greener NHS for more info: https://www.england.nhs.uk/greenernhs/
12. Other	• Publicity / reputation. • Percentage over / under performance against existing budget. • Finance including claims.