

## 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](mailto:wyicb-leeds.qualityteam@nhs.net)

Complete all sections (see instructions / comments and consider the [Impact Matrix](#) in Appendix A).

Assessment Completion	Name	Role	Date	Email
Scheme Lead	[Removed for publication]	Pathway Integration Leader (Cancer and Diagnostics)	13.02.24	[Removed for publication]
Programme Lead sign off	[Removed for publication]	Head of Pathway Integration	13.02.24	[Removed for publication]

A. Scheme Name	O007 - Primary Care Screening Champions Allocation Reduction
Type of change	Partial stop
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).

The Primary Care Screening Champions Programme provides funding to practices in Index of Multiple Deprivation (IMD) 1-4 (the 45 most deprived practices in Leeds) to provide dedicated time to increase screening uptake rates for the cervical and bowel screening programmes. This work mainly entails contacting 'non-responders' to understand why they haven't taken part in the programmes and to encourage them to come

forward and participate in screening. In 2023 / 2024, £100k was available to fund this scheme, divided amongst the practices based on the size of their eligible population. This equates to around £1,250 per year, per screening programme.

Over recent years, during and following the pandemic, we have noted marked changes in uptake rates for the national screening programmes. The latest citywide data available to us reflects this:

- The latest cervical screening uptake data for Leeds shows a declining trend before, during and after the pandemic (68.9% in December 2023 vs 70.1% in January 2022 vs 73.4% in February 2020).
- However, bowel screening uptake rate has gone against this trend (71.2% in August 2023 vs 71.5% in September 2021 vs 66.5% in February 2020).
- Review of February 2020 – August 2023 data suggests a narrowing of the gap between underserved communities (IMD 1-4) (an increase in bowel screening uptake of 5%) compared to the increase in uptake in the least deprived areas (IMD 5-10) (an increase in uptake of 4.6%).

To ensure that the scheme is more focused in future years and to contribute towards the ICB's financial position, the total funding available from 2024 / 2025 onwards will be £75k per year.

A working party including public health, the ICB and primary care has been constituted to consider future options for the programme. In this group's view, continuing with the current scheme for all practices would be unsustainable and some practices would not receive enough funding to make it worthwhile participating, or to make it viable to meet the programme objectives.

We propose to continue to follow the service specification developed for 2023 / 2024 in large part, but to deliver the service within the reduced budget available we will ask practices to focus primarily on increasing cervical screening rates for younger women. 'First timers', as this younger cohort of invitees have been identified by public health colleagues as a group of interest because their rates of participation are declining much faster than any other group.

The most recent data available (December 2023) shows that in IMD 1-4 uptake of Cervical screening for women aged 25-49 was 62.8% (60.4% in IMD 1 and 66.2% for Leeds as a whole). This compares to 65.3% in April 2021.

By comparison, the uptake of cervical screening for women aged 50-64 in IMD 1-4 was 71.1% in December 2023 and 71.6% in April 2021. This shows that amongst this cohort uptake is relatively stable compared to the younger cohort and it implies that once people start to take part in the screening programme and become aware of what it entails and the importance of it, they will continue into later life. This theory is supported by

research which suggests that more than a quarter of women who miss smear tests do so because they are unaware of the programme (CRUK, 2017).

As such, if we can improve uptake for the younger cohort (including 'first timers') we can ensure continued improved performance for years to come as these women are invited back for repeat screening.

As a programme we will continue to encourage and support work to increase bowel screening uptake, but within underserved areas of Leeds bowel screening rates remain above pre-pandemic levels (performance in IMD 1-4 was 64.6% in August 2023 vs 59.6% in February 2020) so with reduced resources there is a strong argument for focusing on cervical screening. We will keep the focus of the programme under review and can / will change this in the coming years if screening uptake data indicates this is necessary.

Unfortunately, screening uptake split by demography is not available at a local level and at this stage we do not have consistent, reliable data to demonstrate the number of contacts being made at a practice level - this is due to issues with recording the data on the clinical system, but we are working to improve this in 2024 / 2025.

### 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
<p>1. Could the project change the way a service is currently provided or delivered?</p> <p>Yes, practices will focus their attention on contacting patients who have not responded to cervical screening invites. This is likely to mean that they do not have the capacity to chase up non-responders on the bowel programme. The data set out above gives a rationale for this decision.</p>	<p><b>Yes</b></p>

Questions (please describe the impact in each section)	Yes / No
<p>Methods of communication for cervical patients will remain as they are now and will continue to be tailored to the needs of target populations. This will be informed by insights from local communities themselves, collected through engagement led by teams commissioned by public health (including the Leeds Health Awareness Service) and the West Yorkshire Cancer Alliance.</p>	
<p>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 <a href="#">Appendix A</a> for more detail.</p> <p>The change in funding will not directly impact patients or service users. They will still be invited to screening programmes in the same way as they are now and will have the same access to the national screening programmes. However, bowel patients may not receive as many reminders to complete screening as they currently do and may not be reminded in the same way as they are now e.g. increased SMS (text message) reminders rather than phone calls. This project currently only operates in the most deprived areas of the city so any change will only impact people in those areas.</p>	<b>No</b>
<p>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?</p> <p>The impact on staff is likely to be minimal as the funding received by each practice is relatively small and the screening champion work makes up only a small proportion of their role.</p>	<b>No</b>
<p>4. Does the project build on feedback received from patients, carers, and families, including patient experience? What feedback and include links if available.</p> <p>The project does not build on feedback received. The change in focus of the project is informed by screening uptake data published nationally.</p> <p>As set out above findings from other work being carried out at a national, regional, and local level are used to inform and develop the targeted interventions delivered by the screening champions. As the scheme develops, we will look to collect feedback from screening champions on effective interventions and on changes in patient behaviour that have resulted from the scheme.</p>	<b>No</b>

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

Insert comments in each section as required	Yes / No
Involvement activity required?  No involvement activity required, we are not proposing a change in the communication method for patients.	No
Formal consultation activity required?	No
Full Equality Impact Assessment (EIA) required?  The minimal reduction in funding for the screening champions in the 45 practices does not stop the national screening programme for bowel and cervical screening for all eligible patients, it may potentially affect the way the champions contact the patients rather than reducing the number of contacts. Decision discussed with engagement and equality colleagues.	No
Communication activity required (patients or staff)?  We will communicate with all practices who will then discuss with staff once the service model has been agreed for 2024 / 2025.	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: <a href="mailto:wycib-leeds.dpo@nhs.net">wycib-leeds.dpo@nhs.net</a> for Leeds ICB or <a href="mailto:wycib-wak.informationgovernance@nhs.net">wycib-wak.informationgovernance@nhs.net</a> 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)	<p>Research from Cancer research UK shows that bowel screening has been increasing since the introduction of FIT testing (CRUK - <a href="https://www.cancerresearchuk.org/health-professional/cancer-screening/bowel-cancer-screening">https://www.cancerresearchuk.org/health-professional/cancer-screening/bowel-cancer-screening</a>) and data from NHS Digital shows that Cervical screening is decreasing (NHS Digital). Campbell et al (2020 - <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6978852/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6978852/</a>) show that the fall in cervical screening rates is greater in the younger cohort of women.</p> <p>This data / research supports that approach set out in the proposal.</p>
Service delivery data such as who receives services	<p>N/A - Unfortunately screening uptake split by demography is not available at a local level and at this stage, we do not have consistent, reliable data to demonstrate the number of contacts being made at a practice level - this is due to issues with recording the data on the clinical system, but we are working to improve this in 2024 / 2025.</p> <p>For the 2023 / 2024 Primary Care Cancer Screening Champions Scheme:</p> <ul style="list-style-type: none"> <li>• 44 out of 45 practices eligible practices signed up to take part.</li> <li>• Of those practices taking part in the scheme: <ul style="list-style-type: none"> <li>○ Analysis suggests that 40 out of 44 have shown an overall increase in uptake of bowel screening between February 2020 and August 2023. In one case the increase in uptake has been as high as 15.4% in that period.</li> <li>○ For IMD 1-4 as a whole in the period February 2020 to August 2023, bowel screening uptake increased from 59.6% to 64.6%.</li> </ul> </li> </ul>

Evidence Source	Details
	<ul style="list-style-type: none"> <li>○ For cervical screening, 7 out of 44 have shown an overall increase in uptake of cervical screening between February 2020 and December 2023. One practice achieved an increase of 4.5% during this period.</li> <li>○ For IMD 1-4 as a whole in the period February 2020 to December 2023, Cervical screening uptake reduced from 69.8% to 65%.</li> </ul>
Consultation / engagement	N/A – Specific consultation / engagement evidence has not been used to inform this proposal.
Experience of care intelligence, knowledge, and insight (complaints, compliments, PALS, National and Local Surveys, Friends and Family Test, consultation outcomes)	N/A - it is not possible to track and trace patients who have attended screening as a result of the work of the primary care screening champions.
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 [Appendix A](#)

<b>Quality Domain</b> 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)	<b>Quality elements and description of impact</b> 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)	<b>Impact: Positive / Negative / Neutral &amp; score</b> (Assess each impact using the Impact Matrix; colour cell RAG)	<b>What action will you take to mitigate any negative impact?</b> How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
<b>1. Patient Safety</b>	<p>N/A - People will continue to be invited for screening following the existing process. No change in patient safety.</p> <p>Evidencing increased patient uptake through the screening champion work rather than national screening be monitored and reported to evidence the value the service adds which may show a positive impact on patient safety.</p>	<b>No impact (0)</b>	<p>Eligible patients will still be contacted through the national screening programme and the screening champions will still be working at the 45 identified practices.</p> <p>We will explore with practices a more robust way of recording the success of the champion's work in the increased uptake of screening, including where possible demographic data.</p>
<b>2. Experience of care</b>	<p>N/A - This scheme is in addition to the existing screening service. No change to experience of care.</p>	<b>No impact (0)</b>	<p>Eligible patients will still be contacted through the national screening programme and the screening champions will still be working at the 45 identified practices</p>



<b>Quality Domain</b> 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)	<b>Quality elements and description of impact</b> 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)	<b>Impact: Positive / Negative / Neutral &amp; score</b> (Assess each impact using the Impact Matrix; colour cell RAG)	<b>What action will you take to mitigate any negative impact?</b> How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
<b>3. Clinical Effectiveness</b>	N/A - This scheme is in addition to the existing service. No change to clinical effectiveness.	<b>No impact (0)</b>	Eligible patients will still be contacted through the national screening programme and the screening champions will still be working at the 45 identified practices.
<b>4. Equality</b>	<p>This work is targeted at a practice level to improve uptake of screening amongst communities who experience health inequalities, barriers to accessing healthcare and often poor health outcomes may be more difficult to complete and the outcomes that these people / communities achieve through screening may be reduced.</p> <p>The data currently evidences a reduced uptake of cervical screening in the lower age bracket.</p>	<b>Negative (-8)</b>	<p>Closer links with Primary Care Networks (PCNs) / Local Care Partnerships (LCPs) in local areas to see whether they could support more to work increase uptake of screening in affected areas.</p> <p>We will explore with practices a more robust way of recording the success of the champion's work in the increased uptake of screening, including where possible demographic data.</p>

<b>Quality Domain</b> 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)	<b>Quality elements and description of impact</b> 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)	<b>Impact: Positive / Negative / Neutral &amp; score</b> (Assess each impact using the Impact Matrix; colour cell RAG)	<b>What action will you take to mitigate any negative impact?</b> How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
			Champions will proactively contact this cohort of patients in the lower age bracket for cervical screening.
<b>5. Safeguarding</b>	N/A - No impact on safeguarding as existing service is continuing.	<b>No impact (0)</b>	Eligible patients will still be contacted through the national screening programme and the screening champions will still be working at the 45 identified practices.
<b>6. Workforce</b>	The focus of the scheme will change which will mean that there will be a stronger focus on first-time attendees for cervical screening. This may change the requirements of the role.	<b>No impact (0)</b>	The screening champions will still be working at the 45 identified practices.
<b>7. Health inequalities</b>	Targeted work at a practice level to improve uptake of screening amongst communities who experience health inequalities, barriers	<b>Negative (-8)</b>	Closer links with PCNs / LCPs in local areas to see whether they could support more to work

<b>Quality Domain</b> 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)	<b>Quality elements and description of impact</b> 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)	<b>Impact: Positive / Negative / Neutral &amp; score</b> (Assess each impact using the Impact Matrix; colour cell RAG)	<b>What action will you take to mitigate any negative impact?</b> How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
	to accessing healthcare and often poor health outcomes may be more difficult to complete and the outcomes that these people/communities achieve through screening may be reduced.		increase uptake of screening in affected areas.  We will explore with practices a more robust way of recording the success of the champion's work in the increased uptake of screening, including where possible demographic data.
<b>8. Sustainability</b>	N/A - No impact on sustainability of the service.	<b>No Impact (0)</b>	
<b>9. Other</b>	N/A - No other issues identified.	<b>No impact (0)</b>	

## H. Action Plan

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

<b>Identified impact</b>	<b>What action will you take to mitigate the impact?</b>	<b>How will you measure impact / monitor progress?</b> (Include all identified positive and negative impacts. Measurement may be an existing or new quality indicator / KPI)	<b>Timescale</b> (When will mitigating action be completed?)	<b>Lead</b> (Person responsible for implementing mitigating action)
Possible increase in health inequalities due to reduction in screening uptake in affected practices.	Form closer links with PCNs / LCPs in local areas to see whether they could support more to work increase the uptake of screening in affected areas.	We will seek feedback from PCNs which are part of the scheme.	March 2025	[Removed for publication]
Possible increase in health inequalities due to reduction in screening uptake in affected practices.	We will explore with practices a more robust way of recording the success of the champion's work in the increased uptake of screening, including where possible demographic data.	We will monitor the completion of the templates to ensure that data recording increases.	March 2025	[Removed for publication]
Possible increase in health inequalities due to reduction in screening uptake in affected practices.	The Champions will proactively contact the cohort of patients in the lower age bracket for cervical screening.	Monitor uptake of screening in areas in practices which are part of the scheme.	March 2025	[Removed for publication]

## 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)

<b>Implementation:</b> State who will monitor / review	<b>Name of individual, group or committee</b>	<b>Role</b>	<b>Frequency</b>
a. that actions to mitigate negative impacts have been taken.	a. [Removed for publication]	Pathway Integration Leader	Quarterly
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]	Pathway Integration Leader	Quarterly

<b>Outcome</b>	<b>Name of individual, group or committee</b>	<b>Role</b>	<b>Date</b>
Who will review the proposal once the change has been implemented to determine what the actual impacts were?	Cancer Population Board	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.

The impacts of this scheme will be minimal, although it is possible that there may be an increase in health inequalities due to a reduction in screening uptake in affected practices. This risk will be mitigated through close working with affected practices and PCNs to ensure that support is provided through alternative structures (e.g. local care partnerships) where possible. We will ensure that data is recorded effectively and that reductions in uptake are identified through regular monitoring of screening returns.

## K: For Team use only

<b>1. Reference</b>	XX /
<b>2. Form completed by (names and roles)</b>	
<b>3. Quality Review completed by:</b>	Name: [Removed for publication] Date: 03.05.2024
<b>4. Equality review completed by:</b>	Name: [Removed for publication] Date: 03.05.2024
<b>5. Date form / scheme agreed for governance</b>	Reviewed at Panel Assurance meeting: 16.05.2024
<b>6. Proposed review date (6 months post implementation date)</b>	January / February 2025
<b>7. Notes</b>	Involvement team reviewed: 8 April 2024 Initial review completed by Quality, Equality, and Involvement in March 2024 Quality and Equality review completed 12.04.2024 and 03.05.2024

## 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	

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

<b>5. Is there any intelligence / service user feedback following the change of the service?</b> 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
<b>Positive</b>	5	Excellence	<p>Multiple enhanced benefits including excellent improvement in access, experience and / or 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.</p> <p>Leading to consistently improvement standards of experience and an enhancement of public confidence, significant improvements to performance and an improved and sustainable workforce.</p>
	4	Major	Major benefits leading to long-term improvements and access, experience and / or outcomes for people with this protected characteristic. Major reduction in health inequalities by narrowing the gap in access, experience and / or 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.
<b>Neutral</b>	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
<b>Negative</b>	-1	Negligible	<p>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.</p> <p>Potential to result in minimal injury requiring no / minimal intervention or treatment, peripheral element of treatment, suboptimal and / or informal complaint / inquiry.</p>
	-2	Minor	<p>Minor negative impact on access, experience and / or 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.</p> <p>Potential to result in minor injury or illness, requiring minor intervention and overall treatment suboptimal.</p>
	-3	Moderate	<p>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.</p> <p>Potential to result in moderate injury requiring professional intervention.</p>
	-4	Major	<p>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.</p> <p>Potential to lead to major injury, leading to long-term incapacity / disability.</p>
	-5	Catastrophic	<p>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.</p> <p>Potential to result in incident leading to death, multiple permanent injuries or irreversible health effects, 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.</p>

## Appendix B: Guidance notes on completing the impacts section G

Domain	Consider
<b>1. Patient Safety</b>	<ul style="list-style-type: none"> <li>• Safe environment.</li> <li>• Preventable harm.</li> <li>• Reliability of safety systems.</li> <li>• Systems and processes to prevent healthcare acquired infection.</li> <li>• Clinical workforce capability and appropriate training and skills.</li> <li>• Provider's meeting CQC Essential Standards.</li> </ul>
<b>2. Experience of care</b>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Coordination and integration of care across the health and social care system.</li> <li>• Information, communication, and education on clinical status, progress, prognosis, and processes of care to facilitate autonomy, self-care, and health promotion.</li> <li>• Physical comfort including pain management, help with activities of daily living, and clean and comfortable surroundings.</li> <li>• 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.</li> <li>• Co-produce with the population and service users as the default position for project design.</li> <li>• Use what we know from insight and feedback in project design and be explicit in the expected outcomes for experience of care improvements.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> </ul> <p>[Adapted from the NHS Patient Experience Framework, DoH 2011] revised in: <a href="https://www.england.nhs.uk/wp-content/uploads/2021/04/nhsi-patient-experience-improvement-framework.pdf">https://www.england.nhs.uk/wp-content/uploads/2021/04/nhsi-patient-experience-improvement-framework.pdf</a></p>

<b>3. Clinical Effectiveness</b>	<ul style="list-style-type: none"> <li>• Implementation of evidence-based practice (NICE, pathways, royal colleges etc.).</li> <li>• Clinical leadership.</li> <li>• Care delivered in most clinically and cost-effective setting.</li> <li>• Variations in care.</li> <li>• The quality of information collected and the systems for monitoring clinical quality.</li> <li>• Locally agreed care pathways.</li> <li>• Clinical engagement.</li> <li>• Elimination of inefficiency and waste.</li> <li>• Service innovation.</li> <li>• Reliability and responsiveness.</li> <li>• Accelerating adoption and diffusion of innovation and care pathway improvement.</li> <li>• Preventing people dying prematurely.</li> <li>• Enhancing quality of life.</li> <li>• Helping people recover from episodes of ill health or following injury.</li> </ul>
<b>4. Equality</b>	<p>In order to answer section C and G4 the groups that need consideration are (use the links for more information):</p> <ul style="list-style-type: none"> <li>• <b>Age:</b> <a href="https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/age-discrimination">https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/age-discrimination</a></li> <li>• <b>Disability:</b> <a href="https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/disability-discrimination">https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/disability-discrimination</a></li> <li>• <b>Gender reassignment:</b> <a href="https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/gender-reassignment-discrimination">https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/gender-reassignment-discrimination</a></li> <li>• <b>Pregnancy and maternity:</b> <a href="https://www.equalityhumanrights.com/en/our-work/managing-pregnancy-and-maternity-workplace">https://www.equalityhumanrights.com/en/our-work/managing-pregnancy-and-maternity-workplace</a></li> <li>• <b>Race:</b> <a href="https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/race-discrimination">https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/race-discrimination</a></li> <li>• <b>Religion or belief:</b> <a href="https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/religion-or-belief-discrimination">https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/religion-or-belief-discrimination</a></li> <li>• <b>Sex:</b> <a href="https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/sex-discrimination">https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/sex-discrimination</a></li> <li>• <b>Sexual orientation:</b> <a href="https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/sexual-orientation-discrimination">https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/sexual-orientation-discrimination</a></li> </ul>

	<p>Other groups would include, but not be limited to, people who are:</p> <ul style="list-style-type: none"> <li>• Carers.</li> <li>• Homeless.</li> <li>• Living in poverty.</li> <li>• Asylum seekers / refugees.</li> <li>• In stigmatised occupations (e.g. sex workers).</li> <li>• Problem substance use.</li> <li>• Geographically isolated (e.g. rural).</li> <li>• People surviving abuse.</li> </ul>
<b>8. Safeguarding</b>	<ul style="list-style-type: none"> <li>• Will this impact on the duty to safeguard children, young people, and adults at risk?</li> <li>• Will this have an impact on Human Rights – for example any increased restrictions on their liberty?</li> </ul>
<b>9. Workforce</b>	<ul style="list-style-type: none"> <li>• Staffing levels.</li> <li>• Morale.</li> <li>• Workload.</li> <li>• Sustainability of service due to workforce changes (Attach key documents where appropriate).</li> </ul>
<b>10. Health Inequalities</b>	<ul style="list-style-type: none"> <li>• Health status, for example, life expectancy.</li> <li>• access to care, for example, availability of given services.</li> <li>• behavioural risks to health, for example, smoking rates.</li> <li>• wider determinants of health, for example, quality of housing.</li> </ul>
<b>11. Sustainability</b>	<p>See: <a href="https://www.bma.org.uk/media/3464/bma-climate-change-and-sustainability-paper-october-2020.pdf">https://www.bma.org.uk/media/3464/bma-climate-change-and-sustainability-paper-october-2020.pdf</a></p> <p>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.</p> <p>Also consider; technology, pharmaceuticals, transport, supply/purchasing, waste, building / sites, and impact of carbon emissions.</p> <p>Visit Greener NHS for more info:  <a href="https://www.england.nhs.uk/greenernhs/">https://www.england.nhs.uk/greenernhs/</a></p>
<b>12. Other</b>	<ul style="list-style-type: none"> <li>• Publicity / reputation.</li> <li>• Percentage over / under performance against existing budget.</li> <li>• Finance including claims.</li> </ul>