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 the appendix).

Assessment Completion	Name	Role	Date	Email
Scheme Lead	[Removed for publication]	Commissioning Programme Lead, Dementia (Leeds City Council job title, in joint role with ICB)	04.09.2024	[Removed for publication]
Programme Lead sign off	[Removed for publication]	Interim Associate Director of Pathway and System Integration, Long Term Conditions, Frailty, End of Life, and Planned Care Populations	04.09.2024	[Removed for publication]

A. Scheme Name	Circles of Support (Provided by Moor Allerton Elderly Care - MAECare)
Type of change	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 proposed change

This QEIA is part of a service review for ‘Circles of Support’, which is one of a group of the NHS West Yorkshire Integrated Care Board in Leeds (ICB in Leeds) third sector contracts under review. Funding has been guaranteed until six months after a decision in September 2024 on the future of the service. The ICB’s ‘funding gap’ has improved, but the financial position of the ICB in Leeds is still under review and savings are still needed.

No decision has been made to date: decommissioning is one option which will be under consideration following the service review. Therefore, decommissioning could be considered a ‘proposal’.

Background & description

Moor Allerton Elderly Care (MAECare) provide an innovative “Circles of Support” model, which was first funded by the NHS Leeds North Clinical Commissioning Group (CCG) ‘Health Grants’ programme in 2016. The service model was designed by MAECare, in response to the unmet needs of local older people and carers living with dementia. The Health Grants programme was administered by Leeds Community Foundation, with the aim of increasing community capacity to support social prescribing. It is an adaptation of a concept originating with people with a learning disability. It’s important to note that it was a provider innovation; so not designed by commissioners and not funded citywide. It has the potential to be the basis of a city-wide model of post-diagnosis care but originated as a local scheme for the MAECare area.

- Enable people living with dementia to stay longer in the mild / moderate stages of the condition.
- Carry out home visits with people and family members / carers, leading to co-produced action plans which include taking up MAECare services and referrals to other services.
- Strengthen people’s support networks and establish routines, to improve wellbeing and keep people living at home for longer.
- Offer group sessions: ‘Active Minds’ Cognitive Stimulation Therapy; a 'Silver Linings’ activity group; and a ‘Sporting Memories’ group.
    - Cognitive Stimulation Therapy is a NICE-recommended non-drug treatment for mild / moderate dementia.

The service was co-designed by MAECare staff and people and carers living with dementia in 2017- 2018, as a successful bid for Health Grants, offered by the former NHS Leeds North CCG. This grant programme aimed to build community capacity linked to social prescribing. It evaluated successfully and since 1 April 2020 has been sustained by a low-value contract (2023-2024 value was £29,205 per annum; a 3% cut has already been applied for 2024-2025, so the current annual value is £28,328).

'Headline’ numbers for service activity and throughput:

- From May 2016 to the end May 2024, the service has worked with 107 people.

- The service typically works with 30 people living with dementia at any one time (this was the figure at the end of May 2024), plus carers and family members.
- The lengths of time with the service for those 30 people ranged from 1 month to 5.6 years; average 1.9 years.
- In the calendar year 2023, 13 people started the service.

ICB strategy and programmes

It thereby has a positive, local impact on all three outcomes defined by the Frailty Programme and the Healthy Leeds Plan.

- Live and age well defined by 'what matters to me'.
    - Keeping up with activities, whether lifelong interests or new opportunities, to live well with dementia.
    - Support to enjoy activities with family / unpaid carers, to sustain relationships; and without, to offer carers a break.
- Be identified, supported and have their needs assessed.
    - A person-centred approach to post-diagnosis care and treatment
    - Home visits, and conversations with people and carers, leading to action plans.
    - NICE-recommended intervention to delay the progress of dementia and reduce demand on NHS provision.
- Reducing avoidable disruption to people's lives as a result of contact with services
    - The service keeps people well for longer with dementia and ensures people are known and monitored, improving the prospects for timely intervention before a crisis.
    - Evidence from carers who attribute their ability to continue supporting the person, to the break they get and the positive impact on the wellbeing of the person with dementia.

Health Inequalities

- MAECare is located on the Cranmer Bank estate, in the centre of three census 'lower super-output areas' among the 10% most deprived areas in Leeds. Most of the MAECare catchment area is more affluent.
- Its geographical catchment area is socially and ethnically mixed. Although the Council's Neighbourhood Networks are based on 'natural' neighbourhoods rather than political boundaries, the MAECare area broadly covers Alwoodley and Moortown wards. These ward populations are, compared to Leeds as a whole:
    - Generally older than Leeds as a whole (Alwoodley has 9.7% of people aged over 75; Moortown 8.1%, Leeds 7.3%).
    - Less likely to live in the most deprived areas: looking at the percentage of the population who live in the most deprived decile of Census output areas, for Leeds, this is 24%; Alwoodley 12.5%; Moortown 7.7%. However, this does mean that approximately 5,000 people across the two wards are among the most deprived 10%. It is striking that the wards have no Census output areas

    in the third, fourth or fifth most deprived deciles – i.e. Localities are divided between a relatively affluent majority and a minority living with social and health inequalities.
  - Regarding unpaid care, very similar to Leeds: 2.3%-2.4% of people are carrying out 50 hrs or more per week of unpaid care.
  - Slightly less likely to say they have a long-term illness that “limits me a lot”: 6.9% for Leeds, 6.6% for Moortown, 6.4% for Alwoodley.
  - Less likely to identify as ‘White’: 79% for Leeds, 69% for Moortown, 67% for Alwoodley. For both wards, 20% of people identify as ‘Asian’. 55% of people in Leeds who identify as ‘Jewish’ (as a religion) live in these two wards.
- People living with dementia often have co-morbid other health conditions – as a consequence of the progress of dementia. The most recent quarterly monitoring (end March 2024) shows that, of 30 people being supported,19 people live with mobility difficulties, sensory needs, breathing difficulties and/or cancer.
- Dementia is a risk factor for isolation, loss of the sense of self and depression. 27 of the 30 people supported at the end March 2024 meet at least one of the following criteria:
  - Lives alone and has very limited or no developed support network.
  - Has very limited or no regular engagement in social activities.
  - Has family living at a distance or not engaged in support.
  - Is part of a couple where the other person has health needs or dementia.
  - Is part of a couple / family where one person is the only carer involved with no formal care package support and cannot leave the person on their own.

Dementia itself is a health inequality; including a risk factor for hospital admissions, long lengths of stay and death in hospital. The prevalence of the condition is similar across different populations, whether more deprived and younger; or more affluent and older.

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

To be completed in conjunction with:

- Quality Manager: [Removed for publication]
- Equality Lead: [Removed for publication]
- Community Relations and 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? The options for changing the service / reducing the funding are limited or absent, especially as a 3% cut (higher in real terms) has already been absorbed from April 2024. • The Circles of Support service is a small-scale operation with one main staff member working 24 hours each week, and two colleagues sharing seven hours each week (also with other main roles in the organisation). There are low management and overhead costs. It is hard to see how a cut in funding could be absorbed by changing the delivery model. MAECare could not sustain Circles of Support without dedicated funding. There is one other Neighbourhood Network in Leeds which has a dedicated role for people with dementia and other access / inclusion needs, and they are currently funding the role from within their own reserves after a one-year grant from the local Primary Care Network. That organisation is developing a business model based on ownership of a community hall asset, which gives opportunities to generate income which are not open to MAECare. • MAECare have already made changes to support more people within the contract funding. They have extended the offer of Cognitive Stimulation Therapy to the wider north-east and east Leeds area, to match the catchment of the Leeds and York Partnership NHS Foundation Trust (LYPFT) Older People's Locality Team, and link with other Neighbourhood Networks. This has been welcomed by the two LYPFT old-age psychiatry consultants for the area. There have been 11 people who have attended / are attending / will attend the 'Active Minds' Cognitive Stimulation Therapy group from outside the MAECare catchment area. • MAECare already offers added value, through four active volunteers on the project and because the Circles of Support service funding does not cover any of the management and overheads. Reducing the grant would affect viability as well as reduce capacity for the number of people supported.	**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. • Dementia is a condition that causes a range of cognitive and physical impairments. Everyone supported by the project therefore has the protected characteristic of disability, and carers experience the impact by proxy. • 19 of the 30 people using the service have other physical disabilities / mobility needs / other long-term conditions. • Three people identify in diverse ethnic communities – 1 'Black African', 2 'Polish'. Two people identify with Jewish religion.	**Yes**

Questions (please describe the impact in each section)	Yes / No
○ Service monitoring has seven people with unknown / not stated ethnicity; [Removed for publication] has asked for improved data quality unless people are asked the monitoring question and prefer not to say. • This is a direct service delivery and any cut in funding would have at least a proportional effect on impact, if not make the service non-viable. • Removal of funding would lead to the loss of the dedicated offer of individual support planning; ‘Active Minds’ CST group; ‘Silver Linings’ group and Sporting Memories group. • There would still be uptake of MAECare Neighbourhood Network mainstream activities by people living with dementia. • Loss of a good practice model for neighbourhood support, which we could seek to expand from other funding sources. • There would be a wider impact on service development with other Neighbourhood Networks. The Circles of Support worker belongs to our Leeds-wide group to extend the availability of CST. She offers opportunities for staff and volunteers to shadow the MAECare sessions and has supported the Royal Voluntary Service (RVS) to set up a CST group covering Roundhay / Meanwood / Chapel Allerton / Chapeltown.	
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? A funding cut would directly cut staffing hours. The main Circles of Support worker is part-time.	**Yes**
4. Does the project build on feedback received from patients, carers, and families, including patient experience? What feedback and include links if available. • MAECare’s quarterly monitoring reports include individual narratives, outcomes and quotes from people, and examples of individual Action Plans. • The commissioning lead [Removed for publication] has visited the service in the past; and during March-May 2024 there have been four visits / meetings, as well as correspondence: • Visit to “Active Minds” Cognitive Stimulation Therapy group, 21 March 2024 • Meeting with MAECare staff 23 April 2024: ○ Chief Operating Officer ○ Dementia Support Worker (main staff member employed with contract funding) ○ Dementia Group Worker ○ Advocacy Worker • Visit to “Silver Linings” group, 14 May 2024	**Yes**

Questions (please describe the impact in each section)	**Yes / No**
• Consultation meeting to discuss service review and impact assessment (see Appendix 1) 23 May 2024. Attended by: ○ People living with dementia and carers who use the service ○ Staff and volunteers with the service ○ Memory Support Worker • Correspondence: with Chair of Trustees; Chief Operating Officer; two people unable to attend the 23rd May meeting. Appendices C, D and E are copied from the service review document and summarises feedback from the 23 May meeting; individual examples from contract monitoring, and an email from a family carer.	

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

Insert comments in each section as required	**Yes / No**
Involvement activity required? Engagement has been carried out as described above. The possibility of decommissioning was open and shared at the meeting with staff on 23 April 2024 and with people and carers who use the service on 23 May. The visits to Active Minds and Silver Linings groups were ‘softer’ engagement, around the experience and value of the service. The decision to not explicitly raise the decommissioning option there was made with the staff, for therapeutic reasons; and because people with dementia and carers had the opportunity to also attend the 23 May meeting. Consultation (engagement) is required with people directly affected by the decision; in the sense of ‘consultation’ used in statutory guidance on decision-making by public bodies (Council). The specific possibility of decommissioning has been consulted on, as described above, with people, carers and staff affected; so, these meetings were more than a general engagement about the experience and value of the service.	**Yes**

Insert comments in each section as required	**Yes / No**
Formal consultation activity required? A formal public consultation exercise is not required, given the small scale of the service.	**No**
Full Equality Impact Assessment (EIA) required? EIA submitted	**Yes**
Communication activity required (patients or staff)? Communications will be required to inform and support staff and people and their family members / carers, including sign-posting to alternative provision.	**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)	• NICE Guideline NG97 (2018) - Dementia: assessment, management and support for people living with dementia and their carers (https://www.nice.org.uk/guidance/ng97/chapter/Recommendations) . The service fits the recommendations under “1.4 Interventions to promote cognition, independence and wellbeing”: 1.4.1 Offer a range of activities to promote well-being that are tailored to the person's preferences. 1.4.2 Offer group cognitive stimulation therapy to people living with mild to moderate dementia. 1.4.3 Consider group reminiscence therapy for people living with mild to moderate dementia. • Leeds Health and Care Plan. ○ Link to Frailty outcomes described above at B. - ICB Strategy and Programmes. • Living With dementia In Leeds – Our strategy 2020 - 2025 (https://www.leeds.gov.uk/Pages/Dementia-strategy.aspx) ○ Outcome 3: People will be connected to support, not slip through the net. They will be less likely to reach crisis point before asking for help. ○ ‘Building Block’ 2 – Timely diagnosis and support references the Circles of Support approach, and Cognitive Stimulation Therapy (CST) Priority 2 – Demographics, diversity, and emerging needs: includes “meet demand by investing in capacity for diagnosis and community support.
Service delivery data such as who receives services	MAECare’s quarterly monitoring provides a great deal of detail regarding people supported; attendance at the different groups; people new to the service and leaving the service, and reasons for leaving; demographic details and health needs of people using the service, safeguarding, successes, and challenges, and ‘case studies.
Consultation / engagement	As described at 4. above, there has been a series of visits, meetings, and correspondence. Appendices C, D and E provide summary plus detail.
Experience of care intelligence, knowledge, and insight (complaints,	No information from these sources, which are mainly relevant to NHS providers.

Evidence Source	**Details**
compliments, PALS, National and Local Surveys, Friends and Family Test, consultation outcomes)	
Other	The LYPFT older people’s locality team, based at St Marys House, LS7 welcomed the opening of ‘Active Minds’ Cognitive Stimulation Therapy places to the whole of their area of east and north-east Leeds, and have referred people in. LYPFT clinical colleagues generally recognise the high importance of community organisations and day activities. The LYPFT Memory Assessment Service pathway has a very limited post-diagnostic offer of one visit from a Memory Nurse, and (when prescribed) stabilisation / titration on Alzheimers medication. They rely on community groups to support people after diagnosis, and a reduction in community capacity risks increased demand on NHS provision.

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	The service does keep people safe and well at home and reduces vulnerability to exploitation by reducing isolation. People with dementia are more at risk from adverse health events and hospital admissions. However, there is no direct impact on NHS service safety or risk.	**-5**	If ICB funding is withdrawn, the service would have to raise alternative funding to continue. Independent funders do not usually wish to replace statutory funding. Some people with mild dementia could continue to access other MAECare activities, but the most vulnerable would lose the dedicated dementia-specific support. In the Service Review this is described in terms of the three Frailty Outcomes; MAECare would be able to achieve only the first of the three outcomes and with fewer people. Mapping to be completed of the full range of dementia interventions available for people with early-stage dementia; and

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?
		🟧	how these are accessed in different communities.
2. Experience of care	Loss of a service that supports people to live well with dementia. Of the 30 people using the service currently, 27 people at the point of referral met one or more of the following: • living alone / no or very limited support network. • No or very limited engagement in social activity. • Family living at a distance / not engaged. Part of a couple and partner living with health needs / dementia.	**-15**	MAECare would still offer access to their mainstream offer to include people with dementia, e.g. reminder calls. However, the loss of specific services would be harmful in the subsequent months / years. The pandemic showed us that people with dementia can deteriorate quickly when routines and opportunities are disrupted. Mapping to be completed of the full range of dementia interventions available for people with early-stage dementia; and how these are accessed in different communities.

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?
3. Clinical Effectiveness	There would no longer be provision by MAECare of Cognitive Stimulation Therapy (CST), an evidence-based therapy for people with mild / moderate dementia. This goes beyond the MAECare catchment area; 11 people from elsewhere in north-east Leeds have been referred for CST in the past year. Furthermore, the Active Minds group has given third-sector staff and volunteers the opportunity to shadow and learn in practice following CST online training.	**-15**	The nearest alternative CST groups currently is at Holt Park, provided by LYPFT and Leeds City Council Peer Support Service. There is a waiting list and a transport barrier. In other areas of Leeds, Age UK Leeds provides CST but this is also at risk from the ending of external funding.
4. Equality	Everyone using the service has the protected characteristic of disability, because of dementia causing cognitive and physical impairments. Service monitoring indicates that of the 31 people using the service at end March 2024:	**-15**	Application for alternative funding as above. There are no comparable services available for this level and quality of community support. Some people would be able to continue accessing other MAECare activities.

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?
	- everyone using the service is aged over 70, of whom, 21 people are people aged over 85. - 19 people live with a long-term physical health condition and / or limited mobility and / or falls risk. Three people identify with minority ethnicities, three with Jewish faith	🟥	
5. Safeguarding	People who are isolated are more vulnerable to scams / exploitation. (See e.g. p7. https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/money-matters/financial_abuse_evidence_review-nov_2015.pdf)	🟧 **-5**	Some people will be able to benefit from MAECare's mainstream service offer, to continue with some level of social engagement.
6. Workforce	Loss of one job (24 hours per week) in the third sector workforce, and reduction in hours for two other posts (four hours plus three hours per week).	🟧 **-5**	The only mitigation for this would be securing an alternative, sustainable source of funding.

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?
7. Health inequalities	Everyone with dementia is living with a health inequality, with higher risks of acute illness, hospital admission, longer lengths of stay, not being able to return home, or mortality in hospital. Carers of people with dementia are more likely to experience poor health outcomes. The MAECare area as a whole is mixed socially and ethnically. MAECare offices are in the middle of three Lower Super Output Areas (LSOAs) in the 10% most deprived areas of Leeds. See Health Inequalities paragraph above, under B. Summary of Change.	**-15**	Mitigation would again be based on the very unlikely event of securing alternative long-term funding, and some people being able to continue accessing MAECare's 'mainstream' services. There are no equivalent alternative services.
	Service monitoring data (April - June 2024) shows that there were 33 people who used the service in that time: • 25 women and eight men. • All 33 people are over the age of 70; of whom 24 are over the age of 85.		

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?
	• 24 identify as ‘White British’; one ‘Black African’, three White European (two Polish, one Austrian). Five people have not specified their ethnicity. • 22 people have at least one element of physical frailty: use of a wheeled walking aid / history of falls / volunteer to assist with mobility needs / long-term health condition / visual impairment. Six people live alone with dementia and had no or very limited support network when referred; six people live with a partner who has significant health needs in their own right; nine people live with a sole carer who cannot safely leave the person alone.	🟥	
8. Sustainability	The loss of this service would lead to more people seeking help and increasing demand for NHS provision. Feedback in the consultation meetings referred to the wellbeing outcomes achieved by the service; the gaps in post-diagnosis support from the	**-5**	Mitigation would again be based on the very unlikely event of securing alternative long-term funding, and some people being able to continue accessing MAECare’s ‘mainstream’ services.

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	NHS; and the way that carers are enabled to sustain caring roles.	🟧	There are no equivalent alternative services.
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)
Range of impacts	Encourage the provider to seek alternative funding. This is unlikely to succeed, and highly unlikely to lead to sustainable recurrent funding.	Success or otherwise of sustaining the service with alternative funding	October 2024 – March 2025	Contracting – suggestion would be included in contract notice letter – [Removed for publication] to ensure completed
Range of impacts	Ensure that whenever possible, people who use Circles of Support are able to access / continue accessing other MAECare services. Ask MAECare to continue with reminder calls, inclusive attitudes, and transport provision.	Count the number of individuals accessing MAECare services; and those unable to because they need a dementia-specific offer.	For discussion with MAECare and Neighbourhood Network	[Removed for publication]
Clinical effectiveness	Seek to make Cognitive Stimulation Therapy (CST) available for Alwoodley / Moortown residents elsewhere in Leeds. However, there is currently no practical alternative.	Success or otherwise at developing alternative CST services without equivalent funding / exploration of provision within statutory services long-term	To progress the exploration of future options via discussions with the Frailty Population Board	[Removed for publication]
Health inequalities	Advise people and carers living with dementia to seek support from primary care,	N/A	Spotlight to remain via Frailty Population Board	[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)
	LYPFT and local authority social care. Engagement to date has emphasised the lack of alternatives and mitigation. Mapping to be completed of the full range of dementia interventions available for people with early-stage dementia; and how these are accessed in different communities.			

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.	Impacts to be assessed by [Removed for publication] and reported to the Frailty Population Board		
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	Impacts to be assessed by [Removed for publication] and reported to the Frailty Population Board		

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?	Impacts to be assessed by [Removed for publication] and reported to the Frailty Population Board		

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.

This is a much-valued service that costs less than £20 per person per week to build and sustain social networks, and activities, and provides a NICE-recommended therapy for people living with dementia. Everyone using the service has the protected characteristic of disability related to dementia, carers experience disability by proxy. Living well with dementia prevents the need for more intensive and unplanned services, and reduces vulnerability caused by isolation. It is an excellent fit with our Frailty outcomes and Leeds dementia strategy. Although the ICB does not fund similar services in other Neighbourhood Networks, it supports service development in other geographical areas and provides an example of excellence that we're building on through networks and partnerships. 'Levelling down' would not be a meaningful example of equality.

K: For Team use only

1. Reference	XX /
2. Form completed by (names and roles)	[Removed for publication]
3. Quality Review completed by:	Name: [Removed for publication] Date: 23.04.2024 Second Review: 19.06.2024
4. Equality review completed by:	Name: [Removed for publication] Date: 23.04.2024 Second Review: 18.06.2024 Third Review: 11.09.2024
5. Date form / scheme agreed for governance	Reviewed at Panel Assurance meeting: 11.07.2024

6. Proposed review date (6 months post implementation date)	September 2025
7. Notes	Involvement team reviewed: 10 April 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	[Removed for publication]	**Yes**	11/09/2024
Proposed 6-month review date (post implementation)	September 2025	**Yes**	

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. 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.

APPENDIX C - Summary of Consultation meeting 23 May 2024

Held [Removed for publication] and reported to the Frailty Population Board 10.45am - 12.15pm, Thursday 23 May. The time was chosen to fit with the usual timing of the ‘Silver Linings’ group, to involve as many people as possible.

Attendance:

Everyone at the meeting took turns to introduce themselves and their role / reason for being there. There were 21 people present: six people living with dementia; seven family carers; three volunteers; three MAECare staff; one Alzheimer’s Society staff (local Memory Support Worker); and [Removed for publication]

The impact of dementia

“I can relax and feel happy here. Outside here I hide that I have a problem. I find it difficult; my sense of self doesn’t hold together.” - Person with dementia

People and carers living with dementia talked about the differences that dementia made in their lives. One carer had given up his retirement plans to look after his mother-in-law, so his wife could continue working; he had managed one long-distance walk between retirement and taking up the caring role. He said that the impact of attending the group is that when he comes to pick her up, “she’s become who she was ten years ago”.

Two carers had found the diagnosis process quick and efficient, but then a strong sense of a gap / “now what?”.

One former carer, who had looked after his mum for ten years, referred to the struggle to cope with the progress of the condition. A person with dementia said that without the service, “…I don’t know where I’d be – it sees me through the day and week”.

1. Being connected to a group, not being isolated.

“Mum has vascular dementia and a severe hearing impairment. She had become isolated, and now has made friends.” - Carer

Although this meeting was at the time of the ‘Silver Linings’ fortnightly group, many people mentioned being connected to other MAECare activities and other local groups, via the ‘Circles of Support’ approach; for example Knit and Natter; ‘Extend’ exercise; Active Minds (Cognitive Stimulation Therapy group); Keep Fit class; Sporting Memories. This works in different ways: At previous visits, I’d seen how the support and structure brought out people who seemed withdrawn; whereas one carer at this meeting said, “She’s a sociable person – without this she wouldn’t have a world”. Another carer said, “It would do her harm if this service were withdrawn”.

2. Access to other services.

The Memory Support Worker explained that she refers a lot of people into MAECare, and also is the contact point for when people “need more” e.g. Older People’s Community Mental Health Team. In the autumn of 2023, she worked with MAECare to put on the Alzheimer’s Society’s “Living Well With Dementia” course, which supported people to access other help, advice and services.

3. Carer Breaks and ability to cope

The son-in-law carer was clear that the two hours at the group is his only break, but that this makes a huge difference for him. He explained that “she wouldn’t cope with a one-to-one service” – but that he can be “at the end of my tether” when dropping her off, at the point of tears; yet ready to “go again” when he picks her up. The bereaved carer’s mum had only had paid care staff for a short time at the end of her ten years with dementia. Another carer said that she works full time, and although her mum (diagnosed a year ago) can sit on her own, there would be “guilt” and “practical problems” if she wasn’t able to leave her mum with the service.

4. Quality of service and activities

“Knowledge, care and preparation.” - Volunteer

The structure of sessions and the planning that goes into the groups and sessions was noted by many people and was a feature of the groups I’d visited previously. One carer said her mum attends voluntary church groups, but it’s “not the same – it’s different here and she changes”. Four men (two with dementia, one former carer, one volunteer) explained how good the Sporting Memories group is for them, and how they wished it could be more frequent. They joked that it involves reminiscing and exaggerating how good they were at sport “thirty years ago”. The “Active Minds” Cognitive Stimulation Therapy group was praised especially for the structure and preparation – which is essential for the therapy – and two people mentioned that it had been difficult to step down from the weekly activity to the fortnightly ‘Silver Linings’ group. So, wanting more of the same was a theme, as was the level of confidence in MAECare.

5. Statement from Chair of Trustees

At the conclusion of the meeting, the Chair of Trustees, who also is a volunteer for MAECare’s work with people living with dementia, pointed out that having twenty-one people present from different areas including service users, carers, volunteers, and staff showed the depth of feeling regarding the important work MAECare was doing in the field of dementia both directly and indirectly. He echoed the feeling by those present that any loss of funding would be outweighed by the probable extra cost many times over in terms of NHS resources including GP practices, social services and even hospital beds. A strong network of staff, volunteers and other resources has been built up since the inception of Circles of Support. MAECare might be seen as an ‘anomaly’ in the work of dementia within Leeds but funding should be extended to other Neighbourhood Networks not reduced or cut in any way.

6. A model for Leeds to follow

In my introduction to the meeting, I mentioned that other Neighbourhood Networks don’t have the equivalent NHS funding to develop the ‘Circles of Support’ model or level of service. This was picked up by carers, with comments including “let’s look at expansion”; “lots of carers talk about a gap - MAECare fills it”; and “build on the pilot”; that it saves funding compared to the one-to-one services, GP practice time and social work time that people would otherwise need.

APPENDIX D - From a family carer unable to attend the consultation meeting

“I’m not sure that there is a more devastating diagnosis, as receiving the news that your loved one has dementia. The thought that you will slowly lose the person you so dearly love over time, seeing every single thing that makes them who they are gradually disappear is heartbreaking.

“But it turns out the reality of it is far worse than you could ever imagine it being. Our family have been dealing with the heartbreak of slowly seeing our beloved mum and wife leave us for the last seven years. Having the grief of not having ‘mum’ around, but instead the increasingly difficult responsibility to care for her, to ensure she is safe, happy, and well looked after, is incredibly difficult emotionally and physically.

“But to add to the personal heartbreak, you find that you are battling against a disjointed and all too often, an unsympathetic system. It feels like hurdles are there at every stage, and every type of support needs its own referral, long waits and that’s when you know about what is available.

“Our personal experience of having a social worker, for whatever limited time they are ‘able to work with us’ before they tick the right box on a form and put us to the back of the queue has been frustrating. All too often we’ve heard ‘I can’t advise on that’, ‘you’ll need to refer to this or that team’, and ‘once I’ve done …. that will be the end of my involvement’.

“The experience is somewhat the same with the interactions with the NHS, you’re only under the care of the memory clinic for short bursts following a referral from the GP. And there is no ongoing support / check-ups by the GP either.

“So, if we can’t rely on the formal systems of care to help and support us to navigate the continual changes in the disease itself as well as the complexities of accessing any help, including just having someone to talk to, really listen and empathise with the hardship, where do we go?

“The answer for us, and I am sure many families like us, is MaeCare. Quite simply without the support of [Removed for publication] the team, we would not have been able to cope. Right from the beginning we have been supplied with information, guidance as well as that all-important sympathetic ear. The team have also helped us link in or reconnect us to support from other relevant professionals, which has been incredibly helpful.

“My mum, before her condition has deteriorated too much, spent time at the Silver Linings group, enjoying the varied activities. This gave my dad a much-needed break to go shopping and have a bit of time to himself. My dad has also been able to meet other carers in his position, and attends the carers group regularly, which provides him with an invaluable source of support and reassurance.

“To date, we have cared for mum, at home, as a family (so no paid-for carers). With my dad being the main carer, and completely exhausting himself doing so. The support provided by MaeCare has helped this to continue as long as it has. I would urge you to consider not whether, as a council, you can afford to continue to fund these services, but whether you can afford the cost of NOT funding this kind of practical and emotional lifeline for those living with dementia and their dedicated but exhausted families.”

APPENDIX E - Individual stories / ‘case studies’ shared as part of contract monitoring

[Removed for publication] from 2021 - 2022

Daughter’s view:

‘My parents moved from London to Leeds at the start of 2022, primarily to be closer to family. Dad was only formally diagnosed with dementia towards the end of 2021, and MAECare was recommended to me by a friend (who had experience of a family member with dementia). From my very first contact with them, they've been nothing short of fantastic. In fact, the MAECare sessions are the focus - and highlight - of Dad's week.

“I was particularly impressed that [the Dementia Project Worker] initially came to visit my parents at home to get to know them. Because of that, she has a real understanding of Dad and what groups might be appropriate and enjoyable for him. From the outset, I got the impression that MAE Care is very focussed on ensuring that all service users are treated as individuals. Nothing has been too much trouble.

“Dad now attends the Tuesday Active Minds group, the alternate Wednesdays Sporting Memories group, and a chair-based exercise group on Mondays (which was recommended by [worker’s name]). He was initially very worried about starting the groups and didn't really know what to expect, but after the first session, he settled right in. The staff and other helpers have been incredibly welcoming and very supportive, and he is now often the last to leave the session as he can’t stop talking! The groups are a fantastic outlet for him to socialise, interact and engage with people, and he really enjoys this. The group sessions are very stimulating for Dad and in my personal opinion the MAECare sessions really enrich his life.

“As a carer, I have also felt the positive impact that MAECare has had on our family. It can be daunting navigating life after a family member is diagnosed with dementia, but [the Dementia Project Worker] has provided support, help and advice to me on an ongoing basis, and I'm very grateful for this.”

[Removed for publication] view:

“Recollecting…. and bringing oneself makes you part of a lived experience. It brings things alive again and gives them animation. It makes life real and enjoyable, otherwise you’re a robot. Fantastic things have been done and lived through and seen and to recollect brings it alive again. We’ve all created things, done things, been moved. And that’s why I enjoy it”.

[Removed for publication], from 2022 - 2023 Q3

[Removed for publication] and her partner moved to Leeds from another county to live with RW’s daughter and son-in-law. Partner was terminally ill and passed away in 2020. [Removed for publication] living with dementia.

[Removed for publication] took part in a few small groups for people living with dementia when MAECare was slowly opening up again after lockdown in Autumn 2021. There was then a lack of contact from family after this and not able to reach [Removed for publication] despite lots of attempts including phone calls, emails and a letter to son-in-law who was the main contact.

COS Dementia Support Worker contacted the Alzheimer's Society worker, who got back in touch with family; the daughter then made contact with MAECare. It seemed that son-in-law was less sure that MAECare activities would benefit [Removed for publication] because of her memory loss and his perceived difficulties with her joining in. So perhaps had not responded because of that. However, the daughter was interested to hear what support was available.

Home Visit carried out to [Removed for publication], daughter and son-in-law in Summer 2022. Identified activities and groups of interest to [Removed for publication] who is a sociable and outgoing person, keen to talk about her past experiences working in the police force and her love of Elvis and his music!

Supported [Removed for publication] and family to gradually build a routine of groups / activities. This included the involvement of MAECare colleagues and volunteers in terms of settling [Removed for publication] into activities / providing appropriate support (such as reminding [Removed for publication] where the toilets were on outings, reassuring her of timings of when being picked up afterwards by family etc).

[Removed for publication] now attends a wide variety of MAECare events: Active Minds CST group, Twilight Zone, outings, and one-off events such as a Christmas party and pantomime. [Removed for publication] is a lively and active participant with a big sense of humour. [Removed for publication] also has quite significant short-term memory loss e.g. will forget what she has been doing earlier that day or what she has just been talking about. However, MAECare has become a familiar, friendly, and safe place for her where she is included and able to take part (both in dementia-specific groups and also in groups open to all which are dementia-friendly).

[Removed for publication]’s comment when we asked for feedback from the Active Minds session was:

“It’s nice because when I came to live with my daughter in Leeds, I left my friends behind. It’s nice to get to know people here. I love coming here."