

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](#) on page 10.

Assessment Completion	Name	Role	Date	Email
Scheme Lead	[Removed for publication]	Integration Manager	21/02/2024	[Removed for publication]
Programme Lead sign off	[Removed for publication]	Head of System Flow	21/02/2024	[Removed for publication]

A. Scheme Name	O024 - Neighbourhood Team top up funding O025 - Community Beds savings (Home First) Delivery of target
Type of change	Start new
ICB	Leeds for WYICB

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).

These two schemes are the benefits realisation of the HomeFirst programme, which is supporting people to better outcomes by supporting people to be independent for longer and providing care closer to home.

O025 - Due to successful outcomes of the HomeFirst Programme the need for intermediate care beds in Leeds is decreasing, this scheme will reduce the intermediate care bed base by 30 beds from 223 - 193 from 15th May 2024. These 30 beds equate to 6 discharges a week from the acute trust at current length of stay and rates of efficiency. The HomeFirst Programme is working to decrease the length of stay within the beds and improve efficiency to support more people through fewer beds; this improvement is coupled with a decrease demand for pathway 2 beds through culture change and capacity improvements in support at home services alongside widening criteria.

O024 - To support acute discharges it is recognised that more care at home is required. For a number of years, the Neighbourhood Teams capacity is being supplemented by non - recurrent funding to partner with private home care, in recognition that a capacity increase is required for future demand, recurrent funding has been provided to LCH from 1st April 2024 to allow substantive staff to be recruited and provide more cost - effective model of care. A non - recurrent funding stream of £769k will be stopped and recurrent provision of £1.5m added to the LCH contract via the Better Care Fund.

Through the HomeFirst Programme there has been a communication workstream working to ensure that patients and staff are aware of the evidence base regarding the benefits of a Home First approach and the improvements in home-based intermediate care service offers. In line with national standards people are offered a choice of intermediate care pathway and not a choice of provider on a given pathway, as such the closure of 30 beds does not change the service offer for people and they will continue to receive the most appropriate care for their level of need. People can stay up to date with the improvements in the intermediate care offer through the HomeFirst communications via the Newsletters and Websites and Public engagement forums. There is a patient representative working with the HomeFirst Programme to ensure that the voice of the patient is considered with all changes the programme is making and the improvements in at home services created through O024 are aligned to what matters most to service users. Patient and Carer experience of intermediate care services is measured through PREMS data and monitored regularly in provider governance groups – the impact of these changes will be measured through the PREMS reports.

Staff who will be moving locations have been informed and provider HR teams are supporting the teams with the move, this does not require formal consultation as the requirement to work across community settings is included in the contract, however, care and consideration is being given to the impact on staff wellbeing.

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?	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 page 10 for more detail.	No
3. Could the project directly affect staff? For example, would staff need to work differently / could it change working patterns, location etc.? Is it likely to specifically affect staff from protected groups?	Yes
<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>HomeFirst Patient and Carer 'I' Statements: [*HomeFirst I Statements.pptx* was reviewed by the panel, the link to this document has been removed for publication] Patient and Staff Experience – PREMS data and Staff survey results [*Frontrunner Presentation Involving People Leeds.pptx* was reviewed by the panel, the link to this document has been removed for publication]</p>	Yes

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

Insert comments in each section as required	Yes / No
<p>Involvement activity required?</p> <p>([Removed for publication] 03/05/24 - As the service offer for patients remains unchanged by these schemes, I don't feel there is a need for any engagement at this time – although I do note there is a potential impact on up to 6 people per week as a result of increased waiting time – mitigation is that this will be closely monitored. As with any service, we would hope that regular collection of patient feedback is implemented and used in ongoing service improvement, and it may be useful to carry out a review with patients, carers, etc. after the first 12 months or so to sense-check how it's going. Also note that a patient representative is involved in the HomeFirst work (am assuming they have some involvement in this change too...), which is really positive. So, I think it's a No for engagement activity at this time.)</p>	No
<p>Formal consultation activity required?</p>	No
<p>Full Equality Impact Assessment (EIA) required?</p>	No
<p>Communication activity required (patients or staff)?</p> <p>([Removed for publication] 03/05/24 - As mentioned above, the project could directly affect staff, and they are being kept informed of changes by provider HR teams and through HomeFirst communications. I think it will be important to continue to communicate with staff throughout the change, ensuring there are opportunities to raise queries, flag any areas of concern and equally note successes and learning. It may also be useful to involve staff in a learning review to feed into ongoing service improvement. So, I think this is a Yes for communication activity with staff. In addition, the HomeFirst communications, including newsletter, website and public engagement forum sound like really positive ways to communicate with wider stakeholders including patients and members of the public).</p>	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?	No
If yes, please email the IG Team at: wycb-leeds.dpo@nhs.net for Leeds ICB or wycb-wak.informationgovernance@nhs.net for the wider West Yorkshire ICB, to complete the screening form.	

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)	Intermediate Care Framework (NHS England 2023) Hospital Discharge and Community Support Guidance (NHS England 2024) Why Not Home? Why Not Today (Better Care Support Programme, 2017) Better Care Fund Best Practice
Service delivery data such as who receives services	<ul style="list-style-type: none">Intermediate care services are predominately used by those are over 65 and living with frailty.The average age of people who use CCBs (intermediate care beds) is 83; 69% of people who use CCBs are over 80.65% of people who use CCBs are female, 35% are male. It is statistically significant that the proportion of males who use CCBs is below the proportion of males in any comparison cohort.

Evidence Source	Details
	<ul style="list-style-type: none"> • The proportion of people from a Black background, a Chinese and other background, and a mixed background who access CCBs is around the proportion of people from Leeds from these backgrounds who are over 80, but lower than the proportion of people from these backgrounds in Leeds who are living with frailty. • 20% of people who use CCBs are living with dementia – this is a significant overrepresentation compared to the frailty population. <p>People who live in areas which are in the three most deprived Index of Multiple Deprivation (IMD) deciles access CCBs in line with the proportion of people living with frailty in these areas and in excess of the proportion of people over 80 in these areas. A typical user in decile one is typically more frail and younger than the users from other deprivation deciles.</p>
Consultation / engagement	<p>Healthwatch Discharge report for Leeds (2023) Healthwatch involved in HomeFirst design Patient Voices Partnership, Frailty Board Involvement Group have been involved in the HomeFirst engagement HomeFirst patient partner and HomeFirst engagement forum</p>
Experience of care intelligence, knowledge, and insight (complaints, compliments, PALS, National and Local Surveys, Friends and Family Test, consultation outcomes)	<p>Healthwatch Discharge report for Leeds (2023) PREMS results for intermediate care services in Leeds – bed-based and home-based</p>
Other	N/A

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 on [pages 10 -11](#).

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 and 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	Waiting times to be admitted to an intermediate care setting could increase due to the closure of 30 beds. Which will result in a longer length of stay in the acute trust and the associated harms. Potential for up to 6 people per week be affected.	Neutral	HomeFirst efficiency gains have improve access to the beds by reducing the length of stay and supporting people to go home more quickly. This allows more people to benefit from each bed. Additional community capacity in NHT will provide intermediate care at home to some people who current are receiving this care in CCBs. Capacity and demand planning has been completed to provide assurance of sufficient capacity in the absence of these beds.

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 and 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?
			<p>To prevent patients from deteriorating in an acute setting; demand on these services will be closely monitored to ensure patients are transferred to their next care setting as soon as possible to continue their recovery.</p> <p>This will be monitored through the operational governance at provider and system level including the Active System Leadership structure.</p>
2. Experience of care	Patients experience of care will be improved by HomeFirst benefits as evidenced by the research findings included in the policies and guidance referenced above.	Positive	N / A
3. Clinical Effectiveness	Care will continue to be delivered in the most clinically appropriate setting.	Neutral	<p>Operational System level meetings will take place to monitor demand on intermediate care settings.</p> <p>Additional surge capacity (home or bed based intermediate care) can be purchased by the system if demand increases to a significant level.</p>

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 and 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?
			Resilience structures are in place to support collaborative decision making about system pressures.
4. Equality	This change will not alter service delivery to any group in relation to protected characteristics.	Neutral	No change to current position.
5. Safeguarding	No impact on the duty of the service to safeguard those at risk.	Neutral	No change to current position
6. Workforce	Health and Care Partnership staff will need to be relocated to other intermediate care settings as primary base – therapy and Social Work teams.	Neutral	Substantive employers will not change nor will employment contract terms and conditions. Good communication and support are being provided to staff by the leadership within their organisations
7. Health inequalities	No change to current position	Neutral	No change to current position

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 and score (Assess each impact using the Impact Matrix; colour cell RAG)	What action will you take to mitigate any negative impact? How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
8. Sustainability	No change to current position	Neutral	No change to current position
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)
Increasing waiting times in hospital due to less intermediate care beds accessible for patients with a therapy need	Operational Leads to monitor demand on intermediate care bed settings and source surge capacity if required	Waiting times for access to bed base and home - based intermediate care through the System Visibility Dashboard	Operational leadership governance structure - continuous Fortnightly system flow governance Monthly exec governance	Programme Director for Intermediate Care and Same Day Response
Staff relocation could cause anxiety or disruption	Substantive employers will not change nor will employment contract terms and conditions. Good communication and support are being provided to staff by the leadership within their organisations	Staff feedback and staff survey results	Continuous	Head of Service for LTHT therapy and hospital social work team
Keeping staff in the system up to date with changes in Intermediate Care services	Continuation of the HomeFirst newsletter, website, and engagement sessions	Staff feedback and staff survey results	During the HomeFirst project and as part of the post-project review	Programme Director for HomeFirst

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

The action plan should be monitored regularly to ensure:

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

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

Implementation: State who will monitor / review	Name of individual, group or committee	Role	Frequency
a. that actions to mitigate negative impacts have been taken.	a. [Removed for publication] and the Active System Leadership – System Flow Group	Coordination of system flow and balance of risks associated	Monthly See Appendix C
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.		

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?	[Removed for publication] and the Active System Leadership – System Flow Group	Coordination of system flow and balance of risks associated	Monthly

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 overall change will be of net benefit to people. Monitoring steps are in place to ensure any adverse impact is highlighted early and mitigation steps have been agreed to manage any adverse impacts.

K: For Team use only

1. Reference	XX /
2. Form completed by (names and roles)	
3. Quality and equality review completed by:	Reviewed on 10/04/2024 ([Removed for publication] – revisited and comments added 3 May 2024)
4. Date form / scheme agreed for governance	Reviewed at Panel Assurance meeting: 16/05/2024
5. Proposed review date (6 months post implementation date)	January / February 2025
6. Notes	

[*Executive Management Team.docx* was reviewed by the panel, the link to this document has been removed for publication]

[*20230524 AACC_EMT_V2.docx* was reviewed by the panel, the link to this document has been removed for publication]

[*20231113 EIA.docx* was reviewed by the panel, the link to this document has been removed for publication]

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

Level of risk to the ICB
Low
Medium
High

M: Approval to proceed

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

N: Review

To be completed following implementation only.

1. Review completed by	
2. Date of Review	
3. Scheme start date	
4. Were the proposed mitigations effective? (If not why not, and what further actions have been taken to mitigate?)	

5. Is there any intelligence / service user feedback following the change of the service?

If yes, where is this being shared and have any necessary actions been taken because of this feedback?

6. Overall conclusion

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

7. What are the next steps following the completion of the review?

i.e. Future plans, further involvement / consultation required?

Appendix A: Impact Matrix

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

Likelihood

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

Scoring matrix

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

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

Category
Opportunity
Low – moderate risk
High risk

Opportunity and consequence

Impact	Score	Rating	The proposed change is anticipated to lead to the following level of opportunity and / or consequence
Positive	5	Excellence	<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.
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	<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
1. Patient Safety	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. <p>[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</p>

3. Clinical Effectiveness	<ul style="list-style-type: none"> • 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	<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"> • 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

	<p>Other groups would include, but not be limited to, people who are:</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Staffing levels. • Morale. • Workload. • Sustainability of service due to workforce changes (Attach key documents where appropriate).
10. Health Inequalities	<ul style="list-style-type: none"> • 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	<p>See: https://www.bma.org.uk/media/3464/bma-climate-change-and-sustainability-paper-october-2020.pdf</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: https://www.england.nhs.uk/greenernhs/</p>
12. Other	<ul style="list-style-type: none"> • Publicity / reputation. • Percentage over / under performance against existing budget. • Finance including claims.