

## 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: [wycb-leeds.qualityteam@nhs.net](mailto:wycb-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]	Programme Director; MHLDND	10/06/2024	[Removed for publication]
Programme Lead sign off				

<b>A. Scheme Name</b>	O130 MH Crisis Flats with Transitional Housing Units (THU)
<b>Type of change</b>	Stop
<b>ICB</b>	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 Integrated Care Board (ICB) have given notice to Leeds City Council (LCC) to discontinue its funding contribution of 100k towards LCC contract for transitional housing units (THU) from 1st October 2024. The ICB contribution had specifically been to reserve 3 individual flats within the THUs to be readily available as accommodation to support people in or at risk of Mental Health crisis, to avoid hospital admission. The majority of care for individuals supported through the flats is primarily provided by LYPFT crisis team wraparound specialist intervention, due to the level of need of the people that access these, although staff in the THUs may provide some low-level intervention if required.

Occupancy data for the flats provided by LCC clearly evidence the flats have been under-utilised by the Leeds and York Partnership NHS Foundation Trust (LYPFT) crisis service as hospital admission avoidance and are not providing value being utilised as crisis flats.

2022: Utilisation of approx. 18%.

2023: Utilisation of approx. 5%.

2024 (to date): Utilisation of approx. 46%-

Leeds City Council have identified that the increased utilisation in 2024 has been due to a greater focus on delayed discharges from mental health inpatient ward- supporting people to leave wards quicker by using the flats whilst they transition into a tenancy. This is evidencing a much more effective use of the properties than the crisis flats/alternative to admission and is more consistent with the purpose and outcomes for a transitional housing unit contract.

The ICB understanding is that the withdrawal of the ICB contribution towards LCC contract will not in itself reduce the overall capacity in the THU, and that the resource is more helpful in supporting system flow as part of their original use as part of the overall THU offer.

The intention behind providing a contribution to THUs for crisis access was well-placed and attended to a gap in provision of an alternative to hospital admission available at the time of the arrangement.

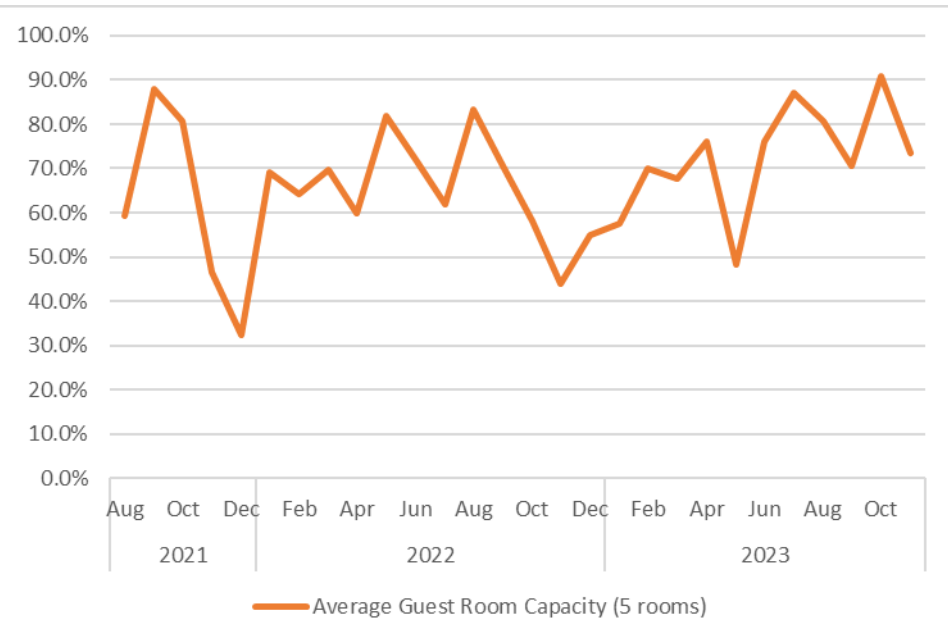
Since that time the ICB has commissioned Oasis Crisis House to support statutory services by providing support for people who are in crisis (who may otherwise be hospitalised) as an alternative to hospital admission and worked with partners to develop and improve the pathway. Oasis is accessed through assessment by the LYPFT crisis team (for those that would otherwise be admitted to hospital) and provides access to more intensive 24 / 7 staffing directly within Oasis, with additional wraparound support from LYPFT crisis team to enable a more responsive and genuinely integrated operational delivery model. This fully replicates and further enhances the provision of support available through the crisis flats agreement. Additionally, we have created an extra bed space within Oasis for supporting people with complex MH rehabilitation needs proactively to avoid crisis and re-admission (anticipated operational by Q3 24 / 25)

The graphs below are taken from a recent evaluation of Oasis provision.

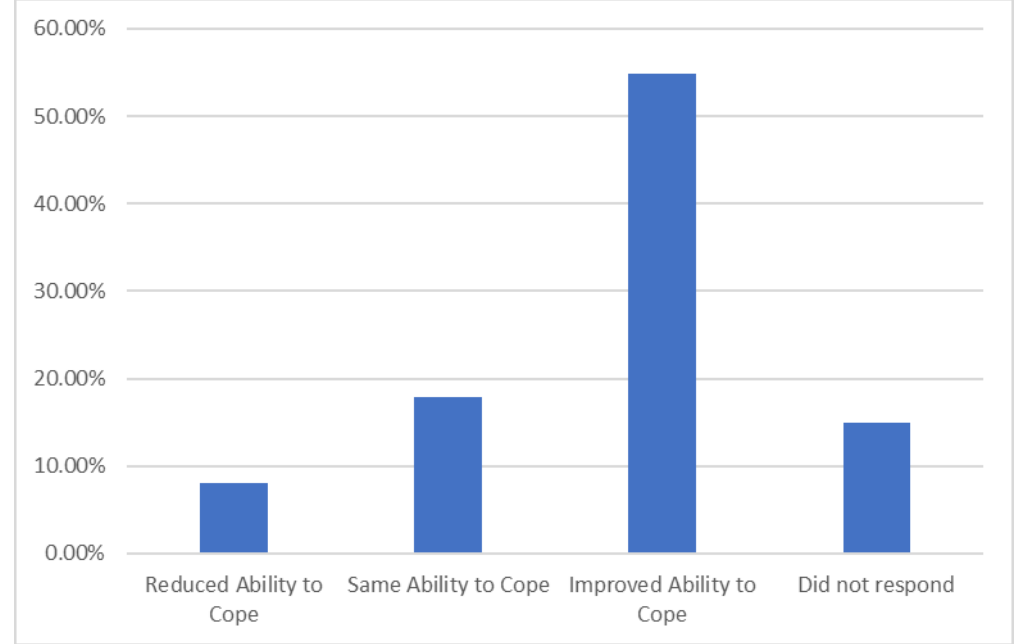
**Graph 1** shows the upward trend from Nov22 (44%) to July 23 (87.1%) for occupancy/utilisation of Oasis as an alternative to hospital admission (i.e. following assessed need by LYPFT crisis team). This improvement has been subsequently maintained with occupancy levels increasing further. The dip in May 23 was because of planned building works.

**Graph 2** shows evidence of positive service user reported outcomes from Oasis.

13/06/2024 Quality + Equality comment – Do you have more information on #beds in Oasis and the THU and what evidence do we have for the THU outcome measures



(Graph 1: Oasis occupancy/utilisation)



(Graph 2 Self-rating ability to cope with crisis following stay)

## 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
<p>1. Could the project change the way a service is currently provided or delivered?</p> <p>The ICB understanding is that the withdrawal of the ICB contribution towards LCC contract will not in itself reduce the overall capacity in the transitional housing units- but the crisis flats will not be accessible directly through LYPFT crisis team in the same way.</p> <p>The ICB has commissioned Oasis Crisis House to support statutory services by providing support for people who are in crisis (who may otherwise be hospitalised) as an alternative to hospital admission.</p>	<b>Yes</b>
<p>2. Could the project directly affect the services received by patients, carers, and families? – is it likely to specifically affect patients from protected or other groups? See <a href="#">page 10</a> for more detail.</p> <p>The service commissioned through Oasis and the integrated delivery model with LYPFT crisis team replicates and further enhances/improves the provision of support accessible through the crisis flats arrangement - the specific change would be the location of the building base from transitional housing unit to Oasis crisis house.</p> <p>The replicated provision through Oasis provides access to more intensive 24 / 7 staffing directly within Oasis, with more clearly defined pathway arrangements for access to additional wraparound support from LYPFT crisis team.</p> <p>The specialist care and interventions remain provided through LYPFT crisis / intensive support team.</p>	<b>No</b>
<p>3. Could the project directly affect staff? For example, would staff need to work differently / could it change working patterns, location etc.? Is it likely to specifically affect staff from protected groups?</p>	<b>No</b>

Questions (please describe the impact in each section)	Yes / No
<p>The majority of care for individuals supported through the crisis flats is primarily provided by LYPFT crisis team wraparound specialist intervention - there is no identified / anticipated staff impact. Similarly, the staffing establishment within the transitional housing units provide low level direct support into the crisis flats within the overall THU - there is no anticipated staff impact.</p>	
<p>4. Does the project build on feedback received from patients, carers, and families, including patient experience? What feedback and include links if available.</p> <p>The Oasis model was commissioned based on service user and carer feedback in relation to experience of mental health (MH) crisis services, including positive service user experience and outcomes evidenced within the evaluation of Oasis.</p>	<b>Yes</b>

**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>The ICB understanding is that the withdrawal of the ICB contribution towards LCC contract will not in itself reduce the overall capacity in the THUs. Any subsequent significant service changes would be taken through LCC consultation and engagement processes.</p>	<b>No</b>
<p>Formal consultation activity required?</p> <p>It is not believed that formal consultation activity is required due to the scale of the impacts, numbers likely affected, and provision replicated. As above.</p>	<b>No</b>
<p>Full Equality Impact Assessment (EIA) required?</p> <p>13/06/2024 Equality comment – Suggested text: All required mitigation in relation to any identified disproportionate negative impact is documented within the QEIA and therefore a full EIA is not required.</p>	<b>No</b>
<p>Communication activity required (patients or staff)?</p>	<b>No</b>

## 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
<p>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?</p> <p>If yes, please email the IG Team at: <a href="mailto:wycb-leeds.dpo@nhs.net">wycb-leeds.dpo@nhs.net</a> for Leeds ICB or <a href="mailto:wycb-wak.informationgovernance@nhs.net">wycb-wak.informationgovernance@nhs.net</a> for the wider West Yorkshire ICB, to complete the screening form.</p>	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)	Learning from shared best practice re: alternatives to hospital models of care (ADASS overview of community transformation best practice with supported housing/crisis house models)
Service delivery data such as who receives services	LCC data re: occupancy / utilisation. Oasis contract data/evaluation data.

Evidence Source	Details
Consultation / engagement	Significant amount of service user/carer insight detailed into MH crisis services - experience / outcomes, inclusive of but not solely the MH insight report
Experience of care intelligence, knowledge, and insight (complaints, compliments, PALS, National and Local Surveys, Friends and Family Test, consultation outcomes)	Supporting evidence in relation to experience/feedback available through original commissioning of Oasis Crisis House – including the city crisis summit to engage people with lived experience and carers in 2020.
Other	No other evidence

## 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](#).

<b>Quality Domain</b> The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	<b>Quality elements and description of impact</b> Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	<b>Impact: Positive / Negative / Neutral and score</b> (Assess each impact using the Impact Matrix; colour cell RAG)	<b>What action will you take to mitigate any negative impact?</b> How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
<b>1. Patient Safety</b>	The provision is replicated and further enhanced through Oasis Crisis House and provides support for people who are in crisis (who may otherwise be hospitalised) as an alternative to hospital admission	<b>0 - Neutral</b>	No mitigating actions required
<b>2. Experience of care</b>	Provision is replicated through Oasis. The model was commissioned based on service user feedback in relation to experience and outcomes of MH crisis services. Recent evaluation of Oasis evidence positive service user experience and outcomes.	<b>0 - Neutral</b>	No mitigating actions required but ongoing patient feedback will continue to be captured, reviewed and shared for ongoing service improvement and including in the LHCP insight library.



<b>Quality Domain</b> The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	<b>Quality elements and description of impact</b> Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	<b>Impact: Positive / Negative / Neutral and score</b> (Assess each impact using the Impact Matrix; colour cell RAG)	<b>What action will you take to mitigate any negative impact?</b> How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
<b>3. Clinical Effectiveness</b>	LYPFT crisis team provide wraparound specialist intervention - this is replicated and improved through Oasis	<b>0 - Neutral</b>	No mitigating actions required
<b>4. Equality</b>	No impacts identified.	<b>0 - Neutral</b>	No mitigating actions required
<b>5. Safeguarding</b>	No impacts identified.	<b>0 - Neutral</b>	No mitigating actions required
<b>6. Workforce</b>	No impacts identified.	<b>0 - Neutral</b>	No mitigating actions required
<b>7. Health inequalities</b>	No impacts identified.	<b>0 - Neutral</b>	No mitigating actions required
<b>8. Sustainability</b>	No impacts identified.	<b>0 - Neutral</b>	No mitigating actions required

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

## 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)

## 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)

<b>Implementation:</b> State who will monitor / review	<b>Name of individual, group or committee</b>	<b>Role</b>	<b>Frequency</b>
a. that actions to mitigate negative impacts have been taken.	a.		

<b>Implementation:</b> State who will monitor / review	<b>Name of individual, group or committee</b>	<b>Role</b>	<b>Frequency</b>
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.		

<b>Outcome</b>	<b>Name of individual, group or committee</b>	<b>Role</b>	<b>Date</b>
Who will review the proposal once the change has been implemented to determine what the actual impacts were?	Continued patient feedback evaluated for Oasis Crisis house (Contract Monitoring)		13/06/2024

## **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 scheme relates to ceasing the ICB contribution of 100k to Leeds City Council Transitional Housing Unit contract. The ICB is not anticipating any reduction to the overall THU capacity available that supports mental health system flow, but rather a change in terms of direct access to 3 flats within the THUs by the LYPFT crisis team to avoid hospital admission. Any significant change to the provision of transitional housing units or capacity would be taken through local authority engagement/consultation processes. The ICB has commissioned a crisis house model (Oasis) Oasis is accessed through assessment by the LYPFT crisis team (for those that would otherwise be admitted to hospital) and provides access to more intensive 24 / 7 staffing directly within Oasis, with additional wraparound support from LYPFT crisis team to enable a more responsive and genuinely integrated operational delivery model. This is expected to fully replicate and further enhance the review actual impacts through the MH Population Board to understand any unintended / unforeseen consequences / impacts.

## K: For Team use only

1. Reference	XX /
2. Form completed by (names and roles)	
3. Quality and equality review completed by:	Name: [Removed for publication] Date: 13/06/2024 Name: [Removed for publication] Date: 13/06/2024
4. Involvement review	Name: [Removed for publication] Date: 14/06/2024
5. Date form / scheme agreed for governance	Reviewed at Panel Assurance meeting: 11/07/2024
6. Proposed review date (6 months post implementation date)	January / February 2025
7. Notes	

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

Level of risk to the ICB
Low
Medium
High

## M: Approval to proceed

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

## N: Review

To be completed following implementation only.

<b>1. Review completed by</b>	
<b>2. Date of Review</b>	
<b>3. Scheme start date</b>	

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

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

**6. Overall conclusion**

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

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

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

## Appendix A: Impact Matrix

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

### Likelihood

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

### Scoring matrix

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

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

Category
Opportunity
Low – moderate risk
High risk



## Opportunity and consequence

Impact	Score	Rating	The proposed change is anticipated to lead to the following level of opportunity and / or consequence
<b>Positive</b>	5	Excellence	<p>Multiple enhanced benefits including excellent improvement in access, experience and / 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.</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	<p>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.</p>
	3	Moderate	<p>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.</p>
	2	Minor	<p>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.</p>
	1	Negligible	<p>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.</p>
<b>Neutral</b>	0	Neutral	No effect either positive or negative.

Impact	Score	Rating	The proposed change is anticipated to lead to the following level of opportunity and / or consequence
<b>Negative</b>	-1	Negligible	<p>Negligible negative impact on access, experience and / or outcomes for people with this protected characteristic. Negligible increase in health inequalities by widening the gap in access, experience and / or outcomes between people with this protected characteristic and the general population.</p> <p>Potential to result in minimal injury requiring no / minimal intervention or treatment, peripheral element of treatment, suboptimal and / or informal complaint / inquiry.</p>
	-2	Minor	<p>Minor negative impact on access, experience and / or outcomes for people with this protected characteristic. Minor increase in health inequalities by widening the gap in access, experience and / or outcomes between people with this protected characteristic and the general population.</p> <p>Potential to result in minor injury or illness, requiring minor intervention and overall treatment suboptimal.</p>
	-3	Moderate	<p>Moderate negative impact on access ,experience and / or outcomes for people with this protected characteristic. Moderate increase in health inequalities by widening the gap in access, experience and / or outcomes between people with this protected characteristic and the general population.</p> <p>Potential to result in moderate injury requiring professional intervention.</p>
	-4	Major	<p>Major negative impact on access, experience and / or outcomes for people with this protected characteristic. Major increase in health inequalities by widening the gap in access, experience and / or outcomes between people with this protected characteristic and the general population.</p> <p>Potential to lead to major injury, leading to long-term incapacity / disability.</p>
	-5	Catastrophic	<p>Catastrophic negative impact on access, experience and / or outcomes for people with this protected characteristic. Catastrophic increase in health inequalities by widening the gap in access, experience and / or outcomes between people with this protected characteristic and the general population.</p> <p>Potential to result in incident leading to death, multiple permanent injuries or irreversible health effects, an event which impacts on a large number of patients, totally unacceptable level of effectiveness or treatment, gross failure of experience and does not meet required standards.</p>

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

Domain	Consider
<b>1. Patient Safety</b>	<ul style="list-style-type: none"> <li>• Safe environment.</li> <li>• Preventable harm.</li> <li>• Reliability of safety systems.</li> <li>• Systems and processes to prevent healthcare acquired infection.</li> <li>• Clinical workforce capability and appropriate training and skills.</li> <li>• Provider’s meeting CQC Essential Standards.</li> </ul>
<b>2. Experience of care</b>	<ul style="list-style-type: none"> <li>• Respect for person-centred values, preferences, and expressed needs, including cultural issues; the dignity, privacy, and independence of service users; quality-of-life issues; and shared decision making.</li> <li>• Coordination and integration of care across the health and social care system.</li> <li>• Information, communication, and education on clinical status, progress, prognosis, and processes of care to facilitate autonomy, self-care, and health promotion.</li> <li>• Physical comfort including pain management, help with activities of daily living, and clean and comfortable surroundings.</li> <li>• Emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families, and their finances.</li> <li>• Co-produce with the population and service users as the default position for project design.</li> <li>• Use what we know from insight and feedback in project design and be explicit in the expected outcomes for experience of care improvements.</li> <li>• Involvement of family and friends, on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as caregivers.</li> <li>• Transition and continuity as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions.</li> <li>• Access to care e.g., time spent waiting for admission, time between admission and placement in an in-patient setting, waiting time for an appointment or visit in the out-patient, primary care or social care setting.</li> </ul> <p>[Adapted from the NHS Patient Experience Framework, DoH 2011] revised in: <a href="https://www.england.nhs.uk/wp-content/uploads/2021/04/nhsi-patient-experience-improvement-framework.pdf">https://www.england.nhs.uk/wp-content/uploads/2021/04/nhsi-patient-experience-improvement-framework.pdf</a></p>

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

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