Quality and Equality Impact Assessment (QEIA)

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

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

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

Assessment Completion	Name	Role	Date	Email
Scheme Lead	[Removed for publication]	Programme Director – Long-Term Conditions, Frailty and End of Life	22/05/2024	[Removed for publication]
Programme Lead sign off	[Removed for publication]	Programme Director – Long-Term Conditions, Frailty and End of Life	20/08/2024 (updated to reflect recommended 46.4% funding reduction – option 2)	[Removed for publication]

A. Scheme Name	William Merritt – QEIA on option 2 – A reduction to the current funding envelope with rescoping of the service specification to support immediate ICB priorities, for example, health inequalities, referrals from healthcare professionals, etc.
Type of change	Adjust existing
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).

This QEIA explores the option of a reduction to the current funding envelope with a rescoping of the service specification to support immediate ICB priorities. The proposed funding reduction is 46.4% of the current financial envelope, bringing total funding available down to £100,000 per annum.

William Merritt has been commissioned by West Yorkshire ICB Leeds Place for a number of years, with a contract value of £186,559 per annum. ICB funding contribution equates to approximately 16% of all income for William Merritt. A detailed service review is attached, which outlines the service descriptions, aims and goals.

[The Service Review document was reviewed by the panel, the link to this document has been removed for publication]

This QEIA explores a reduction to the current funding envelope with rescoping of the service specification to support immediate ICB priorities (option 2):

1. Do nothing – continue funding as is (£186,559 per annum)
2. A reduction to the current funding envelope with rescoping of service specification to support immediate ICB priorities – Proposed 46.4% funding reduction to a total spend of £100,000 per annum.
3. Fully decommission.
4. Realignment of funding contributions between the NHS in Leeds and Leeds City Council (LCC).

In line with system financial pressures, we are asked to consider all individual contracts for review; including those which have been long-running (William Merritt service in place since before 2009) and not routinely reviewed. In addition, other places within West Yorkshire do not commission William Merritt or equivalent service offers. This offer is quite unique to Leeds, and therefore this option may be recommended.

NHS West Yorkshire ICB in Leeds (Leeds Place) has commissioned William Merritt since before 2009 with the primary aim of providing high quality, holistic, efficient, timely and responsive impartial professional advice, information and assessment of assistive technology (equipment). This includes assessment of practical aspects of daily living for people of all ages, their carers, and families to enable people to maximise their life opportunities, supporting their independence, and giving them access to assistive technology.

The current service offer provides a referral route for approximately 1300 people per annum requiring impartial professional advice, information, and assessment of assistive technology (equipment) in Leeds. Referrals are quite often from clients / families directly (self-referrals; approximately 40%), the NHS (30%) and other routes like primary care, the third sector, and police. In turn, approximately 1,175 people receive appointments delivered predominately face to face at the Disabled Living Centre, Rodley, following the processing of referrals and subsequent contact.

This option of change (option 2), would mean that we:

1. Remove the option of patient self-referral. It is understood that approximately 60% of referrals are via a form completed by a referring clinician (GP or other health care clinician) or third sector / police. The other 40% are self-referrals direct from patients / clients.
2. Mandate practitioner referral into the William Merritt service only (with referral form completion) and ask that assessment outcomes / a clinical report are communicated back to the referrer (this would inform Return on Investment (ROI) case longer term)
3. Specify criteria for referral; for example, from specific IMD areas and specific conditions; dementia, stroke, and children (pathways where statutory Occupational Therapy (OT) services are struggling). It is proposed that we agree criteria with William Merritt and local OT teams; including the LCC Occupational Therapy team, that provides clinical supervision to William Merritt staff members.
4. Cap maximum assessment appointment numbers to a total of £100,000 per annum (approximately 630 appointments per annum) and ask that general support and queries also continue to be responded to, plus the management of referrals (approximately 697 per annum) – reductions of 46.4% applied. These numbers are subject to agreement and may change. Approximately 600 fewer people will be supported via this service offer per annum.

As signalled in the service review, William Merritt receives other income from funders like the Department of Transport / private fees for other activities like driving assessments, which form a significant part of William Merritt's core business.

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

To be completed in conjunction with:

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

Questions (please describe the impact in each section)	Yes / No
1. Could the project change the way a service is currently provided or delivered? This option would involve ceasing approximately 46.4% ICB funding for the service (approximately 8% of William Merritt's total income). ICB-funded activities as outlined above (section B) would cease, with the withdrawal of funding potentially also impacting William Merritt's overall business model. Direct effects are detailed in section 2 below.	**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.
 	
This option safeguards some essential provision. Following discussion with the Leeds Long Term Conditions Population Board and other system partners it has been reflected that the William Merritt service provides an invaluable service and if continued we must work to create further efficiency within the service. It is proposed that we explore bringing in occupational therapists from other parts of the system to review the process / practice and explore how we might deliver things differently.
 	
• Primary Care and former clinicians on the Board, all reflected that William Merritt is an invaluable service and undoubtedly saves the NHS and council money; however, these savings are not clearly articulated, and therefore continuation of the offer, must be able to demonstrate this. Onward patient outcomes / return on investment / cost-benefit analysis needs to be strengthened to evidence outcomes (within reason, without reducing service activity to monitor and evaluate significantly)
• Patient satisfaction / clinician satisfaction needs to be explored in greater detail within the revised service offer.
• A reduced service offer to a value of £100,000 will impact on approximately 600 people (predominately self-referrers) who will no longer have this service offer as an option for referral and face-to-face assessment. These people include:
  ○ Individuals living with disabilities:
  People of all ages living with a long-term condition and / or complex health and care needs, physical disabilities, neurological conditions, or injuries that impact their ability to perform daily activities independently. Individuals living with physical disabilities such as paralysis, amputation, or cerebral palsy who require assistive devices to improve their mobility and quality of life.
	Yes

Questions (please describe the impact in each section)	Yes / No
○ Paediatrics: Individuals 0- 25 living with a long-term condition and / or complex health & care needs, physical disabilities, neurological conditions such as cerebral palsy, or autism who require specialist equipment / assistive devices to improve mobility and quality of life for the client and family. We will request that paediatrics be prioritised within the remaining resource / capacity. ○ Seniors: Elderly individuals (plus 65 years) experiencing age-related mobility limitations, arthritis, or other health conditions that affect their quality of life and independence. ○ Caregivers and Family Members: Those providing care and support to individuals living with disabilities or seniors, seeking guidance and recommendations to improve the safety and comfort of their loved ones at home. ○ Healthcare Professionals: Doctors, therapists, and rehabilitation specialists referring patients for assessments to determine their need for assistive devices and adaptations to support their recovery and daily functioning.	

The age profile where this has been recorded in 2023 / 2024 is outlined below:

Age	Q1	Q2	Q3	Q4
Under 18	43	53	51	95
18 - 25 years (Those clients not under the Children's Act therefore Adult Caseload) (19-29)	9	15	4	6
26 – 35 years	11	5	6	11
36 - 45 years	9	11	8	5
46 - 55 years	23	18	21	21
56 - 65 years	30	27	26	28
66 - 70 years	17	12	21	10
71 - 75	26	20	27	21
76 - 85	47	50	47	37
Over 86 years	12	15	22	30
Did not state	0	0	1	0
Total	227	226	234	264

Stroke and dementia represent the two primary conditions with most referrals to William Merritt to support maintenance or improvement in independence and mobility. The full range of primary clinical conditions are shown in the table below:

Condition	Percentage of referrals
Other physical conditions	25%
Stroke	11%
Dementia	11%
Arthritis	8%
Learning disabilities	7%
Other neurological conditions	5%
Parkinson's disease	5%
Cerebral palsy	5%
Older people – no identifiable medical condition	3%
Back problems	3%
Mild cognitive impairment	3%
Acquired brain injury	3%
Multiple Sclerosis	3%
Amputations	1%
Spinal cord injuries	1%
Congenital musculoskeletal conditions	1%
Mental health	1%

Individuals surviving stroke and living with dementia, will likely be supported by carers, who may also be impacted through non-provision of this service offer. Some support is currently available also via community stroke / dementia teams; for example, the Leeds community stroke service offered OT / physio assessments; however, waiting times are currently long.

A feel of patient numbers by patient cohort, currently recorded via the service from routine monitoring is detailed below for additional information.

Patient cohort	Q1	Q2	Q3	Q4
Number of people attending appointments who have a learning disability / difficulty	13	10	17	8
Number of people attending appointments who have visual impairments	3	1	1	0
Number of people attending appointments who have physical impairments	185	176	168	177
Number of people attending appointments who have mental ill health including dementia	27	25	31	28

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, a reduction to the current funding envelope could mean that the following staff would be at risk of changes to their employment, unless mitigated by William Merritt: • Whole Time Equivalent (WTE) staff members (nine people in total as many work part-time). 2.5 WTE staff members are Occupational Therapists. 2.2 WTE's are therapy assistants, management, and administration staff. These individuals are currently funded directly by the ICB income.	**Yes**
4. Does the project build on feedback received from patients, carers, and families, including patient experience? What feedback and include links if available. The service provides client experience feedback as part of its monitoring. The service has high satisfaction levels.	**Yes**

Service user experience feedback for 2023 / 2024 is listed below:

Questions / category	Q1	Q2	Q3	Q4
Number of service user satisfaction surveys disseminated in quarter (including those sent to carers)	506	465	460	

Questions / category	Q1	Q2	Q3	Q4
Number of satisfaction surveys received back in quarter from service users, parents and carers	166	166	164	
Q1 - Were you happy with the service you received?	98%	96%	93%	
Q2 - Was the amount of time from initial contact to appointment date satisfactory?	95%	95%	88%	
Q3 - Were you made to feel at ease and shown care and compassion during your assessment?	99%	98%	95%	
Q4 - Did you feel listened to and given the opportunity to share your concerns?	98%	97%	96%	
Q5 - If you tried equipment, adaptations, or vehicles, were you satisfied with the range available?	95%	98%	96%	
Q6 - Did you feel the time taken over your appointment was sufficient?	98%	97%	97%	
Q7 - Do you feel we improved your situation / or level of independence?	88%	93%	91%	
Q8 - Do you feel you have a clear understanding of the options available to you following your assessment?	94%	99%	94%	
Q9 - Do you feel we explained things clearly, providing you with information and the next steps?	98%	96%	94%	
Q10 - Did your appointment meet your expectations	94%	94%	92%	
Average %	96%	96%	93%	
Average NPS Score	86	76	77	

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

Insert comments in each section as required	Yes / No
Involvement activity required? A reduction to the current funding envelope with rescoping of the service specification to support immediate ICB priorities, for example, health inequalities, referrals from healthcare professionals, etc, will have an impact on approximately 600 people per annum as outlined above who will no longer be able to access this provision, the majority of whom have disabilities. Although the William	**Yes**

Insert comments in each section as required	Yes / No
Merritt Centre does not have any direct 'competitors' for its business in Leeds, there are other avenues to at least some services / equipment available e.g. through specific charitable routes / core statutory services (although with long waiting times). Mitigating the reduction in referrals / face-to-face appointments we could consider providing guidance to people to help them access available support themselves. Clear communications will be provided, to be clear that the service can no longer accept self-referrals in advance of the new financial year, commencing 1 April 2025. In addition to asking what is working well and what could be improved to inform the new service specification and referral criteria for 2025 / 2026, an engagement commencing in October would seek to understand the following: • What are the demographics of people receiving support, and what support are they receiving? • What are the demographics of people buying their own equipment following assessment? • What are the demographics of people accessing charitable funding? • Are particular groups / communities accessing / receiving particular types of support? • There are high numbers of self-referrals – how are these people finding out about the service? From where? This will help inform clear communications regarding self-referral route no longer being available. • The wider picture in relation to the city-wide offer. An engagement would aim to hear from: • People accessing the William Merritt service. • People currently on the waiting list for the statutory provision. • Unpaid carers and family members. • Staff, including referrers to the service, particularly occupational therapy team members and stroke, community neurological rehab service staff. A potential engagement activity, and mitigation, could include the proposal of a guide (maybe like the Oxfordshire County Council resource) for people to use to inform them where to go / who to contact for particular needs. The aims of the guide could include supporting increased self-management and helping to reduce the potential for people to make uninformed decisions that could put them at risk of falls, accidents and expenditures that may not be needed.	

Insert comments in each section as required	Yes / No
We would anticipate any engagement to be survey-based, with the possibility of some more focused sessions to hear from particular groups like people with a learning disability / dementia and would look to run it for around four to six weeks to ensure we hear from as many people as possible.	
Formal consultation activity required? Although this proposed change may have an impact for the people using the service, it would not negatively affect significant numbers of people and therefore a formal consultation is not required.	**No**
Full Equality Impact Assessment (EIA) required? [EIA Included in the Appendix removed for publication, available on request]	**Yes**
Communication activity required (patients or staff)? Communication required to involve staff in developing service priorities, and to inform support groups and service users about reasons for change, what to expect and opportunities to ask questions.	**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)	William Merritt works to deliver the commitments of the National Disability Strategy (2021) by enhancing the quality of life for individuals of all ages living with disabilities or long-term conditions (https://www.gov.uk/government/publications/national-disability-strategy)
Service delivery data such as who receives services	Service delivery data is detailed in section 2.
Consultation / engagement	We do not have previous examples of local engagement about, or insight into, this service. Although the service has received high satisfaction scores from service users, we are working to explore if more detailed responses can be provided; regarding what people found worked well / what could have been improved.
Experience of care intelligence, knowledge, and insight (complaints, compliments, PALS, National and Local Surveys, Friends and Family Test, consultation outcomes)	There have been no safeguarding, incidents or complaints relating to the service in the last year. Service user experience feedback for 2023 / 2024 is listed in section 4.
Other	None

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

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

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

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

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
1. Patient Safety	A reduction to the current funding envelope with rescoping of the service specification to support immediate ICB priorities, for example, health inequalities, referrals from healthcare professionals, etc, will have an impact on approximately 600 people per annum as outlined above who will no longer be able to access this provision. They will not have a safe service to be referred in to for assessment and to receive advice on their equipment needs; therefore, resulting in people making uninformed decisions that could put them at risk of falls, accidents and expenditures that may not be needed. There may be greater demand on Leeds Teaching Hospital Trust / Leeds Community Health/Leeds City Council Occupational Therapy Team members in specialisms where there are often long waits. Whilst	**12 - Likely / Moderate**	Agreement of referral form with clear referral criteria for access to the service; for agreement with local OTs led by William Merritt Mapping of waiting times across OT teams in specialism areas that might need to manage this demand going forward, i.e. LCC OT, Stroke, Community Neurological rehab services. All currently have waiting times running into months. Exploration of how to reduce waiting times for core OT teams.

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?
	people wait, inappropriate unassessed equipment may be purchased causing injury.		Explore how healthcare systems without an offer like William Merritt operate. Development of written resources / sign posting.
2. Experience of care	A reduction to the current funding envelope with rescoping of the service will have an impact on approximately 600 people per annum as outlined above who will no longer be able to access this provision. These 600 people per annum may need to wait for an offer within core statutory health and care services. LCC, OT Adults and Health team routinely sign-post people to William Merritt, due to a typical waiting list size of over 1000, waiting months for review. This is similar in areas like stroke, where waits to be seen by an OT within the community stroke team can run into months if not a Priority 1 patient, i.e. patient of greatest risk following clinical assessment.	**12 - Likely / Moderate**	Mapping of waiting times across OT teams in specialism areas that might need to manage this demand going forward, i.e. LCC OT, Stroke, Community Neurological rehab services. All currently have waiting times running into months. Exploration of how to reduce waiting times for core OT teams. Communication of other support routes / core services and online literature.

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	The current service offer helps people recover from episodes of ill health or injury, by ensuring that appropriately assessed equipment is recommended to enhance recovery and quality of life for those referred into the service. Reduced provision of this service offer will reduce availability and access times for this provision in Leeds. Leeds City Council Occupational Therapy team members provide clinical supervision to William Merritt staff, approximately once every six weeks. This arrangement will require review. The service does not collect for all people the recorded destinations following assessment (as this is challenging and time-consuming and not everyone offers this information), so it is challenging to have a full sense of monitoring / reductions to statutory services.	**-0 - Possible / Moderate**	Ensure written materials are available describing top tips for equipment selection when proceeding without expert input (the key function that William Merritt undertakes which cannot be replicated) Sign-post people to support like Carers UK website and the AskSara tool and develop resources like Oxfordshire County Council have: http://bit.ly/4dsyLa4 Please note that resources like AskSara require some license funding (to be explored). Material produced for mitigation will be accessible and we will need to consider resources for those who are digitally excluded.

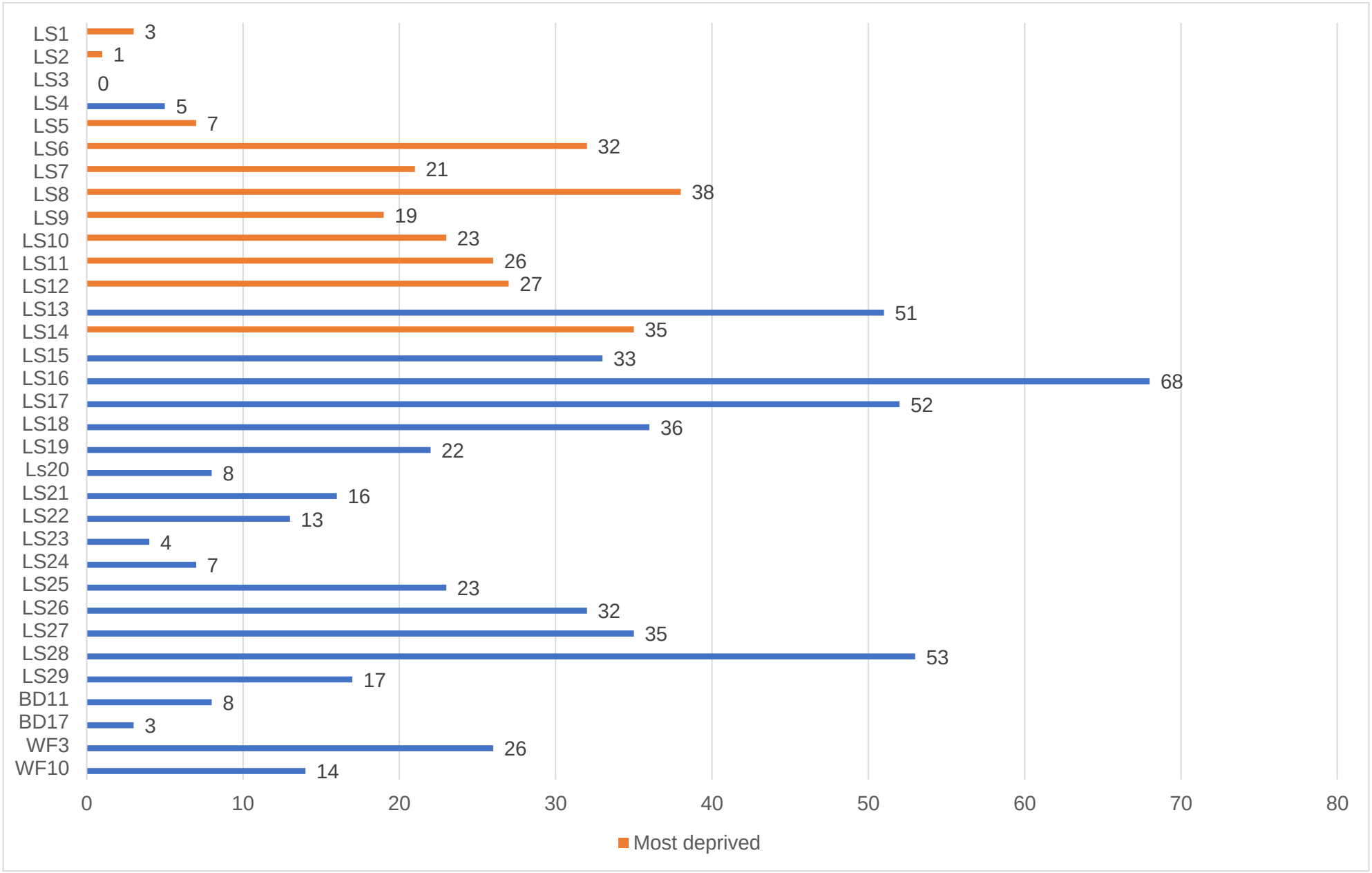
Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or 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?
	Recorded destination, where known, in 23 / 24 shows that the most common outcomes are (listed in order, with most common first): • Charitable funding • Client intends to buy own equipment • Unknown • Solution provided • Client undecided • Client referred elsewhere For example, William Merritt supported 99 patients in receiving funding for their equipment via charitable routes. This route to obtaining equipment in the absence of William Merritt might not be followed if services ceased.		From 2025 / 2026 onward destinations must be recorded to inform ROI case for each patient.

4. Equality	In terms of protected characteristics, disability needs to be considered. Based on quarterly numbers, approximately 75% of people referred into the William Merritt service have a recorded disability. Reduced provision of service will impact significantly on this patient cohort. The impact on those living with a learning disability should also be noted, and recognition that non-provision of service could impact on carers significantly. No further comorbidity is reported on by the service, other than the high-level summary of primary conditions presented in section 2. Age demographics of the adult patient cohort is outlined above. Over 50% of all referrals are for people aged 65 years and over. Approximately 200 children / young people are supported per annum also. Of adults attending for assessment appointments, the gender split in 2023 / 2024 was 52% males, 48% females. Referral spread across the city with consideration of IMD is reflected on in the health inequalities section below.	**-15 - Almost Certain / Moderate**	Sign-post people unable to access this offer to support like Carers UK website, The AskSara tool and develop resources like Oxfordshire County Council have: http://bit.ly/4dsyLa4 Please note that resources like AskSara require some license funding (to be explored). Material produced for mitigation will be accessible and we will need to consider resources for those who are digitally excluded. Mapping of waiting times across OT teams in specialism areas that might need to manage this demand going forward, i.e. LCC OT, Stroke, Community Neurological rehab services. All currently have waiting times running into months. Exploration of how to reduce waiting times for core OT teams.

5. Safeguarding	There have been no safeguarding concerns within the service, and the service has not identified any safeguarding concerns for escalation on to partners.	**0 x 0 = 0**	No mitigation required
6. Workforce	4.7 Whole time equivalent (WTE) staff members may be at risk as a result of this option. In addition, non-provision of the offer will have an impact on the workforce working in other services, i.e. the Leeds City Council Occupational Therapy team who will likely see an increase in referrals	**-9 Possible / Moderate**	Share vacancy positions being recruited too within core statutory OT services with staff members that may be at risk from the reduction in the funding envelope.
7. Health inequalities	In terms of referral spread across the city, 16.5% of referrals result from the top five deprived areas of the city. As detailed in the table below. A data table can be seen in Appendix C. It should be noted that those postcode areas in more affluent areas / IMD classifications receive higher levels of referrals; for example LS16; Adel / Lawnswood, LS17; Shadwell / Alwoodley, LS28; Farsley. Learning disability referral numbers are documented earlier within this paper, along with primary referral reason. More detailed comorbidity data is not available from the service.	**-9 Possible / Moderate**	Health inequalities / IMD to be considered as part of the criteria for access in new referral criteria. Sign-post people unable to access this offer to support like Carers UK website, The AskSara tool and develop resources like Oxfordshire County Council have: http://bit.ly/4dsyLa4 Please note that resources like AskSara require some license funding (to be explored) Material produced for mitigation will be accessible and we will need to consider resources for those who are digitally excluded.

			Mapping of waiting times across OT teams in specialism areas that might need to manage this demand going forward; i.e. LCC OT, Stroke, Community Neurological rehab services. All currently have waiting times running into months. Exploration of how to reduce waiting times for core OT teams.

Areas of Leeds clients are from



8. Sustainability	Where feasible William Merritt recycles and repurposes equipment for issue to individuals; this sustainability route will cease. There is no formal data with regards to what equipment is recycled / repurposed; this is not a primary function like Leeds Community Equipment service.	**-6 - Moderate / Minor**	No mitigations identified
9. Other	ICB reputation. Adverse publicity. Likely to adversely affect clinical and staff networks across Occupational Therapy services.	**-12 - Major / Moderate**	Engagement with population boards and relevant committees re decision. Implementation of all mitigations as included within this paper.

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)
Reduced service provision	Mapping of waiting times across other OT services so aware of where referrals may go instead; services made aware of change / to plan for this	System awareness of the change	August - September 2024	[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)
Reduced service provision	Engagement / communication of the decision	Awareness	September - October 2024	[Removed for publication]
Reduced service provision	Production of patient resources – written resources / support pack for patients		August - October 2024	[Removed for publication]

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

The action plan should be monitored regularly to ensure:

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

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

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. LTC population board	Oversight	Bi-monthly
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. LTC population board	Oversight	Bi-monthly

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?	LTC population board	Oversight	

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 most significant risks are to:

- Patient outcomes, long-term mental and physical health, wider social impacts, e.g. inability to work.
- Patient experience and access to independent equipment advice.
- System networks and relationships.
- Staff and volunteers.

K: For Team use only

1. Reference	XX /
2. Form completed by (names and roles)	
3. Quality Review completed by:	Name: [Removed for publication] Role: Quality Improvement and Patient Safety Manager Date: 11.07.2024 Name: [Removed for publication] Role: Senior Equality, Diversity and Inclusion Manager Date: 11.07.2024 Name: [Removed for publication] Role: Involvement Team Date: 31.05.2024 and 11.07.2024
4. Equality review completed by:	Name: [Removed for publication] Role: Quality Improvement and Patient Safety Manager Date: 11.07.2024 Name: [Removed for publication] Role: Senior Equality, Diversity and Inclusion Manager Date: 11.07.2024 Name: [Removed for publication] Role: Involvement Team Date: 31.05.2024 and 11.07.2024
5. Date form / scheme agreed for governance	
6. Proposed review date (6 months post implementation date)	
7. Notes	

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

Level of risk to the ICB
Low
Medium
High

M: Approval to proceed

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

N: Review

To be completed following implementation only.

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

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

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

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

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

Appendix A: Impact Matrix

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

Likelihood

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

Scoring matrix

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

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

Category
Opportunity
Low – moderate risk
High risk

Opportunity and consequence

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

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

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

Appendix B: Guidance notes on completing the impacts section G

Domain	Consider
1. Patient Safety	• Safe environment. • Preventable harm. • Reliability of safety systems. • Systems and processes to prevent healthcare acquired infection. • Clinical workforce capability and appropriate training and skills. • Provider's meeting CQC Essential Standards.
2. Experience of care	• Respect for person-centred values, preferences, and expressed needs, including cultural issues; the dignity, privacy, and independence of service users; quality-of-life issues; and shared decision making. • Coordination and integration of care across the health and social care system. • Information, communication, and education on clinical status, progress, prognosis, and processes of care to facilitate autonomy, self-care, and health promotion. • Physical comfort including pain management, help with activities of daily living, and clean and comfortable surroundings. • Emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families, and their finances. • Co-produce with the population and service users as the default position for project design. • Use what we know from insight and feedback in project design and be explicit in the expected outcomes for experience of care improvements. • Involvement of family and friends, on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as caregivers. • Transition and continuity as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions. • Access to care e.g., time spent waiting for admission, time between admission and placement in an in-patient setting, waiting time for an appointment or visit in the out-patient, primary care or social care setting. [Adapted from the NHS Patient Experience Framework, DoH 2011] revised in: https://www.england.nhs.uk/wp-content/uploads/2021/04/nhsi-patient-experience-improvement-framework.pdf
3. Clinical Effectiveness	• Implementation of evidence-based practice (NICE, pathways, royal colleges etc.).

	• Clinical leadership. • Care delivered in most clinically and cost-effective setting. • Variations in care. • The quality of information collected and the systems for monitoring clinical quality. • Locally agreed care pathways. • Clinical engagement. • Elimination of inefficiency and waste. • Service innovation. • Reliability and responsiveness. • Accelerating adoption and diffusion of innovation and care pathway improvement. • Preventing people dying prematurely. • Enhancing quality of life. • Helping people recover from episodes of ill health or following injury.
4. Equality	In order to answer section C and G4 the groups that need consideration are (use the links for more information): • **Age**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/age-discrimination • **Disability**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/disability-discrimination • **Gender reassignment**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/gender-reassignment-discrimination • **Pregnancy and maternity**: https://www.equalityhumanrights.com/en/our-work/managing-pregnancy-and-maternity-workplace • **Race**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/race-discrimination • **Religion or belief**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/religion-or-belief-discrimination • **Sex**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/sex-discrimination • **Sexual orientation**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/sexual-orientation-discrimination

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

Appendix C – Data table for location of clients

Area	Number of clients
WF10	14
WF3	26
BD17	3
BD11	8
LS29	17
LS28	53
LS27	35
LS26	32
LS25	23
LS24	7
LS23	4
LS22	13
LS21	16
Ls20	8
LS19	22
LS18	36
LS17	52
LS16	68
LS15	33
LS14 (most deprived)	35
LS13	51
LS12 (most deprived)	27
LS11 (most deprived)	26
LS10 (most deprived)	23
LS9 (most deprived)	19
LS8 (most deprived)	38
LS7 (most deprived)	21
LS6 (most deprived)	32
LS5 (most deprived)	7
LS4	5
LS3	0
LS2 (most deprived)	1
LS1 (most deprived)	3