

## 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](#) in the appendix).

Assessment Completion	Name	Role	Date	Email
<b>Scheme Lead</b>	[Removed for publication] [Removed for publication]	Pathway Integration Leader Senior Pathway Integration Manager	22.02.2024 (last updated 1.7.24)	[Removed for publication] [Removed for publication]
<b>Programme Lead sign off</b>	[Removed for publication]	Director of Primary Care and Same Day Response		[Removed for publication]

<b>A. Scheme Name</b>	00140 Acute Respiratory Infection Hub: – Community Ambulatory Paediatric Service (CAPS) and Acute Adult Respiratory Clinic (AARC)
<b>Type of change</b>	<b>Stop</b>
<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).

An Acute Respiratory Infection hub model is a system approach that drives a collective objective to provide timely and appropriate care to the population and helps reduce pressure on other parts of the system.

As a result, the goals are to:

1. Support patients with urgent clinical needs by enhancing same day access to assessment and specialist advice as needed. This includes access to respiratory 'clinics'. Access to point of care (POC) testing or other diagnostics may be helpful if available.
2. Seek to reduce ambulance callouts, Emergency Department (A&E) attendances and hospital admissions for patients who could be appropriately managed in the community.
3. Reduce the burden of acute respiratory illness on primary care and provide more time for practice teams to support patients where continuity of care is most important.

The CAPS service for children and young people was developed during winter 22 / 23 with national pilot funding. Regional underspend was then secured to continue the pilot throughout 23 / 24 to support ongoing national evaluation. Funding was non-recurrent and currently there is no identified longer-term funding available. AARC was additionally developed to support winter pressures, with funding secured from the Integrated Care Board's (ICB) winter 23 / 24 allocation. This enhanced primary care service offer was established during high system pressures seen in the autumn of 23 / 24 (specifically supporting primary care with reported surges in demand for on the day appointments and higher than predicted A&E attendances).

The CAPS / AARC model is based on referral following clinical practitioner assessment (no self-referrals accepted into the service). In the main this is usually a clinical practitioner within primary care, with those patients requiring additional assessment and intervention booked directly into a clinical appointment. Patients can also be routed from Primary Care Access Line (PCAL) and other urgent care services (such as Urgent Treatment Centres (UTCs), NHS 111, A&E and Yorkshire Ambulance Service (YAS)).

**CAPS Data:** During mobilisation, CAPS has demonstrated that this model of care is accessible and has been utilised by all Primary Care Networks (PCNs) across Leeds; travel has not been a barrier to access. CAPS appointments are 20 minutes per patient opposed to the standard 10 minutes

within primary care, with evaluations which demonstrate their impact on the wider determinants of health having the time to discuss and manage the causes of the respiratory exacerbation. Evidence from this model of care demonstrates the goals listed above are achieved as only 0.8% of patients are admitted to secondary care appropriately managing 99.2% in the community. Data analysis also identifies a correlation between a reduction (particularly over the winter months) in children and young people (CYP) respiratory admission and attendances at A&E and Children’s Assessment and Treatment Unit (CAT) at Leeds Teaching Hospitals NHS Trust (LTHT).

**AARC Data:** AARC was only launched in November 2023 in response to high system winter pressures. Since service introduction, 1127 patients have been booked into a clinical appointment (382 directly from Primary Care, 545 from NHS 111 and 200 from the two UTC’s). Of those who attended an appointment (minus DNAs / cancelled appts) 63% were female. Access by PCN and GP practice is restricted to those practices experiencing high demand (reported via the Operational Pressures Escalation Level (OPEL) framework) or where patients seek an alternative service via NHS 111 or attending a walk-in urgent service (Urgent Treatment Centre). The table below shows the top 20 GP practices patients accessing the service are registered with. It also shows access routes into the service and whether that was directly booked by:

- A primary care provider (when the patient has attempted to gain a same day GP appointment however capacity has been reached and clinically it is deemed appropriate that the patient is seen within a set time period (OPEL4)).
- NHS 111 following patient contact (with an outcome for urgent primary care for respiratory illness / infection).
- After the patient sought treatment / care at an Urgent Treatment Centre (patient directly booked into AARC by UTC provider when it was more appropriate that the patient was seen by expert clinician for presenting symptom or when access to the UTC was restricted due to high demand).

Practice	OPEL 4	111	UTC	Attended
Shaftesbury Medical Centre	103	34	3	125
Oulton Medical Centre	36	15	5	51
The Garden Surgery	40	14	1	51
Lingwell Croft Surgery	13	18	16	41
Lofthouse Surgery	1	22	19	41
Allerton Medical Centre	24	15	2	29
Manston Surgery	23	10	1	30
Chevin Medical Practice	25	7	1	30
Dr G. Lees & Partners	0	27	5	31
West Lodge Surgery	3	22	4	25
Colton Mill Medical Centre	20	7	2	24

Practice	OPEL 4	111	UTC	Attended
Moorfield House Surgery	13	4	12	29
Bramley Village Health and Well Being Centre	1	11	15	27
Alwoodley Medical Centre	7	15	2	22
Fountain Medical Centre	0	13	9	22
Oakwood Lange Medical Practice	5	18	0	19
Whitehall Surgery	7	9	6	19
The Street Lane Practice	15	4	0	17
Diamond Medical Group	0	14	2	17
Priory View Medical Centre	0	14	3	14

CAPS and AARC have the ability as a model to support system demand and pressure. They are listed on the decision management tool and often in times of increased acute demand over winter and in response to national strikes have increased their capacity following discussion at System Resilience Operational Group (SROG). Consideration should also be taken from the cessation of the same day response service (SDR). Over a year combined CAPS and Same Day Response (SDR) saw 17,904 Children and Young People (CYP) which primary care will have to maintain management for in 24 / 25. Feedback from primary care leads states:

“We have already seen an impact with regards to increase in demand particular on Mondays due to ceasing of SDR appointments which then cascades over the rest of the week. Ceasing of CAPS will only add to this, particularly in the most deprived areas (IMD1) which the full Equality Impact Assessment (EIA) shows high usage of the service and great benefits to the population.”

**Decision:** Following a review of activity and spend, in light of no available funding stream and the requirement for the ICB to achieve a balanced financial position, the Leeds ICB is unable to continue these services in 24 / 25.

**Expected outcomes:** During 23 / 24, 10,153 patients have accessed CAPS and 1029 patients accessed AARC, without these services being available these patients would have remained under the care of their registered GP practice (if the patient seeks support from their GP practice), or attended another same day service (i.e. A&E) with respiratory illness symptoms. Predictions from data analysis of the CAPS service and service user feedback suggest on average there will be an additional 50 CYP appointments required in primary care per week and an additional 36 CYP presenting at an unplanned care service such as A&E per day.

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

To be completed in conjunction with:

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

Questions (please describe the impact in each section)	Yes / No
<p>1. Could the project change the way a service is currently provided or delivered?</p> <p>Change to current respiratory pathway (seasonal) for both Children and Young People (CYP) and Adults with primary care retaining management of acute illness and potential increase demand within primary and secondary care (A&amp;E attendances, unplanned admissions i.e. CAT unit).</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 appendix for more detail.</p> <p>It would affect all protected characteristics and all populations as CYP and Adults accessing the current service offer(s).</p> <p>For CAPS, there is concern specifically around children from IMD1 and IMD2, and specifically children from diverse ethnic communities living in these areas. The highest attending diverse ethnic groups to unplanned care for respiratory related reasons are African and Pakistani, the majority of which live in IMD1. Additionally, the third highest usage of CAPS comes from Chapeltown PCN where 66.1% of CYP are of a non-white ethnic background. The two highest rates of attendance for CAPS belonged to: York Road PCN (31.5 per 1000) and Seacroft PCN (27.6 per 1000). Within York Road PCN 66.7% of children live in IMD1, and within Seacroft PCN 60.2% of children live in IMD1.</p> <p>Children living in the most deprived areas is positively correlated with increased unplanned attendances / admissions. By removing access to CAPS there is the potential these children will present at an unplanned care service, providing a worse patient experience and placing increased strain on the system.</p> <p>See CAPS EIA for further information.</p>	<b>Yes</b>

Questions (please describe the impact in each section)	Yes / No
<p>For AARC, access to the service was restricted to those GP practices reporting high pressure (via the OPEL reporting platform). This meant that access was based on demand not on presenting symptoms. Ten GP practices utilised nearly 50% of all appointments. Of these 20% of attendances were from practices based within IMD 1 communities with another 20% from IMD 7 and 8.</p>	
<p>3. Could the project directly affect staff? For example, would staff need to work differently / could it change working patterns, location etc.? Is it likely to specifically affect staff from protected groups?</p> <p>Staff currently delivering the service(s) are employed on a sessional basis by the Leeds GP Confederation. Now the service has ended staff employed by the Leeds GP Confederation are likely to now pick up consistent, sessional work elsewhere. This means that if the service was ever to be re-instated, staff who were familiar with the service, and could easily mobilise, would likely no longer be available, which could have an impact on quality. Furthermore, one of the key reasons CAPS was conceived of was a lack of confidence in managing paediatric patients in a ten-minute primary care appointment. The staff who were regularly filling shifts in CAPS had experience, competency, and confidence to manage illness in children. This resulted in the low conversion rate to the clinical assessment and triage unit (CAT) at the children's hospital. Workforce competence could be reduced without this service.</p> <p>Specifically for CAPS, there is also likely to be an impact on morale in the Paediatric Emergency Department (PED) and the CAT Unit. Overall, PED attendances reduced during the period CAPS ran, and staff in both PED and CAT said they could feel a noticeable difference during this period, which made their jobs easier, and staff felt their time was better spent on children who did need to be in the department. It is estimated that without CAPS an additional 35 children per day would present at PED, this would harm staff morale as these children are likely to be 'green stream' kids who do not have an urgent need. It would also impact overall functioning of the department.</p> <p>The following is a quote from a Paediatrician and Clinical Lead for CAT Unit LTHT:</p> <p>"We have definitely been less busy on CAT than we would have been through the same months last year... the impact on CAT has been noticeable and all my colleagues are highlight impressed and appreciative of the work CAPS is doing."</p>	<p><b>Yes</b></p>

Questions (please describe the impact in each section)	Yes / No
<p>Furthermore, CAPS closing will cause an extra 50 children per week to be seen in primary care (less during spring / summer seasons). This will also cause lower morale in GPs and practice staff, who may feel they do not have the confidence in paediatrics to send the children home, but do not have any alternatives for a safety netting appointment. It will also likely contribute to further system pressures in primary care and therefore may result in front of house staff receiving negative comments or even abuse, as patients become frustrated.</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>Service evaluation reports produced annually based around patient feedback and embedded into the EIA document.</p> <p>During the initial CAPS delivery period of 23 January 2023 – 10 April 2023, 125 families of service users were surveyed to gather their feedback on their experience of CAPS. Of 125 families surveyed, 99.2% were happy with being booked into the CAPS service. One person advised that they were unhappy with the location. 100% said they would recommend the service to friends and family.</p> <p>[The CAPS case studies were reviewed by the panel, the link to this document has been removed for publication]</p> <p>[The CAPS service review was reviewed by the panel, the link to this document has been removed for publication]</p> <p>AARC evaluation highlighted that 96% of those accessing the service believed they were seen in a timeframe appropriate to their symptoms and that 67% would have considered accessing A&amp;E, UTC or NHS 111 if they were unable to get an appointment. Patients also valued same day appointment especially during the weekend when their normal GP may be closed.</p>	<p><b>Yes</b></p>

**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>Access to both CAPS and AARC was only available to patients once they met the criteria and referral from relevant provider. No self referrals were accepted. Given patients only access route was via the established pathway no broader public engagement is required. Communication on service end date has been shared with relevant stakeholders including workforce.</p>	<p>(assume) <b>No</b></p>
<p>Formal consultation activity required?</p>	<p><b>No</b></p>
<p>Full Equality Impact Assessment (EIA) required?</p> <p>A full Equality Impact assessment has been completed for CAPS only.</p>	<p><b>Yes</b></p>
<p>Communication activity required (patients or staff)?</p> <p>The provider informed the workforce (those in referring services i.e NHS 111, YAS, LTHT) of the changes to both services. External communication shared with Primary Care and relevant services via Primary Care Bulletin.</p>	<p><b>Yes</b></p>



## 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>	<b>No</b>

## 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)	Guidance suggests Acute Respiratory Infection (ARI) hub model supports system pressures, flow and management of acute respiratory illness specifically during winter - NHS England Combined adult and paediatric ARI hubs September 2023 and NHS Futures report, published September 2023, Acute Respiratory Infection (ARI) hub learning.
Service delivery data such as who receives services	Service delivery data demonstrates service utilisation and positive service user feedback. Detailed in full EIA.

Evidence Source	Details
Consultation / engagement	Primary care access – data linked to primary care insight report and detailed in full EIA.
Experience of care intelligence, knowledge, and insight (complaints, compliments, PALS, National and Local Surveys, Friends and Family Test, consultation outcomes)	Service delivery data demonstrates service utilisation and positive service user feedback. Detailed in full EIA and within service evaluation.
Other	<b>Finance</b> - The CAPS service was developed during winter 22 / 23 with national pilot funding. Regional underspend was then secured to continue pilot throughout 23 / 24 to support ongoing national evaluation. AARC was additionally developed to support winter pressures, with funding secured from winter 23 / 24 allocation. Funding for both was non-recurrent and currently there is no identified longer-term funding available.

### 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.

<b>Quality Domain</b> The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	<b>Quality elements and description of impact</b> Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	<b>Impact: Positive / Negative / Neutral &amp; score</b> (Assess each impact using the Impact Matrix; colour cell RAG)	<b>What action will you take to mitigate any negative impact?</b> How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
<b>1. Patient Safety</b>	<p>Increased presentations (both primary and secondary care) and more crowding in the paediatric emergency department with respiratory illness during seasonal peaks. Models of care and staffing numbers unable to meet service demand within relevant time frames. Potentially resulting in preventable harm from increased exacerbations and poorer outcomes. Additionally, due to increased demand and waiting times this change may affect other children and adults using services in Leeds. For example, wait times are likely to be longer in both children’s emergency department, as well as children’s clinical assessment and triage unit, and on the phones via PCAL (primary care access line). This will have a knock-on effect on general staff morale and wellbeing and may cause other service users to be more frustrated.</p> <p>Furthermore, this change will see more poorly children attending hospital, which increases infection risk for other children.</p>	<b>-10 - Likely / Minor</b>	<p>Primary care maintaining management of acute respiratory illness.</p> <p>Communications has been issued to system partners via the GP bulletin, and from the workshop hosted in April.</p> <p>It is not felt the patient communication is necessary as this was a pathway amendment that was not open to the public, and it is not a service that the public was likely aware of as being any different to other out of hour’s services.</p> <p>It is felt communicating this to the public would lead to confusion.</p>

<b>Quality Domain</b> The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	<b>Quality elements and description of impact</b> Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	<b>Impact: Positive / Negative / Neutral &amp; score</b> (Assess each impact using the Impact Matrix; colour cell RAG)	<b>What action will you take to mitigate any negative impact?</b> How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
<b>2. Experience of care</b>	<p>Reduced access to same day appointments for respiratory presentations resulting in increased waiting times both in primary and secondary care.</p> <p>Feedback from family and friends highlights the positive impact this service has had to date as well as the negative impact if this service ceased to exist in our models of care.</p>	<b>-10 - Likely / Minor</b>	<p>Primary care maintaining management of acute respiratory illness as was the previous model of care prior to mobilisation of CAPS and AARC.</p> <p>It is impossible to say whether this will continue to impact patient experience, as the service no longer exists, there will be no way for patients to be asked about it. However, it is likely parents will now wait for longer in paediatric emergency department, which is likely to cause frustration and anxiety. Experience can be monitored at paediatric emergency department and across primary care to measure levels of satisfaction.</p> <p>It is also unlikely that the mitigation will be sufficient, however until money is sourced from elsewhere there is little that can be done. This is set against the backdrop of growing pressures in</p>

<b>Quality Domain</b> The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	<b>Quality elements and description of impact</b> Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	<b>Impact: Positive / Negative / Neutral &amp; score</b> (Assess each impact using the Impact Matrix; colour cell RAG)	<b>What action will you take to mitigate any negative impact?</b> How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
			primary care in general, so it's very hard to measure the specific impact of CAPS closing against other pressures.
<b>3. Clinical Effectiveness</b>	<p>CAPS and AARC are both evidence-based models of practice recommended nationally by NHSE.</p> <p>The models have clear clinical leadership and respiratory expertise with additional time per appointment to address the wider determinates of health and reduce re attendance.</p>	<b>-12 - Likely / Moderate</b>	<p>Pathway Integration to continue to scope models of practice where learning from CAPS and AARC can be incorporated into developing service specifications.</p> <p>We will continue to monitor the overall performance of the emergency department against nationally recognised standards of care (including admission for respiratory illness), and this will be used to show impact. For example, Leeds children's emergency department performed significantly better than other national departments last winter in terms of patient's waiting. It will be monitored how we perform this winter to see the difference.</p>

<b>Quality Domain</b> The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	<b>Quality elements and description of impact</b> Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	<b>Impact: Positive / Negative / Neutral &amp; score</b> (Assess each impact using the Impact Matrix; colour cell RAG)	<b>What action will you take to mitigate any negative impact?</b> How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
<b>4. Equality</b>	<p>CAPS and AARC are accessed by every population segment including all protected characteristics. Therefore, the cessation of these services will impact those service users in relation to accessible and timely care.</p> <p>See full EIA for detailed breakdown. CAPS was used disproportionately by children from IMD1 and IMD2, as well as children from ethnic minority backgrounds. 45% of CYP accessing CAPS service are from IMD1. Therefore, significant disproportionate impact on our most deprived CYP across Leeds. Resulting in a negative impact of their quality of life, experience and access to care.</p> <p>AARC utilisation was shared across geographical locations. There was higher use by females than males (63% female). Review of age highlighted a fairly even split of access across the 3 age categories (young adults 18-34, middle aged 35-54, older adults 55+)</p>	<b>-12 - Likely / Moderate</b>	Primary care maintaining management of acute respiratory illness.

<b>Quality Domain</b> The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	<b>Quality elements and description of impact</b> Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	<b>Impact: Positive / Negative / Neutral &amp; score</b> (Assess each impact using the Impact Matrix; colour cell RAG)	<b>What action will you take to mitigate any negative impact?</b> How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
<b>5. Safeguarding</b>	No predicted impact on the duty to safeguard CYP and adults at risk.	<b>0 - Neutral</b>	Red flags seen as priority via primary care pathways.
<b>6. Workforce</b>	Model of practice where staff were employed on a sessional basis. No future commitment of continued employment / session availability.	<b>0 - Neutral</b>	Bank staff ability to redeploy
<b>7. Health inequalities</b>	45% of CYP accessing CAPS service are from IMD1. Therefore, significant disproportionate impact on our most deprived CYP across Leeds. Resulting in a negative impact of their quality of life, experience, and access to care. The service could be seen as more accessible to those with who are neurodivergent, as it is located in a smaller (arguably calmer) environment than paediatric ED, and there is not a 4-hour wait associated which could be stressful for those with sensory disabilities. This is not something we have evidenced, but it is something to consider.	<b>-12 - Likely / Moderate</b>	Primary care maintaining management of acute respiratory illness and therefore health inequalities jointly related to the population.  Some consideration around removing funding from other contracts to support this, however this seems unlikely in the short / medium term.

<b>Quality Domain</b> The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	<b>Quality elements and description of impact</b> Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	<b>Impact: Positive / Negative / Neutral &amp; score</b> (Assess each impact using the Impact Matrix; colour cell RAG)	<b>What action will you take to mitigate any negative impact?</b> How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
	<p>Secondary impact effect on the wider determinates of health such as the health and housing pathways which are addressed through this model of care.</p> <p>Data collected during service delivery doesn't allow for further consideration of impact on specific characteristics or communities (i.e disabilities, health inclusion and occupation)</p>		
<b>8. Sustainability</b>	No predicted impact on sustainability.	<b>0 - Neutral</b>	Access to same technology in primary and secondary care.
<b>9. Other</b>	<p>Likely to draw some publicity with a negative impact on reputation in relation to Leeds not following national recommendations and not prioritising funding to address respiratory presentation in A&amp;E.</p> <p>Increased financial spend and cost pressure in particular relation to secondary care.</p>	<b>-12 - Likely / Moderate</b>	Mitigation workshop aided partner concerns and fears. Some consideration around removing funding from other contracts to support this, however given the financial situation it unlikely that funding will be removed from contracts.



## 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)
Increased respiratory attendances in Primary and Secondary care	Clear communication of pathways including PCAL for advice and guidance (ensuring correct use of services / pathways) this will be shared at the end of summer and at periods throughout winter.	Data analysis of urgent care attendances with respiratory presentations, admissions, same day primary care demand and PCAL (Primary Care Advice Line) utilisation.	Throughout 24 / 25 with a particular focus over winter September - April	CYP Urgent care group [Removed for publication], Senior Programme Lead System Flow and SDR, [Removed for publication], Senior Programme Manager Childrens and Young People
Increased respiratory attendances in Primary and Secondary care and therefore staff under more pressure	Education of prevention of respiratory presentation based on learning from the wider determinates of health such as housing to Primary are via TARGET session	As above and attendance at TARGET sessions	As above	As above with support from GP Confed and primary care team
Increased respiratory attendances in Primary and Secondary care and therefore staff under more pressure	Raising awareness of service withdrawal specifically to primary care providers through via updates in news bulletins. There will be no communications to parents, as the service was no accessible via walk in, or self-referral. The message to parents	As above	Prior to AARC withdrawal (end of March 24) communication has been shared with primary care colleagues. Further communication was shared detailing fully service closure (CAPS at the end of April)	[Removed for publication], Senior Programme Lead System Flow and SDR, [Removed for publication], Senior Programme Manager Childrens and Young People, Support from GP Confed

<b>Identified impact</b>	<b>What action will you take to mitigate the impact?</b>	<b>How will you measure impact / monitor progress?</b> (Include all identified positive and negative impacts. Measurement may be an existing or new quality indicator / KPI)	<b>Timescale</b> (When will mitigating action be completed?)	<b>Lead</b> (Person responsible for implementing mitigating action)
	remains to visit GP as first point of contact.			
Increased respiratory attendances in Primary and Secondary care and therefore staff under pressure	Stakeholder workshop planned for late April 24 looking at a clinical based discussion about what we have learned from the CAPS / AARC pilot and what good would look like in the future	Shared learning and action plan to be developed following session	Workshop in late April	[Removed for publication], Programme Director for System Flow and SDR, [Removed for publication], LTHT Medical Director for Operations
Clinical effectiveness impact	There is little more that can be done to mitigate this impact unless further funding is found, as pathways will return to as they were before the service was instated.	We will monitor Leeds emergency department performance against national standards (including attendances, breaches and admissions), and against performance last year (when these services were in place) to see effectiveness	November 2024 – March 2025 monitoring to compare	[Removed for publication], Senior Programme Lead System Flow and SDR, [Removed for publication], Senior Programme Manager Childrens and Young People

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

The action plan should be monitored regularly to ensure:

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

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

<b>Implementation:</b> State who will monitor / review	<b>Name of individual, group or committee</b>	<b>Role</b>	<b>Frequency</b>
a. that actions to mitigate negative impacts have been taken.	a. Same Day Response Board b. Children Urgent Care Group	Oversee full mitigation and ongoing assessment	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)	c. TBC		

<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?	Same Day Response Board		Initially at end of Quarter 3 (Oct – Dec) prior and repeated after Q4 (Jan – Mar)

## 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.

A workshop took place on 29 April 2024, in which we discussed:

- Level of change
- Impact / displaced demand
- Actions to mitigate.
- Data / impact monitoring – attendances in A&E, UTC, PC / CAT admissions, PCAL calls.

There were a series of mitigating actions explored, including:

- Reducing services in LTHT, such as agency cover, One Medical Group service, or releasing money from Local Care Direct service. All of these are complicated, and we do not want to ‘take with one hand and give with another’ to destabilise the system further, so will need to be thought through carefully.
- Mainstream primary care managing this on a PCN footprint with their own mini hubs, which would require funding.

No one preferred option was identified, or further formal solutions proposed which aimed to establish a like for like service for 24 / 25. Current plan remains to move ahead with actions identified above.

### K: For Team use only

<b>1. Reference</b>	O140
<b>2. Form completed by (names and roles)</b>	[Removed for publication] Pathway Integration Leader [Removed for publication] Senior Pathway Integration Manager
<b>3. Quality Review completed by:</b>	Name: [Removed for publication] Quality Manager (Long term conditions, End of life, QEIA, IFR and LTHT) Initial review date: 20.05.2024
<b>4. Equality review completed by:</b>	Name: [Removed for publication] Senior Equality Diversity and Inclusion Manager Initial review date: 20.05.24 Second review date: 29.05.2024 Third review date: 19.06.2024
<b>5. Date form / scheme agreed for governance</b>	Reviewed at Panel Assurance meetings: <ul style="list-style-type: none"> <li>• 13.06.2024</li> <li>• 11.07.2024</li> </ul>
<b>6. Proposed review date (6 months post implementation date)</b>	TBC
<b>7. Notes</b>	Involvement team reviewed: <ul style="list-style-type: none"> <li>• 8 April 2024</li> <li>• 29 May 2024</li> </ul>

### 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 / 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.</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>

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 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.

## 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> </ul>

	<ul style="list-style-type: none"> <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> </ul>

	<ul style="list-style-type: none"> <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>
<p><b>8. Safeguarding</b></p>	<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>
<p><b>9. Workforce</b></p>	<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>
<p><b>10. Health Inequalities</b></p>	<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>
<p><b>11. Sustainability</b></p>	<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>

	Visit Greener NHS for more info: <a href="https://www.england.nhs.uk/greenernhs/">https://www.england.nhs.uk/greenernhs/</a>
<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>