Quality and Equality Impact Assessment (QEIA)

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

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

Complete all sections (see instructions / comments and consider) Impact Matrix on page 10.

Assessment Completion	Name	Role	Date	Email
Scheme Lead	[Removed for publication]			
Programme Lead sign off	[Removed for publication]			

A. Scheme Name	O074 - Oral Nutritional Supplementation (ONS) Project
Type of change	Review
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).

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

To be completed in conjunction with:

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

Questions (please describe the impact in each section)	**Yes / No**
1. Could the project change the way a service is currently provided or delivered? It has the potential to impact: • Procurement in secondary and primary care (currently undertaken in isolation) which has huge cost impact to primary care prescribing budget. • Improve the quality of prescribing by stopping ONS in people that have no clinical need of it any longer. • Reduce wastage and costs in ONS that isn't required, liked, or wanted. It is well known that many patients don't utilise the ONS that they are prescribed because they simply don't like it; however, as they haven't been reviewed, they are not swopped to something more acceptable or stopped. • Highlight the increasing costs of ONS in non-first line prescribing and promote the use of the formulary in community Dietetics, Secondary Care and in Primary care. A clinical audit is demonstrating that only 1 in 26 people were prescribed a first line product. • May be able to instigate the provision of a Dietetic Advice & Guidance Pathway for GP practices re: complex patients where there is a lack of clarity about if ONS is needed. • This is not a service/policy change but seeks only to emphasise the importance of following national guidance around prescribing ONS While this will support QIPP, this work to improve ONS prescribing has been ongoing for some time, has a national mandate, follows good practice guidance and should improve health outcomes.	**Yes**

Questions (please describe the impact in each section)	Yes / No
2. Could the project directly affect the services received by patients, carers, and families? – is it likely to specifically affect patients from protected or other groups? See page 10 for more detail. The service should improve, as this work will involve a discussion with a pharmacist to review their ONS needs. Some individuals may have their ONS stopped as there is no clinical reason this is needed. This is better for patient health. Some individuals may be switched to a product that better meets their needs. Patients that are identified as needing additional support re: malnutrition will be highlighted and addressed via GP (for example Social Prescribing for advice re: finances, budgeting, food banks, community cooking classes) or Dietetics.	**Yes**
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? It will not impact an individual's day to day role. It will only impact them via: Making them aware of the Formulary regarding ONS. Making them aware the reviews will be taking place. Possibly having to field enquiries from patients regarding the ONS review.	**Yes**
4. Does the project build on feedback received from patients, carers, and families, including patient experience? What feedback and include links if available. No official feedback, however, conversations with staff have picked up that patients are not asked if they like milky drinks or prefer juice, or if they even want the ONS at all in some cases. This is to be addressed as part of the wider work regarding ONS usage, which includes: Looking at ONS prescribing at source (GP, Hospital or in community) Digital flags when leaving hospital to stop repeat prescriptions where not needed. Adult Malnutrition With Food First & Guidelines on the Prescribing of Oral Nutritional Supplements in the Community (leedsth.nhs.uk) Wider discussions at West Yorkshire level re: how other areas tackle ONS over prescribing, are taking place with a view to sharing good practice, learning from other areas and harmonising approaches to ONS where possible.	**No**

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

Insert comments in each section as required	Yes / No
Involvement activity required? It is understood that any changes to individual's prescribing will be discussed with the patient through shared decision - making to ensure that people are aware of any change, and as such can discuss it with their prescriber.	**No**
Formal consultation activity required? No formal consultation is required for the ONS project.	**No**
Full Equality Impact Assessment (EIA) required? In relation to the ONS project a full (comprehensive) equality impact assessment is not required. Consideration to equity / equality in relation to ONS is covered in the QEIA / Concise Impact Assessment.	**No**
Communication activity required (patients or staff)? Communication with staff to update on the project and any changes they need to know about. Including, as below... Community Dietetics, Hospital Dietetics, Community Pharmacy, GP Practices and PCNs	**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.	Yes

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)	
Service delivery data such as who receives services	
Consultation / engagement	
Experience of care intelligence, knowledge, and insight (complaints, compliments, PALS, National and Local Surveys, Friends and Family Test, consultation outcomes)	
Other	

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

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

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

For negative impacts, list the action that will be taken in mitigation. See guidance notes on pages 10 -11.

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)
1. How does this project / decision impact patients?	**Quality** It will improve the quality of service regarding provision of ONS. Currently ONS should be reviewed in primary care on a 4 - weekly basis. This is not happening. This means that there are people receiving ONS that isn't needed, that they may not like or may not use. There are huge waste implications for this. The reviews will also take into consideration regarding a patient's preference over ONS – is it something they want (if its needed) and what sort of ONS may suit their needs (e.g. Milky based drink or juice style).
2. How does this project/decision impact protected or vulnerable groups? E.g. their ability to access services and understand any changes? (see notes in Section I6)	**Equality** The reviews will be undertaken via whatever means the GP practice has to support people with protected characteristics and other health inclusion groups. For example, using Language Empire in the case of non - English speakers and patients who use British Sign Language (BSL), System1 and EMIS highlighting any specific needs that may be taken into consideration such as a disability, mental capacity, non - English speakers.

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)
	We have consulted with the Dietetic Leads regarding patients with mental health and or learning disabilities. Any of these patients will be flagged to the dietetic leads to make them aware and ensure the review / decision is appropriate to individual needs. Anyone that highlights during the review they are having financial or social difficulty that impact their nutrition will be referred to social prescribing for support and advice. Any safeguarding issues that are highlighted will be managed via the GP safeguarding route for that practice. It should also be highlighted that there are strict exclusion criteria for ONS management which are outlined in the Leeds malnutrition guidelines. This will protect those patients who could most likely be negatively impacted by this work. These are identified here: Chronic kidney disease stage 4 and 5, patients with high potassium and/or high phosphate, severe liver disease, dysphagia, cystic fibrosis, inherited metabolic conditions, eating disorders, at risk of refeeding syndrome, enterally (tube) fed patients. This cohort of patients will be under the care of clinicians specific to their needs who will manage their ONS needs. Link to the Leeds malnutrition Guidance can be found here: Adult Malnutrition With Food First & Guidelines on the Prescribing of Oral Nutritional Supplements in the Community (leedsth.nhs.uk)

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)
3. How does this project / decision impact on the duty to safeguard children, young people and adults at risk (including Human Rights e.g. restrictions of liberty and adherence to Mental Capacity Act)?	**Safeguarding** This project has no impact on children as is focussed on adults only. Adults will be communicated with as they are usually communicated with via their GP Practice. This will consider an individual's capacity to make decisions (particularly older people, or people with learning disabilities). *Older adults (aged 65 years and over) account for 52% of the total costs of malnutrition*[1] It is likely that this work will involve a higher proportion of Older people. Many of these will be in care homes that host an MDT to manage nutritional issues, or where they are not, support can be given by the Dietetics Advice & Guidance Clinic. [****managing-malnutrition.pdf***** *was* reviewed by the panel, the link to this document has been removed for publication]
4. Are there any other impacts to consider? (E.g. Workforce, organisational or system wide)	This work may have impacts on: **Secondary Care:** • Work is being done to discuss the impact of unnecessary prescribing of ONS when people leave hospital. These discussions are being had with dietetics and with digital colleagues to reduce over prescribing. **Primary Care:** • This work will highlight the volumes of people being prescribed ONS (some of which inappropriately). The reviews being conducted should reduce this; however, there is a possibility that GP's will need to speak to some patients if their needs are particularly complex, or if further advice is needed from dietetics. (Development of Dietetic Advice & Guidance clinic is underway)

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)
	• It will also highlight the need to use first line choice in ONS products which is currently not happening in primary care. **Community Dietetics:** • Have been made aware of highlight the need to use first line choice in ONS products which is currently not happening in Community Dietetics. • Will raise the need to ensure patients are offered frequent ONS reviews. • Offer an opportunity to discuss the possibility of a Dietetic Advice & Guidance service for GP practices **West Yorkshire Wide:** As mentioned previously, wider discussions at West Yorkshire level re: how other areas tackle ONS over prescribing, are taking place with a view to sharing good practice, learning from other areas and harmonising approaches to ONS where possible

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)	**Are there any communications or engagement considerations or requirements?**
Those in section G.	Reviews will only be conducted if a GP practice agrees to it. Where a practice declines the option to take part in the review process, this is work that the practice will need to undertake themselves in house. The practice will be specifically aware of any patients that have additional needs such as Learning Disabilities, Communication Issues, Language etc. The Pharmacists will use the means normally engaged by the practice to communicate with the patient as per their identified needs e.g. Language Empire	The pharmacists conducting these reviews will be having a Bi-weekly meeting with the ONS team at the ICB. This is to highlight or make aware any issue of problems that need addressing. The pharmacists conducting this work are well versed in carrying out these reviews and understand some people may have additional needs or require extra support. This is where the lead will be taken from how the GP practice usually engages with these patients.	A communication will be sent to: • Community Dietetics • Hospital Dietetics • Community Pharmacy • GP Practices • PCNs This communication will outline why the work needs to be undertake, the process of how it will be done and a timeline. Patients will be communicated with via the appropriate way their individual practice decides. We have requested patients are spoken to, and then followed up with a letter. Interface Clinical Systems provide the ICB with numbers of practices that sign up or decline the review process. They then also provide each GP practice with an end of review report detailing what work has been done, and of there are any further works to be done (patients may need onward referral to dietetics for example).

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

The action plan should be monitored regularly to ensure:

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

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

Implementation: State who will monitor / review	**Name of individual, group or committee**	**Role**	**Frequency**
a. that actions to mitigate negative impacts have been taken.	a.		
b. the quality indicators during the period of service delivery. State the frequency of monitoring (e.g. Recovery Group Monthly, QSC Quarterly, J. Bloggs, Project Manager Unplanned Care Monthly	b.		

Outcome	**Name of individual, group or committee**	**Role**	**Date**
Who will review the proposal once the change has been implemented to determine what the actual impacts were?			

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.

K: For Team use only

1. Reference	XX /
2. Form completed by (names and roles)	
3. Quality and equality review completed by:	Involvement team reviewed: 10 April 2024 [Removed for publication]: Quality review completed 07/05/2024 Equality & Quality review completed 15/04/2024 - EDI Review: 07/05/2024 - Minor changes
4. Date form / scheme agreed for governance	Reviewed at Panel Assurance meeting: 16/05/2024
5. Proposed review date (6 months post implementation date)	
6. Notes	In order to answer C and E2 the groups that need consideration are; Protected characteristics; age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation (Use the hyperlinks for further information) 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) and surviving abuse

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	17.07.23

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

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

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

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

Appendix A: Impact Matrix

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

Likelihood

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

Scoring matrix

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

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

Category
Opportunity
Low – moderate risk
High risk

Opportunity and consequence

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

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

Appendix B: Guidance notes on completing the impacts section G

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

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

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