



Fertility Preservation

Commissioning Policy Document

**Yorkshire and Humber
(Incorporating the Integrated Care Boards (ICBs) of**

**NHS Humber and North Yorkshire ICB
NHS South Yorkshire ICB
NHS West Yorkshire ICB)**

2025 – 2028

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Glossary

Term	Meaning
Artificial insemination	The process by which sperm is directly placed into a woman's cervix, fallopian tubes or uterus. The most common method is intrauterine insemination (IUI).
Embryo	A fertilised egg that has started to develop is known as an embryo until eight weeks of pregnancy, and then a foetus until birth.
Female sterilisation	This is a permanent type of contraception, where the fallopian tubes are blocked or cut to stop sperm meeting an egg. This is sometimes called tubal ligation.
Gametes	Male sperm and female eggs.
Human Fertilisation and Embryology Authority (HFEA).	The UK wide regulator of fertility treatment and embryo research.
Integrated Care Board (ICB)	Integrated care boards (ICBs) are NHS organisations responsible for planning health services for their local population.
Intrauterine insemination (IUI) IUI	Also known as artificial insemination, involves sperm being placed directly into the womb.
In vitro fertilisation (IVF)	A procedure that involves removing eggs from the ovaries and fertilising them with sperm in the laboratory outside the body. The resulting embryos may then be replaced into the womb.

For other terminology that might be used when as part of fertility treatment that is not included in the glossary please see the [HFEA A-Z Fertility Glossary](#)

NHS Yorkshire and the Humber policy for preservation of fertility

Item	Policy Statement
1. Title	Preservation of future fertility
2. Inclusion Criteria	<p>Patients requesting cryopreservation must satisfy all the following criteria:</p> <ul style="list-style-type: none"> • Patient is due to start or has already had chemotherapy, radiotherapy or other medical or surgical treatment which the treating clinician believes is likely to permanently affect their future fertility. • This could include but is not limited to treatment for cancer and for gender dysphoria. • Treatment must be clinically indicated, and part of an NHS funded intervention or course of treatment • Funding for preservation of fertility in the case of NHS treatment for gender dysphoria is included as part of the episode of ICB commissioned care. • Fertility preservation for patients who are self-funding assessment and treatment of gender dysphoria is not routinely commissioned. • Cryopreservation after fertility compromising treatment should only be undertaken when: <ul style="list-style-type: none"> ○ it was not clinically prudent to delay treatment long enough to allow gamete retrieval AND ○ assessment by a clinician with expertise in this field indicates a reasonable likelihood of successful gamete retrieval AND ○ the patient has not reached or passed their 43rd birthday • The impact of the treatment on the patient's fertility has been explained by the treating clinician as soon as possible, including any impact of the process of gamete harvesting on the patient's health. • The patient can make an informed choice to undertake gamete harvesting and cryopreservation of semen, oocytes or embryos for an initial period of 10 years. • For children and those not competent to provide consent, consent should be provided by parents or legal guardians. • Extension for further periods of 10 years or until the age of 42, whichever is the longer, are routinely commissioned and do not require IFR approval.

Item	Policy Statement
	<ul style="list-style-type: none"> • Prior to the commencement of subsequent 10-year storage periods, clinical assessment should determine whether ongoing fertility preservation is required. • NHS funded storage should only be continued if fertility has been affected by the medical treatment or if it is likely to cause future fertility problems. • The patient is aware that funding for gamete harvesting, and cryopreservation of material does not guarantee future funding of assisted conception or fertility treatment. If the patient requests an estimate of the current costs of privately funded fertility treatment, then details of how to find a clinic should be given, along with information on the current local commissioning position for NHS fertility treatment, recognising this may be subject to change
3. Age	<ul style="list-style-type: none"> • There are no specific lower age limits to this policy for males or females. The decision to attempt to preserve fertility is a clinical decision. • Cryopreservation of fertility is not routinely commissioned for patients who have reached or passed their 43rd birthday • New or additional storage periods which commence on or after the patient's 43rd birthday are not routinely commissioned.
4. Duration of storage	<ul style="list-style-type: none"> • People who preserve their fertility should be offered follow up after an appropriate interval (normally around one to two years) after the conclusion of treatment for their medical condition. This should include discussion as to the need for ongoing storage depending on the existing or potential future effect on fertility. NHS funding would only continue if fertility has been/is likely to be affected. • The legal duration of storage is governed by statutory HFEA legislation and regulations; the ICB will routinely fund storage of gametes or embryos for an initial 10-year period. Extension for further periods of 10 years or until the age of 42, whichever is the longer, are routinely commissioned and do not require IFR approval. • New or additional storage periods which commence on or after the patient's 43rd birthday are not routinely commissioned. • Statutory storage periods for gametes and embryos permit patients to store for a maximum of 55 years.

Item	Policy Statement
5. Cryo-preservation of gametes	<ul style="list-style-type: none"> • The ICB will normally fund the collection and storage of at least two semen samples over a period of one week before any treatment that is likely to affect fertility. • Where semen samples contain a low concentration of sperm (1-2 million per ml) further samples may be collected and stored as part of one collection and storage episode. • Surgical retrieval of sperm is currently commissioned by NHS England and is not included in this policy. It is not commissioned by the ICB. • The ICB will normally fund one cycle of egg retrieval, with or without fertilisation. • If fewer than 10 eggs are retrieved following this first cycle of egg retrieval, then one further cycle can be offered.
6. Expectations of providers	<ul style="list-style-type: none"> • Cryopreservation of gametes or embryos must meet the current legislative standards, i.e. under Human Embryo and Fertility Act 1990. • The provider of the service must ensure the patient receives appropriate counselling and provides full consent. The patient and their partner must be made aware of the legal position on embryo ownership should one partner remove consent to their ongoing storage or use. • The provider of the service must ensure patients are aware of legal issues on posthumous use of gametes and embryos should they wish a partner to be able to use these should treatment not be successful. This should include the time limits / duration of the consent and cessation of NHS funding for storage following the death of the patient. • Patients will need to maintain regular contact with the service provider. This is usually every 2 years after preservation of sperm and every 5 years after preservation of eggs. • The provider must ensure appropriate consent to storage is in place and that the patient understands the need for on-going consent and has outlined the purposes for which the gametes/embryos can be used.

Item	Policy Statement
7. Expectations of the patient	<ul style="list-style-type: none"> • The patient will be responsible for ensuring the storage provider has up to date contact details. The ability to maintain communication with the patient is essential for renewal of consent prior to extension of storage after 10 years. Failure to provide ongoing consent may result in the destruction of stored materials. • Patients should be made aware that being registered with a GP in another ICB area may change their entitlement to NHS funded gamete / embryo storage. It is the patient's responsibility to ascertain their entitlement following any change of registered GP and, if ongoing NHS funding is not available, it is the patient's responsibility to meet those costs should they wish to continue to preserve their gametes / embryos.
8. Policy exclusions	<ul style="list-style-type: none"> • Fertility preservation for children who have not yet completed puberty is commissioned by NHS England and is not included in this policy. It is not commissioned by the ICB. • Gamete retrieval and cryopreservation will not be funded for patients who have previously been sterilised.
9. Immigration Health Surcharge	<ul style="list-style-type: none"> • Fertility Preservation is included in the Immigration Health Surcharge as part of assisted conception. • Assisted conception services are defined in the Charging Regulations NHS-cost-recovery-overseas-visitors-guidance-July-2024 as: <ul style="list-style-type: none"> • any medical, surgical or obstetric services provided for the purpose of assisting a person to carry a child. Broadly speaking, this means any medicines, surgery or procedures that are required to diagnose and treat infertility so a person can have a child. It includes procedures such as intrauterine insemination (IUI), in vitro fertilisation (IVF) and egg and sperm donation. Overseas visitors who have been granted a visa which attracts payment of the IHS (including: where they have paid any amount of IHS, received a full or partial refund, or had their IHS waived) must pay for assisted conception services in England, even if their partner is ordinarily resident. • The only exceptions to this are if: <ul style="list-style-type: none"> ○ the services are provided by NHS England to armed forces members, veterans and their families, in accordance with the terms of the armed forces covenant. ○ the services form part of a course of treatment that began before 21 August 2017.

Item	Policy Statement
	<ul style="list-style-type: none"> ○ the IHS payer makes an application for leave to remain under the Home Office destitution domestic violence concession, which means they might be entitled to receive assisted conception services for free, if the need for those services was a result of prior abuse and the person had not travelled to the UK to receive treatment. ○ the IHS payer is exempt from charge for other reasons (for example, they are an asylum seeker or victim of modern slavery). ● In general, a patient who is not ordinarily resident in the country is an overseas visitor and may not be eligible for assisted conception services funded by the ICB. The ICB will comply with government guidance regarding these patients. ● Further information on assisted conception services can be found on the in vitro fertilisation https://www.nhs.uk/conditions/ivf/ and infertility pages https://www.nhs.uk/conditions/infertility/ on NHS.UK. FAQs can also be found on the OVM toolbox.

Quality, Equality, Health Inequality and Sustainability Impact Assessment

Intro and Context

Name of the proposal (policy, proposition, programme, proposal, project, strategy or initiative)	Joint Yorkshire and Humber Preservation of Fertility Treatment Policy DEC 25			Version number	1
Project lead name:	Lisa Kell (Executive lead Dr David Crichton ICB Chief Medical Officer)				
Project lead job title:	Director of Population Health Commissioning				
Project lead directorate	Medical Prevention and Population Health				
Project lead contact details	Phone				
	Email	lisa.kell@nhs.net			
Project manager (if applicable):	Name	N/A	Email		
Project sponsor/SRO:	Name	Dr David Crichton	Email	david.crichton2@nhs.net	
Summary of Proposal (more detail to be provided below)	This impact assessment is on the updated Joint Yorkshire and Humber Preservation of Fertility Treatment Policy . This policy is adhered to across the 3 YH ICBs and replaces the previous version of the Y&H Preservation of Fertility Treatment Policy. The Policy has been developed by the YH expert fertility panel and sets out the criteria for when the ICB will fund the collection and cryopreservation storage of gametes or embryos for patients with medical conditions / at risk of treatment induced fertility (for example chemotherapy, radiotherapy, gender affirming treatment or other gonadotoxic therapies. The aim is to ensure equitable access for fertility preservation on clinical grounds while ensuring clarity of criteria and safe high quality provision.				
Who has been consulted to support and inform completion of this Impact Assessment - i.e. Clinical Lead, relevant commissioning lead, provider, stakeholder, patient experience leads					
Have any key involvement or consultative activities been undertaken that considered how to address equalities issues or reduce health inequalities? If yes, please briefly list up the top 3 most important engagement or consultation activities undertaken, the main findings, with whom and when the engagement and consultative activities were undertaken		Name of activity undertaken	Details of activity undertaken, including with which citizen group and breadth of activity	Month/ Year	
	1			july - oct 2025	
	2				
	3				

Project Overview

Current service/policy/project/strategy

See above summary

Planned changes

The Policy will replace the current one in Dec 2025 when approved by the ICB Board

Future service/policy/project/strategy

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What key sources of evidence have informed your impact assessment and are there key gaps in the evidence? Please include published evidence, research, involvement & consultation findings and participant and expert findings

Sources of evidence (please list all)

key national, statutory, and local evidence sources that underpin this Impact Assessment (QEIA) for the proposed reduction in NHS-funded IVF cycles.

1. NICE Guideline NG156: Fertility Problems: Assessment and Treatment 2013 (updated 2023)
2. Human Fertilisation and Embryology Authority (HFEA) – National Data Dashboard and annual reports (2023, 2022)

Any key gaps in evidence? (please state)

no

Outstanding key issues/questions that may require further involvement, research or additional evidence.

Key issue or question to be answered	Type of involvement, research or other evidence that would address the issue and/or answer the question

Quality Impact Assessment

Stage 1

Domain	Criteria	Answer (select from drop down list)	Score	Next Stage required	Rationale <small>(Please provide rationale for scoring for each question ie. If the project might increase number of admissions then there may be more incidence of HCAI)</small>
Patient Safety	Q1 Is there an impact on avoidable harm / incidents?	No impact on harm/incidents	+ 0		
	Q2 Is there an Impact on Health Care Associated Infection (HCAI)?	No impact on HCAI	+ 0		
	Q3 Will there be an impact on the number of safeguarding incidents?	No impact on safeguarding	+ 0		
	Q4 Does the Business Decision impact on ability to follow current guidance from professional bodies?	Expected to be able to follow guidance fully	+ 3		
Patient Experience	Q5 Is there an impact on patient experience (complaints / PALS)?	No impact on patient experience	+ 0		
	Q6 Is there an impact on patient and staff consent and confidentiality?	No impact on consent and confidentiality	+ 0		
	Q7 Is there an impact on informed choice and involvement in care planning?	No effect on choice and involvement in care planning	+ 0		
	Q8 Is there an impact on personalised care?	No impact on personalised care	+ 0		
	Q9 Is there an impact on quality of the environment for patients?	No impact on patient environment	+ 0		
	Q10 Has there been involvement of patients / carers in Business Decision development?	No patient / carer involvement required	+ 0		
	Q11 Have lessons learned from patient experience been used to develop scheme?	Nothing available	+ 0		
Clinical Effectiveness	Q12 Has evidence based practice been utilised?	Project fully developed using EBP	+ 3		policy is based on national clinical guidelines and best practice
	Q13 Does the Business Decision have clinical leadership / engagement?	Clinical leader identified	+ 2		
	Q14 How does the Business Decision reduce variations / improve consistency in care?	Not applicable/no impact	+ 0		
	Q15 Will quality metrics that measure outcomes be used to measure success?	Not required	+ 0		
	Q16 Does the Business Decision impact on ability to follow current NICE guidance?	Improved ability to follow current NICE guidance.	+ 3		policy is based on NICE CG 156 and HFEA guidance
	Q17 How will the Business Decision impact upon re-admission to inpatient facilities?	Not applicable/no impact	+ 0		
Productivity	Q18 Will the Business Decision help to improve organisational performance?	Not applicable/no impact	+ 0		
	Q19 Will the Business Decision improve care pathways?	Not applicable/no impact	+ 0		

Prevention	Q20	Will the Business Decision promote people to stay well?	Not applicable/no impact	+ 0		
	Q21	Will the Business Decision promote self care for long term conditions?	Not applicable/no impact	+ 0		
	Q22	Will the Business Decision help reduce health inequalities?	Not applicable/no impact	+ 0		
	Q23	Will the Business Decision prevent inappropriate hospital admissions or A&E attendance/ use of emergency services?	Not applicable/no impact	+ 0		
	Q24	Will the Business Decision prevent people dying prematurely?	Not applicable/no impact	+ 0		
Operational Impact	Q25	Will staff have capacity, capability, knowledge and skills?	Not applicable	+ 0		
	Q26	Will this Business Decision impact upon the level of violence & aggression experienced by patients, service users and staff?	Not applicable/no impact	+ 0		
	Q27	Could there be impact on service reputation / media coverage	Not applicable/no impact	+ 0		
	Q28	Does the Business Decision affect effective support in the community?	Not applicable/no impact	+ 0		
	Q29	Does the Business Decision impact on waiting times?	Not applicable/no impact	+ 0		
	Q30	Will the Business Decision impact on current Clinician availability?	No impact	+ 0		
	Q31	Are staff engaged in the scheme?	Not applicable	+ 0		
	Q32	Any impact on staff (e.g. Staff experience, Staff wellbeing, terms and conditions, base change, role change etc.)?	No impact	+ 0		
	Q33	Any impact on any other services or stakeholders.	No impact	+ 0		
Data Security	Q34	Will this Business Decision change the way data is used in the organisation.	No impact	+ 0		
	Q35	Could the Business Decision pose a risk to the confidentiality, integrity or availability of data?	No impact	+ 0		
COVID 19	Q36	Is the proposed business decision a result of new ways of working developed in response to the COVID-19 pandemic	NO	+ 0		
RISK	Q37	Does this business decision reduce a recognised risk as contained on the Provider risk register?	NO	+ 0		

There are still 35 rationales you have not answered

RISK LEVEL

NO Risk

No negative scores for any of the criteria

No further action required

Sustainability Impact Assessment

Domain		Criteria	Answer (select from drop down list)	Score	Rationale <small>provide rationale for scoring for each question</small>	Mitigations <small>(Please provide details of any possible mitigations for any negative scores)</small>
Carbon emissions & resource efficiency	Q1	Will there be an increase, or decrease, in the amount of electricity used?	Not applicable	+ 1	N/A	
	Q2	Will there be an adjustment to the quantity of hot water or heating that is necessary?	Not applicable	+ 1	N/A	
	Q3	Will there be a change in the amount of carbon emissions caused by the energy use in buildings?	Not applicable	+ 1	N/A	
Waste	Q4	Will the waste be burned or dumped in a landfill at the end of its useful life, or may it be recycled, repurposed, mended, or composted?	Not applicable	+ 1	N/A	
	Q5	Will the amount of waste created rise or decrease as a result?	Not applicable	+ 1	N/A	
Travel	Q6	Can 'care miles' (telecare) be decreased by the service?	Not applicable	+ 1	N/A	
	Q7	Does it mean fewer follow-up appointments?	Same amount of follow up appointments	+ 1	N/A	
	Q8	Would it encourage the sharing of cars, low-emission cars, and community transportation—all more efficient uses of automobiles?	Not applicable	+ 1	N/A	
	Q9	Will walking and cycling be encouraged as a form of active travel?	Not applicable	+ 1	N/A	
Procurement	Q10	Will it encourage people to buy fairtrade or ethical products?	Not applicable	+ 1	N/A	
	Q11	Are the goods you've bought made to make it easier to reuse, repair, or replace parts?	Not applicable	+ 1	N/A	
	Q12	Will it encourage more economical use of resources?	Not applicable	+ 1	N/A	
	Q13	Does it help supply networks that are local or regional?	Not applicable	+ 1	N/A	
Built environment & adaption to climate change	Q14	Is the use of building materials with minimal environmental impact being promoted during construction or renovation?	Not applicable	+ 1	N/A	
	Q15	Will construction and renovation debris be burned, recycled, or dumped in a landfill?	Not applicable	+ 1	N/A	
	Q16	Will new or renovated buildings' resource efficiency (heating, power, water) be enhanced by the development?	Not applicable	+ 1	N/A	
	Q17	Will the building's usable life be extended by the development?	Not applicable	+ 1	N/A	
	Q18	Have the designs risks related to climate change been taken into account i.e. heatwaves, floods, storms, and extremely cold weather?	Not applicable	+ 1	N/A	
Community involvement	Q19	Will it lead to more people participating in the decision-making process, such as patients, the general public, health professionals, and elected officials?	Not applicable	+ 1	N/A	
	Q20	Have you asked our communities for their opinions on how this activity will affect sustainable development?	Not applicable	+ 1	N/A	
	Q21	Will it encourage sustainable development, improve social cohesiveness, foster a stronger sense of community, lessen social isolation, and improve health?	Not applicable	+ 1	N/A	
Additional information that is not covered by the questions above. This can include details of overall impact on the environment					N/A	
All questions completed Thanks						
SUSTAINABILITY SCORE						

48%

The Equality Duty has three aims. It requires public bodies to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it;
- foster good relations between people who share a protected characteristic and people who do not share it.

Having due regard means consciously thinking about the three aims of the Equality Duty as part of the process of decision-making. This means that consideration of equality issues must influence the decisions reached by public bodies – such as in how they act as employers; how they develop, evaluate and review policy; how they design, deliver and evaluate services, and how services are commissioned and procured.

When completing this assessment:

- Be proportionate to your work, i.e. the more significant the change, the more rigorous you will need to be.
- Be honest in the actions you state that you will undertake to address any negative issues.
- Use intelligent information for your analysis that helps you to understand who your service users/patients are and how they will be affected by the change.
- Work in collaboration with others.

This EHIA is a two stage process. There are occasions where there is no impact on people accessing the service in which case a stage 2 is not needed. For anything with a negative impact then stage 2 needs to be completed.

Protected Groups		Impact	Score	Rationale (completed for all protected characteristics)
Q1	Sex - In the Equality Act, sex can mean either male or female, or a group of people like men or boys, or women or girls	Reduction of inequality possible	1	Women are more likely to face higher medical restoration preservation procedures however criteria is based on clinical guidelines on best practice. Male and female pathways for preservation are offered equally where clinically safe
Q2	Race/Ethnic group - Under the Equality Act 2010, the Protected Characteristic of Race means: A person's skin colour, nationality, ethnic or national origin	No impact on inequality	0	no expected impact
Q3	Disability/Long term condition - In the Equality Act a disability means a physical or a mental condition which has a substantial and long-term impact on your ability to do normal day to day activities	Reduction of inequality possible	1	Many patients qualifying for cryopreservation have a disability or chronic illness that would be eligible for preservation
Q4	Sexual orientation - This is in relation to who a person is, or in the case of asexual is not, attracted to	No impact on inequality	0	no expected impact
Q5	Gender reassignment - When a person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex	Reduction of inequality possible	1	Policy supports fertility preservation prior to gender affirming hormones or surgery which can cause irreversible infertility

Q6	Age - Individuals are protected from discrimination on the basis of their age and/or because they are part of an age group - this can be specific (e.g. people in their mid-30s) or broader (e.g. people under 50)	Reduction of inequality possible	1	Younger patients benefit significantly from the policy offering cryopreservation where affected by medical conditions that reduce fertility
Q7	Faith or belief - This is when someone is treated differently because of their religion or belief, or lack of religion or belief	No impact on inequality	0	Some religions prohibit or restrict certain fertility treatments. Some groups may avoid donor gametes or embryo freezing
Q8	Maternity or pregnancy - This is when someone is treated unfairly because they are pregnant, breastfeeding or because they have recently given birth	No impact on inequality	0	no expected impact
Q9	Marriage or civil partnership - This means someone who is legally married or in a civil partnership. Marriage and civil partnership can either be between a man and a woman, or between partners of the same sex. People do not have this characteristic if they are: single	No impact on inequality	0	no expected impact
Q10	Geographically isolated - rural communities or other geographical barriers	No impact on inequality	0	no expected impact
Q11	Carers	No impact on inequality	0	no expected impact
Q12	Looked after children	No impact on inequality	0	no expected impact
Q13	Care leavers	No impact on inequality	0	no expected impact
Q14	Digitally excluded - those unable to access digital services	No impact on inequality	0	no expected impact
Q15	Socio-economically deprived - those with low incomes, low education, unemployed or unstable employment, or unstable housing situations	Reduction of inequality possible	1	People from more deprived communities have lower cancer survival may have higher incidence of certain conditions requiring gonadotoxic treatment. The policy is clear around equal access to preservation
Q16	Inclusion health groups - Including Gypsy, Roma, Travellers and Boater communities, people experiencing homelessness, offenders/former offenders, and sex workers	No impact on inequality	0	no expected impact

All questions completed Thanks

IMPACT LEVEL

NO negative impacts

No negative scores for any of the criteria

No further action required

Please summarise your next steps:

EIA recommendations (If negative impacts cannot be mitigated the project must be escalated to Governance Committee)

The EIA demonstrates that the proposal is robust. The evidence shows no potential for discrimination and opportunities to promote equality have been taken.

Adjust the project/proposal/plan to remove barriers or to better promote equality. This might mean introducing measures to mitigate the potential effect.

Continue the proposal, project or policy – adopting the proposal, despite any adverse effect or missed opportunities to advance equality, provided you have satisfied yourself that it does not unlawfully discriminate.

Stop and remove the proposal, project or policy – If there are adverse effects that are not justified and cannot be mitigated, you will want to consider stopping the proposal, project or policy altogether. If a proposal, project or policy shows a potential for unlawful discrimination, it must be removed or changed to remove such discrimination.

Please note:

An EIA is a live document that should be reviewed and developed at intervals throughout the life of the project and beyond.

Version 1 - when it is agreed a change needs to happen this EIA outlines the potential impact of moving from the status quo. Provides information to inform discussion and debate. Identifies gaps in knowledge and understanding to inform the comms and involvement plan.

Version 2 - continues from version 1, and takes place after discussion and debate about solution exploration to help agree options. Need to update potential impacts and mitigating actions based on this further discussion and debate. Takes into account insight from any planned involvement.

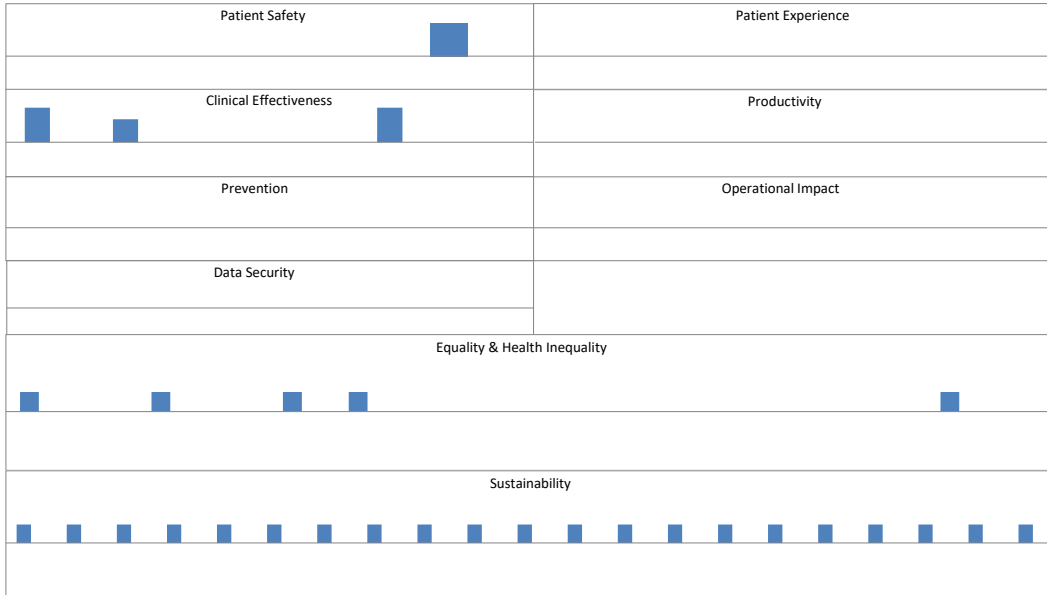
Version 3 - updated prior to any public involvement process and outlines an accumulation of what has been learned and considered and what the actual, likely and potential impacts might be on each characteristic, for each option proposed, to allow these to be discussed, debated and considered.

Version 4 - should include everything that has been learned, all the impacts that should be considered alongside mitigating actions putting decision makers in a position where they can make an informed decision and display due regard.

Version 5 - this should be completed after the decision has been made to reflect the decision made, how it was made (considered) and detail and explain any mitigations for negative impacts.

PLEASE NOTE: Panel are unable to consider incomplete QEHSIAs

Summary - Stage 1 Assessment					
	Questions Answered	Questions NOT	Positive Scores	Neutral Scores	Negative Scores
Patient Safety	4	0	1	3	0
Patient Experience	7	0	0	7	0
Clinical Effectiveness	6	0	3	3	0
Productivity	2	0	0	2	0
Prevention	5	0	0	5	0
Operational Impact	9	0	0	9	0
Data Security	2	0	0	2	0
COVID 19	1	0	0	1	0
Risk	1	0	0	1	0
Sustainability	21	1	21	0	0
Equality / Inequalities	16	0	5	11	0
WHOLE PROJECT	37	0	4	33	0



QIA RISK LEVEL

NO Risk

No negative scores for any of the criteria
 No further action required

Who will own this risk? (e.g. Organisation, Committee, Individual)

POST MITIGATION (MODERATED) RISK LEVEL

NO Risk

JUSTIFICATION FOR MODERATED RISK LEVEL

SUSTAINABILITY SCORE

48%

EQUALITIES AND HEALTH INEQUALITIES IMPACTS

NO negative impacts

No negative scores for any of the criteria
 No further action required

POST MITIGATION (MODERATED) IMPACT LEVEL

NO negative impacts

JUSTIFICATION FOR MODERATED IMPACT LEVEL

REVIEWS

Planned Review Date Actual Review Date

- 1. Have the anticipated quality impacts been realised?
- 2. Have there been any unanticipated negative quality impacts?

Comments:

Quality Impact Assessment
Stage 2 Assessment

	Question	Answer	Score	Stage 2 required?	What are the issues?	How will they be mitigated?	When can this be completed by?	Who will own it?
Patient Safety	Q1 Is there an impact on avoidable harm / incidents?	No impact on harm/incidents	+0	NO				
	Q2 Is there an Impact on Health Care Associated Infection (HCAI)?	No impact on HCAI	+0	NO				
	Q3 How will the reporting of safeguarding incidents be affected?	No impact on safeguarding	+0	NO				
	Q4 Does the Business Decision impact on ability to follow current guidance from professional bodies?	Expected to be able to follow guidance fully	+3	NO				
Patient Experience	Q5 Is there an impact on patient experience (complaints / PALS)?	No impact on patient experience	+0	NO				
	Q6 Is there an impact on consent and confidentiality?	No impact on consent and confidentiality	+0	NO				
	Q7 Is there an impact on informed choice and involvement in care planning?	No effect on choice and involvement in care planning	+0	NO				

	Q8	Is there an impact on personalised care?	No impact on personalised care	+0	NO				
	Q9	Is there an impact on quality of the environment for patients?	No impact on patient environment	+0	NO				
	Q10	Has there been involvement of patients / carers in project development?	No patient / carer involvement required	+0	NO				
	Q11	Have lessons learned from patient experience been used to develop scheme?	Nothing available	+0	NO				
Clinical Effectiveness	Q12	Has evidence based practice been utilised?	Project fully developed using EBP	+3	NO				
	Q13	Does the project have clinical leadership / engagement?	Clinical leader identified	+2	NO				
	Q14	How does the project reduce variations / improve consistency in care?	Not applicable/no impact	+0	NO				
	Q15	Will quality metrics that measure outcomes be used to measure success?	Not required	+0	NO				
	Q16	Does the Business Decision impact on ability to follow current NICE guidance?	Improved ability to follow current NICE guidance.	+3	NO				
	Q17	How will the project impact on re-admission?	Not applicable/no impact	+0	NO				
Productivity	Q18	Will the project help to improve provider performance?	Not applicable/no impact	+0	NO				
	Q19	Will the project improve care pathways?	Not applicable/no impact	+0	NO				
Prevention	Q20	Will the project promote people to stay well?	Not applicable/no impact	+0	NO				
	Q21	Will the project promote self care for long term conditions?	Not applicable/no impact	+0	NO				
	Q22	Will the project help reduce health inequalities?	Not applicable/no impact	+0	NO				
	Q23	Will the Business Decision prevent inappropriate hospital admissions or A&E attendance/ use of emergency services?	Not applicable/no impact	+0	NO				
	Q24	Will the project prevent people dying prematurely?	Not applicable/no impact	+0	NO				
	Q25	Will staff have relevant capability, knowledge and skills?	Not applicable	+0	NO				
	Q26	Will this project impact upon the level of violence & aggression experienced by patients, service users and staff?	Not applicable/no impact	+0	NO				

Operational Impact	Q27	Could there be impact on service reputation / media coverage	Not applicable/no impact	+0	NO				
	Q28	Does the project affect effective support in the community?	Not applicable/no impact	+0	NO				
	Q29	Does the project impact on waiting times?	Not applicable/no impact	+0	NO				
	Q30	Will the Business Decision impact on current Clinician availability?	No impact	+0	NO				
	Q31	Are staff engaged in the scheme?	Not applicable	+0	NO				
	Q32	Any impact on staff (e.g. Staff experience, Staff wellbeing, terms and conditions, base change, role change etc.)?	No impact	+0	NO				
	Q33	Any impact on any other services or stakeholders. If yes, this QEIA should be escalated to the JUCD QEIA panel.	No impact	+0	NO				
Data security	Q34	Will this Business Decision change the way data is used in the organisation.	No impact	+0	NO				
	Q35	Could the Business Decision pose a risk to the confidentiality, integrity or availability of data?	No impact	+0	NO				
COVID-19	Q36	Is the proposed business decision a result of new ways of working developed in response to the COVID-19 pandemic	NO	+0	NO				
RISK	Q37	Does this business decision reduce a recognised risk as contained on the Provider risk register?	NO	+0	NO				

	Protected groups	Impact- carried across from stage 1	Score- carried across from stage 1	Rationale. Must include Impact Source - How have you assessed the impact or potential impact? Is it from research, or other evidence? Data on user trends? Has a member of the public or a stakeholder made you aware?	What are the issues? Must include if there been any specific engagement with this group. If no engagement, will this need to be done?	How will they be mitigated? Must include information about if the mitigations need to be discussed, debated and considered. If this is the case, please indicate how this will happen. Include evidence of how this will solve the issue	When can this be completed by?
Q1	Sex/Gender - In the Equality Act, sex can mean either male or female, or a group of people like men or boys, or women or girls.	Reduction of inequality possible	1				
Q2	Race/Ethnic group - Under the Equality Act 2010, the Protected Characteristic of Race means: A person's skin colour, nationality, ethnic or national origin.	No impact on inequality	0				
Q3	Disability/Long term condition - In the Equality Act a disability means a physical or a mental condition which has a substantial and long-term impact on your ability to do normal day to day activities.	Reduction of inequality possible	1				

Q4	<p>Sexual orientation- This is in relation of who you a person is or in the case of asexual us not attracted to.</p>	<p>No impact on inequality</p>	<p>0</p>				
Q5	<p>Gender reassignment- When a person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex.</p>	<p>Reduction of inequality possible</p>	<p>1</p>				
Q6	<p>Age- Individuals are protected from discrimination on the basis of their age and/or because they are part of an age group - this can be specific (e.g. people in their mid-30s) or broader (e.g. people under 50).</p>	<p>Reduction of inequality possible</p>	<p>1</p>				

Q7	Faith or belief- This is when someone is treated differently because of their religion or belief, or lack of religion or belief.	No impact on inequality	0				
Q8	Maternity or pregnancy- This is when someone is treated unfairly because they are pregnant, breastfeeding or because they have recently given birth.	No impact on inequality	0				
Q9	Marriage or civil partnership- This means someone who is legally married or in a civil partnership. Marriage and civil partnership can either be between a man and a woman, or between partners of the same sex. People do not have this characteristic if they are: single.	No impact on inequality	0				
Q10	Geographically isolated - rural communities or other geographical barriers	No impact on inequality	0				
Q11	Carers	No impact on inequality	0				
Q12	Looked after children	No impact on inequality	0				
Q13	Care leavers	No impact on inequality	0				
Q14	Digitally excluded - those unable to access digital services	No impact on inequality	0				
Q15	Socio-economically deprived - those with low incomes, low education, unemployed or unstable employment, or unstable housing situations	Reduction of inequality possible	1				
Q16	Inclusion health groups - Including Gypsy, Roma, Travellers and Boater communities, people experiencing homelessness, offenders/former offenders, and sex workers	No impact on inequality	0				

Date of review	Comments from IA Review Group
22.10.25	