Leeds Health & Care Partnership

NHS
NHS West Yorkshire
Integrated Care Board

Quality and Equality Impact Assessment (QEIA)

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

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

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

Assessment Completion	Name	Role	Date	Email
Scheme Lead	[Removed for publication]	Pathway Integration Leader	Start Date: 05.02.24. Completion Date: 19.08.24	[Removed for publication]
Programme Lead sign off				

A. Scheme Name	Community (was COVID) Urgent Eyecare Service (CUES)
Type of change	Adjust existing
ICB	Leeds

B: Summary of change

Briefly describe the proposed change to the service, why it is being proposed, the expected outcomes and intended benefits, including to patients, the public and ICB finances. Describe in terms of aims; objectives, links to the ICB's strategic plans and other projects, partnership arrangements, and policies (national and regional). Please also include the expected implementation date (or any key dates we need to be aware of).

Introduction

Since August 2020, the CUES service has provided rapid access to symptomatic / urgent ocular or visual symptom (telemedicine) assessment, and where necessary face-to-face assessment, by a network of Optometrists led by Primary Eyecare Services Ltd (PES). The current pathway includes

an initial triage process (undertaken by either PES or directly with an Optometrist based within an Optical Practice) which is available to self-referring patients and referrals from other services including from General Practice and NHS 111. For those patients who enter the service, the vast majority are managed within the service (around 80% are discharged with no further follow-up or referral to another service required) with only 11% referred to the Hospital Eye Service.

Leeds CUES is established and operates well, this alongside improved local and national awareness, has resulted in activity / spend growing year on year, the circa spend in 2023 / 2024 was £650,000 against a plan of £499,000.

Proposed change and reason

Following a review of activity, outcomes and spending, in light of the requirement for the NHS Integrated Care Board in Leeds (ICB) to manage budgets appropriately and achieve a balanced financial position, the Executive Management Team (EMT) recommended that the CUES contract is not renewed in its current form, from the 31 March 2024 – however we offered the provider a short-term contract until 31 September (this was initially until the 31 July, but due to the election, and any relevant requirement for public engagement this was pushed back) while the ICB and partners develop an alternative model addressing the key clinical and access risks of terminating the existing contract.

The current service was commissioned for urgent symptoms only, we are not planning to stop people accessing with urgent symptoms, but we want to stop providers allowing non-urgent symptoms to access the service.

Following an extensive review of available activity data, delivery of two workshops (22 May 2024 and 7 June 2024) attended by a range of stakeholders and further discussions with the lead provider, it is proposed that access to the service will be centralised through a single point of access - utilising the existing PES Triage Hub (resulting in no self-presentation to an optical practice). The two workshops identified several themes for further exploration, these were:

- Triage – improve / enhance triage to reduce the number of non-urgent / minor conditions accessing the service (i.e. no pain),
- Clinical governance - strengthen approaches to the current triage across providers and oversight.
- Tariff – explore what is affordable and relevant to clinical time required to undertake telemedicine assessment or face-to-face assessment (i.e. telemedicine and face-to-face tariffs are currently paid at the same rate)

Further exploration highlighted the opportunity to provide greater consistency within the triage process by introducing a single point of service access. This is seen as the only identified modification to the service which provides a consistent offer while minimising any impact across health

and care settings (including general practice and secondary care). The rapid review and analysis of presenting symptoms had identified opportunities to review the current triage approach / process and eligibility criteria, however, we haven't been able to identify any evidence-based triage approaches (different to the current model) which could be safely adopted. Finally, during contract renegotiation with the current provider for the remainder of 2024 / 2025 we will be exploring alternative tariff models which aim to achieve a more equitable price between telemedicine assessment and face-to-face.

Demand and activity

Finance activity data indicates that in 2023 / 2024, just over 10,500 individual patients accessed the CUES service. The majority of these patients are self-presenting, or diverted via another health professional without any triage / assessment (as detailed in the table below).

Referral Route	% of cost
Patient self-referred	47.23%
GP staff not seen a GP	32.90%
GP after seeing a GP	9.32%
Other optometrist	4.16%
111 service	2.54%
Pharmacist	1.36%
Other	0.83%
Hospital eye clinic	0.59%
Referral following a GOS sight test at this practice	0.42%
GP out of hours service	0.28%
Accident and Emergency (A&E)	0.15%
Community ophthalmologic clinic	0.09%
Referral following a private sight test at this practice	0.06%
Minor injuries unit	0.04%
None	0.02%
Urgent Treatment Centre (UTC)	0.02%
Grand Total	**100.00%**

Furthermore, around 69% of all attendances present directly to a participating high street optical practice with the remainder contacting the PES Hub directly. Of those coming directly through the PES Hub (31% of all activity in Q4 2023 / 2024), 13% are identified as ineligible for the service (identified through non-clinical triage) and directed to self-care or a more appropriate service. It is not clear how many individuals are deemed ineligible and are directed to self-care or other services when presenting directly to a high street practice.

Analysis of presentations highlights a range of conditions are identified through assessment (assessment includes telemedicine and those requiring face-to-face). The table below shows those conditions with over 100 presentations within a 12-month period (1 Oct 2022 – 30 Sept 2023).

Condition	Number	% of sore eye presentations
Evaporative dry eye	1017	14.60%
Bacterial conjunctivitis	707	10.20%
Blepharitis	573	8%
Allergic conjunctivitis	460	7%
Sub conjunctival haemorrhage	398	5.70%
Viral conjunctivitis	378	5.40%
No ocular pathology identified	326	4.70%
Chalazion meibomian cyst	231	3.30%
Hordelolum stye	203	2.90%
Preseptal cellulitis	190	2.70%
Meibomian gland dysfunction	181	2.60%
Corneal abrasion	164	2.40%
Corneal foreign body	145	2.10%

When focusing on self-referrals, the table below shows the number of self-referrals who are discharged with no onward referrals and with self-care advice or therapeutic recommendations. This helps indicate who may be impacted if changes are made to the current service pathway (i.e. if those with minor conditions such as conjunctivitis were identified as ineligible through centralised triage / single point of access and prevented from accessing the service). However, some of these patients could present in other settings if they feel they require treatment / support such as A&E, minor injuries, GP etc.

Patient self-referral discharge outcome:
Total patients self-referred:

- 2022 – 2023: 3979
- 2023 – 2024: 5214

Other sources of referral totals:

- 2022 – 2023: 3719
- 2023 – 2024: 6484

Total of referrals:

- 2022 – 2023: 7698
- 2023 – 2024: 11678

Discharge with self-care advice / therapeutic recommendation

Category	Latest Diagnosis	2022 - 2023	2023 - 2024
Top 3 – First	Evaporative dry eye	457	704
Top 3 – Second	PVD – Posterior vitreous detachment	349	476
Top 3 - Third	Bacterial conjunctivitis	276	298
Top 3 total		1082	1478
Other diagnoses		1921	2570
Total		3003	4048
% of referral		75.5%	77.6%

Other outcomes

Category	Latest Diagnosis	2022 - 2023	2023 - 2024
Top 3 – First	Evaporative dry eye	42	67
Top 3 – Second	PVD – Posterior vitreous detachment	43	52
Top 3 - Third	Bacterial conjunctivitis	42	30
Top 3 total		127	149
Other diagnoses		849	1017
Total		976	1166
% of referral		24.5%	22.4%

Comparing diagnosed condition and outcome (i.e. advice / next action) the data highlights that for some minor conditions (such as dry eye and conjunctivitis) the main outcome on discharge was either self-care advice (56% and 50%) or recommended therapy (32% and 29%). For these conditions centralised triage may identify greater opportunities to direct people with minor symptoms to self-care / other services without entering the service (triggering a payment to the provider). This data does suggest though that the service is able to assess and manage symptoms without the need for onward referral.

Reasons for attendance and outcomes with numbers (April 2023 – March 2024)

Top 10 reasons for attendance and outcome – all ages	Dry eye	Bacterial / viral conjunctivitis	PVD	Sub conjunctival haemorrhage	Blepharitis	Vitreous floaters	Chalazion meibomian cyst	Hordelolum stye	No ocular pathology identified	Migraine visual aura	Other	Total
Discharge with self-care advice	866	632	633	398	314	388	223	213	257	241	2386	6551
Discharged with therapeutic recommendation	497	371	3	40	89	5	83	50	6	2	419	1565
Urgent referral to HES	25	25	38	3	12	10	1	8	10	9	1035	1176
Referral to GP general health	49	151	1	39	39	1	22	48	9	27	515	901
Telemedicine	0	4	0	0	0	0	1	0	0	0	395	400
Routine referral to HES	27	5	7	0	3	2	34	2	4	1	192	277
Refer to other CUES practice, unable to see within 48 hours	28	23	12	0	7	10	12	6	2	5	158	265
Self-care advice and follow-up arranged	26	20	4	2	9	2	9	5	1	0	83	161
Therapeutic recommendation	14	30	0	2	6	0	3	4	0	0	82	139

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and follow-up arranged												
Action at this practice	6	1	16	0	1	7	0	0	4	1	96	133
Discharge after epilation	4	0	0	1	0	0	0	1	0	0	33	35
Face-to-face at this practice	3	0	3	0	0	1	0	0	0	0	13	20
IP assessment at this practice	1	3	0	0	1	0	0	0	0	0	14	19
Refer to act optometrist	1	0	1	0	0	0	0	0	3	1	11	17
Refer to IP optometrist	0	3	0	0	0	0	0	0	0	0	13	16
Discharge and defer referral – arrange to see in 4-6 months	0	0	0	0	0	0	0	0	0	0	2	2
Total	1544	1268	718	485	481	426	388	337	296	287	5448	11678
Percentage (%)	13.2%	10.9%	6.1%	4.2%	4.1%	3.6%	3.3%	2.9%	2.5%	2.5%	46.7%	

At the time of reviewing the data (reviewing 12-month data 2023), ‘dry eye’ and bacterial / viral conjunctivitis accounts for around 23% of total activity. 2366 (84%) individuals diagnosed with these conditions were discharged with self-care or a therapeutic recommendation. Analysis by PES has identified opportunities where some patients diagnosed with bacterial conjunctivitis may have been suitable for management under a pharmacy (majority of these patients were referred from other sources i.e. GP, 111). This supports the view that in some cases minor conditions can be initially self-managed or treated with over-the-counter drops or ointments from a pharmacy or through self-care.

Who is currently accessing CUES

Access to CUES is varied by Primary Care Network (PCN). The data below shows service attendances (as a rate per 1000) and level of deprivation in those PCNs over a 12-month period. Patients registered at GP practices (grouped here as PCNs) within the highest deprived areas of Leeds are generally lower users of the service (except for [Removed for publication]) when compared to practices / PCNs in the least deprived areas. This may be a result of higher A&E presentations in the more deprived communities for eye-related problems (however, again [Removed for publication] are higher users of A&E for eye-related problems when comparing attendances at a rate per 1,000 registered population).

Tables showing uptake by PCN / GP practice have been reviewed by the assurance panel, the tables have been removed for publication as they are deemed commercially sensitive.

Access to participating optometrists is open and not specific to location (i.e. any Leeds patient can attend any optical practice). Links between the prevalence of need to locations are unclear, however, when looking at the top activity locations for face-to-face appointments [details of areas removed for publication]. On average, a third of all presentations contact PES directly via telephone to access the service. The remaining two-thirds attend a local optical practice. Tables showing uptake presentation by provider have been reviewed by the assurance panel, the tables have been removed for publication as they are deemed as commercially sensitive.

Activity and diagnosis also vary by age, and we would expect more people as they age to access this service (as people age, even a small to moderate change in visual acuity creates a greater impact due to other age-related eye conditions).

When considering diagnosed minor conditions, around a quarter of all conjunctivitis presentations are from the under 12 age group and nearly a third of all dry eye presentations are from those aged 65 and over (careful attention will need be given to specific age groups who may be affected by changes to how people access the service).

Age	Sum of price
Under 12	8.06%
12 – 17	3.34%
18 – 24	5.32%
25 – 34	11.67%
35 – 44	13.87%
45 – 54	11.70%
55 – 64	16.24%
Over 65	29.81%
Total	**100.00%**

Age	All other	Blepharitis	Conjunctivitis	Dry eye	Total
Under 12	5.92%	2.41%	26.68%	3.01%	8.15%
12 – 17	2.95%	4.82%	6.40%	2.89%	3.48%
18 – 24	5.24%	6.01%	6.22%	4.86%	5.36%
25 – 34	12.01%	9.30%	13.49%	10.69%	11.91%
35 – 44	12.90%	8.57%	14.97%	15.37%	13.31%
45 – 54	11.94%	11.37%	9.14%	13.63%	11.76%
55 – 64	17.67%	17.22%	10.06%	14.68%	16.24%
Over 65	31.37%	40.30%	13.03%	34.88%	29.79%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Proposed change to service / pathway

The proposed change to the current pathway incorporates centralising access / triage. All self-presenting and referred activity will flow through the PES Hub which, it is hoped, will result in a greater level of consistency within the triage process. This change in pathway aims to strengthen adherence to the (service) eligibility criteria and result in fewer non-urgent symptoms entering the service.

It is hoped this change will take effect from 1 November 2024 (subject to change) and will form the basis for ongoing review and evaluation looking at clinical outcomes, incidents, service user experience and collection / monitoring of detailed demographic information. This will be used to develop new contractual requirements and service specifications from April 2025.

Centralising triage provides a signal model for individuals seeking urgent eye care which funnels both eligible and those who don't meet the service criteria individuals to the right level of intervention including alternative help / advice options (such as those who have non-urgent symptoms, including red eye but no pain). It is key that only patients with clinically required needs are examined by an eye health specialist. However, if presenting symptoms include any red flag symptoms, including sudden-onset pain or visual loss, then the patient would still need to be examined by an eye health specialist.

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

To be completed in conjunction with:

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

Questions (please describe the impact in each section)	Yes / No
1. Could the project change the way a service is currently provided or delivered? The initial proposed change related to the access pathway, triage process and reduced presenting symptoms criteria (one option considered triage being undertaken in general practice). Following further analysis of service level data and stakeholder discussions including two delivered workshops the only current viable opportunity around the approach to triage individuals seeking an urgent eye care service would be to ensure a consistent approach was taken. Discussions with PES have resulted in a suggested approach whereby all individuals seeking access to the service will be required to contact the PES Hub for triage. Individuals will still receive the same level of service (triage, telephone assessment if eligible and face-to-face at a suitable local optical practice if deemed applicable). Those with symptoms that are not within the service criteria will be supported to access alternative advice / self-management such as local pharmacy.	**Yes**
2. Could the project directly affect the services received by patients, carers, and families? – is it likely to specifically affect patients from protected or other groups? See appendix for more detail. Those with symptoms which are not deemed eligible will follow the same process currently set out in the service model (i.e. no red flag symptoms such as red eye but no pain). The suggested change may increase the numbers identified as ineligible (i.e. those with minor symptoms who accessed the service previously, due to inconsistent triage, may not be eligible if they presented with the same symptoms within the new model). This may include minor conditions such as dry eye (one-third currently accessing CUES are over 65) and conjunctivitis (one-third accessing CUES are under 18). We are unable to identify other groups that could be affected by the change to a single point of access for the service due to a lack of demographic information available to analyse. As part of any future service model, we will build procedures to collect a greater level	**Yes**

Questions (please describe the impact in each section)	Yes / No
of demographic and protective characteristics information to ensure we understand who is accessing the service and their experiences.	
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? This change could increase the number of patients contacting their GP practice or other services resulting in increased demand for staff working in these settings. Specifically, community pharmacies may also see an increase in people seeking advice / over the counter items, however, we believe this will be minimal. Referral from general practice and other settings to the PES Hub is currently within the current pathway and will remain. When access is centralised (no signposting / navigating individuals to optical practices) clearer guidance will be required and related public-facing resources.	**Yes**
4. Does the project build on feedback received from patients, carers, and families, including patient experience? What feedback and include links if available. General feedback provided in contract reports highlights high patient satisfaction, this insight isn't detailed enough to understand feedback on separate presenting symptoms (i.e. conjunctivitis, dry eye, blepharitis) or access route into the service (i.e. self, diversion from another service or direct referral).	**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? The information and proposed pathway amendments to this service don't require any engagement to be undertaken before the change. However, we have developed with the Insight, Communications and Involvement Team a draft engagement plan which has two sections. Initial communication which: • Explains the change to both the public and health and care professionals.	**Yes**

Insert comments in each section as required	Yes / No
• Gives basic advice (who can I contact, contact number, link to more information on a dedicated webpage). Monitoring / change survey: • Shared by PES to users of CUES following service presentation / attendance. • Open from 1 November (coincides with the opening of Single Point of Access, SPA). • Initially run for 4 – 6 weeks, but should continue elements to support ongoing service improvement. Our approach will be continually monitored and amended as we near the change date, 1 November 2024.	
Formal consultation activity required?	**No**
Full Equality Impact Assessment (EIA) required? The information and evidence included within this QEIA provides proportionate and reasonable assurance with respect to equality, equity and health inequalities, potential impacts / risks and subsequent mitigating actions. We have noted that any subsequent remodelling of CUES across Leeds place may require a full / comprehensive Equality Impact Assessment (EIA), in addition to a QEIA, both of which should be initiated at the start of the re-modelling programme / project process and therefore inform decisions.	**No**
Communication activity required (patients or staff)? Stakeholder communication is required, this will include details of any pathway changes or clinical service criteria amendments. Specific messages will be required to those providers (i.e. primary care including pharmacies) who either direct or refer patient to the service given any changes. Patient level information will be required detailing changes to pathway (to single point of access)	**Yes**

E. Data Protection Impact Assessment (DPIA)

A DPIA is carried out to identify and minimise data protection risks when personal data is going to be used and processed as part of new processes, systems, or technologies.

Question	Yes / No
Does this project / decision involve a new use of personal data, a change of process or a significant change in the way in which personal data is handled? If yes, please email the IG Team at; wyicb-leeds.dpo@nhs.net for Leeds ICB or wyicb-wak.informationgovernance@nhs.net for the wider West Yorkshire ICB, to complete the screening form.	**No**

F. Evidence used in this assessment

List any evidence which has been used to inform the development of this proposal for example, any national guidance (e.g. NICE, Care Quality Commission, Department of Health, Royal Colleges), regional or local strategies, data analysis (e.g. performance data), engagement / consultation with partner agencies, interest groups, or patients.

Where applicable, state 'N/A' (not applicable) in boxes where no evidence exists, 'Not yet collected' where information has not yet been collected or delete where appropriate.

Evidence Source	Details
Research and guidance (local, regional, national)	Service activity has been reviewed during the development of possible options presented to EMT. This included diagnosis and outcome. In the development of a new service model detailed current activity data for the CUES service has been reviewed to understand outcomes and opportunities to tighten clinical criteria to ensure only those who require access to urgent eye care are able to access the service (based on clinical effectiveness). Furthermore, two workshops have been arranged and delivered. The workshops were co-designed with the Chairs of the Leeds Optical Committee and the support unit LOCSU (who nationally provide training, policy, communications, governance and compliance support as well as developing clinical pathways to deliver a range of

Evidence Source	Details
	eye health services through primary care). A number of service models / pathways have been considered (including CUES / PEARS / MECS) and the recently released national standard clinical specification: https://locsu.co.uk/
Service delivery data such as who receives services	Activity and outcome data including diagnosis was reviewed as part of the options review. Further detailed data was requested from the provider. SUS data was analysed alongside provider data as well as activity presenting at A&E for eye related problems.
Consultation / engagement	CUES service patient satisfaction survey results
Experience of care intelligence, knowledge, and insight (complaints, compliments, PALS, National and Local Surveys, Friends and Family Test, consultation outcomes)	Quarterly details of CUES complaints are received and reviewed within contract monitoring information.
Other	Finance-based CUES activity is received monthly, this has been overtrading on its contracted indicative activity plan and overtraded significantly in 2024 / 2025. During January 2024, we have had discussions on the growth in activity and initiatives to manage this. In addition, as mentioned above, a review of the service has been undertaken which has been supported by information provided by the lead provider. A paper was taken to the ICB (Leeds Office) EMT setting out contracting options for 2024 / 2025. Unfortunately, in view of the limited resources and prioritisation of available commissioning spend for next year, the decision was made to not re-contract with PES.

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 the appendix.

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
1. Patient Safety	Preventable harm – tightened clinical criteria and a change in access points to urgent eyecare may increase preventable harm however, access to urgent eyecare will still be available where clinically required. Possible slight increased presentations and more crowding in the A&E department may result from service change. Models of care and staffing numbers unable to meet service demand within relevant time frames. Potentially resulting in preventable harm from undiagnosed eye conditions and poorer outcomes.	**-9 - Possible / Moderate**	Access to primary care will still be available as will urgent eyecare, for those patients initially triaged out of the service advice. This will include self-care, pharmacy support and advice (and over-the-counter options) or back into service if symptoms worsen. Clear patient-level and health & care workforce information will be developed (using accessible forms of communication / information).

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
2. Experience of care	Change in access route / expectation of care – for those patients currently accessing CUES is likely to change or advice / assessment may be different if symptoms do not meet service criteria. If patients decide to seek alternative care, it could lead to longer waiting times for other services such as primary and secondary (urgent) care.	**-10 - Likely / Minor**	Patients requiring clinically appropriate urgent eyecare assessment and intervention will still receive a fitting level of care. The development of a revised service model may provide opportunities to open up access for some populations / communities. Signposting to other available services using accessible forms of communication and information will be in place.
3. Clinical Effectiveness	Revised service model aims to provide the most clinically and cost-effective service for urgent eye care issues, eliminating waste and reducing variation in care. This change may reduce the number of minor eye conditions for entering the service	**-10 - Likely / Minor**	Clear patient information and signposting will provide patients with steps to self-manage symptoms or seek advice from alternative services (i.e. pharmacy). Those with progressive symptoms will be

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
	and signpost to alternative / appropriate services.		reassessed as clinically appropriate.
4. Equality	Change of pathway to a single point of access will only change for patients who directly contact a local optical practice. Limited data is available on utilisation by different groups / communities (apart from age and deprivation relating to the location of registered GP practice).	**-4 - Likely / Negligible**	Information on current service users will be used to design and create relevant communication messages, public facing resources and ensure the SPA is able to meet the needs of service users and future users. A proportion of patients currently access the service by contacting PES directly (so no change is foreseen for them). Improved monitoring of service users and engagement findings will provide a greater awareness of who is accessing. Revised service pathway / model will include ongoing considerations of access and

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			outcomes. This may include increasing access for those living in the most deprived communities or with protective characteristics / social positions. Access to the service also needs to be considered to ensure there are no unintended consequences (increasing health inequalities and barriers to access for some communities).
5. Safeguarding	It is not clear through the data available including if vulnerable patients access the service.	**0 - Neutral**	Provider protocols will remain in place as a contract requirement.
6. Workforce	Workload may increase within primary care (including pharmacies) and secondary urgent care impacting staff morale. Community optometrist workforce may also feel they are being deskilled.	**-12 - Likely / Moderate**	Clear guidelines / protocols will need to be in place to support the re-direction of patients to the most clinically / cost-effective service. It is possible that changes may result in increased demand in

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
			some settings. Some community optometrists may see less activity resulting in consideration of business model / workforce. Current pathways for eye care already exist, signposting to other available services using accessible forms of communication and information – to be monitored for capacity issues.
7. Health inequalities	Utilisation of the current service is proportionally higher in communities with lower levels of deprivation. However, for some presenting conditions, there are differences seen across age groups. Patient outcomes / level of satisfaction with the service is high across all demographics.	**-9 - Possible / Moderate**	Revised service pathway / model will include consideration of access and outcomes. This may include increasing access for those living in the most deprived communities or with protective characteristics / social positions. Amending the access route into the service also needs to be

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
			considered to ensure there are no unintended consequences increasing health inequalities and barriers to access for some communities or those with protected characteristics. We will work with the lead provider to ensure their processes and protocols do not disadvantage people.
8. Sustainability	Centralising triage should support greater appropriate utilisation of service (resource). It will also ensure a more consistent offer is in place resulting in only appropriate symptoms entering the service.	**0 - Neutral**	Clear information will aim to support patient decision-making. Only those requiring face-to-face assessments will be required to travel to a local optical practice.
9. Other	Publicity / reputation	**-6 Possible / Minor**	Clear guidance with rational, ongoing stakeholder communication and engagement. PES have already discussed possible changes to pathway with the Local Optical Committee and

Quality Domain The list in each domain is not exhaustive; it is illustrative of the type of impact that should be considered. When describing impacts; use words that you consider are meaningful)	**Quality elements and description of impact** Where appropriate provide information about the proposed or current service that contextualises the impact. (Quantify where possible, e.g. number of patients affected) (List and number if more than one in each domain)	**Impact: Positive / Negative / Neutral & score** (Assess each impact using the Impact Matrix; colour cell RAG)	**What action will you take to mitigate any negative impact?** How could the impacts and / or mitigating actions be monitored? Are there any communications or involvement considerations or requirements?
			Specsavers (the largest provider undertaking both telephone and face-to-face assessments). In principle, the proposed change outlined has been accepted and supported given it aims to safeguard the delivery of the service for the people of Leeds. Alternative pathways for eyecare already exist, signposting to other available services using accessible forms of communication and information – these will be monitored for capacity issues.

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 eye related attendance in Primary and Secondary care	Clear communication of pathways including General Practice, Pharmacy and PCAL for advice and guidance (ensuring the correct use of services / pathways) will be shared at the end of summer and at periods throughout winter.	Data analysis of urgent care attendances with eye conditions presentations, same-day primary care demand and PCAL (Primary Care Advice Line) utilisation.	Throughout the remainder of 2024 / 2025 with a particular focus over winter October - March	[Removed for publication]
Increased eye presentations in Primary and Secondary care and therefore staff under more pressure	Education on self-care resources and relevant services shared on Leeds Health Pathways and at TARGET sessions.	As above and publication of resources and attendance at TARGET sessions.	As above	[Removed for publication]
Increased eye presentations in Primary and Secondary care and therefore staff	Raising awareness of service change specifically to primary care providers (the largest referrers) through updates in news bulletins and TARGET.	As above	As above	[Removed for publication]

Identified impact	**What action will you take to mitigate the impact?**	**How will you measure impact / monitor progress?** (Include all identified positive and negative impacts. Measurement may be an existing or new quality indicator / KPI)	**Timescale** (When will mitigating action be completed?)	**Lead** (Person responsible for implementing mitigating action)
under more pressure				
Clinical effectiveness impact	Patients will still have access to urgent eyecare services however the number of serious incidents and patient complaints will be closely monitored during the initial change period	Number of serious incidents and missed opportunities	As above	[Removed for publication] with support from Quality and BI colleagues (process overseen by PES)
Patient guidance and self-management resources stocktake and refresh	Review and refresh of patient-facing resources and guidance relating to minor and urgent eyecare (including patient leaflets describing the service)	Number of resources and guides reviewed / updated (including those available via the PES website https://primaryeyecare.co.uk/services/urgent-eyecare-service/ and via the College of Optometrists) https://lookafteryoureyes.org/eye-conditions/)	September - October	Comms with Pathway Int support

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

The action plan should be monitored regularly to ensure:

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

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

Implementation: State who will monitor / review	**Name of individual, group or committee**	**Role**	**Frequency**
a. that actions to mitigate negative impacts have been taken.	a. Same Day Response Board ([Removed for publication] and [Removed for publication] as Pathway Leads)	Oversee full mitigation and ongoing assessment	Monthly initially during the change period (Oct-Mar) with progress reported to Same-Day Response Board bi-monthly.
b. the quality indicators during the period of service delivery. State the frequency of monitoring (e.g. Recovery Group Monthly, QSC Quarterly, J. Bloggs, Project Manager Unplanned Care Monthly	b. TBC		

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?	Same Day Response Board	Assurance and impact	April 2025

J. Summary of the QEIA

Provide a brief summary of the results of the QEIA, e.g. highlight positive and negative potential impacts; indicate if any impacts can be mitigated. Taking this into account, state what the overall expected impact will be of the proposed change.

The QEIA and summary statement must be reviewed by a member of the Quality Team and include next steps.

The CUES service has been operating since 2020 with increasing numbers of individuals accessing the service each year. Outcomes (including patient satisfaction) demonstrate the positive impact the service has on managing urgent eye-related symptoms. The review of activity and outcomes for individuals accessing the CUES service and stakeholder workshops / discussions highlighted a number of opportunities to improve the service and manage activity. This included introducing a greater level of consistency across the pathway (initial triage on point of entry). Support for centralising triage through the lead provider (PES) has been supported by the Local Optical Committee and Specsavers (Specsavers are the largest sub-contractor delivering the highest number of face-to-face assessments). Currently around one-third of service users contact PES directly with the rest contacting a local Optical Practice with symptoms. The change suggested here would see all individuals contacting PES for triage prior to any assessment (either over the telephone or face-to-face if deemed required). We expect that around 13% of all individuals contacting PES would not require any further assessment based on their presenting symptoms. This threshold is not being changed and is based on the current clinically developed triage offered within the service. Clear patient information and resources will be required which support this change (including supporting greater level of self-care). Furthermore, clarity on the pathway will also need to be shared with health and care professionals (i.e. general practice, pharmacy). Clear and relevant measures including ongoing data / monitoring are being developed prior to service change implementation – i.e. attendance in A&E, UTC, Primary Care (for urgent eye care), demographic uptake and outcomes will be monitored to understand. This amendment to the current service should provide a greater consistency and service offer to patients and assurance that only those with urgent symptoms are accessing the service.

K: For Team use only

1. Reference	XX /
2. Form completed by (names and roles)	[Removed for publication] (Pathway Integrator)
3. Quality Review completed by:	Name: [Removed for publication] Date Started: 12.04.2024
4. Equality review completed by:	Name: [Removed for publication] Latest Review: 07.08.2024 and 08.08.2024 Date Started: 12.04.2024
5. Date form / scheme agreed for governance	19.08.2024
6. Proposed review date (6 months post implementation date)	01.04.2025
7. Notes	

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

Level of risk to the ICB
Low
Medium
High

M: Approval to proceed

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

N: Review

To be completed following implementation only.

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

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

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

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

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

Appendix A: Impact Matrix

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

Likelihood

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

Scoring matrix

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

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

Category
Opportunity
Low – moderate risk
High risk

Opportunity and consequence

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

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

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

Appendix B: Guidance notes on completing the impacts section G

Domain	Consider
1. Patient Safety	• Safe environment. • Preventable harm. • Reliability of safety systems. • Systems and processes to prevent healthcare acquired infection. • Clinical workforce capability and appropriate training and skills. • Provider's meeting CQC Essential Standards.
2. Experience of care	• Respect for person-centred values, preferences, and expressed needs, including cultural issues; the dignity, privacy, and independence of service users; quality-of-life issues; and shared decision making. • Coordination and integration of care across the health and social care system. • Information, communication, and education on clinical status, progress, prognosis, and processes of care to facilitate autonomy, self-care, and health promotion. • Physical comfort including pain management, help with activities of daily living, and clean and comfortable surroundings. • Emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families, and their finances. • Co-produce with the population and service users as the default position for project design. • Use what we know from insight and feedback in project design and be explicit in the expected outcomes for experience of care improvements. • Involvement of family and friends, on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as caregivers.

	• Transition and continuity as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions. • Access to care e.g., time spent waiting for admission, time between admission and placement in an in-patient setting, waiting time for an appointment or visit in the out-patient, primary care or social care setting. [Adapted from the NHS Patient Experience Framework, DoH 2011] revised in: https://www.england.nhs.uk/wp-content/uploads/2021/04/nhsi-patient-experience-improvement-framework.pdf
3. Clinical Effectiveness	• Implementation of evidence-based practice (NICE, pathways, royal colleges etc.). • Clinical leadership. • Care delivered in most clinically and cost-effective setting. • Variations in care. • The quality of information collected and the systems for monitoring clinical quality. • Locally agreed care pathways. • Clinical engagement. • Elimination of inefficiency and waste. • Service innovation. • Reliability and responsiveness. • Accelerating adoption and diffusion of innovation and care pathway improvement. • Preventing people dying prematurely. • Enhancing quality of life. • Helping people recover from episodes of ill health or following injury.
4. Equality	In order to answer section C and G4 the groups that need consideration are (use the links for more information): • **Age**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/age-discrimination • **Disability**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/disability-discrimination • **Gender reassignment**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/gender-reassignment-discrimination • **Pregnancy and maternity**: https://www.equalityhumanrights.com/en/our-work/managing-pregnancy-and-maternity-workplace • **Race**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/race-discrimination

	• **Religion or belief**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/religion-or-belief-discrimination • **Sex**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/sex-discrimination • **Sexual orientation**: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010/sexual-orientation-discrimination
	Other groups would include, but not be limited to, people who are: • Carers. • Homeless. • Living in poverty. • Asylum seekers / refugees. • In stigmatised occupations (e.g. sex workers). • Problem substance use. • Geographically isolated (e.g. rural). • People surviving abuse.
8. Safeguarding	• Will this impact on the duty to safeguard children, young people, and adults at risk? • Will this have an impact on Human Rights – for example any increased restrictions on their liberty?
9. Workforce	• Staffing levels. • Morale. • Workload. • Sustainability of service due to workforce changes (Attach key documents where appropriate).
10. Health Inequalities	• Health status, for example, life expectancy. • access to care, for example, availability of given services. • behavioural risks to health, for example, smoking rates. • wider determinants of health, for example, quality of housing.
11. Sustainability	See: https://www.bma.org.uk/media/3464/bma-climate-change-and-sustainability-paper-october-2020.pdf Climate change poses a major threat to our health as well as our planet. The environment is changing, that change is accelerating, and this has direct and immediate consequences for our patients, the public and the NHS. Also consider; technology, pharmaceuticals, transport, supply/purchasing, waste, building / sites, and impact of carbon emissions.

	Visit Greener NHS for more info: https://www.england.nhs.uk/greenernhs/
12. Other	• Publicity / reputation. • Percentage over / under performance against existing budget. • Finance including claims.