CLINICAL COUNCIL

FOR EYE HEALTH COMMISSIONING

Primary Eye Care Framework for first contact care

June 2016 (revision February 2018)

Contents

Primary Eye Care forms part of the CCEHC System and Assurance Framework for Eye-health (SAFE). This sets out the overall architecture for how pathways of care within an integrated eye care system are organised, delivered and monitored, based on the clinical risk stratification of a patient's condition and the skills and competence of the health care practitioner.
SAFE is available at: www.ccehc.org.uk

Target Audience:	CCG Clinical leaders, CCG Accountable Officers, CCG Directors of Commissioning, STP leads, NHS England - Primary Care leaders, Local Eye Health Network Chairs.
Date of Review:	July 2020

1 Introduction

This document has been developed using the best evidence available (NICE guidance, NICE Quality Standards, NHS Evidence, ophthalmic research literature, case studies and service audit) and relates solely to the commissioning of NHS Primary Eye Care Services in England beyond the NHS sight testing service.

Most primary eye care is already delivered in optical practices. However, in many areas, there is no effective primary and community services to free up Hospital Eye Service (HES) capacity. To tackle this problem, in line with recommendations of *The Five Year Forward View* (5YFV)[1], the Clinical Council for Eye Health Commissioning (CCEHC) has already developed a framework for Community Ophthalmology[2]. Appropriate risk stratification of patients, more consistent pathways of care and use of the framework models will together lead to better value eye health care, better patient experience and better outcomes. As a result, HES clinics can focus on those patients who really need consultant expertise.

This framework outlines the broad components of the Primary Eye Care Service in England. This is needed to support the clinical decision-making of primary eye care practitioners up to the point of referral. This document is not relevant to Scotland or Wales, where Primary Eye Care is contracted as a national service.

What can be managed within the Primary Eye Care Service depends on skills and equipment, and on the risk of deterioration of the patient's condition but will typically include the ability to:

- manage a wide range of low-risk primary eye conditions
- address the needs of a patient presenting with an acute eye condition (first contact)
- conduct re-checks to confirm abnormal test results (detected by a NHS eye test / eye examination) as outlined in NICE Glaucoma guidance (NG81)[3] and Standard (QS7)[4,5]
- further refine the decision to refer e.g. where risks and benefits are discussed with the patient prior to referral for cataract surgery (NICE Cataract guidance 1.2 (NG77)[6]

Use of the term 'Primary Eye Care' can cover both urgent and routine care provided in a setting which is convenient for patients. In developing the framework, the focus has been on ensuring safe care, maintaining quality, reducing service variation, improving equity of access, and enhancing outcomes through timely interventions.

Given the current capacity issues in the HES and pressures on general practice, the status quo is not sustainable; and this model of eye care should be commissioned for a population that would cover multiple CCGs to have maximum impact and cost-effectiveness. To date, these services have been commissioned by Clinical Commissioning Groups (CCGs) piecemeal and in isolation. However, a proportion of the local population will not stay within CCG boundaries when seeking their primary eye care and so will bypass locally targeted services and be more likely to be referred to the HES unless services are commissioned across a large enough NHS area.

Like the Community Ophthalmology Framework, this service needs to be integrated across public health, wider primary care, community ophthalmology, HES and low vision pathways as part of an integrated care system (ICS) to eliminate unwarranted variation and duplication.

2 Case for change

Increasing demands on eye health services due to the ageing population and the availability of new treatments are creating acute capacity bottlenecks within the HES, especially in relation to age-related macular degeneration (AMD), diabetic eye disease and glaucoma.

It was predicted that between 2010 and 2020, there would be a 26% increase in patients with AMD, a 20% increase in patients diagnosed with Ocular Hypertension (OHT) or glaucoma and a 25% increase in people with diabetic eye disease[7]. These figures have been exceeded resulting in significant capacity issues; a 30% increase in ophthalmology outpatient attendances over the last five years has already been reported by the Royal College of Ophthalmologists and this is set to rise further leading to unmanageable capacity problems in the HES[8].

Urgent change is needed if we are to avoid unnecessary sight loss, and this will involve risk stratification across the eye health pathways, using all the skills available across the eye care team.

The main aims of a Primary Eye Care Service are listed below, some of which may not be relevant in some areas.

1. Provision of safe and effective care by appropriately trained and competent professionals.
2. Delivery of high quality clinical services that ensure patient safety and a positive patient experience.
3. Ongoing development of the current and future workforce supported by receipt of feedback to the practitioner following referral.
4. Reconfiguration of patient flows to make best use of available resources and skills.
5. Embedding governance structures into the service.
6. Provision of clinical services in a setting closer to home or work.
7. Reduction of referrals to HES to reduce waiting times for outpatient appointments and/or enable greater capacity for the care of higher risk patients.
8. Integration with other parts of service.
9. Empowerment of patients through education and self-care.
10. Support for a seven-day service across an area.

Key outcomes from the Primary Eye Care framework are:

- Improved access and choice.
- Services delivered consistently across an area and integrated with the rest of the pathway
- Less duplication and waste (fewer inappropriate and low-quality referrals, and more patients with relatively low-risk conditions managed in Primary Care)
- Sign up to work to nationally or locally agreed protocols.
- Better data to inform commissioning and delivery plans.

There should be close working with GPs, and provision for GPs to refer patients into the Primary Eye Care Service for further local assessment. The Community Ophthalmology Service should not be undertaking work which should be managed in the Primary Eye Care Service.

Through the General Ophthalmic Service in Scotland[9] and the Welsh Eye Care Service in Wales[10], optometrists are commissioned to carry out more accurate diagnostic tests, recall patients for repeat abnormal test results where necessary and manage patients with non-sight threatening urgent conditions. In Wales, practitioners also lead low vision services in primary care to increase access. Cost-effective change has happened in Wales and Scotland through commissioning at scale for their populations.

This service framework provides the opportunity for more eye care problems in England to be managed within primary care. Currently in England, when not locally commissioned, these options can only be offered privately to the patient. The current NHS England funded sight test provides for one consultation and in most cases not more than every two years, which must include a refraction for spectacles. As a result, the decision to refer might often be based on a single atypical result at that one appointment. If there was NHS funding to see patients who present with minor eye conditions, or to see a patient again to monitor their condition or recheck suspect results, this would help to reduce referrals and ease the capacity pressures faced by the HES. When practitioners have to make the right decision on the results from only one appointment and may not have seen that patient before, they rightly play safe and refer.

NHS Five Year Forward View

The drive for more healthcare in the community is embedded throughout the NHS 5YFV[1]. Key objectives in reorganising services is to achieve better integration, efficiencies and the better management of patient flows as well as freeing up capacity in the HES.

Patient centred pathways and care

The traditional separation between primary care, community services, and hospitals - largely unaltered since the foundation of the NHS can be a barrier to the personalised and coordinated health services patients need unless there is proper planning, cross-referral, and signposting and inter-professional communication. All services need to provide patients with improved access and clearly understandable information.

Population size

The size of population served by the Primary Eye Care Service in England will depend on a number of geographical and demographic factors. However, there are significant financial and operational advantages for groups of neighbouring CCGs to collaborate and commission services to meet the eye health needs of a much larger population while minimising procurement costs. In many cases, it makes sense to design services so that referral entry routes to the HES are similar. In Wales, commissioning of Primary Eye Care is set at the 3 million population level and in Scotland, at the 5 million population level.

3 Current services / pathways and available workforce

Before commissioning a Primary Eye Care Service, an eye health needs assessment[11] should be completed to provide a baseline and establish if there are specific local priorities that need to be addressed in the short term. There are some key questions to consider:

- Have you engaged patients and the wider public to hear their views?
- Have you consulted current primary and secondary care providers?
- How is care currently delivered, by whom and where?
- What is the level of activity/demand that needs to be delivered?
- Have you identified which patient groups will be included in the service specification?
- Are there health professionals ready and willing to develop their skills and take on a wider role?

4 Primary Eye Care team

The Primary Eye Care team includes:

- Optometrists
- Dispensing Opticians
- Ophthalmic Medical Practitioners / Ophthalmologists
- General Practitioners (including those with an interest in ophthalmology)
- Pharmacists
- Orthoptists
- Ophthalmic Nurses

NB some may have additional qualifications

Primary Eye Care pathways rely on a multi-professional workforce covering both urgent and routine activity. However, for the majority of GPs and pharmacists in primary care, eye care is a small part of their routine workload.

Pharmacists can offer an important primary care role in dealing with minor ailments, medicines management and in signposting to local Primary Eye Care Services rather than GPs or A&E.

There is evidence that some glaucoma patients are defaulting from treatment because they do not fully understand their condition and, crucially, how to self-administer eye drops effectively. Pharmacists can help with education and training.

5 Competencies required for service components

The clinical skills required for this framework fall within the core competencies of practitioners, but commissioners may seek evidence of continuing professional development and revalidation of skills for quality assurance purposes.

The roles and responsibilities in the processes of commissioning and provision of eye care need to be clear to ensure safe, effective care based on clinical need.

The integrated Primary Eye Care Service includes:

- a glaucoma 'repeat measures' pathway[3,4,5]
- an enhanced cataract referral linked to post-operative assessment and audit [6.12]
- a minor eye conditions pathway[13]

There should be a single overarching service specification. Additional eyecare services for the management of patients with learning disabilities and low vision may be commissioned but need not be delivered in every practice.

Extended clinical roles in primary care (e.g. GPs with special interest in ophthalmology, community-based ophthalmologists, those practitioners who have independent prescribing, higher qualifications or equivalent expertise as outlined in the community ophthalmology framework) are beyond the scope of this framework. They must undergo the necessary training to obtain nationally approved qualifications for assurance of competency as specified by, or equivalent to those specified by the relevant professional bodies and demonstrate maintenance of competences through continuing professional development thereafter. These qualifications and competency standards are currently available.

6 Clinical leadership and governance

Effective local clinical leadership is essential to support the Primary Eye Care Service with appropriate clinical governance and clinical accountability arrangements. There should be a clinical lead in primary care whose role is to liaise with lead colleagues in community and hospital services, promoting a more joined-up approach and better communication across the pathways.

Governance arrangements should not only include having appropriate procedures to demonstrate information and financial governance, but also procedures for prospective evaluation of the design and delivery of new care pathways which show:

- Effective outcomes
- More appropriate and effective patient management
- Patient safety
- Clinical audit
- Competence of the workforce
- High levels of patient experience
- Appropriate infrastructure (equipment, premises etc.)

7 Defining outcome measures and how to evaluate outcomes

The VISION UK portfolio of eye health indicators[14] has been endorsed by the CCEHC. These indicators are designed to review and monitor population eye health and wellbeing at a national and CCG level. Indicator 4 monitors the implementation of the NICE Glaucoma Quality standard relating to 'repeat measures' which is included in the Primary Eye Care Service.

A robust evaluation of the Primary Eye Care Service is essential to demonstrate value and the effectiveness of the service. Well defined outcomes, key performance indicators (KPIs) and methods of measuring them are vital. Example outcomes and associated measures are listed below.

Performance / Outcome Measures

Performance Indicator	Desired Outcome	Threshold	Measure
NICE Quality Standard QS7	There are agreements in place for repeat measures (via the primary eye care service).	>90% of practices participating	Number (and %) of participating practices in the service (repeat measures) *Portfolio Eye Specific Indicator 4iia*
Quality	Glaucoma repeat measures Minor Eye Condition Service Enhanced Cataract referral	Establish baseline	% of patients referred onwards following repeat measures (<30%) % managed within primary care % seen within 24 hours % seen within 48 hours % referred who are listed (audit)
Patient Experience	Patients are satisfied with the care they receive under the primary eye care service Low Did Not Attend (DNA) rates	>90%	Proportion of patients who are satisfied or highly satisfied with the care they received at their appointment with the primary eye care service % DNA
Activity	a) Referral rates b) Impact on ophthalmology first attendances c) Hospital and community service discharge rate after first appointment	Establish baseline	Local audit SUS data

When commissioning a Primary Eye Care Service, it is essential to avoid duplication of effort and costs that occur elsewhere in the system.

Each provider should be required to audit and review their service regularly. They should work collaboratively with other providers to implement a continuous quality improvement approach.

8 Integrating the Primary Eye Care Service with community, hospital and local authority services

The Primary Eye Care and Community Ophthalmology frameworks describe a greater role for practitioners working in primary and community eye care; the benefits of which can then be maximised through greater integration with the HES.

This approach not only supports greater efficiency of the clinical referral system but also the common vision for an integrated care system from the service user's perspective which is described as *'my care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes*'.

To maximise an integrated care system, these additional aims need to be considered:

- Agreement of whole system eye care pathways starting in primary care, minimising duplication and streamlining processes where necessary.
- A communication plan so that all practitioners and patients are engaged and informed.
- A referral route to the Primary Eye Care Service for the assessment of minor eye conditions (typically from NHS 111, HES A&E and UCC, GPs and Pharmacists).
- Where possible, there should be direct referral from the Primary Eye Care Service to the HES (by clinic sub-speciality) and community ophthalmology.
- Direct referral to low vision services supported by eye clinic liaison officers (ECLO).
- A fast track urgent referral pathway for patients suspected of wet age-related macular degeneration [NICE CG82][15].
- An emergency eye referral pathway for high risk conditions.
- Closer working in the cataract pathway with cataract post-operative assessments performed in the community. This has been recommended by NHS Improvement (previously Monitor) to release capacity within the HES[10] and would provide the necessary post-op refraction audit data required for the National Ophthalmology Database.
- Closer working between optometrists, orthoptists and dispensing opticians in managing children referred from school screening.
- Where community ophthalmology services are commissioned, a local management process may be required to select appropriate patients with low risk conditions.
- The requirement for better sharing of data. Good communication and secure sharing and feedback of relevant information between health and care professionals, and their patients, is required at each stage of the patient's pathway, facilitated by electronic patient records and underpinned by community optometric connection to NHS IT infrastructure.
- There needs to be a robust IT system so that eye images and scans can be sent electronically with any referral.
- Better data collection and audit across the pathways will help identify patients who are lost to follow-up and enable those managing service provision to plan more effectively.
- Low vision services need to work as seamlessly as possible with other services, including primary care, community, HES, education, social care, voluntary organisations and stroke, learning disability, rehabilitation and falls teams.
- Primary Eye Care Services will need to be included in the Local Digital Roadmaps to deliver 'Paper Free at the Point of Care'[16] in line with the 5YFV and 'Personalised Health and Care 2020'[17]. The GP has a key role for holding patient information and should receive notification every time patient care is transferred from one setting to another.

9 Referral feedback

Good communication including referral feedback and information sharing is important in any integrated clinical pathway. The Caldicott 2 report highlighted that care professionals should have the confidence to share information in the best interests of their patients and be supported by the policies of their employers, regulators and professional bodies.

In 2015, the Royal College of Ophthalmologists and the College of Optometrists issued new advice for members on the sharing of patient information following referral[18].

Many practitioners often work in isolation in primary eye care and can benefit from advice and support when trying to decide whether they need to refer a patient. Ensuring there is feedback to the referring practitioner (optometrist, nurse and GP) following every referral helps to inform their decision making and improves the quality of future referrals. HES/community ophthalmology clinic staff are in the ideal position to provide support to those who refer to them. Audit has shown that HES clinicians write back to the GP in 99% of cases following a referral but as few as 12 per cent of optometrist referrals result in a letter being copied to the optometrist (Moorfields at Bedford).

There should be opportunities to bring together all practitioners involved in eye care for periodic Continuing Professional Development (CPD) and peer training sessions e.g. feedback on referrals, the type of information that is most useful in a referral letter, current pathways and treatments for eye conditions, and referral timescales for acute eye conditions.

Good quality referral information enables signposting of the patient into the appropriate community clinic or ophthalmology sub-speciality clinic at the first attempt without the need to be seen in a general ophthalmology clinic or other referral refinement scheme in the first instance. This reduces the number of appointments for the patient, improving the efficiency of the pathways.

10 Collaborative commissioning approach

The commissioning and delivery of eye health and sight loss services can be complex; pathways frequently cut across boundaries and involve many providers in a network of care. A more co-ordinated approach is necessary to support the integration between services and pathways. With an average population of 1.2million, Sustainability and Transformational Partnerships (STP) or developing Integrated Care Systems (ICS) provide the opportunity for groups of CCGs to work with providers and local authorities to agree consistent pathways, ideally over an area served by the HES, to develop truly transformed and sustainable services – and deliver the ambitions of the 5YFV.

By working together at a greater scale with clear responsibilities and objectives, there are opportunities for greater efficiency in the commissioning, procurement and delivery of the same service specification by reducing the duplication of effort and the waste of resources.

For example, the glaucoma repeat measures pathway is now in set out in NICE guidance[3,5] as well as a quality standard[4] and specifically designed to reduce unnecessary referrals to the HES. To have maximum impact, it needs to be available and followed before any referral for management of raised intraocular pressures.

Low vision services can be delivered by community practices, HES, social care or by voluntary sector providers. These need to be better integrated so that other primary care practitioners can refer directly to and have improved links with rehabilitation services.

Having a more consistent approach to eye care pathways will lead to earlier detection of eye problems, and quicker access to appropriate services and treatment which are so important to achieve better outcomes for patients. Working at STP level will lead to better management of limited NHS resources.

All local eye care providers should be able to collaborate to deliver a Primary Eye Care Service and there are benefits in administering one contract with a regional provider while still offering patients a wide choice of practices for eye health services. At the same time, optometrists and opticians will be attracted by the efficiency of the approach, as it eases the administrative burden and allows practices of all sizes to participate in pathways.

There are various contracting models to choose from – we are not advocating a 'one size fits all' approach. The model should be at sufficient scale to deliver maximum efficiencies for commissioners, providers and patients.

11 Equality provision of the Primary Eye Care Service

Services are required to meet the legislation requirements under the Equality Act 2010.

The law requires providers to make reasonable adjustments when seeing people with disability.

NHS information must be provided in an accessible format.

In order to ensure equitable access and uptake of Primary Eye Care Services, repeat measures, enhanced cataract referral and minor eye conditions services should also be applied to domiciliary services.

12 References

1) NHS Five Year Forward: https://www.england.nhs.uk/ourwork/futurenhs

2) CCEHC Community Ophthalmology Framework: https://www.college-optometrists.org/the-college/ccehc.html

3) NICE Glaucoma: diagnosis and management: https://www.nice.org.uk/guidance/ng81/chapter/Recommendations#case-finding

4) National Institute for Health & Care Excellence: https://www.nice.org.uk/guidance/QS7/chapter/Quality-statement-2-Referral

5) NICE Quality and Productivity - Proven Case Study: https://www.nice.org.uk/guidance/qs7/resources/qipp-case-study-avoiding-unnecessary-referral-for-glaucoma-use-of-a-repeat-measurement-scheme-110018-485840557

6) NICE Cataract in adults: management: https://www.nice.org.uk/guidance/ng77/chapter/Recommendations#referral-for-cataract-surgery

7) Epidemiological & Economic Model Sight Loss in the UK: 2010-20: Minassian & Reidy, EpiVision and RNIB (2009)

8) The Royal College of Ophthalmologists: https://www.rcophth.ac.uk/2016/03/increasing-demand-on-hospital-eye-services-risks-patients-losing-vision/

9) Scotland General Ophthalmic Service: http://www.isdscotland.org/Health-Topics/Eye-Care/General-Ophthalmic-Services

10) Eye Health Examination Wales: http://www.eyecare.wales.nhs.uk/eye-health-examination-wales

11) UK Vision Strategy's Eye Health Needs Assessment: http://www.ukvisionstrategy.org.uk/get-involved-england-commissioning-eye-care-and-sight-loss-services-commissioning/needs-assessment

12) Monitor - Helping NHS providers improve productivity in elective care: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/466895/Elective_care_main_document_final.pdf

13) Minor Eye conditions pathway: http://www.locsu.co.uk/community-services-pathways/primary-eyecare-assessment-and-referral-pears/

14) Portfolio of Indicators for Eye Health and Care: https://www.visionuk.org.uk/vision-2020-uk-ophthalmic-public-health-committee-portfolio-of-indicators-for-eye-health-and-care/

15) NICE Age-related macular degeneration:

16) Paper Free at the Point of Care: https://www.england.nhs.uk/digitaltechnology/wp-content/uploads/sites/31/2015/09/digi-roadmaps-guid.pdf

17) Personalised Health and Care 2020: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384650/NIB_Report.pdf

18) Sharing of patient information between ophthalmologists and optometrists: http://www.college-optometrists.org/en/college/news/index.cfm/sharing_patient_information_following_referral

19) LOCSU Community Service Pathways: http://www.locsu.co.uk/community-services-pathways/

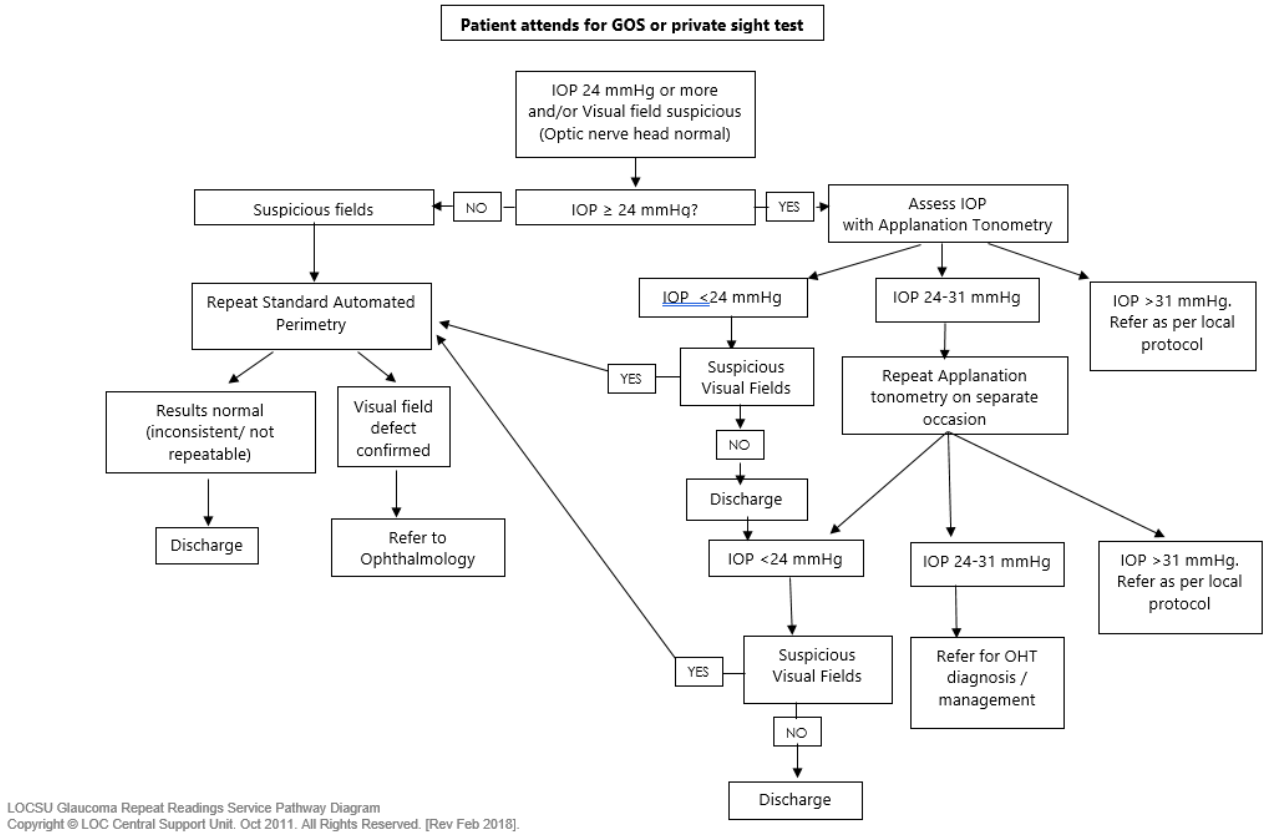
13 Framework development group

A framework development group was established to review and advise on the content of the framework. This group met fortnightly via webinar and face-to-face over a period of three months, with additional interaction taking place via email.

Name	Organisation
Jane Bell	Chair – Wessex Local Eye Health Network, Clinical Advisor to the Local Optical Committee Support Unit
Lydia Chang	Consultant Ophthalmologist, Hinchingbrooke Hospital NHS Trust
Parul Desai	Consultant in Public Health and Ophthalmology, Moorfields Eye Hospital NHS Foundation Trust, London
Barry Duncan	Dispensing Optician representing the Association of British Dispensing Opticians
Karen French	Head of Optometry, Hinchingbrooke Hospital NHS Trust
Mercy Jeyasingham	Chief Executive Officer, VISION 2020 UK
Wojciech Karwatowski	Consultant Ophthalmologist, Chair - Leicestershire and Lincolnshire Local Eye Health Network
Fergus Macbeth	Patient Representative
Rowena McNamara	Head Orthoptist, Imperial College Healthcare Trust, Chair - British and Irish Orthoptic Society
Wendy Newson	Lead Optometrist, Moorfields Eye Hospital at Bedford Hospital
David Parkins	Chair - Clinical Council for Eye Health Commissioning, Chair - London Eye Health Network, Immediate Past President - College of Optometrists
Dharmesh Patel	Chair - Greater Manchester Local Eye Health Network, GM Health and Social Care Partnership
Pritesh Patel	Optometrist / Chair - Lambeth, Southwark and Lewisham Local Optical Committee
Geoff Roberson	Optometrist representing the Optical Confederation
Katrina Venerus	Managing Director, Local Optical Committee Support Unit representing the Optical Confederation
Russell Young	Chief Executive Officer, International Glaucoma Association
Olivier Denève	College of Optometrists, CCEHC secretariat

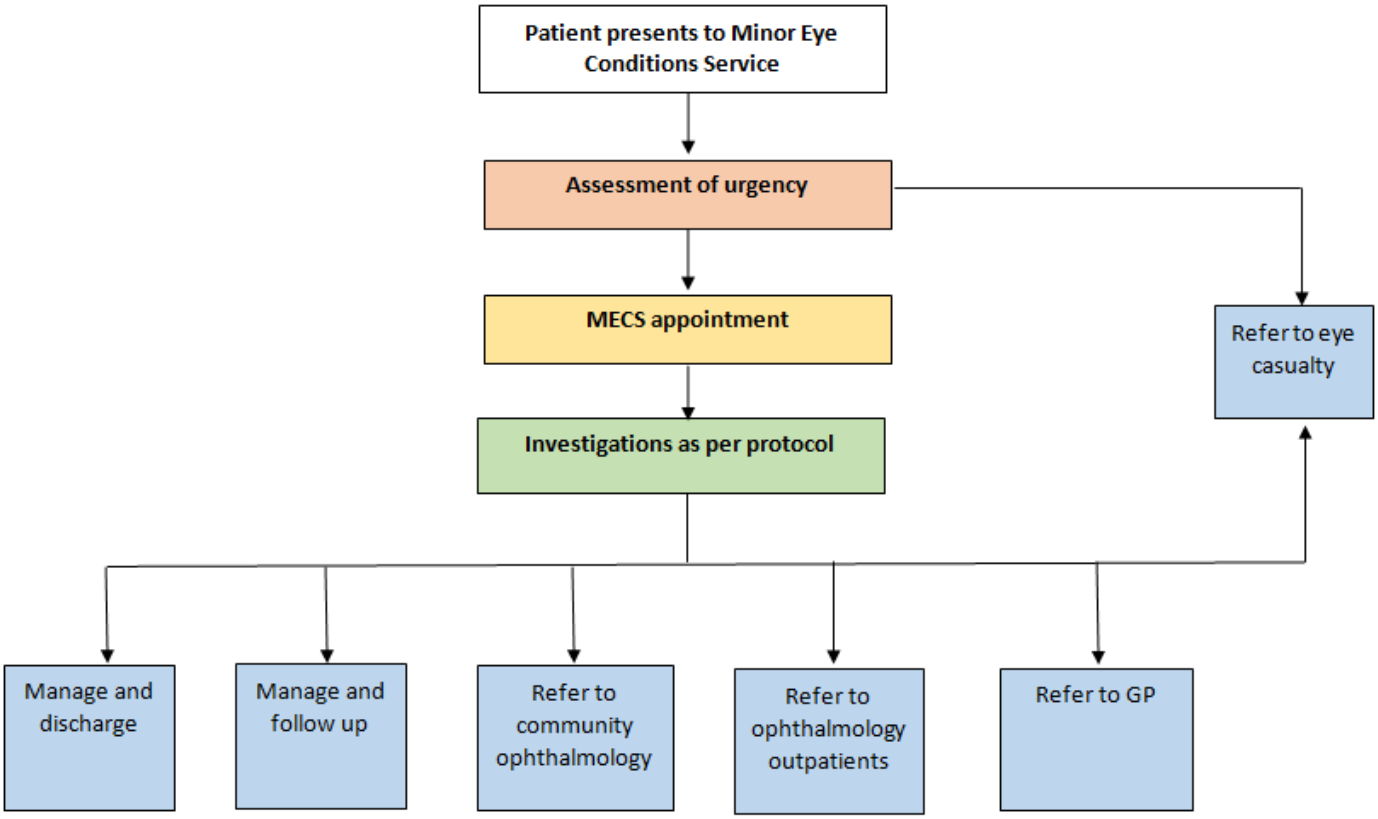
Appendix A Pathways

Glaucoma repeat measures pathway[19]



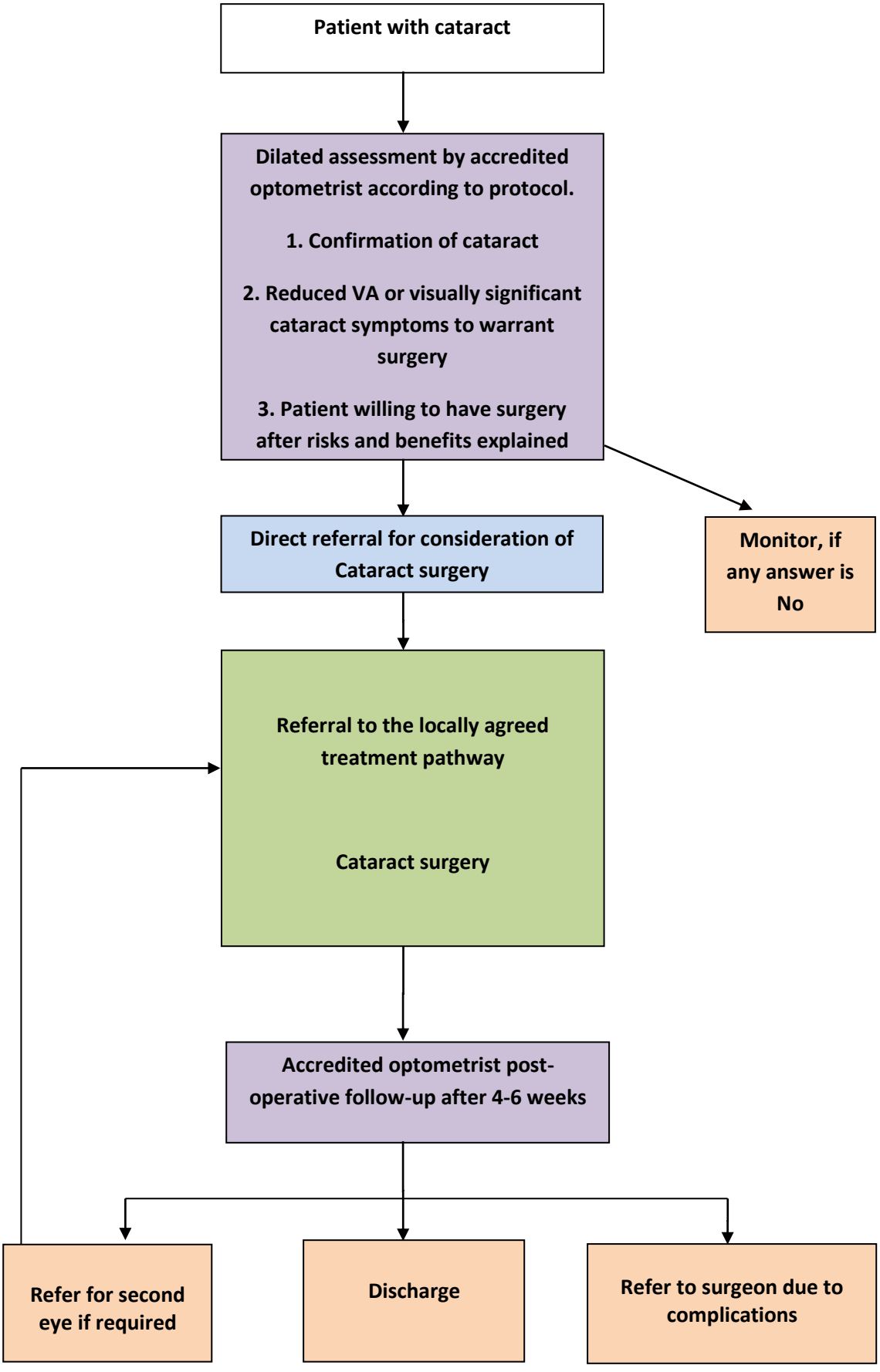
source: LOCSU

Minor eye conditions (MECS) pathway[19]



source: LOCSU

Integrated cataract pathway



Appendix B Glossary

- **Service System** includes the range of pathways of care delivering services that may involve multiple providers and settings, to address the needs of a defined patient population or condition.

- **Sustainability and Transformation Partnerships (STPs)** Plans were introduced in 2015 as a means for delivering the objectives of the NHS Five Year Forward View. STPs now operate across geographic areas, adopting a system-wide approach to transform the way that health and care is planned and delivered to their populations, whilst improving efficiencies in the services provided. It involves a collaborative approach within the NHS and between health and social care providers; and the development of new (increasingly integrated) models of care to meet changing population health needs. STPs have no basis in statute and are not legal entities; raising issues around their operational and financial governance, accountability and authority for policy and decision-making.

- **Integrated Care System (ICS)** This term has been developed from STPs, to provide an understanding of current accountability arrangements. Within an ICS, health and care organisations voluntarily come together to provide system leadership for integrated services for a defined population, agreeing to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations. This facilitates system-based working whilst clarity on statutory authority for collaborative working is pending (or developed).

- **Community Ophthalmology Service** - involves the assessment and management of patients whose eye conditions are at low-risk of deterioration who are either referred by primary care for further assessment or discharged from secondary care for monitoring, in order to release capacity and improve patient flows within the system. It has some or all of the following characteristics:
  - the ability to make definitive diagnoses to manage and treat the majority of cases referred into it
  - be effective as a monitoring service for patients at risk of their condition deteriorating asymptomatically
  - provides an access point for patients with recurrent symptomatic disease

- **Eye Health Needs Assessment** - a review of the provisions for eye health in relation to perceived (current and predicted) needs of a population in a specific locality.

- **Primary Care** - day-to-day healthcare given by a health care provider. Typically, this provider acts as the first contact and principal point of continuing care for patients within a healthcare system, and coordinates other specialist care that the patient may need.

- **Referral Management Service** - a specific type of interface service that does not provide treatment, but accepts GP (or other) referrals and provides advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient.

- **Secondary Uses Service (SUS**) is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

- **Urgent Care Centre -** an alternative to accident and emergency (A&E) for a range of minor injuries and urgent medical problems.