



Primary Care Contracting

(in partnership with the Department of Health)

**Community Eye Care Services:**

**Review of Local Schemes for  
Low Vision, Glaucoma and Acute Care**

**January 2007**

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Thanks are also conveyed to the team at Primary Care Unlimited – [www.primarycareunlimited.com](http://www.primarycareunlimited.com) – who researched and followed up the individual scheme examples and developed this final review document.

## SECTION 1. INTRODUCTION

This document contains a review of local examples of community eye care services. It has been developed as part of the Department of Health's on-going programme of support for community eye care services in partnership with NHS Primary Care Contracting (PCC). It complements and sits alongside the 'Commissioning Toolkit', developed by the Department of Health, following the General Ophthalmic Services (GOS) Review. More details can be found at the [DH site](#)

This resource also supports the delivery of key Department of Health policy objectives for both commissioning and provision of high quality local services, closer to where patients live, moving appropriate primary care services outside the hospital setting, and providing greater choice and accessibility of services to patients. It supports the objectives within recent publications such as the White paper 'Our health, our care, our say: a new direction for community services', Practice Based Commissioning guidance, and the NHS Operating Framework for 2007-08.

The main sections within this document describe

- the objectives of the project
- the method by which the project team obtained examples of local schemes
- key themes drawn from the summarised detail
- a set of self-assessment questions for PCTs and Practice Based Commissioners which help describe the important areas to consider in local planning
- other useful web-based resources
- the summaries of local schemes which can be searched quickly according to clinical area, geographical area or significant feature.

### 1.1 Objectives of this project

The objectives of this project were commensurate with a short timeframe for project delivery. They were

- to provide a summary of current or planned examples of community eye care services, schemes or pathways for **Low Vision services, Glaucoma or Acute Care**.
- to capture some generic themes from these examples to support the local planning and commissioning process for future services
- to use the PCC website as a means of sharing these examples across the country, with the opportunity to capture further examples by way of an electronic feedback form and discussion forum.

For more details and further resources, you are encouraged to visit the [PCC website](#)

## SECTION 2. HOW WAS THIS PROJECT UNDERTAKEN?

The project team followed a number of discrete stages in delivering this piece of work. Local examples were sourced through PCC databases and other recognised contacts. Written evidence about schemes was summarised and every effort was made to follow up each scheme with individual contacts. The significant features of each scheme were then extracted and key commissioning and implementation themes were derived from the information obtained.

### 2.1 A note about the schemes and written evidence obtained

In sourcing local examples of community eye schemes for this project, four important issues should be highlighted at this point:

- a) The project team were able to draw upon written evidence from PCTs where this was available. While some schemes had written information, others did not. This is not to say that PCTs did not have this evidence or that it has not been developed as part of the planning and commissioning process locally. **The project team have not focused on the quality of written evidence or made any judgement on it.** It has been used only as a guide and a basis for further discussion. It has been qualified by follow up contact with each local scheme where possible.
- b) Schemes were **not all at the same stage of development.** Some schemes are still in the early planning stage, some are being tendered, some are pilots and others are now well established over a number of years.
- c) Recent **PCT reconfiguration has had a significant effect** on progress towards implementing some schemes. Key personnel have moved roles or left the PCT and new relationships need to be formed. Some schemes are on hold.
- d) While every effort was made by the project team to contact and follow up each respondent following the request for information, due to the short timeframe of this project a minority of scheme examples have been **summarised only from the written evidence provided.** Where respondents can be contacted or further information is provided, this will be included in the final web product.

## **SECTION 3. KEY THEMES FOR COMMISSIONERS AND PROVIDERS**

The following is a collection of implementation and commissioning themes derived from the local scheme examples shared within this project. They are not exhaustive, nor are they debated. However, others with an interest in commissioning or providing community eye services in primary care may find it useful to consider these themes as they plan, commission and develop their own local service(s). Scheme examples are also included for ease of reference.

### **3.1 Clinical Leadership and Engagement**

There was clear evidence of good clinical leadership in the majority of schemes. A recognisable leader who is able to commit the time and energy to ensuring all local stakeholders are consulted and engaged appears to be a major factor for success ([Gateshead & S.Tyneside or Bedfordshire \(a\)](#)). Key players in this role were Optometric Advisers to the PCT and those sitting on, or advising, the PEC. In many cases, secondary care consultant engagement was driven by evidence of need, both nationally and locally, and the demands on hospital eye care services ([Manchester](#)). Engagement and commitment of local practitioners with the relevant skills and competencies, including community optometrists, are critical to implementation success. Their clinical input and challenge, knowledge of their patient's experiences and behaviours, and understanding of practical issues affecting patient pathways can contribute to overcoming local inertia in service development and commissioning.

### **3.2 Patient and Public Involvement**

The schemes demonstrated a mixture of patient and public involvement. Many schemes were extremely patient focused and had an integrated and on-going approach to using patient experience outcomes ([Camden & Islington](#) or [SW Kent & Maidstone \(a\)](#)). This was evident from patient representatives on local service decision-making groups or patient satisfaction surveys that were either planned or underway. Some schemes were more fragmented with little patient input. It was difficult to determine how schemes were linked to wider community involvement approaches through local authority partners. Furthermore, it was sometimes difficult to establish what skills these patients had, what level of involvement was achieved, and what overall impact they had made on services. optometrist activity on a per patient basis.

### **3.3 PbR Savings and Other Drivers for Change**

In many examples, the drive to develop local community eye care services has come from the need to develop alternative, more cost-effective local services without committing resources away from primary care under PbR tariff. These savings can then be re-invested in primary care services which help to deliver on many of the current national policy objectives such as the 18-week referral to treatment wait and moving care closer to home.

Whilst the relationship between Practice Based Commissioning, local commissioning decisions and changes in patient pathways is still emerging, many schemes have adopted this invest-to-save principle as the fundamental lever for change. This reflects both national policy (including the recent NHS Operating Framework for 2007-08) and local need. There is some evidence that demand for services can be managed effectively in the community and cost comparisons are also made ([Bexley](#) or [East Hull](#)). While cost-effectiveness measurement may still be necessary in more detail, local savings have already been identified using other recognised community practitioners and accessible locations.

### **3.4 Workforce Issues**

The importance of the links made with secondary care cannot be underestimated, particularly when it comes to providing acceptable training programmes for community staff and clinical supervision ([Buckinghamshire](#)). Most schemes have worked hard to secure Consultant Ophthalmologists as the service leads for training and continuing professional development but some have struggled to pin down local training courses. Secondary care clinicians/practitioners have a key role to play in developing the patient pathway and some take overall responsibility for the management of the patient's condition, even though this may be provided in a community setting. Consultants also play their role in annual appraisal of local practitioners and as providers of refresher training ([Huntingdonshire](#)).

Interestingly, it is apparent that most schemes have been developed with conventional and enhanced skill mix providing the front line service to patients. This has involved either up-skilled community optometrists or GPSI's ([Airedale](#)) or even use of academic optometrists ([Shipley](#)). While these are clearly strengths of many schemes, those more established schemes may be in a position to consider using other staff with appropriate competencies, such as ophthalmic nurses, to deliver some or all of the service specification that previously could only be done by more qualified personnel. This is a model used across other primary care pathways and may be a more cost-effective approach depending on local need and staffing capacity.

### **3.5 Partnership Links**

Certainly there are examples of fully integrated health and social care community eye schemes with formal partnership links and joint commissioning arrangements established with different stakeholders ([Camden & Islington](#)). Low Vision services are an obvious place to explore ongoing partnership opportunities both with social care and the voluntary sector.

### 3.6 Planning Processes

Most schemes were clearly planned and structured, with some offering robust business cases and tendering processes. Pilot schemes have been used to test the patient pathway, service effectiveness and to consider patient and commissioning outcomes. What is apparent is the period of paralysis around the re-configuration and re-structuring of local NHS organisations through 'Commissioning a Patient-led NHS'. Existing, stable relationships have been replaced by new, untested, and more challenging ones. This is particularly evident where commissioning staff have moved on or been replaced.

The publication of White Paper 'Our health, our care, our say: a new direction for community services' and Practice Based Commissioning has also overlapped this period of implementation. This has also brought about significant change and challenge. GPs are in the driving seat to determine the use of local commissioning resources and many schemes are already making an impact on PBC budgets ([Buckinghamshire](#) or [Northumberland](#)). Ongoing support of local GPs and their commissioning and scrutiny groups will be necessary if some schemes are to be fully implemented or survive in future financial years.

### 3.7 Performance Measurement and Management

The majority of schemes had addressed how often the service should be monitored (quarterly or annually) and through which mechanism (annual contract monitoring, review of activity volume, review of patient experience). The most successful schemes were those where quality and service indicators had been agreed between PCTs and service providers at both primary and secondary care along the patient pathway ([Nottingham](#)). In many cases, it was unclear whether these indicators stretched further than just a measure of provider behaviour into the more difficult area of measuring patient eye health and other health outcomes. There was also limited reference to whether additional financial incentives within the provider agreement were structured in such a way as to reward achievement of associated local or national priorities (such as improved weight management) or reductions in hospital outpatient appointments or emergency admissions as described in the recent Department of Health PBC guidance (November, 2006).

Defining appropriate and sensitive local indicators that are easily measurable in practice is always challenging. It will only be achieved by real engagement of local practitioners and patients and agreement of minimum standards of performance as well as support for good quality information capture and management. Some schemes have underpinned their service provision with robust and detailed provider contracts or Service Level Agreements ([Northumberland](#) or [Nottinghamshire County \(b\)](#)).

### **3.8 Governance and Risk Assessment**

There was widespread evidence that integrated governance – covering aspects such as clinical, financial, contractual, and infrastructure risk – was a fundamental aspect of planning and implementation in most local schemes. Robust governance processes have provided all round confidence for joint working between local secondary care consultants and committed community optometrists or GPs. Additionally, patients can be reassured of a high quality experience of the service when it is provided outside a hospital setting in line with Standards for Better Health. The culture of clinical audit seems apparent across local optometrist practice. This is maintained and developed within most schemes ([Bedfordshire \(a\)](#) or [Middlesbrough](#) or [East Hull](#)).

Few schemes were able to provide a clear indication of assessment or management of risk. Contingency planning for service breakdown or handling faster entry and exit of community providers within the local market were not apparent.

### **3.9 Capacity and Capability**

It cannot be overstated how much time and effort from a small number of individuals has gone into designing, developing, implementing and managing these local eye care schemes. PCT re-organisation has re-positioned people with the knowledge and experience of developing and implementing services along with the limited range of community providers that do currently exist – most being skilled community optometrists or GPwSIs. Over time, PCT capacity needs to improve its focus and encourage further provider diversity as well as improve commissioning support for local practitioners. Commissioners and providers will need to understand the range of potential providers as this grows over time. All this will help community services be more competitive in relation to their secondary care counterparts and patients will be able to be offered a wider choice and better access to services.

The recent [PBC guidance](#) - emphasises that support for new PBC processes needs to be addressed quickly and comprehensively to handle the range of suitable primary care providers as well as developing more skilled commissioning roles.

### **3.10 Resources**

Few schemes were established as block contracting arrangements and many were related to fees based on activity and not necessarily quality of care or delivery of local health improvement targets. There was a significant range of prices on offer to local providers. Newly re-organised PCTs may need to address these differences locally at an early stage and look to benchmark prices, where possible, for the deliverables within the service. Under the emerging commissioning paradigm, clearer indications to local community providers of where resources can be freed up from (and where these can be re-invested) will offer further transparency within the system. Initial non-recurrent set up costs can be significant and, as new pathways should realise cost savings, can be recouped over time.

New roles are developing including those dedicated to providing training or managing locality clinics. These will need to be resourced along with dedicated funding to support local training or new diagnostic technology located in community practices or clinics.

### **3.11 Infrastructure**

There was a range of locations where these services were delivered from. This included locally accredited community optometrists practices, local integrated primary care centres, community hospitals, GP surgeries, and hospital eye clinics. More flexible use of primary care premises has allowed services to be delivered outside the hospital environment and can be more cost-effective. However, it is important to point out that where local practices have been used, premises inspections have been carried out to ensure it is 'fit for purpose' and can help deliver the service required ([Northumberland](#)).

Many schemes have invested in a range of up-to-date equipment within local premises ([East Hull](#) or [Nottinghamshire County \(a\)](#)) which makes it easier for community practices to deliver like-for-like hospital assessment services.

### **3.12 Information Management and Technology**

The detail about information management and IT systems has been limited in many cases. However, there are examples of where time and resources have been invested in making transfer of information seamless and secure, fully integrated with financial and activity related systems needed in primary care ([Northumberland](#) or [Middlesbrough](#)).

## SECTION 4. BUSINESS PLANNING AND SELF-ASSESSMENT

The following section describes a selection of questions covering a number of important commissioning aspects. While not exhaustive, they can be used as a guide to assess how local implementation of community eye care services can be commissioned and implemented more quickly, comprehensively and effectively.

These questions will also provide a useful guide to local business case planning for Practice Based Commissioners. The answers can be used as the beginning of a coherent business plan which will need to be discussed with local stakeholders and submitted to the PCT for ratification. They reflect the recognised elements of the commissioning cycle as described by the Department of Health in the '[Health Reform in England: Update and Commissioning Framework](#)' document published in July 2006 (Annex - p6)

*Note – Not all questions will be relevant to local circumstances*

<b>Assessing Local Need &amp; Priorities</b>	<ul style="list-style-type: none"> <li>▪ Has a local needs assessment taken place?</li> <li>▪ Is there evidence suggesting a need for improved eye health across the whole area or in more targeted localities?</li> <li>▪ Will this service have an impact on local delivery plan and public health targets or PBC objectives, such as addressing health inequalities or improving access to care?</li> <li>▪ Can demand for hospital services be determined accurately? What is the current waiting time for services and how does this impact on patient experience? How can the 18 week target be delivered?</li> </ul>
<b>Shaping Supply &amp; Provider Workforce</b>	<ul style="list-style-type: none"> <li>▪ Is there a clear projection of workforce capacity needed to cope with current and future patient demand?</li> <li>▪ Are there contingencies in place for cross cover during holidays/sickness?</li> <li>▪ Will service providers be able to demonstrate the required competencies and use the full range of skill mix where appropriate?</li> <li>▪ Have providers got access to accreditation and continuing professional development opportunities locally? Have training needs been identified?</li> </ul>
<b>Stakeholder Engagement &amp; Service Re-Design</b>	<ul style="list-style-type: none"> <li>▪ Has a clinical lead for the service been identified?</li> <li>▪ Is there visible/active clinical engagement in the planning, delivery and monitoring of the service? Is there a local eye care working group?</li> <li>▪ Have all other local stakeholders been identified, including patient representatives, local people, Secondary Care, LOC, Local Authority, Voluntary Sector and Third Sector?</li> <li>▪ Are they involved in design of the patient pathway, service model and local indicators of performance?</li> </ul>
<b>Practice Based Commissioning</b>	<ul style="list-style-type: none"> <li>▪ Are local GPs and PBC clusters involved in local commissioning decisions?</li> <li>▪ Is there expert support provided to local practices?</li> <li>▪ Can it be demonstrated that commissioning resources will be freed up to re-</li> </ul>

	<p>invest in primary care?</p> <ul style="list-style-type: none"> <li>▪ Is there access to high quality data at regular intervals?</li> </ul>
<b>Infrastructure</b>	<ul style="list-style-type: none"> <li>▪ Do provider premises offer a good range of choice and accessibility for local patients?</li> <li>▪ Have equipment and premises been checked and do they comply with minimum standards?</li> <li>▪ Is there a mechanism to utilise or develop an integrated IT solution for dealing with patient records management and clinical audit? How will patient data be shared?</li> </ul>
<b>Governance</b>	<ul style="list-style-type: none"> <li>▪ Has there been an analysis of risks in developing and implementing this service?</li> <li>▪ Is there a clear integrated governance framework and a process for monitoring arrangements on an ongoing basis?</li> <li>▪ Is there a clinical governance lead identified? Are clinical protocols widely understood and implemented?</li> <li>▪ What is the reporting structure for governance and service performance?</li> <li>▪ Is information available to patients in a format appropriate to their needs?</li> <li>▪ How is the patient experience measured and how is feedback acted upon?</li> </ul>
<b>Funding</b>	<ul style="list-style-type: none"> <li>▪ Have resources for a full service been clearly identified, including any set up costs?</li> <li>▪ How and when will providers get paid and for what deliverables?</li> <li>▪ How cost-effective is this service in relation to hospital services under tariff?</li> <li>▪ Is there a reward structure for local or alternative providers to provide a higher quality service, delivering better patient outcomes?</li> </ul>
<b>Monitoring &amp; Managing Performance</b>	<ul style="list-style-type: none"> <li>▪ Have simple, measurable criteria for provider behaviours/activity and patient outcomes been developed?</li> <li>▪ Is there a clear process of monitoring and reviewing performance of individual providers and the service as a whole?</li> </ul>
<b>Primary Care Contracting</b>	<ul style="list-style-type: none"> <li>▪ Has the appropriate primary care contracting route for the service been identified?</li> <li>▪ Is there a clear process for reviewing contracts and managing entry and exit of local providers?</li> </ul>

## SECTION 5. OTHER USEFUL RESOURCES

Below is a list of other useful, more general, web-based resources for commissioners and providers of community eye care services.

- **Department of Health** – Strategic policy and guidance for commissioning and provision; General Ophthalmic Services Review. Further optical information at [www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Optical/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Optical/fs/en)
- **NHS Primary Care Contracting** – [www.primarycarecontracting.nhs.uk](http://www.primarycarecontracting.nhs.uk) – dedicated optometry page; primary care contracting routes; implementation resources; primary care contracting advisor support; discussion forum; national and regional events
- **National Eye Care Programme** – [www.eyecare.nhs.uk](http://www.eyecare.nhs.uk) – details of national NHS Eyecare Services programme (national pilots)
- **Association of Optometrists** – Primary care commissioning toolkit available – [www.aop.org.uk/uploaded\\_files/toolkit\\_artwork\\_final.pdf](http://www.aop.org.uk/uploaded_files/toolkit_artwork_final.pdf)
- **Royal National Institute for the Blind** – [www.rnib.org.uk](http://www.rnib.org.uk) – information for patients and the public; other linked resources
- **Royal College of Ophthalmologists** – [www.rcophth.ac.uk](http://www.rcophth.ac.uk) – professional standards in ophthalmic practice; College activities and events; training and education
- **Improvement Foundation** – [www.improvementfoundation.org](http://www.improvementfoundation.org) – developing capacity and capability in public services; Practice Based Commissioning support programme; spread of good practice in service re-design
- **NHS Alliance** – [www.nhsalliance.org](http://www.nhsalliance.org) – Practice Based Commissioning resources
- **National Association of Primary Care** – [www.napc.org.uk](http://www.napc.org.uk) – Practice Based Commissioning resources
- **Cataracts**

## SECTION 6. SUMMARIES OF LOCAL SCHEMES

As there are many schemes to share, two main ways to quickly search through information is provided below. Each scheme has been categorised into **Low Vision**, **Glaucoma** or an **Acute Care** pathway or service. A further category (**Other**) is used for schemes which do not sit exclusively into the other three categories but may include one or more of the services.

**6.1 Quick Reference A** – shows the name of each scheme by clinical area of Low Vision, Glaucoma, Acute Care or Other. This allows you to focus on one pathway should you need to. It cannot be assumed that these are directly comparable schemes focusing on the same aspects of care within the patient pathway.

Simply click on the scheme name in [blue](#) and you will be taken straight to the example you wish within the main document.

### Quick Reference A

Pathway or Service	Scheme Name/Location
<b>Low Vision</b>	<a href="#">Camden &amp; Islington</a> <a href="#">East Hull</a> <a href="#">Nottinghamshire County (a)</a>
<b>Glaucoma</b>	<a href="#">Bedfordshire (a)</a> <a href="#">Bedfordshire (b)</a> <a href="#">Bexley</a> <a href="#">Gateshead &amp; South Tyneside</a> <a href="#">Huntingdonshire</a> <a href="#">Manchester</a> <a href="#">Nottingham</a> <a href="#">SW Kent &amp; Maidstone (a)</a>
<b>Acute Care</b>	<a href="#">Buckinghamshire</a> <a href="#">Middlesbrough</a> <a href="#">Northumberland</a>
<b>Other</b>	<a href="#">Airedale</a> <a href="#">Bradford</a> <a href="#">Essex</a> <a href="#">Nottinghamshire County (b)</a> <a href="#">Shipley</a> <a href="#">Suffolk</a> <a href="#">SW Kent &amp; Maidstone (b)</a>

**6.2 Quick Reference B** – shows each scheme by name and clinical area but also provides a selection of significant features to help you search quickly for specific aspects that may be most pertinent to your needs.

Simply click on the scheme name in [blue](#) and you will be taken straight to the example you wish within the main document.

### Quick Reference B

Scheme Name/Location	Pathway or Service	Significant Feature(s)
<a href="#">Airedale</a>	<b>Other (Minor Eye)</b>	<ul style="list-style-type: none"> <li>▪ Well established scheme linked to LDP</li> <li>▪ GPSI triage</li> </ul>
<a href="#">Bedfordshire (a)</a>	<b>Glaucoma</b>	<ul style="list-style-type: none"> <li>▪ Robust governance and risk assessment</li> <li>▪ Significant Full Year Effect savings</li> </ul>
<a href="#">Bedfordshire (b)</a>	<b>Glaucoma</b>	<ul style="list-style-type: none"> <li>▪ Community-based Consultant Ophthalmologist</li> <li>▪ Funding breakdown within proposal</li> </ul>
<a href="#">Bexley</a>	<b>Glaucoma</b>	<ul style="list-style-type: none"> <li>▪ 43% decrease false positives numbers</li> <li>▪ Good PCT involvement</li> <li>▪ Referral guidance/protocols</li> </ul>
<a href="#">Bradford</a>	<b>Other (Triage/Treat)</b>	<ul style="list-style-type: none"> <li>▪ Well established scheme</li> <li>▪ Consultant triage supported by Optometrists</li> <li>▪ Clinical engagement</li> </ul>
<a href="#">Buckinghamshire</a>	<b>Acute Care</b>	<ul style="list-style-type: none"> <li>▪ Working well under PBC and business plan processes followed</li> <li>▪ Thresholds for referral rates measured</li> <li>▪ Patient groups consulted</li> </ul>
<a href="#">Camden &amp; Islington</a>	<b>Low Vision</b>	<ul style="list-style-type: none"> <li>▪ Fully integrated health, social care, and voluntary sector-led</li> <li>▪ Formal partnership and team approach</li> <li>▪ Comprehensive training provision</li> </ul>
<a href="#">East Hull</a>	<b>Low Vision</b>	<ul style="list-style-type: none"> <li>▪ Clinical governance and accreditation framework developed</li> <li>▪ 63% now treated in primary care</li> <li>▪ Patient satisfaction questionnaires utilised</li> </ul>
<a href="#">Essex</a>	<b>Other (General Eye)</b>	<ul style="list-style-type: none"> <li>▪ Eligibility criteria for optometrists to participate</li> <li>▪ Voucher system for patient choice and optometrist reimbursement</li> <li>▪ Clinical and LOC involvement</li> </ul>
<a href="#">Gateshead and S.Tyneside</a>	<b>Glaucoma</b>	<ul style="list-style-type: none"> <li>▪ Acute Trust leadership</li> <li>▪ Combination of service locations</li> </ul>
<a href="#">Huntingdonshire</a>	<b>Glaucoma</b>	<ul style="list-style-type: none"> <li>▪ Detailed local planning and staged implementation</li> <li>▪ Waiting times reduced</li> <li>▪ Robust training and accreditation process</li> </ul>

<a href="#">Manchester</a>	<b>Glaucoma</b>	<ul style="list-style-type: none"> <li>▪ Medically (Ophthalmology) led and evidence based</li> <li>▪ Clinical engagement</li> <li>▪ Clear stages of implementation</li> </ul>
<a href="#">Middlesbrough</a>	<b>Acute Care</b>	<ul style="list-style-type: none"> <li>▪ Resources supporting the scheme</li> <li>▪ Governance and operational processes as practical guides for providers</li> </ul>
<a href="#">Northumberland</a>	<b>Acute Care</b>	<ul style="list-style-type: none"> <li>▪ 'One Stop Shop' with fast access</li> <li>▪ Fully integrated IT system (MIDAS)</li> <li>▪ Use of Patient Group Directions</li> <li>▪ Commissioned by PBC clusters</li> </ul>
<a href="#">Nottingham</a>	<b>Glaucoma</b>	<ul style="list-style-type: none"> <li>▪ Patient self care support</li> <li>▪ Clear commissioning and performance measures</li> <li>▪ Computerised glaucoma management system</li> </ul>
<a href="#">Nottinghamshire County (a)</a>	<b>Low Vision</b>	<ul style="list-style-type: none"> <li>▪ Many recognised optometrist providers and referral routes in</li> <li>▪ Equipment list and supplier relationship</li> <li>▪ Expert Patient involvement</li> </ul>
<a href="#">Nottinghamshire County (b)</a>	<b>Other (Triage)</b>	<ul style="list-style-type: none"> <li>▪ Clinical engagement and supervision</li> <li>▪ Integrated with Choose &amp; Book</li> <li>▪ Demand management achieved</li> </ul>
<a href="#">Shipley</a>	<b>Other (Triage/Treat)</b>	<ul style="list-style-type: none"> <li>▪ Well established service with Optometrist triage</li> <li>▪ Local GP ownership and involvement</li> <li>▪ High patient satisfaction and reduction in referrals</li> </ul>
<a href="#">Suffolk</a>	<b>Other (General Eye)</b>	<ul style="list-style-type: none"> <li>▪ Clear service objectives</li> <li>▪ Tender specification stage</li> <li>▪ Links between GPSI and COSI</li> </ul>
<a href="#">SW Kent and Maidstone (a)</a>	<b>Glaucoma</b>	<ul style="list-style-type: none"> <li>▪ Clear patient pathway</li> <li>▪ Performance management and funding arrangements</li> </ul>
<a href="#">SW Kent and Maidstone (b)</a>	<b>Other (Minor Eye)</b>	<ul style="list-style-type: none"> <li>▪ Robust scheme</li> <li>▪ Stakeholder engagement including voluntary sector</li> </ul>