

***Minutes for the Dudley LOC Committee Meeting held at 6.30p.m. on Monday 21st March 2022***

**Held as a Zoom Meeting**

**Committee in Attendance**

Shamina Asif (Chair), Paul Sidhu (Secretary), Mark Tuffin (Treasurer), Charles Barlow, Hussnan Ejaz, Sunit Jolly, Rosie Birhah, Kay Reeves, David Wright, Nicky Ferguson

**1. Apologies**

Gurdeep Dosangh, Sonia Tyrell, Sheena Mangat

**2. Declarations of Interest**

There were no new declarations.

**3. Minutes of Previous Meeting**

The minutes were proposed by SA and seconded by SJ as a correct record of the meeting.

**4. Matters arising**

* Paediatric Referrals- CB has dealt with and can be closed off.
* Action point for SA is to ask Wasim why Optoms are unable to view previous patient episodes on the CUES system – Wasim has had a response from Dharmesh, they are working on it and it may be available in the future. Can be closed off

**5. Correspondence**

PS had nothing to report.

**6. CUES Update**

Wasim Sarwar provided the LOC with the following update:

*Includes the CUES figures up until December 2021:*

*The COVID Urgent Eyecare Service (CUES) commenced in Dudley on 24th July 2020 and is provided by Primary Eyecare Services Ltd.*

*Primary Eyecare Services Ltd is the lead for the network of around 18 optical practices across the area.*

*The service has been running across the area with the support of the Opera data collection, reporting and administration IT platform developed and maintained by FDS.*

*This report outlines some metrics measured.*

*Telemedicine only: 75% discharged and 12% referred after TM only*

*F2F: 74% of patients were discharged from the service, 19% referred to hospital (14% urgently and 5% routinely)*

*OCT: 54% of patients were discharged from the service and 30% were urgently referred*

*IP: 75% were discharged from the service, 8% were referred*

*It is clear most patients were managed within primary care as was the main aim of the service. The clear distinction between CUES and MECS is that CUES is an urgent eyecare service, with fewer milder cases being seen, the % of referrals to secondary care will naturally be higher as the % of sight threatening conditions will be greater.*

*Learnings and referral guidelines are shared with all practitioners on a regular basis, as with time and experience, it is expected that the % of urgent referrals to secondary care will reduce.*

*Close monitoring of the service will continue.*

***Wasim Sarwar***

*Clinical Lead  
Primary Eyecare Services Ltd*

*KPIs*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Quality and Performance Indicators* | *Quality and Performance Indicators* | *Threshold* | *Method of measurement* | *Achieved Level* |
|  | *CUES patients that require urgent referral to secondary care, will have been seen for a face to face assessment within 24 hours of contacting the service* | *95%* | *Monthly Report* | *93%* |
| *CUES patients that require a Face-to-face appointment, will be seen within 48 hours of contacting the service* | *90%* | *Monthly Report* | *89%* |
| *Percentage of CUES patients offered follow up appointments* | *<13%* | *Monthly Report* | *4%* |
| *Quality and performance indicators* | *Percentage of patients referred on to secondary eye care services (urgent)* | *20%* | *Monthly Report* | *12%* |
| *Percentage of CUES patients referred onto secondary care services*  *(Non-urgent via GP)* | *<10%* | *Monthly Report* | *4%* |

*CUES patients that require urgent referral to secondary care, will have been seen for a face to face assessment within 24 hours of contacting the service (KPI 95%)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | *Urgent referrals seen within 24 hours for F2F* | *Total number of urgent referrals* | *Percentage* |
| *Numbers* |  | *381* | *93%* |

*Patients who chose not to be seen within 24hrs were excluded from the above figures.*

*CUES patients that require a Face-to-face appointment, will be seen within 48 hours of contacting the service (KPI 90%)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | *Seen within 48 hours* | *Total number* | *Percentage* |
| *Numbers* | *2489* | *2801* | *89%* |

*Patients who chose not to be seen within 24hrs were excluded from the above figures.*

*Follow ups (KPI<13%)*

|  |  |  |  |
| --- | --- | --- | --- |
| *Assessment type* | *Follow up* | *Total number seen* | *Percentage* |
| *Numbers* | *182* | *4691* | *4%* |

*KPI: Percentage of patients referred on to secondary eye care services (urgent) 20%*

|  |  |  |
| --- | --- | --- |
|  |  | *Numbers* |
| *CUES SERVICE Percentage of patients referred on to secondary eye care services (urgent)* | *Numerator: Number of urgent patients who referred onto secondary care services during the reporting period* | *540* |
| *Denominator: Number of patients that have been assessed, during the reporting period* | *4691* |
|  | *Total* | *12%* |

*Total number of patients include TM + F2F + OCT*

*KPI: Percentage of patients referred on to secondary eye care services (non-urgent) <10%*

|  |  |  |
| --- | --- | --- |
|  |  | *Numbers* |
| *CUES SERVICE Percentage of CUES patients referred onto secondary care services (Non-urgent via GP)* | *Numerator: Number of non-urgent patients who are referred onto secondary care services during the reporting period* | *186* |
| *Denominator: Number of patients that have been assessed, during the reporting period* | *4691* |
|  | *Total* | *4%* |

*Total number of patients include TM + F2F +OCT*

*All referrals are sent directly to the hospital via nhs.net*

*Activity*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Month* | *Dudley* | *SWB* | *Walsall* | *Wolverhampton* |
| *October* | *383* | *618* | *453* | *382* |
| *November* | *322* | *486* | *371* | *325* |
| *December* | *300* | *436* | *317* | *298* |

*Source of referral*

|  |  |
| --- | --- |
| ***Source of referral*** | ***Oct-Dec*** |
| *Patient Self referred* | *3211* |
| *GP staff (not seen a GP)* | *476* |
| *Other optometrist* | *244* |
| *GP (after seeing a GP)* | *240* |
| *111 Service* | *153* |
| *Pharmacist* | *139* |
| *Referral following a GOS sight test at this practice* | *73* |
| *Other* | *58* |
| *Hospital Eye Clinic* | *48* |
| *Accident & Emergency* | *19* |
| *Referral following a private sight test at this practice* | *12* |
| *GP out of hours service* | *11* |
| *Community ophthalmology clinic* | *5* |
| *Minor Injuries Unit* | *2* |
| ***Grand Total*** | ***4691*** |

*These figures include all episodes, including screenings only/deflections*

*Analysis of referral source shows that self-referral is still the single highest referral source.*

*GP engagement is important to ensure they are aware of the eligibility criteria and patients are being referred into CUES by GP staff rather than by GPs themselves to save unnecessary appointments.*

*Method of assessment*

|  |  |  |  |
| --- | --- | --- | --- |
| ***Method of assessment*** | ***October*** | ***November*** | ***December*** |
| *Telemedicine only* | *542* | *492* | *414* |
| *Telemedicine + Face to Face Assessment* | *1145* | *889* | *817* |
| *Screening only* | *20* | *26* | *26* |
| *Follow up assessment* | *78* | *48* | *56* |
| *OCT assessment* | *46* | *44* | *35* |
| *IP assessment* | *5* | *4* | *3* |

*Most patients seen had a face to face assessment*

*One episode can have multiple assessments – e.g. one patient can have TM+F2F(+OCT)*

*Number of patients requiring F2F seen within 24 hours*

|  |  |  |  |
| --- | --- | --- | --- |
|  | *Seen within 24 hours* | *Total number seen* | *Percentage* |
| *Numbers* | *2353* | *2801* | *84%* |

*This is dependent on urgency of symptoms, working days, patient and practice factors*

*Outcomes*

|  |  |
| --- | --- |
| ***TM outcome*** | ***Oct-Dec*** |
| *Discharge: Discharged with therapeutic recommendation* | *373* |
| *Discharge: Discharge with self-care advice* | *336* |
| *Discharge: Discharge with advice* | *273* |
| *Refer On: Urgent Referral to HES* | *121* |
| *See at practice: OCT at this practice* | *87* |
| *Refer On: Referral to GP (General Health)* | *48* |
| *See at practice: Face to Face at this practice* | *36* |
| *Refer On: Routine Referral to HES* | *35* |
| *Follow Up: Therapeutic recommendation and follow-up arranged* | *16* |
| *Follow Up: Self-care advice and follow-up arranged* | *15* |
| *See at practice: IP assessment at this practice* | *6* |
| *Discharge: Discharge - no pathology identified* | *4* |
| *Refer On: Refer to OCT optometrist* | *3* |
| *Discharge: Discharge after epilation* | *1* |
| *Discharge: Defer referral - arrange to see in 4-6 months* | *1* |
| ***Grand Total*** | ***1355*** |

*75% discharged after TM only (including follow up), 12% referred after TM only*

*Please note over 50% of TM patients were booked in for a F2F assessment (and some will also have OCT scans), so many patients will have multiple outcomes*

|  |  |
| --- | --- |
| ***F2F outcome*** | ***Oct-Dec*** |
| *Discharge: Discharge with advice* | *782* |
| *Discharge: Discharged with therapeutic recommendation* | *594* |
| *Discharge: Discharge with self-care advice* | *515* |
| *Refer On: Urgent Referral to HES* | *381* |
| *Refer On: Referral to GP (General Health)* | *173* |
| *Refer On: Routine Referral to HES* | *144* |
| *Follow Up: Self-care advice and follow-up arranged* | *54* |
| *Follow Up: Therapeutic recommendation and follow-up arranged* | *45* |
| *Discharge: Discharge - no pathology identified* | *39* |
| *See at practice: OCT at this practice* | *24* |
| *Discharge: Discharge after epilation* | *21* |
| *Discharge: Discharge after foreign body removal* | *19* |
| *See at practice: Face to Face at this practice* | *8* |
| *Refer On: Refer to IP optometrist* | *1* |
| *See at practice: IP assessment at this practice* | *1* |
| ***Grand Total*** | ***2801*** |

*74% of patients were discharged from the service after F2F (including follow up), 19% referred to hospital after F2F (14% urgently and 5% routinely)*

|  |  |
| --- | --- |
| ***OCT outcome*** | ***Oct-Dec*** |
| *Discharge: Discharge with advice* | *55* |
| *Refer On: Urgent Referral to HES* | *38* |
| *Refer On: Referral to GP (General Health)* | *9* |
| *Refer On: Routine Referral to HES* | *7* |
| *Discharge: Discharge - no pathology identified* | *7* |
| *Discharge: Discharged with therapeutic recommendation* | *3* |
| *See at practice: IP assessment at this practice* | *2* |
| *Discharge: Discharge with self-care advice* | *1* |
| *See at practice: Face to Face at this practice* | *1* |
| *Discharge: Discharge after foreign body removal* | *1* |
| *Follow Up: Therapeutic recommendation and follow-up arranged* | *1* |
| ***Grand Total*** | ***125*** |

*54% of patients were discharged from the service after OCT, 30% were urgently referred*

|  |  |
| --- | --- |
| ***IP outcome*** | ***Oct-Dec*** |
| *Discharge: Discharged with therapeutic recommendation* | *8* |
| *See at practice: OCT at this practice* | *2* |
| *Follow Up: Therapeutic recommendation and follow-up arranged* | *1* |
| *Refer On: Routine Referral to HES* | *1* |
| ***Grand Total*** | ***12*** |

*75% were discharged from the service, 8% were referred*

*Diagnoses*

|  |  |
| --- | --- |
| ***TM diagnosis*** | ***Oct-Dec*** |
| *Bacterial Conjunctivitis* | *188* |
| *Evaporative dry eye* | *186* |
| *Hordeolum (Stye)* | *68* |
| *Sub Conjunctival Haemorrhage* | *66* |
| *Chalazion (Meibomian Cyst)* | *65* |
| *Blepharitis* | *50* |
| *Allergic Conjunctivitis* | *46* |
| *Allergy - Eye lids* | *39* |
| *Migraine Visual Aura* | *29* |
| *Vitreous Floaters* | *28* |
| *No Ocular Pathology Identified* | *27* |
| *Corneal abrasion* | *26* |
| *PVD - Posterior Vitreous Detachment* | *25* |
| *Meibomian Gland Dysfunction* | *24* |
| *Viral Conjunctivitis* | *12* |
| *ocular migraine* | *12* |
| *Pinguecula* | *11* |
| *Internal Hordeolum* | *11* |

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| ***F2F diagnosis*** | ***Oct-Dec*** |
| *Evaporative dry eye* | *361* |
| *Vitreous Floaters* | *169* |
| *PVD - Posterior Vitreous Detachment* | *157* |
| *Blepharitis* | *127* |
| *Bacterial Conjunctivitis* | *101* |
| *Sub Conjunctival Haemorrhage* | *99* |
| *Allergic Conjunctivitis* | *99* |
| *Hordeolum (Stye)* | *95* |
| *Meibomian Gland Dysfunction* | *81* |
| *No signs of PVD or RD* | *77* |
| *No Ocular Pathology Identified* | *70* |
| *Chalazion (Meibomian Cyst)* | *62* |
| *Allergy - Eye lids* | *61* |
| *Migraine Visual Aura* | *60* |
| *Corneal abrasion* | *59* |
| *Ocular Migraine* | *41* |
| *Ingrowing eyelash* | *32* |
| *Corneal ulcer* | *32* |
| *Posterior Sub-capsular Opacification* | *31* |
| *Foreign Body – Corneal* | *30* |
| *Episcleritis* | *29* |
| *Retinal Tear/Hole* | *28* |
| *Internal Hordeolum* | *23* |
| *Headache* | *22* |
| *Foreign Body* | *21* |
| *Anterior Uveitis* | *20* |
| *dry eye* | *17* |
| *Retinal Detachment* | *17* |
| *Pterygium* | *17* |
| *Trichiasis* | *17* |
| *Migraine* | *16* |
| *Cataract – Cortical* | *15* |
| *Blocked tear duct* | *15* |
| *Viral Conjunctivitis* | *14* |
| *Foreign Body - Conjunctival* | *14* |
| *Other - please specify* | *13* |
| *Recurrent corneal erosions* | *12* |
| *dry eyes* | *12* |
| *Conjunctival Abrasion* | *12* |
| *Wet AMD* | *11* |
| *Pinguecula* | *10* |
| *Cataract – Nuclear* | *10* |
| *Foreign Body - Sub Tarsal* | *10* |
| *Sudden onset diplopia* | *10* |
| *Preseptal cellulitis* | *10* |

*Listed were the most common diagnoses, the most common will have had the presentation of flashes and floaters (PVD).*

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| --- | --- |
| ***OCT diagnosis*** | ***Oct-Dec*** |
| *PVD - Posterior Vitreous Detachment* | *9* |
| *No Ocular Pathology Identified* | *7* |
| *Wet AMD* | *7* |
| *Vitreous Floaters* | *5* |
| *Epiretinal membrane* | *5* |
| *Migraine Visual Aura* | *5* |
| *Cataract - Posterior Subcapsular* | *5* |
| *Central Serous Retinopathy - CSR* | *5* |
| *Cataract – Cortical* | *4* |
| *Macular Oedema* | *3* |
| *Dry AMD* | *3* |
| *Cataract – Nuclear* | *3* |
| *BRVO/CRVO* | *3* |
| *Posterior Sub-capsular Opacification* | *3* |
| *Headache* | *3* |
| *Wet Age-Related Macular Degeneration* | *3* |
| *Suspect glaucoma* | *2* |
| *Dry Age-Related Macular Degeneration* | *2* |
| *Ocular Migraine* | *2* |

|  |  |
| --- | --- |
| ***IP diagnosis*** | ***Oct-Dec*** |
| *Contact Dermatitis* | *2* |
| *Evaporative dry eye* | *2* |
| *Anterior Uveitis* | *2* |
| *Evaporative dry eye with associated inferior superficial punctate keratitis* | *1* |
| *MILD Corneal abrasion due to superior tarsal fb - removed* | *1* |
| *Internal Hordeolum* | *1* |
| *Assessment of reported 'red eyes' - Px excluded from school* | *1* |
| *Blepharitis* | *1* |
| *Cystoid macular Oedema* | *1* |
| ***Grand Total*** | ***12*** |

**7. NHS Updates**

Nationally nothing to report. No further information on electronic referral scheme.

**8. Chair’s Business**

**8.1 Extended Primary Care Services**

**HLOP Meeting – 16/03/2022**

The training went ahead in March with 5 optical practices signing up as HLOP. In order to progress they need health promotion zones and need t be signed off. Shamina and Wendy to arrange visiting the practices to sign off and give material. Public Health are planning on doing some mop up training for optical practices in the future.

Any payment for alcohol screening will only be paid if the information is inputted within 2 weeks. So far, public health are happy with the performances of optical practices.

6 campaigns are to be launched for health promotion zones – the aim is to try and align this with pharmacies. Shelagh from NHS health checks came in and spoke about the possibility of BP monitoring in optical practices, if this happens then it will be in October 2022, so an update will be provided at the next meeting. Public health are interested to know if face to face meetings are better or online. SA to find out

LOCSU interviewed Shahzad about what it is like to be an HLOP.

SA has attended the LOC forum where everyone gives an update in terms of what is happening in their respective areas.

SA has joined the paediatric working group for workforce development as Rosie is unable to continue due to personal life commitments. First meeting is on Thursday 24th March 2022.

**9. Charles Barlow**

**9.1 Eyecare Company Update**

**9.2 HWMROC (including Confederation)**

CB Report to Dudley LOC 21st March 2022

Updates since last meeting

BlackCountry Eyecare Group

Working group now meeting every 2-3 weeks with sub groups.

There was a Black Country Eyecare Network group meeting last week to assess the progress from the first working group and to plan for the next groups and the Away Day on the 29 April 2022. (08:30-13:00 at West Bromwich Football Club (The Hawthorns, Birmingham Road, West Bromwich, West Midlands, B714LF)

We worked on the Away Day Agenda which will be sent out to attendees closer to the date. In essence there will be a couple of presentations, then into the breakout groups. There are I believe 50 attendees invited from across the whole eyecare sector, including patients.

The breakout groups and our LOC reps are:

* High Volume Cataract (Charles Barlow)
* Medical retina (?triage) diagnostic hub (Aisha Jeewa)
* Glaucoma (?triage) diagnostic hub (Peter Rockett)
* Digital/IT communication group – trusts and community links
* Paediatric ophthalmology (Shamina Asif)
* Community pathways – separate post cataract/MR referral/glaucoma pathways or link into above? Also potential PIFU community supported PIFU pathway with separate finance. (Peter Bainbridge)

At today’s meeting I requested:

* Future Meetings to be better structured. I received agreement for an Agenda to be available before hand and distributed to all.
* Prioritise agreement on the terms of reference of the group. This has still not been done.
* Prioritise work on a Black Country Vision Strategy. I have provided a copy of the Dudley Vision Strategy that I worked on some years ago and Lisa (from the Beacon Centre) circulated a copy of the recently developed vision strategy from Nottingham.
* Measurement of the progress of the Network by reporting against an implementation plan. ( To hep with this I attach a draft workstream started by Leann)

One of the topics at the away day (for the Digital/IT group) will be how we can share Eyecare Resources across the Black Country. On this topic I have asked that the Black Country Eyecare Network share files via MS Teams and that is being trialled. I’m not sure how well this will work for us as from personal experience I struggle to access MS Teams files from my personal MS Teams account but sometimes can through my NHS Mail account.

The next meetings are:

Glaucoma working Group on the 25th March for APR

Medical Retina Working Group on the 1st April for Aisha.

Paediatrics Working Group on the 8th April for Shamina

Community Working Group on the 22nd April for Peter B

EeRS

No formal news, gossip is that the tender will go out soon, with implementation for later 2022 or early 2023

Midlands Eyecare Transformation Network

February- diagnostic hubs

March – Cataract and new contract contracts and tariffs

Birmingham, Solihull & Black Country Regional Optical Committee

* Routine information sharing meeting last held 13th January.
* PES - change in the CGPL:s
* Wton have launched their cataract post op service
* ROC confederation document – final version now agreed to take back to LOCs for approval
* Still no LEHN

Birmingham, Solihull & Black Country Workforce Development Project

Funding now received, next meeting scheduled for Thursday 24th 2022.

Midlands LOC Regional Forum

8th March - LOCs from the across the whole Midlands meet to receive information from NHS and other stakeholders and share experiences and work collaboratively.

**Info for LOC Understanding of current concepts & workstreams**

ICS = Integrated Care System

This covers a similar population to local authority. We currently have a Blackcountry CCG formed April 2021 this will become an ICS in April 2022. As there are multiple LOCs within our ICS footprint we must (with the support of LOCSU) work closely together. CB is already working and collaborating with the other Blackcountry LOCs. ICS will include more than just the CCGs and will have a much wider remit.

PCN = Primary Care Network

PCNs are a key part of the NHS Long Term Plan, with general practices being a part of a network, typically covering 30,000-50,000 patients. The networks will provide the structure and funding for services to be developed locally, in response to the needs of the patients they serve. It is important that LOCs are fully involved in the work of their PCN and plan for local representatives. The six Dudley localities for PCNs are named:

* Brierley Hill,
* Dudley Netherton,
* Halesowen,
* Kingswinford Wordsley,
* Sedgley Coseley Gornal,
* Stourbridge Wollescote Lye

National Eye Care Recovery and Transformation Programme

Bringing together all NHS improvement programmes

Keywork Streams are:

* Pathway Improvement and Recovery
* implementing standardised integrated care pathways across cataracts, urgent care (CUES/MECS), medical retina and glaucoma pathways.
* Primary care optometrists as first contact practitioners and managing low risks in the community.
* Digital Hubs - Eye Care Hubs to receive clinical data from any source and respond with the clinical expertise required to support care in non-hospital settings.
* Home Care - home care monitoring using multiple channels including patient-initiated follow-up (PIFU), symptoms monitoring and video consultation
* Workforce optimisation - supporting systems to identify and quantify staff recruitment, training, and optimisation with planning for the delivery of eyecare across whole systems. This will include the development of a Healthcare Professionals Qualifications, Capabilities and Competence reference document and a workforce matrix tool.
* Commissioning - will identify commissioning mechanisms to enable delivery.
* Data and analytics - Develop metrics for reporting on the Eye Care programme and modelling for a wide range of benchmarking and monitoring metrics for Eye Care
* Eyecare Electronic Referral System (EeRS) - It is expected to work closely with pathway implementation and digital hubs. – See Appendix for up to date information

None of this affects General Ophthalmic Services (GOS) other than to require direct referrals to HES (rather than via GPs). However, guidance contains very positive messages about the role of primary eye care and should lead to wider roll out of extended services and the early implementation of EeRS across some systems. We may therefore be renamed from “ Primary care optometry” to “Optometry First”.

**10. Hospital Liaison Business**

NF had nothing to report although she has suggested roles for Optoms to help with the hospital needs. How this is to be funded is to be confirmed and evidence of it's efficiency is paramount to it's consideration. NF also confirmed that an Optom has been recruited.

NF reported that the High Volume Cataract Pathway is available, however, CB reminded the Committee that it could take between 10-12 weeks for OPERA to implement the necessary changes.

**11. Secretary’s Business**

**11.1 AGM date**

The LOC agreed to hold this years AGM on Monday 20th June 2022. This will be face to face and with CET. RB will contact Russells Hall and enquire if they are able to accommodate us, as well as arranging for CET.

**Action RB**

**12. CET Officer's Business**

RB has confirmed that on Monday 9th May there will be a Peer discussion on Dry Eye/Cataract.

CB suggested that the CET Officer's title should be changed to 'CPD' Officer (Continual Personal

Development)

RB informed the Committee that she may step down from her current role but would confirm this by the AGM.

Workforce Development - CB confirmed that 2 years worth of funding (£50K) has arrived. The Black Country Eyecare Group are aware of the grant and they are hoping that this will ultimately lead to a reduction in patient waiting lists. CB asked for ideas from the Committee. IP was suggested plus RB suggested a GERS scheme be introduced in the Dudley area. NF agreed as this is always the hospital's biggest waiting list. NF would also like to see some enhanced services for children with learning difficulties. KR suggested courses on Foreign Body Removal, however, this would need to be supported by suitable remuneration. CB suggested additional OCT Training

**13. Treasurer’s Business**

Currently the balance after:

1 assumed March income similar to Feb (NHS pays after the 15th of the month)

2 meeting expenses are paid including 6 monthly honorarium

3 Locsu account is paid up to date

will be £29K.

This is in comparison to a balance of £18K at the same time last year. The balance increase seems to be due to :

1 an increase in NHS eye examinations compared to previous period in 2021

2 a reduction in lOC expenses, having zoom meetings and less external meeting expenses etc

Can I ask for all expenses claims for March to be completed promptly as it is the year end 31/3/22

MT to attend LOC treasurers zoom meeting on 14th of March - report below:

Details of LOC treasurers meeting from 14th of March

Meeting hosted by Lisa Stoneham and Max Halford and the main points arising were:

It was advised that each LOC has a vice treasurer with access to the account so that in event of a serious illness or worse so that the account is still accessible. I would ask the committee to vote on this and propose a suitable candidate. I would propose the role would be solely for emergency only and from time to time check that I am carrying out a reasonable job.

Many Loc’s are being charged to run a bank account and it was advised that treasurers should look at alternative providers. At the moment Lloyds are not charging us so I would suggest to stay as we are at the moment.

Another concern was that more practices are becoming private only and dropping all NHS work and it was suggested that they should no longer be supported by the LOC as our funding comes from GOS work. Is anyone aware of practices like this in our area?

**14. Authorisation to act and email conversations**

The motion from previous meetings was put to the committee (*the committee give continued permission and authority for officers to deal with and make decisions on matters that arise that need urgent attention. When this occurs, wherever possible a discussion by email with the Committee should take place before a decision is made. Whenever possible and reasonable officers should bring all matters that require decisions to the next committee meeting, and decisions will only be made outside meetings where waiting is not a realistic option.)*

Agreed unanimously

**15. Authorisation to act on ROC**

The motion from previous meetings was put to the committee (*The committee to agree to Charles Barlow and Paul Sidhu continuing to represent the LOC at HWMROC, with permission for them to use their judgement when deciding if individual decisions made there amount to minor decisions or major decisions. For decisions they consider minor they are authorised to act on the LOCs behalf. For all decisions they consider major they must seek to have those ratified by the LOC, and they must make this clear to the ROC.)*

Agreed unanimously

**16. A.O.B.**

DW stated that he had not been paid by OPERA for any of his Cataract referrals. The Committee suggested that he chased up using the 'Talk' button on the platform.

DW asked if Post-Operative patients from Optegra would generate a fee. The Committee confirmed that it would.

The Committee confirmed that YAG referrals need to be submitted separately.

**17. Date of Next Meeting**

The next meeting will be held on Tuesday 24th May – 6.30pm via Zoom

Meeting closed at 8.30pm.

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| --- | --- |
| **Action** | **Action by** |
| Book AGM venue and arrange for CET | RB |
| Find out if practices prefer face to face or online for HLOP training | SA |