Northumberland and Tyne and Wear LOC Committee meeting 19/3/19
Held at M Offord Optometrist , Kingston Park. 6.30

**Present** Lesley Oglethorpe Naomi Smith Kevin Gray Iain Armstrong Sarah Pencott Craig Sixsmith Mike Offord David Knight Kaye Winship Stephanie Cairns Andy McGregor Lisa Gibson

**Apologies** Wendy Bradshaw Ian Hickson Matt Cooper Simon Raw Caoimhe Mcgovern
Bill Lowry has stepped down from the committee for personal reasons

**Conflict of interest** Naomi Smith due to involvement with PECS

**Minutes** of last meeting accepted

**Chair's report**
Naomi has contacted consultants with regard to the proposed education meeting – the date is still to be finalised.
Fastmail is now sorted although Lesley reported some problems accessing minutes. Naomi suggested refreshing the list after the meeting

**MIAA** – Some contractors have had their further meetings. Andy McGregor attended one such meeting to support the contractor as they requested LOC support. NHSE are working to resolve these cases as soon as possible.

**Cataract** –LOC report has been submitted to NHSE who are formulating a report on this.

**Newsletter** – These seems to have been well received. I suggest we continue with the newsletter every 2-3 months.

**MECS** – We held a very thought-provoking meeting with Peter. He is very passionate about making progress in the area with a MECS style service. His suggestion of the PhD was to use this as an incentive for the CCG to commission these services. The PhD would be used to evaluate the MECS service and provide evidence-based analysis and improvements to the service. This would take around 4 years.
Our concerns regarding this is that MECS services currently run in 50% of LOC areas. There are a further 20+ LOCs areas with CCG's with "commissioning intentions". So there are already many services in operation where research could be based. We have reservations that commissioning a service to research it when there are already many successful MECS services in operation would not be beneficial to the CCG. It would make more sense for Peter to work with LOCSU and arrange a review of the services already in commission. Then use this work to further promote the services locally.

**Teeside Uni** – the open evening appears to have been well supported and the LOC will continue support as and where required.
The university wants to encourage placements with Independent practitioners one day a week. They would expect this to start with clerical and reception duties. The course is still not recognised so there is a possibility that intake for 2009 would be through clearing.

**Join our Journey - shaping health and social care –** Apologies I had to pull out of this event at the last minute. Many thanks to Stephanie for standing in. Lisa, Bill, Stephanie and Sarah attended the two events in our region. They will report on this separately.

**SEI** – We've been approached by SEI to discuss neuro -ophthalmology. SEI are interested in organising an educational event. The LOC have been asked to provide support. NS will work with Chris Steele on this.

**IOPRR/Childrens** – We are looking at changing to GRR across the CCG areas to align with the Durham services. We are still awaiting info if all CCGs have recommissioned these services.
GRR would involve repeat field testing
A launch event will be planned for the AGM.

**Secretary's report**
**New Contractors Or Changes To Practice Ownerships**
Termination of Contract: Demster Optometrist, 5 Wool market, Bewick Upon Tweed, Northumberland date of termination 08/01/2019

Change of address: Caring Practice North East Limited t/a Vision Call
Old Address: 125 Cambuslang Road, Cambuslang Investment Park, Glasgow, G32 8NB
New Address: Metropolitan House, Long Rigg Road, Swalwell, Gateshead, NE16 3AS
**LLG Meeting & LOC Forum**

**LLG Meeting**
NHSE and NHS improvement are preparing for a new landscape which will be a more integrated system and be part of an integrated care partnership and come together. It hasn't impacted yet but should from Autumn 2019. Each region will be looking at structures and what needs to happen with delivery of Optometry services. The aim is to take pressure off the hospitals at the acute end.

Has Optometry prepared for the potential of bad weather?
ACTION LOCS – REMIND CONTRACTORS UNPLANNED CLOSURES (FOR EXAMPLE IN BAD WEATHER) NHSE MUST BE INFORMED. England.pharmacyandoptometry@nhs.net

Update on Safeguarding training; Barbara? Has organised safeguarding sessions for dental. She is waiting to see how these work out and then adapt for Optometry. At that point will be in touch to look at venues suitable for everyone.

Nationally NHSE will be getting audited by Deloite? From week commencing 28/01/19 they will be auditing on how services are being delivered. Our local office is confident that they are performing well in most areas. The national audit will be looking for inconsistencies across patches.

NHSE will be looking to bring in a national policy of 'return of quarterly complaints' – this is already the case in our area. There have been some practices that appear to have high levels of complaints, because they are listing complaints such as 'glasses took to ling to come'.
QiO
New cycle starts 01/04/19
Consolidation – still reissuing new contracts (slowed down with the audits) everyone will get them. Contracts are getting consolidated where contractors want to.
MIAA
All contractors have been written and have responded. All cooperative.

Meetings and decisions will lie with NHSE. Attending the meeting will be Ken, miaa (just to go through findings) Ahcene, ?? Davison (from finance) and Richard PPV colleague.
Richard from PPV are come up with top 5 issues

1. Codes must be used for early recalls on GOS1
2. Make sure information on forms is written up and consistent with record cards.
3. For GOS 4 – Full reason on record card
4. Make sure amounts claimed is consistent with what's on the record card
5. Make sure record cards are clear and eligible.

NHS Mail
Shirley who works with Pharmacy NHS Emails has a budget for 60 NHS emails. Ahcene is passing it to the LOCs to see how they would like to share them out. Must has IG Toolkit though.
Next meeting date is 29th April 2019.

**LOC Forum**

Mapping Cataracts pathways – Mapping exercise completed, reported completed. Signed off by LOCs and submitted to NHSE

Children Visual Screening – ZR has asked all LOCs to look at children screening in our areas as there are inconsistencies. NS is going to do some work on this on behalf of primary eyecare.

Eye Health Messages - Discussed 'Eye Health Messages' that can be posted on Council well-being websites and social media – LOCs in favour of this.

Wasn't much news to report back from other LOCs – Durham has had reports of a domiciliary provider using NHS logos and confusing patients that they were from GP's or hospital

**NHS Mail**

We have been told that NHSDigital have agreed to accept the IGtookit in the QiO for NHS email. We have had about 30 requests for NHS mail so far (that's across Cumbria, Tees, Durham and NTWLOC)

More applications were expected. Andy suggested that people may not feel that they need an NHS e mail address

The new e GOS system has still not been trialled at Andy's practice. Naomi reported that the Irish system is up and running and flags if a voucher is not due, but idoes not reveal the date of last sight test due to data protection issues.

**LRC Meeting Newcastle/Gateshead CCG**

Tuesday 16th April 2019

**Other Communications**

Rachel Shields is coming to be an observer at this committee meeting.

**PEC**

News flash 13/02/19

Primary Eyecare Services is delighted to announce the appointment of Mike Fegan as Chairman of their Board.

Mike brings a wealth of business and finance experience which is invaluable as the Company continues to grow. He is an experienced Finance Director and spent 15 years with FTSE 100 companies; he has held roles at ITV, Granada, Forte and the Football Association; he is currently a director of the Association of Optometrists and has recently been appointed as Chair of LOCSU.

He will be replacing Trevor Warburton who was the interim initial Chair of PEC Services and who will remain on the board.

Note:

Primary Eyecare Services Ltd is one of the companies created by LOCSU into which many of the smaller Primary Eyecare companies have merged.

**Treasurer's report.**

The balance remains healthy.and there are no problems with levies.

Request for everyone to submit expenses before 27th March so payment can be made in this financial year.

Stuart Henderson no longer wishes to audit the accounts. Bill Lowry was suggested as someone we could approach. Auditors will need to be co-opted and formally elected at the AGM. The accounts may need to be audited before the AGM.

Stuart has not been paid for last years audit. He has requested a charitable donation rather than payment. Lesley suggested a donation to Andy McGregor who is running the Falklands marathon in aid of a forces charity.

**Vice Chair Report -** Stephanie Cairns
LD - Hannah Morrow IGA has requested some support at an event speaking to people with LD in North Tyneside, I've arranged to join her on the morning of the next Forum meeting in April.
LV - nothing to report regarding LOC, I've set up a multi-disciplinary FB group, over 250 members.
I've had no contact with any of the people I tried to link with at the integrated meeting in Newcastle which Sarah and I attended.
I requested the the Falls & Failty group link with NTW LOC GOS with a view to a possible training event around falls and vision? September Eye health week coincides with falls week.
There's been some promotion of sight tests and Eye Health messages going on. I've emailed Matt with some info and had no reply.
Still some people missing off the LOC Whats APP group. It was emphasised that posts on this group will be read by everybody.
AOB - LOC to discuss;- is this a pathway that could be developed;
Deborah Batey (Diabetic screening service) would like to find away to increase communication between the service and community optometrists, ideally to send queries about patients they see in practise directly to the Screening service, rather than via the GP. If you are a non-screening optometrist you have to take the patients word that they are attending screening. If maculopathy or retinopathy is spotted it can be hard to judge if this was noted at the last screening, if they've been. One option may be to use NHS mail(once available) to send queries to the screening service and copy the GP in. Could there be a referal option out for reduced v/a's but no obvious maculopathy. Like in the childrens screening?
There's been 3 people recently who have presented at eye A&E after attending community opticians with rampant retinopathy. All 3 cases weren't known to the Retinopathy Service. While these direct referals to A+E were warranted its highlighted to her that the Diabetics who choose not to attend screening (can op out for up to 3 years at time) are potentially more likly to turn up in community or A+E with reduced vision.
This was discussed by the committee and it was felt that communication via the gp was the best route.

**Service Development**

Enhanced services survey - overlaps with MECS .
Codes can be obtained from LOCSU to do Glaucoma and cataract modules. WOPEC can not give list of who has completed modules due to data protection
Steph suggested Googleform may be better than Surveymonkey- access may be restricted to Bill unless we pay.
Survey could wait until after the AGM
A replacement is needed for Bill Lowry – Craig Sixsmith agreed to take on the role.

**GOS Report – Matthew Cooper**

Advice was sent out on recall dates, -link not working due to a letter accidentally missed off. Online version different to hardcopy I was working from.

Many people think MOU is advised recall date, not minimum without code. Although any claim that is within MOU will be paid,it is possible that at a later date an audit may deem claim to not be justified and reclaim.

GOS sight test uptake

Although it seems possible to get numbers for sight test uptake in regions, and some for reason for GOS, I can't seem to find anything of demographic of claimants. As I understood the brief we are looking to find if people/children from vulnerable backgrounds are making full use of available GOS provision. Will carry on digging

Domicilliary

Haven't had a chance to get into this yet, due to work and personal commitments

**North East and Cumbria Local Eye Health Network (LEHN)**

**Meeting in a Minute**

**Tuesday 9 October 2018**

**LEHN & Northern England Clinical Networks**

Ben Clark Associate Director to the Clinical Networks & Senate for CNE attended to provide an oversight of the clinical networks and how they fit with the future landscape of Integrated Care Systems (ICS). The Northern England Clinical Networks bring together differing types of networks included those mandated by NHS England (Cardiovascular disease, diabetes, mental health & maternity services) other networks such as the Learning disability and the emerging ICS Workstream such as Child Health and Wellbeing. All of the networks work very closely with the Northern Cancer alliance, Public Health England, Health Education England and the improvements programmes such as 'Getting it Right First Time' (GIRFT).

It is felt that the LEHN is much more aligned to the Northern clinical Networks than other Local Professional Networks (LPN's) where NHS England has direct commissioning responsibilities. It is also felt that the following benefits would be seen:

- Greater alignment of work and learning across the differing clinical pathways and specialties
- A stronger overall clinical voice into emerging ICS
- Access to resources and expertise from partners with Network specific posts
- Opportunity to influence the developments of network web space in the ICS website.
- Ability to input into work harmonising clinical guidelines working into the ICS digital workstream.

It was agreed that this is the action that should be taken, and the LEHN will take steps to do the following:

1. Review the ToR and objectives
2. Review LEHN ways of working with the support of the Associate Director to the Clinical Networks & Senate for CNE to take on board learning from other networks

3. A communication strategy will be developed to re-launch the LEHN under the banner of Northern England Clinical Networks.

**Elective Care Transformation Programme - Ophthalmology**

Katrina Venerus provided an update on the progress of the ECTP.
All regions in England have been tasked with completing three priority actions in the High Impact Intervention for Ophthalmology:

1. Hospital Eye Services develop failsafe prioritisation processes and policies to manage risk of harm to ophthalmology patients
2. Hospital Eye Services should undertake a clinical risk and prioritisation audit of existing ophthalmology patients.
3. Each CCG undertakes an eye health capacity review to understand demand for eye services and to ensure that capacity matches demand with appropriate use of resources and risk stratification.

Actions 1&2 are the responsibility of Acute Trusts with support from the Getting it Right First Time (GIRFT) team. Action 3 is the responsibility of commissioners.

Action 3 is progressing in the form of a single capacity review being carried out across North East and Cumbria, the LEHN is playing a key role supporting this work and is expected to be completed by end of March 2019. As part of this work an experienced Ophthalmologist is being recruited into an advisory role to inform and influence the eye health capacity review. Closing date for applications is 9 October 2018. Project management and data analytic support is being provided by NHS England and by a Public Health Registrar.
A stakeholder engagement event is proposed for the first quarter of 2019 where preliminary findings of the capacity review will be shared and input on regional and local priorities and potential next stets will be sought.

Hayley Coleman, Public Health Registrar provided an update of the work she has undertaken to date on in support of the capacity review. Hayley described some headlines identified but is concerned that the data sources currently available are not robust and access to better data (CCG) is required to take this piece of work forward. Work is underway to ensure this data can be made available.

**Mapping of Habilitation and Rehabilitation Services**
It has been a struggle to obtain information relating to Habilitation and Rehabilitation Services from the commissioners. The LOC have supported with provision of information the objectives being to:

1. Identify gaps
2. Produce information about what is available locally to be able to share a service guide.

Consideration needs to be given about how we could enhance information by working with ROVI's in future or if there is anything that could be done with what is available now.

**Eye Health Need Assessments**
Eamon Dunne tabled a paper the purpose of which outlines aligning and comparing the similarities/differences in EHNA's and highlighting the gaps in scope and recommendations. It was agreed that the paper would be shared with Zoe Richmond for review and comment and bring back to the group.
The ECTP will not specifically be looking at demand for support services or prevention, it was agreed that any evaluation of this would be very useful.
AOB
Emergency Eye Care Guidelines
There is a little bit if work to do on the presentation of the guidelines and services available across the region. This should be completed within the next couple of weeks and the final document will be circulated all stakeholders

**LRC**
Rebecca attended a short meeting on 17/1/19 -there was no CCG involvement.
A summary of DDES& Darlington MECATS service was given to Bill Westwood who will pass it on to the appropriate people. This will highlight the usefulness of MECATS especially to service users.
GP2 service was discussed by pharmacists – GP receptionists are trained to sent certain conditions to local pharmacists rather than waiting for a GP or nurse appointment.
Primary care networks should be up and running by July 2019. Already well established in Gateshead, Sunderland is 'getting there' but the network in South Tyneside is a long way from being established.

**CCG leads**
**Report for South Tyneside CCG** Kaye Winship

I have tried to rally interest in MECS in South Tyneside and there is lots of enthusiasm from GP's and Pharmacy.
Unfortunately the CCG is less interested, citing availability of same day appointment and cost as the main barriers.
I've arranged a meeting with local pharmacists and GP's to just see if we could influence any better collectively or collaboratively and could do with a committee member who is more in the loop to come to it with me.

Caoimhe McGovern is standing down as lead for Gateshead/ Newcastle. Mike Offord will take over this role.

North Tyneside- nothing to report.

**Join Our journey.**
Sunderland event attended by Lisa- did not feel it was relevant to Ophthalmology
Newcastle event attended by Steph and Sarah . Report follows

**Prof Chris Gray, NHS Medical Director for Cumbria and North East**

**What is an integrated care system?**

An ICS is not a statutory organisation; it's made up of individual organisations working together in partnership to improve health and care based upon:
They are a pragmatic & practical way of delivering the 'triple integration' of primary and specialist care, physical and mental services, and health with social care.
Organisations taking devolved responsibility for key NHS resources
Collaboration across boundaries, e.g clinical staff from different organisations working in networks

*Chris Gray told us that our regions has big challenges. We have the worst health outcomes in our region. The money doesn't stack up, we have a workforce problem and increasing cancer rates*.

**What is Integrated Care?**

- Patient focussed and holistic
- Doing what is needed and wanted
- Not doing unnecessary – follow ups, travel
- Reducing duplication
- Arranged around patients not practitioners
- Citizens, patients, clinicians and carers co-designing and delivering pathways to optimise health and wellbeing

*Chris Gray gave an example that the way the current system works. We currently may have blood tests done at the GPs, then get referred to hospital and they repeat the tests. Then referred to a more specialist department who repeat the tests again – with an ICS information would be shared more easier so these tests only need to be done once.*

**What can the ICS do?**

- Support emerging health and care systems at local (place level)
- Collectively address population health priorities and inequalities where approrpite
- Ensure equitable access to high quality care
- To be the best place to 'Work & Care'
- Ensure patients and staff are informed and enabled (CNE digital solutions)
- Support and sustain health and care services for the people of Cumbria and the North East
- To have the best health outcomes

*In our region in some areas life expectancy between 2 metro stops can be a difference of 10 years!!!*

**Aims for today**

**We want you to share with us:**

- In the place you live and work, what are your priorities for health care and well being?
- Your ambition to transform health and care
- What needs to happen to make this a reality?
- How can we collectively deliver this?

**Together we will**

- Celebrate innovation and excellence
- Inform the CNE ICS health and care strategy

From four event we will:

- Identify priorities and actions for the health and care system across Cumbria and North East
- Share the outcomes with system leaders at a Summary Event on 20th March in Newcastle
- Co-produce a narrative to support the vision, mission and strategy of the Cumbria and North East integrated Care system
- Celebrate excellence across CNE

*This was the fourth event in the area, they had them at Carlisle, Sunderland and South Tees and Newcastle was the last.*
*The event was attended by NHS workers, public sector, volunteers, system leaders, charity sector and over the course of the 4 events they will have had over 500 people attended.*
*We were then shown details of an ICS service in our area;*
*Onecall is a service in Northumberland to keep vulnerable people safe by bringing adult social care and health care services together and also works alongside Children's services and Northumberland police. So this includes social workers, district nurses, therapists telecare, home improvements etc.*

**Mark Adams addressed the room;**

Both Cumbria & The North East

- Longest established health region
- Highest performing NHS organisations
- Best education and training
- Strong track record of collaborative working
- Strong clinical and local authority leadership

But ……..

- Worst health outcomes
- Emerging long standing system pressures

**<u>What the NHS Long Term Plan will deliver for patients;</u>**

The NHS Long Term Plan describes a range of specific ideas and ambitions for how the NHS can improve over the next decade, covering all three life stages:

- Making sure everyone gets the best start in life
- Delivering world-class care for major health problems
- Supporting people to age well

Delivering world class care for major health problems …..

Including

- Preventing 150,000 heart attacks, strokes & dementia cases
- Providing education & exercise programmes to tens of thousands more patients with heart problems, preventing up to 14,000 premature deaths
- Saving 55,00 more lives a year by diagnosing more cancers early
- Investing in spotting and treating lung conditions early to prevent 80,000 stays in hospital
- Spending at least £2.3bn more a year on mental health care

- Helping 380,000 more people get therapy for therapy for depression and anxiety by 2023/24
- Delivering community-based physical & mental care for 370,000 people with severe mental illness a year by 2023/24

Making Sure Everyone Gets The Best Start In Life …..

Including:

- Reducing stillbirths & mother and child deaths during birth by 50%
- Ensuring most woman can benefit from continuity of care through and beyond their pregnancy.
- Providing extra support for expectant mothers at risk of premature birth
- Expanding support for perinatal mental health conditions
- Taking further action on childhood obesity
- Increasing funding for children and young people's mental health
- Bringing down waiting times for autism assessment
- Providing the right care for children with a learning disability
- Delivering the best treatments available for children with cancer, including CAR-T and proton beam therapy

Supporting People To Age Well …..

….. including:

- Increasing funding for primary and community care by at least £4.5bn
- Bringing together different professionals to coordinate care better
- Helping more people to live independently at home for longer
- Developing more rapid community response teams to prevent unnecessary hospital spells and speed up discharges home.
- Upgrading NHS staff support to people living in care homes
- Improving the recognition of carers and support they receive
- Making further progress on care for people with dementia
- Giving more people more say about the care they receive and where they receive it particularly towards the end of their lives.

***Questions from the Room***

***Q.*** *How can ground staff communicate to make services better?*

***A.*** *We need to admit the problems and work with Health Watch more. Need to start working with the professionals and the start of the process – the aim of this w=event is to learn what can be improved.*

***Q.*** *Are patients at this event*

***A.*** *No, patient groups and patient representatives – will engage with patients at a local level.*

*The 2 groups I attended were;*

*'Pharmacy – A integrated Model of Care and Collaboration' & 'Integration of MSK services in Gateshead and Newcastle'. Unfortunately, Ophthalmology were not at the Newcastle event*

***Pharmacy*** *talked about a model they are running out of 4 Hubs with Vanguard Funding. This 4 hubs in Alnwick, Hexham, Blyth & ??. They are teams of pharmacists and technicians' workings in hospitals and primary care settings. This team is part of a wider team community, nursing, social care and GP's. It is*

*integrating health and social care. They have IT access to GP Clinical, Hospitals and social care. It is to help patients with low to high need for support with medicines and is to avoid admissions and readmissions. The service is very patient centred. They look at medicine optimisation and deprescribe where necessary, it is based on shared decision making.*
*They have a case load of patients so they find work and have patients referred in from GP's.*
*Over the last 15 months they have made 5124 interventions. Avoided 223 hospital administrations and stopped 1000 medications.*
***Tyneside Integrated Musculoskeletal Service** started in October 2018. It is a service that patients can access themselves. The resources they have is; a website with advise, activities, contacts and links.*
*They have local services at 8 different locations (reducing need for hospital care).*
*They provide help and advice for patients and GPs.*
*Patients can refer themselves in to access local NHS physiotherapy and other musculoskeletal & pain services without visiting the GPs.*
*They are receiving 1500 self-referrals a month.*

*- doesn't involve awareness of visual impairment, loss of confidence due to visual loss or directing people to opticians for sight tests. SC provided business card – waiting for contact.*

Integrated Care System Digital Care
Presented by Dr Graham Evans, Chief Digital Officer
The General perception from the public is that the NHS is a single entity with well-connected systems and services that enable patients and service users to move seamlessly between point of care. The reality is the NHS and broader Health and Care System, is a complex amalgamation of different organisation operating in a dynamic and and fast moving environment. Often working in isolation but starting to move towards integration.
North East & North Cumbria (NENC) Integrated Care System (ICS)
This area has a population of 3.6M. Looking at a digital care programme involving system convergence.

*Projects that have been tried in our region include 'Well Connected Care Homes'. This is a record keeping App for tablets to keep patient information including care plans, patient wishes about their care and their life. The devices would be able to communicate between other care homes, primary care and emergency care. Information can easily be transferred. This is gradually being rolled out throughout our region*
*SC asked if eye sight data is recorded. Was told 'no, currently only summarised clinical record & end of life care plan'. SC pointed out that patient's information about visual impairment is important to help patient with tasks such as eating.*
*Long term the NHS would lie to have total convergence with all their operating systems as currently this varies between trust. This is a huge task as it involved everyone being on the same technology and systems. They are keen to hear from people on the ground with ideas for system improvement by contacting Academic*

*Health Science Network (AHSN). They are hoping to see in future. Collective communications people between health professionals and patient. E.G Skype for business and virtual consultations.*
*SC asked if they are looking at community optometry as part of this. Their response was no, but pharmacy and dentistry is. SC highlighted this was important due to problems we currently have with urgent referrals into primary care and the issues that keep arriving with the current referral process. – SC has provided email for lead to get in touch.*
***Integrated Working**- many examples*
*Gateshead care partnership -place based – North ICP – NCNE ICS*
*Talking to Healthwatch!!!*
*Stroke based – work to prevent stroke - Allied health professionals are involved in developing and identifying people at risk. – no input from community optometry*
*Children, health start and prevention – local authorities (nhs funding) – regional work*

- *Does the vision screening and community service fall under this.*

*Alnwick GP center – Social prescribing including making appointments with Citizen advice, run weekend walking group. Do they direct people for ST and or rehabilitation support???*

*Frailty Toolkit for multi-disaplinary use deveopled by Care Closer to Home – http://frailtyicare.org.uk – under development – Frailty icare is a new regional approach to frailty led by the Care Closer to Home Programme of the shadow Integrated Care System for the North East, North Cumbria and*
*Hambleton, Richmondshire and Whitby.*

- *Apparently had vision input from third sector (Sight Service!!) But not LEHN or LOC's*
- *http://frailtyicare.org.uk/frailty-i-care/in-detail/respond/- only 1 word of 'vision on the website so far*
- *– the aim is prevention of frailty, SCairns explained that Community opticians play a vital role in picking up sight threatening condition while potentially treatable and therefore have a role in this. SCairns provided business card – waiting for contact.*

*Regional frailty strategy – lots of engagement events but no optician's – never been directly invited (SCarins did highlight the Gosforth park September 2018 to LOC when found out about following the S.Tyneside frailty meetings but too short notice for anyone to attend) SCairns provided business card – waiting for contact.*

*North Tyneside Integrated Falls pathway – restarted 18mths ago – apparently refer a lot of people to the community opticians. Have anyone seen this paperwork as we only asked Newcastle so far. The head physio does not like bifocals! SCairns provided business card – waiting for contact.*
***Primary Care Networks** (under development) – groups of GP to come together to work together and engage community, had thought CCGs would sort improved local services but hasn't happened. So the idea is that GP groups will therefore LOC will*

*need to make contact with the Networks. Find Leads in June via CCG's and make contact early July.*

**Presentation Sarah Pencott Stephanie Cairns**

**Ophthalmology Event**
Elective care pressures
Re-thinking referrals
Great focus on shared decision making -Whole age , self-care - long term
Transforming outpatients
K.Venerus LEHN – data capture around CCG/trust – demand and capacity review – report due end of May.
Mike Clarke – in his opinion!!
1)Primary care relationship is based on obsolete, inefficient model
2)Limited decision making in the community
Lack of pathology training????, no referral feedback loop
-lack of barriers to optometric referral
-relative lack of GP gatekeeping
-lack of registration of patients with optoms
PHengland website – CVI registration certificate– outcomes not great due to capcity issues
**HES – Getting It Right First Time (GIRFT)** – National report being finalized – by May 2019.
Lack of capacity -20 patients a month losing vision due to delay follow up– visiting 120 trusts (finished last month), implemention on going from 2018. – working with NHS England
*Cataracts* – simple or complex (iris expanders etc)- different traffic/pathways
77% convert to surgery after referral – not all providers use the NICE guidelines (some providers less 66%)median v/a-6/12, high through put lists – patient turn over rather than surgical difference – reporting visual outcomes not done consitently.
A lot of discharge done in house – nurse practioners
Refractive data –90% -moorfields using a community portal
(possible Optomananger though not sure)

*Glaucoma* - Referral filtering – if not commissioned!! 15% who are at risk of sight loss get lost in the larger group of people with lower risk in glaucoma clinics. – needs to be optomised! Currently no national targets to review follow up data.
*Retina* – D. Retinal screening – no OCT included in most commissioned service (when OCT done at Trust level 46% discharged back to community– Portsmouth)
30 Trusts found it difficult to identify their retina patients in delayed follow up
Looking at referrals, optomising pathways,
*Strabismus + paediatric ophthalmology* – 9% said no school screening
Variation in post-op surgical care
*Emergency* – 79% provide emergency care – but many only during the day, 26 had no service level agreement for those out of hours in a different trust.

*Procurement*
Relies on high-cost, high-technology equipment for diagnosis and intervention.
Most conditions are chronic
Cataract surgery-No clinical data outcome compared to different types of lens-12 different lenses.
Recommend improve transparency of procurement
*Specilised services* often done but often commissioned! – procedures/patients and outcomes not counted.
HES -most are compromised by space and unfilled positions (not enough ophthalmologists)
*Litigation*- nationally ophthalmology 1/3 of NHS bill – often due to delayed follow up.
*Variation in service* – Full Vision Focus Pack – CCG with 17/18, outpatient data - System Improvement Priorities (due out)

**UK Ophthalmology Alliance UK** - www.uk-oa.co.uk
Procurement guideline in Ophthalmology on it way, IOL's already out.
Extended roles/Advanced practice – multi-disaplinary team – huge amount of variation Developing national documents/procedure
Eyefficency app – cataract op info to benchmark, developing an viteral injection version and website.

**Local Evidence** City Hospital Sunderland, Tees and D&D – High Impact Intervention Not all gotfailsafe function/officer accept for retinal screening

**Outcome from capacity/demand –** PHEngland
Data is from NECS(CCG level) – mixed coding on notes so hard to compare – only had data for a week
2.8% rise in pop. 1 in 5 to be over 70 by 2040, Northumberland & cumbria greater raises
26,000 to A+E last year, this years estimate 40,000 (S.Tyneside & Sunderland the most)
(Mainly between age 45-85)
Afternoon Workshops
**Children Screening service** – Zoe Richmond and Kate (Deputy Head orthoptist at RVI)
Very positive feedback regarding Community optom involvement, but some areas across the region not doing this. Large discrepancy in eligable number of children 4/5year olds Newcastle/Gateshead between RVI figures and CCG's. CCG's will include home schools/LD children, RVI's includes independent schools.
N.Tyneside and S.Tyneside have relatively low number of children passing through the service. Both use Screeners with secondary Orthoptist screening level. But if meet reasonable v/a's not cyclo done.
If children are seen in community later than reception screening i.e. turn up in community around approx.. 8-12yrs with reduced v/a's not responding to glasses and get referred into the Orthoptists. They can tell on the system if they were screened in

Reception and whether they passed/failed at that point. *A possible piece of work for the LOC may be to 'audit' how many children are turning up with undiagnosed/ corrected hyperopia/amblyopia/anisometropia in community who aren't being picked up via screening, but also not referred in to the Orthoptist, i.e. either because missed screening or because parents oped out or don't respond to the screening results. Should there be guidelines for Community Optoms to decide what v/a' level these children should be referred in regardless of age? i.e. is 6/9 acceptable. There is evidence to suggest that amblyopia therapy can benefit up to mid teens.*

Tees and Cumbria both not commissioned the children service and orthoptists/ optom lead from these Trusts were very interested in the results and plan to speak to Zoe in more depth.

**Cataract** – Specalist Nurse RVI and Angela Henderson, NHS England, Newcastle presented their pilot which they now run for all non-complex second eyes? Post-op telephone call is after the patient is asked to present for a sight test (approximately 6-8weeks). They feel most complications present at A+E with in 2-3 days. *(Not sure what happens to people who live a long way from the RVI A&E)*. They are really happy with the results its freed up 2000 clinic appointments. They have looked at the letters and apparently they don't say 2-3 weeks. (However there are definitely some still going out with this, though the one I saw last week was following 2nd eye surgery but had a follow up clinic appointment). He denied all knowledge of being aware of any concerns raised by the LOC.

Mr. Clarke unaware of the LOC mapping process regarding services, this it was explained was due to the lack on engagement with the LOC in the first place.
He seemed suprised to hear N.Cumbria were discharging with no phone call based on the 'excellent' RVI pilot results. It was explained to him that the current situation doesn't qualify as a GOS test and that an NHSEngland report will be out soon.

– no pre or post op commissioned services across the region– Mr. M. Clarke felt these may be a waste of NHS money. But he was willing to listen to the 2 ophthalmologists from the UK Ophthalmology Alliance UK and HES – Getting It Right First Time (GIRFT), who were pro- community services to manage patients. *He has agreed to meet with the LOC and discuss!!*

Glaucoma – Steve Thomas presented – Lisa will have the report but I understand Mike Clarke was less than complimentary about the role of community optometry and the CoO Glaucoma Certificate.
Wet ARM – LG will have the report.

**AGM and Launch**
14 th May. GRR and Children's scheme will be relaunched- this will be mandatory for new participants. We hope to be able to offer some CET- possibly around Glaucoma. Iain will contact Ophthalmologists- possibly Zoe Johnson.

**AOB**
Lisa will write to SEI about the GRR service relaunch.
LOC will try to engage with RVI- Naomi will compose a letter, possibly inviting them to LOC meetings.
LEHN is to be enlarged and relaunched.
Meeting in Durham around IT- little interest but David Knight may possibly attend.
Discussion around a patient being deflected to community care from A&E- Mike explained that triage nurses try to turn away patients deemed inappropriate.
Short discussion about use of fax machines ending and the subsequent need for NHS e mails
Recent MECS survey – 99 replies including 17 IP optoms and 4 C/L opticians.90% of those not yet accredited said they would be interested in participating if a MECS service was commissioned.

**DONM** AGM 14/5/19