**Northumberland, Tyne and Wear Local Optical Committee**

**Committee Meeting,12.1.2016 6.30pm Waterfront4, Newburn Riverside NE15 8NY**

**Members present**:

Ian Hickson, Kaye Winship, Pauline Wellstead, Lisa Gibson, Tony Marshall, Sylvia Bailey, Naomi Smith, Lesley Oglethorpe, Iain Armstrong, Mike Offord, Andy McGregor, Stephanie Cairns, Carole Thorpe

**Apologies:**

Gary McMullen

**Minutes of previous meeting:**

Had been distributed and were accepted prop. Iain, sec Lesley.

No matters arising other than those covered below.

**Secretary Report:** Naomi

One new contractor – Boots Cramlington.

One change of address – Specsavers Newcastle.

One new performer registered with the LOC. As we are now not informed about new performers NS

is going to use the IOP launch events to update the performer lists as much as possible. Also we

should be able to work with webstar on this so NS will speak to Gian. The schemes are run by PENE

so data sharing should not be an issue.

Tynedale eye clinic – again I have received numerous complaints about the letters sent out by this

clinic which are very misleading to patients about domiciliary testing. I have also had a complaint

from one of my patients last week that they were telephoned by Tynedale eye clinic to make an

appointment for a home visit. NHS England is aware of this and are currently reviewing this with the

intent of them “taking appropriate action”. I have asked for this to be added to the agenda for the

LLG meeting on Fri 15th so hopefully we will receive an update.

**Treasurer Report:**

Lesley- battle goes on as payments are impossible to reconcile, random and varying in amount with no way of tracing. Lesley has spent hours on the phone and has been promised information/answers by the end of the week. Otherwise all well with accounts.

**Roll out of single Children’s and IOPRR service:**

Sarah- PENE has been very busy. Gary had to step down from project bid team due to exams. Unsure whether he will continue or not.

Launch events: Pauline- Newburn is well supported, spaces remain at Pelaw. Committee well represented at both.

Hope that multiples will sign up new practices.

Is possible to sign up to one and not other service.

Sarah would like Q&A recorded on night.

**Chair Vacancy**

We need a strong LOC to address forthcoming NHS changes. GOS is likely to become local via CCGs rather than national. Mike thinks multiples will become interested.

Andy McGregor is willing to stand: he will act as chair up to AGM then we will have election.

No-one has offered to take the deputy PENE role- Sarah could not manage if further scheme was to be commissioned.

We need new blood…Jane Ranns has put forward 2 proposals:

I have 2 proposals that I would very much like your opinions on, we can pick them up at the LOC/PENE meeting in Jan or discuss via email.

1 - That we collectively find/ advertise for an administrator to support all 3 LOC's and PENE, as a suggestion of duties I would include:

keeping an up to date list of practices; including those in enhanced services

distributing circulars to all contractors and performers (when possible) as necessary

updating policy documentation for PENE and LOC's as required

ensuring website is up to date

access to emails to help with distribution to the correct committee members

support with expressions of interest and tender work?

2 - A region wide CET event including NECLS, NEOS, ABDO, NYASDAOP and Cumbria

the aim to bring shine light on the work of the LOC and promote the need for support ie new member recruitment

networking event/ dinner

CET to cover all areas on our doorstep not at the other end of the country

I have already mentioned this to Angela Henderson who suggested it could be used for pre reg students and the wider profession to showcase

alternative roles within the profession

It would be good if you could take these suggestions to your respective LOC's and see if you have any support for this.

Committee discussed and felt proposal 1 was a good idea to employ on a locum basis. Durham have paid £15/hour for admin work.

Also in favour of 2nd proposal.

Naomi will take this to forum meeting.

**NOC 5&6 November 2015 Birmingham:**

Meeting report from Clare Warrior (Durham) had been circulated. Attached at end of minutes. The Central LOC Fund is a new company and we will need to apply to join. Monies should be sent directly to fund, not via LOC. Lesley is trying to sort this. Naomi thanked members for attending and for a good report (Julie Breen Tees; Clare Warrior Jane Ranns Durham; Tom Hedley rep Northumberland Zoe Richmond LOCSU)

**Community Service Leads Reports:**

**Cataract:**

**ST:** Cataract choice scheme to end 31.3.2016 but door is open for discussion.

**Sunderland:** scheme to continue, door is open

**NT:** Zoe has meeting with CCG re cataract referrals and will put proposal forward.

**RVI:** Kevin Gales interested in community cataract scheme.

**MECS:**

Tony has kept low profile 2015. Kevin Thompson has contact with Tony Brown, practice manager in Alnwick who is interested so will have conversation with him

Steve Summers Kingston Park GP is lead for planned care N/cle and Gateshead planned care. They have no one for ophthalmology.. Mike will speak with him.

All informal but some interest has been shown.

**Diabetes:**

MIUK won bid. Gateshead to continue image capture only, not grading. Naomi feels this is solely to keep the patients happy by not introducing any further change to them at present. There is a very good take up to the service.

**PwLD:**

Stephanie informed no progress. N/cl and Gateshead PwLD lead v keen- possibility of small practice based pilot.

N/T: PwLD not on Vanguard.

Zoe has said a LD forum may be set up nationwide to gather information. Stephanie will attend if necessary.

Durham: Pilot launched June very slow take up, possibly as relevant people don’t know about it. Difficult to collate this group as dispersed.

**Reports from CCG leads:**

LRC: -Mike has emailed contacts for Vanguard but no response.

-GP event re IOPRR good idea but worry that not many would attend so if Mike can get a GP list he will email information.

Glaucoma: Mike will attend glaucoma awareness week meeting at RVI tomorrow.

Northumberland CCG: Andy- no progress. We are low down their list.

Sunderland and SoT: both are open and awaiting information- we are in their priorities but not high.

**PENE**: no meeting. Sarah will email a report for circulation. She is concerned that payments for services are poorly referenced.

**LOC Forum:** meeting Monday

Zoe emailed update:

**Optical Lead Update - Zoe Richmond NE LOC Forum Meeting January 2016**

**Northumberland Tyne and Wear IOP RR and Children’s service contract.** Awarded to PENE. Service commencement Jan 4th. Work on the OptoManager module for the Children’s service is well progressed and should be available from 1st March. Areas for service development:

IOP level 1C utilised fully

South & North Tyneside CRS service doesn’t use Orthoptists but school nurses – PENE need to work with screening providers

**Direct referrals in Durham.** Still waiting for NECs to facilitate – slow progress. Meetings held with all local Trusts. JR and ZR to progress

**NHS England Vanguard sites** – **New models of Care Programme.** Better Care Together programme in North Lancs and Cumbria is making good progress and appears to be the only Vanguard currently considering Ophthalmology services. All LOCSU Core pathways are being considered (IOP RR and Cataract are in phase 1; MECs phase 2; OHT monitoring, Childrens services & Low vision phase 3) All phases implemented by end of 2016

Contract likely to be between Morecombe Bay Trust and Primary Eyecare Lancashire.

**Communications -** LOCSU continue to promote community services and the wider role of community Optical practice. A number of articles have been published in both the eyehealth and commission press, both PENE and NE LOCs are well represented. Any local news stories or press releases should be shared with Chris McGachy – [cmcgachy@locsu.co.uk](https://web.nhs.net/OWA/redir.aspx?SURL=FWR83xJecfsobq6jtTqBhTViVkXUh6bvH8FZwnI52I0IquYtZBfTCG0AYQBpAGwAdABvADoAYwBtAGMAZwBhAGMAaAB5AEAAbABvAGMAcwB1AC4AYwBvAC4AdQBrAA..&URL=mailto%3acmcgachy%40locsu.co.uk)

**New Opportunity - North Tyneside CCG** have asked for lots of information about all community services. I have been engaging with with Steve Rundle, their commissioning manager, and will continue to progress and keep LOC leads copied in. It seems Pre and Post Op Cataract appear to be their priority.

**LEHN work on Children’s vision** presents an opportunity for a post screening community pathway across DDT. Zoe working to progress this but will soon require clinical leads from both Durham and Tees LOCs to support.

**RVI and community Optometry – areas of opportunity** I met with Mike Bearn of RVI to discuss areas of opportunity for joint working. NTW LOC to consider next steps.

A contracting model where the Trust maintains ownership and subcontracts to PENE / Optical practices removes the commercial barriers and may open more doors. This could work for Glaucoma and Post-op cataract

Joint working with the Trust to ensure all referrals for IOP alone have been through the community service.

Pilot for post-op cataract patients in rural areas

Support for audit to improve referral feedback (Although this is something I have also taken to the LEHN – an audit across Cumbria and the NE would be significant)

**OA vacancy NHS England (Cumbria and the NE)** – Jane Ranns has been appointed as OA for a short term contract to add much needed capacity. Angela Henderson remains in post.

**Tees STORP project** – Direct referrals from community Optometry to Neurosciences going well. 15 referrals to date. No progress on Direct referral to TIA clinics

Apparently Sunderland (Mr Bell) have been sending out forms with cataract patients – audit??- Lisa will email a query.

**LEHN:** meeting next week.

**CET Events:** on back burner- possibility of joint event to consider.

**Referral Management Systems:**

Naomi received the following letter from Nick Croft.

Dear Naomi

I remember that you had asked for any information about referrals being blocked by the RVI referral management system. I have now had 2 patients who have had their referrals stopped by the RVI through the above system, both of whom I have serious concerns about.

To give you the background I was among a number of optometrists from the North East who attended the Optometry Tomorrow 2014 conference in York. There was a lecture by Dr Saurabh Goyal who is an ophthalmologist who specialises in glaucoma at St Thomas’s Hospital in London on angle closure glaucoma. He spoke about the potentially blinding consequences of angle closure.  His closing message was to ask all the optometrists present to start checking the angles of their patients by Van Herick’s and anybody of grade 1 or shallower should be referred for further investigation.

So I duly started checking the angles of all my patients. The first few were referred via my local GP’s surgery in Corbridge to the RVI or Hexham. To my knowledge all except one underwent YAG laser iridotomy surgery. The other one was being monitored.

Earlier this year I referred a patient to Burn Brae surgery in Hexham.  They had Grade 1 angles with Van Hericks , which was confirmed by an OCT scan of the angle. Their referral was sent by the GP to the RVI referral management service. Mr Clarke looked at it and gave advice to the GP ( see attached PDF’s for RVI and GP’s advice given )  She was spoken to by her GP and no further onward referral was made.

The second case was in September and involved a patient I referred when working at JA Hicks Optometrists in North Shields. Again I found them to have an angle grading of 1 with Van Hericks. I was copied in to the GP’s letter to the patient which said the following, ‘ …All the eye referrals now are passed by something called a Referral Management System to try and reduce the number or referrals seen by the hospital. Your referral was thought to be unnecessary and something that the optician can keep under review, which is good news as they think that it is not worrying. I would be grateful if you could go back for an eye examination in approximately six months time with your optician though if you have any concerns before that you could go sooner or come and see us at the surgery. ‘ ( see attached PDF for copy of letter)

As I said I have very serious concerns about both of these referrals for the following reasons.

Firstly it appears that Mr Clarke and the RVI are not following national guidelines with regards to glaucoma. I have attached a page of the draft commissioning guide for  Glaucoma which was published by the Royal College of Ophthalmologists in March 2015. I shall quote from it ‘ …. Where a narrow and potentially closable angle is suspected, timely onward referral should be made….’ It continues later, ‘ Commissioner’s should ensure that they commission services which: 1/ Specify that all people seen at their first visit for diagnosis in community based ophthalmology or the HES undergo peripheral anterior chamber assessment and gonioscopy to identify angle closure.  2/ Discuss the option of LPI with primary angle-closure suspects to potentially reduce the risk of angle-closure and glaucoma . The evidence for benefit is currently uncertain and the risks and benefits of LPI should be discussed with each patient. If the patient opts for observation rather than LPI, they should be fully informed regarding the symptoms of possible acute angle-closure attack and be aware that emergency treatment in the HES would be necessary should this occur. ‘

I have also attached a page of the 2015 Scottish glaucoma referral guidelines. These state the following, ‘ Irrespective of intraocular pressure, patients with one or more of the following findings should be referred to secondary-eye-care services: …..risk of angle closure (occludable angle) –using Van Herick technique, if the peripheral anterior chamber width is one quarter or less of the corneal thickness.

In both cases if we follow the guidelines they need to be referred for further investigation. I am concerned that these patients are being given advice without a full gonioscope examination.

Mr Clarke states in his advice that there is poor evidence for performing peripheral iridotomies . If this is the case, why at the same time as he is stopping referrals are his own glaucoma specialists carrying out these procedures on patients?

In the first case is a GP an appropriate person to discuss the ‘risks and benefits’ of LPI and was this done fully?

In the second case no discussion has occurred with the patient, except for them to be told, ‘ Your referral is unnecessary , which is good news as they think it is not worrying.’ There was no discussion of possible symptoms of angle closure and what the patient should do if they suffer these symptoms.

Finally in the second case I have been asked to see the patient in six months and keep them under review. A shallow anterior chamber is an anatomical problem which will not get better. How can I monitor them and also is this in my terms of service?

Sorry this seems  a lot to plough through. But I do feel that it needs to be brought to your attention.

Kind Regards

Nick Croft

BSc(hons)  MCOptom Dip Tp(IP)

Naomi put this to Zoe who feels we need to get to the bottom of what exactly the Referral Management Systems are and what is actually going on.

Sylvia met with Ruth Evans, GP contact coordinating RMS, she will forward letter to her.

Mike- it depends on who sees the patient.if narrow angles and symptomless the PI may not be appropriate. We could enquire as to their policy.

Sarah-if they decide not to treat we have met our responsibility by referring.

Letter will be forwarded to LEHN and also discussed at LOC Forum.

**DBS Checks:**

Kaye- new signatories to schemes need DBS checks how do we do this? It can be done through AOP. Can appoint a member of staff (not relation) to sign forms.

**AOB:**

Sarah- RVI orthoptists are handing out new Children’s screening forms too early so if we get one please download old form and use until new scheme in place.

**DONM:** need a meeting before AGM- will arrange to coincide with next Forum atc meetings.

# Appendix1.

# NOC (5th & 6th November) 2015 Report

# Hilton Birmingham Metropole, NEC

Our contingent from our North East England area this year included LOC Committee Members from Tees (Julie Breen - JB), Durham (Clare Warrior – CW and Jane Ranns - JR), LOCSU Local Lead Zoe Richmond (ZR) and Tom Hedley (TH) representing Northumberland, Tyne & Wear LOC. We travelled down during Wednesday 4th November and back during the afternoon of Friday 6th November. This Report is more a summary of the *personal experiences* of the Conference, as the official information will come down to us all from the AOP / LOCSU / various of our journals fairly soon, if not already by the time that this report is disseminated.

**First day** - Theme: **Strategic View** - **Alan Tinger** welcomed us to this 2015 Conference and stated that we should have pride in ourselves and in the work that we have done to punch above our weight and involve such a small sector and be much less isolated these days. Other health care professions are here at the Conference with us, showing greater involvement.

**Katrina Venerus** chaired the First Session and introduced **Professor Carrie MacEwen** from Dundee Hospital and RCOphth. President, who had a busy day and due to dash off to London. New ways of working via good leadership and all health care workers collaborating was the key to her vision of evolution (e.g. the explosion of ARMD and ocular vascular treatments needed this kind of feed-through support). Prevention strategies, communication, good use of current and ongoing constrained financial resources vs demographic demands, working ‘smarter’ (*again*), everyone being ‘patient-centred’ (*again*), maintaining good relationships across the board, continual revision of the ‘best’ of care pathways, confident consistency of operational applications (whilst resisting the usual temptations of cherry-picking), upskilling via regular CET / CPD programmes (local and national direction), ensuring that CCGs / Local Authorities (LAs) have the ‘right’ professionals on board to be fit for purpose, avoiding any endemic distrust / *perceptions* of rivalry by good contact messages – all this to improve progressive beneficial change, given the limitations of resources. Wales spearheaded Community Services’ changes (PEARS) along with Scotland (Grampian optometrist / nurse collaborative working and better GOS provision) with England in the rear (hopefully not for long). Q & A’s highlighted poor feedback on referrals back from ophthalmologists, data-sharing hiatus and to encourage better use of nhs.net (the latter being an inexpensive, secure and generally efficacious way for all health care organisations to communicate, report and link-up).

**David Geddes**, NHS England Head of Primary Care Commissioning and also a York GP gave us an NHS Strategic view. He added more to that signposted by Prof. MacEwen. He felt that the ‘picture’ of the present state of our NHS is ‘from hero to zero’ just recently. This may not be necessarily true but we do have to improve as we have an aging population and develop the ability for people to ‘live’ with illnesses as well as cures. Long-term conditions such as diabetes and Parkinson’s require management and more collaborative working between health care professions is needed to spread the consultation time overload. Family back-up can perhaps be harvested to help cope. GP’s don’t usually pick up on vision problems in Annual Reviews so a ‘forward’ working pattern needs us to, yet *again*, work ‘smarter’ (e.g. given the double-jeopardy of visual impairment and Falls). Mention of “Vanguard” sites that are currently testing models of care closer to home. Better ways of working across borders and how to cope with hard to reach populations / various disabilities. Local Eye Health Networks (LEHNs) can greatly help with awareness for CCGs and LAs. Q & As mentioned the Atlas of Variation signpost, shortness of time for the Vanguard site initiatives and how we should reflect more on the effects of co-morbidity.

**Richard Knight** (LOCSU) and **Gian Celino** (Webstar) reviewed on national commissioning and the Company Model for LOCs. 209 CCGs, 78 LOCs (of which 63 have the Company Provider Model and numbers are growing). The Company Model is the best for multiple / joint CCG commissioning as costs are kept down, is more flexible, faster to mobilise, matching up with hospital systems and data more easily accessed. There are direct procurement and competitive tender processes in play. The statistics were outlined and can be checked with LOCSU. Webstar Health was established in 2001, has a French parent company, works across around 3,000 pharmacy and optical sites and has worked with LOCSU since 2009. Key elements are performance evaluation and data collection to also create a repository of information.

**Zoe Richmond** and **Dharmesh Patel** (LOCSU Optical Leads) jointly presented on new care models’ delivery. 50 Vanguard sites are a way to evaluate a Lead / Blueprint grass roots upwards with the potential of accelerated service transformation. Integration of Primary and Secondary / Acute Care, multi-speciality working / redesign and enhancement of health care in the community and care homes. More are planned and it does not specifically have to be a ‘Vanguard’ site per se, if a way of working together can naturally evolve. TIA / Stroke services evolution in South Tees, Learning Disabilities in Durham, London and other possibilities (check with LOCSU). ASK all who can be involved – (ophthalmologists, GPs, Nurses, other health *and* care professionals as well as the most important, our patients / service users. A ‘pyramid’ diagram of this is often used to link in with the ‘patient journey’. Other descriptors are relevant ’five year forward’, ‘integrated accountable care organisation’, ‘stress testing’ of systems and ‘exemplar pathways’.

The **Leadership Programme Alumni** group of 2015 were formally presented with their achievement certificates and both **Jane Ranns** and **Kaye Winship** from our area were successful in this Programme. Congratulations from us *all*!!

**Katrina Venerus** talked about shaping the future of Community Services. It can be better and ease pressures on hospital services and triage efficiencies. Moorfields have a Vanguard site and helped signpost on digital care information etc. Jeremy Hunt wants a paperless NHS by 2018!! The LOCSU Annual Report shows many positive indications. Evidence and evaluation are key. More secure communications, e-referrals, integrate everyone in two-way communications within the ‘new’ NHS IT system in 2017 (will this be possible). Data sharing with Secondary care a factor. Fit for purpose education programmes with the colleges, LEHN support, dove-tailing the CCGs, acute trusts and LOCs with the population whom we all serve means that we all require a seat at the table and keep talking to each other.

**Jill Matthews**, National Director of Engagement, outlined happenings regarding Primary Care Support Services. Capita is the new agency who will receive the outsourced GOS forms. She mentioned that she was wearing a bar-coded dress for her presentation. The current capacity of offices is to be reduced from 50 offices nationally from 1st September 2015 and further changes will have advance notice of closures sent to us. The preferred future will be online ordering of items by us and changes in these logistics will be phased in. GOS forms are due for a redesign by around September 2016 and Capita are currently looking for expenses paid volunteers for a panel to help with this process. Many of their staff will face redundancy – so we are asked to be patient and sensitive to this. Capita are good at back-office services. Eventually GOS forms will be scanned in rather than the current manual ‘batch’ process, so neat and accurate writing will be helpful otherwise delays in payments will be caused if forms are rejected. Some reassurance……no ‘big’ changes for another year.

**Workshop Sessions**. Six alternatives. **TH** attended “**Developing an Inclusion Strategy to help meet the needs of local communities**”. **Angela Henderson** and **Katrina Venerus**. Angela outlined work for the EHNA process and evolved Reports (e.g. one for Durham, Darlington & Tees), the Annual Health Check (AHC) by GP surgeries, the low Registration / uptake of *nhs.net* amongst optical colleagues, need for improved data collection, agreed further training (Dementia Awareness event due soon for North East England), formal reporting mechanisms, equitability of care in our communities (e.g. children’s services in Northumberland, Tyne & Wear areas, learning disability eyecare in DDES and North Durham) and also introduced the Dudley Healthy Living Optician scheme (based on a similar one for the local pharmacists). The latter is to give advice relating to eye health, smoking, alcohol and other related conditions. **Shamina Asif** (Dudley LOC Chair) and **Michelle Dyoss** (Pharmacy Public Health Lead) presented the programme. It showed an improvement in the potential of life years gained. Portsmouth have also introduced a similar service. Staff and professionals undertook accreditation courses. A catchy logo and promotion launched the service in August 2015. It has proved popular with 731 screens so far. Check out the website: <http://dudleyhlo.co.uk/>

There followed a peer group discussion with CET points.

**Workshop session -** **CW** attended “**Development session for first time NOC delegates”**

Facilitated by **Hayley Rowbottom** who has been a LOCSU Optical Lead since August 2014. Hayley works as a clinical lead optometrists for Boots and also does some locum work. The main focus of the workshop was to help first time delegates to understand more about the conference and its main

Goals. It was also aimed at new committee members. It was a very interactive session which highlighted the support that was available to new members. We discussed the current Induction strategy and gained some feedback on how effective it was. There was also time to discuss all the terms and acronyms that perhaps newer members would be unfamiliar with. There was also some time allocated to how the conference could be improved for next year.

**The Central LOC Fund AGM** was at 5.15 pm. Our local Director is **Susan Bennett** and she was also in attendance. The new Company Limited by Guarantee structure with the new Logo is up and running. Three new LOCs have just joined up. £93k of funding has been dispersed in support of a range of national programmes and projects. A national Repository of data storage was one of the more important projects that will have lasting benefit for our professions. There is less income coming in now, although retained income is reasonable, we need to be watchful for the future and *hope for more donations to the Fund.* There was one retired Director and so a vacancy currently exists for the South East. The reference to North of Tyne in the Income spreadsheet was corrected to: Northumberland, Tyne & Wear LOC. Some of the recipients of funds expressed their thanks, especially **Richard Knight** from LOCSU for the aforementioned National Data Repository that will have a significant positive impact on supporting the case for Community Services across our nation. Please see the website: <http://www.centralfund.org.uk/>

The **AOP Awards** and Dinner followed late on in to the evening. Congratulations to all who took part and in particular to **Lesley Oglethorpe (Dispensing Optician of the Year)** and **G. T. Harvey & Partners (Practice of the Year)** from our area. *End of the first day*.

The start of the **second day** on the Theme of **Data** – a choice of six networking meetings. Delegates from or area shared out attending these: **TH** attended “*Clinical Governance and Performance Leads*”. A lively forum, this was. However, a few pearls: - generally a ‘familiar’ discussion on aspects of problem-solving….outliers and how to be gentle with the need for information gathering and specific cases of careful realignment of service operations following performance assessments. Emails better but sometimes a need for ‘phoning and even practice visits / face to face meetings to help. Mentoring or buddying can be a way forward to help with a range of issues but is draining on time and other resources that have to be budgeted. Ophthalmology input helpful, depending upon the service scope and type although functions can be split to cover ground. Watch carefully for the build up to quarterly reports, data assessments, evidence base information and annual summaries as time slips by so easily. Fee levels require ongoing evaluation and negotiations or interest can drop off. Accreditation, retraining, CPD, peer reviews etc. all contribute to maintaining compliance and competencies. Stand your ground on core competencies as fulfilling abilities to deliver services with the commissioners. Service delivery mechanisms can be different in different areas but there are common themes.

**CW** attended the *CET Leads* workshop chaired by **Hayley Rowbottom**. The aim of the workshop was to understand the ways in which we currently offer CET and what the positive and negative aspects of the current offering were. We discussed in small groups ways in which to encourage members to attend CET events and how to get support from suppliers. We also discussed the topic of charging for CET and how that could affect numbers in general but also prevent people from not attending at the last minute. A common theme for attracting more members and CET delegates was to open up the event to other people. It was suggested that the local LOC work more closely with ABDO to encourage new members and also improve attendance for CET.

*Data Repository – Community Services* (**Richard Knight and Trevor Warburton**) brought us all back to the main lecture theatre. This project was possible due to funding from the Central LOC Fund (i.e. the ‘Voluntary Levy’) together with LOCSU. Compilation of anonymised evidence and comparative data that adds significant weight to the enterprise of Community Service evolution nationwide – bigger numbers are important. Two phases via Optomanager and initially MECS Reports: phase I by end of first quarter 2016 (foundation / core reports) and phase II by mid-2016 (report suite). Results coming out can be distilled down for suitable uses by CCGs and LOCs and allow for any customisation filtered for each area involved. Mapping achieved locally and nationally should eventually mature the full picture. Deflections from eye casualty may be difficult to fully work out just yet. Patient survey results show that all is satisfactory so far. Eventually data and other information should be helpful for research purposes – watch this space.

**Parul Desai**, Public Health Ophthalmology Consultant at Moorfields – *P.H. Outcomes Data Across Eye Health* provided an insight in to work analysing and harvesting data, in local and national contexts. This can perhaps stimulate /revive not only discussions around what the currently active baseline is but also point forward to face the challenges of that which we need (both management and workforce) to build and reinforce a clinically efficacious range of durable eye health services and wellbeing in our communities. Although England-centred at present – plan to roll out to other three nations soon. EHNAs and therefore inequalities can be addressed as there is room for improvement in young and adult social care, once the national data collection is more in gear (see Vision 2020 website). ‘Whole’ pathways need to be shown (e.g. diabetes – ours is the largest in Europe, the likes of high volume AntiVEGF treatment pathway support and how ECLOs services can be linked in more to communities). Next steps are to evolve on the broad and the eye-specific indicators and build the better map by Area Team.

**Dr Robert Harper** outlined the *Enhanced Services Research Project*, instigated via the College of Optometrists and published in a BMJ qualitative study open paper (<http://openaccess.city.ac.uk/4823/>). MECS and glaucoma referral refinement plus cataract assessments were covered. GPs, ophthalmologists and patients were all supportive of the model. Optometrists participated as a further add-on for professional development and those who did not take part cited no fit with their business / practice aims. There was a low false positive rate but the false negatives need to be assessed.

*National Ophthalmology Audit* presentation by **Prof. John Sparrow** (RCOpth) and **Wendy Newsom** (Lead Optometrist) signposted the potential of electronic links and feedback from community optometrists to hospitals (via a secure Medisoft web portal) – post-op cataract assessments were exampled and work done to show how it works. A spin off could hopefully be the potential for more extensive / expanded two-way electronic links between Primary and Secondary Care. Other Enhanced / Community Services in assessment. Great if this could be evolved in to better *feedback* to and from ophthalmology / hospital services / GP Surgeries / other health and social care services.

**Panel Q & A’s**……Maybe we could *challenge* health and social care entities to link in with secure information dissemination across the board, beginning with the ‘easy’ ones first? It is possible to map to CCG areas (links to Optomanager?) and information can be exported. Feasible to factor in community optical links to and from hospitals form a list of patient PIN numbers. To bear in mind that Freedom of Information requests can ‘blow access arrangements out of the water’. Hospitals have a preference for the range of fast-track referral systems currently in place and any scope for more. Various algorithms on i.o.p. and other data need to address ‘insufficient’ data availability in order to properly understand the likes of statistics such as some false negatives – important not to mislead by default.

*The Great Debate – Should the optical professions support the concept of mandatory enhanced services? Interesting debate*…… the balance of opinion, and by definition the vote, was in favour of us being tied in to this kind of enhanced / community services’ formulation. No problem if anyone wants to come back to each LOC on this, from our wider grass-roots professional base over the coming months.

**Conclusion** – The *Healthy Living Scheme* in Dudley won the Poster competition. We need to pay heed to the outcomes from the Vanguard sites and develop local leadership in our professions as far as we are able. The new NOC six Workshop sessions’ format was successful. We need to keep talking to the acute trusts, CCGs and keep on trying to join-up the loose ends. Dates in your diary for the NOC next year: 10th & 11 the November 2016. PDFs of presentations and other items can be found via the web link below: -

<http://www.locsu.co.uk/training-and-development/national-optical-conference-2015>

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Appendix2 PENE Reports November and December 2015

November2015

Work as director for NT&W LOC, PENE e mail enquiries, Policy documents, Accounts, declarations etc.

Work communicating with Zoe Richmond, Jane Ranns, Steve Thomas and Eric Hagan.

Communications with Sunderland CCG regarding invoice issues. (None payment of one invoice Q2 2015 SLD IOPRR – plus lack of upload of invoice to SBS noted by NECS Q1 N Tyneside.)

Communication with John D/ Gill M CG & P Leads.

Letter to NECS accepting apology for information breach of PENE financials details.

Participating in creation of CG&P Lead reporting document

Work relating to subcontractor/performer declarations/QiO

Update on policies for PENE board and project bid

December 2015

Work as director for NT&W LOC, PENE e mail enquiries, Policy documents, Accounts, declarations etc.

Work communicating with Zoe Richmond, Jane Ranns, Steve Thomas and Eric Hagan.

Communication with John D/ Gill M CG & P Leads.

Work relating to subcontractor/performer declarations/QiO / Continued work on QiO subcontractor checklist upload, agreeing SOP.

Communications with subcontractors about QiO and Head Office Specsavers / Boots about group QiO upload.

E mails to NECS to discuss change from 3 monthly invoicing to monthly invoicing – agreed.

Resolution of ICO registration issue with NECS for PENE.

E mails with GC (Webstar) to arrange/discuss training requirements CG&P Leads, list creation, new fees for services, updated documents IOPRR & CRS

Editing children service Px satisfaction survey with GM.

Discussions with NECS about extending contract launch date from 4th December to 31st December then to January 4th 2016.

Finalizing Launch dates etc

Invitation letter for launch event (with LOC reps). Agenda for launch.

Information to Contractors about changes to services

Information to contractors about QiO uploads for multiple practices.

Update on policies for PENE board and project bid.

Starting to gather the requirement documents from PENE for NECS to meet the new service contracts.

Finalising the CRS service specification with Amy at NECS /ZR.

Work related to mobilization of the successful bid for CRS and IOPRR, including ‘phone’ meetings with Zoe/Gian.

Project board conference call.

Discussion on contract switch over for IOPRR, risks, implications, practice sign up roll over etc etc

Declarations for performers for new IOPRR service and Children service.

Chasing NECS for required amended documents for new contract by Dec 21st.

Chasing NECS for GP details across all areas plus ‘Newcastle Gateshead’ as three old CCG’s. Discussion around service development to use e mail secure nhs.net put onto workplan.

Investigation into subcontractor protocol breach in Sunderland with GM

Work with GM/ Nutan on Children Webstar module development, FTA and GP letter, CRS protocol, new reporting form.

Responding to queries from subcontractors about DBS, unusual instances that don’t match the pathway, sign off questions, signed up questions, change of bank details, chasing payments, queries relating to requirements for the bid.