Minutes of LOC meeting Tuesday 17th November 2020 via Zoom

Present: Alvaro Borges, Tony Burke, Amy Clarke, Clare Griffin, Nigel Harris, Eshmael Palmer, Ian Shapcott, Adrian Street, Ankur Trivedi

Guests: Sid Maher, Fawn Bennett – both were welcomed to the meeting by Alvaro.

1. Apologies

Apologies had been received from Kerry Irvine.

2. Declarations of conflicts of interest

There were no new declarations of conflicts of interest.

3. Minutes of last meeting

The minutes of the last committee meeting were approved with spelling mistakes corrected.

4. Matters Arising and Action Points

Action Points from last meeting

i	Minutes for website	Adrian
ii	Redesign YAG referral form, check if specific format required.	Clare/Alvaro/Kath
iii	NHS payment details	Tony
iv	Remove administrator e-mail address	Ian
v	County wide e-mail re Wet AMD pathway	Alvaro
vi	County wide e-mail re Opera	Ankur
vii	Update e-mail distribution list	Ankur
viii	Low vision information & add to agenda	Amy/Adrian
ix	ECF referral options	Ankur

i. Action points only had been completed for the March meeting due to Covid pressures. Clare would have another look for May and Alvaro would find the link for the AGM. [i]

ii. The Trust preferred a pdf format, Alvaro was having difficulty producing an editable version, Ankur offered to help. [ii]

iii. Alvaro had escalated the query; Tony had received some payments and was in the process of reconciling the amounts.

iv. Ian reported that this was in process, it would be completed before the next meeting.

v. An e-mail had been sent but there had been some discussion on a WhatsApp group regarding the pathway. Eshmael reported that the revised pathway discussed previously was still a work in progress and it was likely to be several months before it was ready. It was agreed to add this as an item for the next meeting.

vi. The e-mail had been sent

vii. The e-mail list had been updated

viii. It was noted that the LOCSU Low Vision pathway is only in practice and not domiciliary and WOPEC accreditation was required. Ankur suggested checking to see if home visits were specifically excluded. Amy noted that the service was provided in 8 practices in Worcestershire, and Eshmael noted that there was a long waiting list for new low vision referrals due to Covid-19. Fawn also stated that the Domiciliary company she worked for concentrated on Care Homes and didn't currently provide magnifiers as many patients suffered from dementia and magnifiers would not be used, she felt a service to patients living at home would be beneficial. Sid would assist Alvaro to investigate the options further [iii]

ix. Alvaro would produce a survey to find out which ECF practitioners would accept referrals from other practices and possibly come up with a protocol for this. [iv]

5. Treasurer's Report

Nigel noted that the on-line banking had finally been sorted out and any future expenses payments would be by BACS, he asked if bank details could be added to any future claims.

Nigel stated that income was down due to the reduced GOS activity, but the accounts still showed a healthy balance, but he was finding that the amounts paid by PCSE were variable and difficult to keep track of.

Nigel reported that there were a few cheques outstanding that he needed to chase to ensure the accounts balanced and that the LOCSU quarterly payments had restarted. LOCSU were also going to try and standardise the way LOC accounts were run across the Country as there was apparently quite a bit of variation.

6. PES Update

Ankur reported that the migration from Optomanager to Opera was in progress and on track but he hadn't received any specific dates for any of the Gloucestershire modules. Nigel asked if there were many practitioners not getting involved? Ankur replied he did not think so as he hadn't received many queries. Ian noted that the current message from PES was to have the various documents ready but not to take any action now. Ankur would share any updates as soon as he received them.

7. CUES Participation

There had been some reports that practices registered for CUES were not able to offer emergency appointments and were leaving patients to ring round practices themselves rather than following The protocol and sorting out an appointment for the patient. Ankur recognised the frustration of the practices that these enquiries fell to and asked for patients effected to contact him.

8. CET for Primary Care Optometry

An e-mail had been received from Dr John Everett regarding CET courses (Appendix 1). Ankur felt that helped improve referrals would be good, and thought mentoring would be helpful alongside CET. Nigel & Clare agreed but Clare felt Kerry needed to be consulted regarding any CET.

Adrian asked about CET for DOs and CLOs as the LOC represented the whole Optical community, not just Optometrists.

Alvaro felt some locally co-ordinated CAT would be beneficial and asked Eshmael if anyone from Eye Casualty would be able to help? Eshmael would enquire [v] Clare suggested a Peer Discussion session and Ankur agreed the 'networking' with hospital staff would be beneficial.

Tony asked if there needed to be clarity on any potential payments as opposed to funding any other CET providers, Ankur felt that CET commissioned for identified need might be appropriate.

Alvaro would feed these points back to John [vi]

9. New Members

Alvaro hoped Fawn and Sid had enjoyed the meeting and invited them to the next one in December. Sid said that he looked after Social Media as part of his day job and offered to help the LOC, the offer was gratefully accepted.

10. Community Ophthalmic Link

Alvaro reported that the responses to the survey had been very positive (Appendix 2), practitioners generally seemed very keen.

Tony reported that the results had been forwarded to Kerry O'Hara from the CCG with a business plan and he was awaiting a response. Tony also shared that a dummy run had been tried from his practice to check accessibility. The link seemed to work, there were a few issues that would need to be ironed out and the final format still needed to be decided. He noted that appropriate funding would be critical for the project to move forward.

11. Low Vision Pathway

This had been covered earlier under 'Matters Arising and Action Points' but Eshmael added he felt there could be an option to discharge low vision patients to the community.

12. NOC Attendance

Alvaro asked who wanted to attend which virtual session at the NOC? Nigel would organise a spreadsheet to assess interest [vii] and it was agreed the committee members would be able to claim £45.00 expenses for each session attended. Ankur thought the sessions would be recorded and could be reviewed later if required.

13. Any Other Business

Alvaro asked the Trust representatives if there were any reports of difficulties with accessing Medisoft? Tony reported that the Medisoft Portal seemed to be the issue and Nigel noted that an e-mail update regarding the data entry had been received. Ankur also noted that Opera should provide a solution to the double entry problem.

Alvaro raised an e-mail that had been received from Steve Guilford (Appendix 3). It was suggested that any discharge letters should not specify how often patients should be seen in practice but use 'regularly' or similar instead. Eshmael noted that a comprehensive discharge letter was produced but Tony stated it was very difficult to ensure any letter got sent to the correct practitioner. Alvaro

pointed out that feedback from other secondary providers was generally satisfactory. It was noted that the proposed Community Ophthalmic Link would also be a big help in resolving the issue.

Tony asked if IOP could be included in the YAG referral as it would be helpful for the hospital practitioners. Alvaro would include and asked if unaided vision was required? Tony agreed this was not necessary but added that an e-mail address would be helpful.

14. Date of Next Meeting

Monday 14th December 7:00pm

Action Points

i	Minutes for website	Adrian/Clare/Alvaro
ii	Editable pdf version of YAG referral form	Alvaro/Ankur
iii	Low Vision Pathway	Alvaro/Sid
iv	ECF referral survey	Alvaro
v	Possible CET from Eye Casualty staff	Eshmael
vi	Feed back to John re CET	Alvaro
vii	Interest in NOC sessions	Nigel

APPENDIX 1

From: **EverettDJ**
Date: Sat, 7 Nov 2020, 15:39
Subject: CET courses for primary care optometry
To: Alvaro Borges

Hi Alvaro,

I am going to be working with Prof Scanlon and the rest of the team at Gloucestershire Retinal Education Group (GREG) based at Cheltenham General hospital, 1 day a week from next Friday.

My remit is to develop some CET courses for primary care Optometry.

I am looking into subjects to develop as courses, including AMD, glaucoma, common and uncommon OCT appearances and emergency care.

The emphasis will be on what we should do with each condition in primary care, refer or monitor, refer to whom, urgency of referral, which tests to do before referral and what to tell the GP if they need to do any blood tests (within our level of competency). Do you think any of these or any other course subjects would be something that the LOC would be interested in funding for all local Optoms?

I am hoping to obtain the audit information from Tony about Optom referrals to see if there are specific areas of weakness that we can improve.

I Look forward to hearing from you.

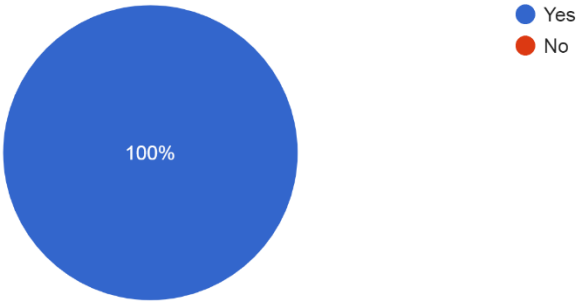
Kind regards,

Dr John Everett MSc, DOptom, MCOptom, Prof Cert Glaucoma, Prof Cert Med Ret, PG Cert therapeutics, Dip Clin Optom, Dip OCT Interpretation

Results of Survey on Community Ophthalmic Link

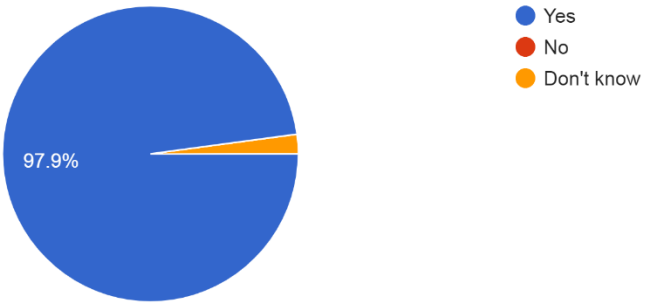
As a practitioner would you like to have access to patients HES records, all previous imaging and data, including DES screening data and GP letters?

47 responses



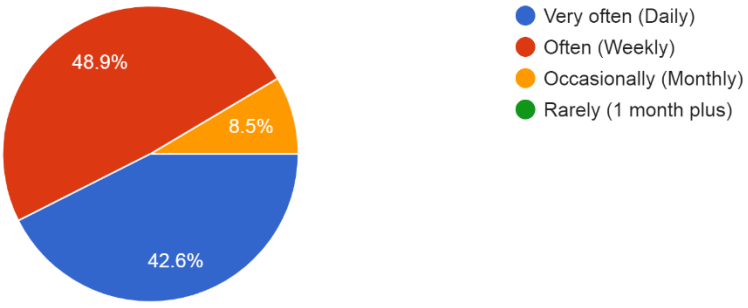
Would this in your opinion reduce the number of or refine your referrals into secondary care?

47 responses



How often would you see yourself using the Community Ophthalmic Link?

47 responses



From: Steve Guilford
Subject: Hospital discharges
Date: 12 November 2020 at 13:54:14 GMT
To: Alvaro Borges , Ankur Trivedi

Alvaro and Ankur

You will have seen my exchange with Tony re hospital discharges. This is a repeat of something that happened about 10 years ago. The LOC was strong then and we informed everyone about the position. We must do the same now.

We must set our stall out as a profession.

If a patient has nothing wrong with them then they should indeed be discharged. We should see the patient (presumably for Sight Tests) at intervals that are appropriate for Sight Testing and based upon our (rather than the hospital's) clinical judgement.

If a patient is being discharged but is considered to be at risk (eg from developing glaucoma) such that the hospital recommends more frequent assessments then those assessments should either be conducted in the hospital (but that is often rather wasteful of NHS resources) or be conducted by us within a dedicated community service which must be entirely outside of GOS (eg like post-op cataract assessments). But we do not have a NHS funded contract to provide a monitoring service, so for the time being we must provide that service as a privately funded service. As a profession we must take a stance on this, together, and we should negotiate for a suitably funded NHS service (and if it is not suitably funded we should walk away from the negotiations).

In cases of hospital discharge, when there is the expectation that the community optom will monitor the patient thereafter, the hospital should write (or email) to the patient's optom with the relevant details, and explain at what point a referral back to the hospital would be appropriate (ie whether it should follow the usual national/local guidelines, or whether a specific criteria needs to apply to this patient). Tony says that they can't phone the patient in order to obtain the community optom's details in order to do this, but that's a cop out: what should be happening is that each time a patient attends the eye clinic for any appointment at all the clinician should note the name of the patient's community optom in the records; then that information will always be up to date. It will take 10 seconds to do that each time....surely they can't complain about 10 seconds !

Please will you take this up with the HES and CCG.

Steve