Lincolnshire LOC Meeting –   
25th November 2024

# Agenda

1. Apologies
2. Declarations of conflict of interest
3. LEHN and associate medical director introduction (Farra and Deepal)
4. Eye Casualty Referrals – Kelly and Martin
5. Emergency referrals and Urgent referral issues – Sab
6. Referral Guidance Document – Deepal – (Adrian/Sab have phone numbers been updated)
7. CVD pilot – Deepal
8. Eyecare delivery group – Sab/Adrian
9. Primary Care recognition event – Deepal
10. Dry Eye Prescribing guidelines - Martin/Annabelle
11. PES conference – Deepal
12. Regional Conference – Deepal
13. Bassett Law OCT triage scheme - Chaz
14. Treasurer Update
15. AOB
16. Date of next meeting

# Attendees

Annabelle Magee  
Laura Tope  
Lynsey Doherty  
Deepal Burgess  
Adrian Cobb  
Amit Patel  
Andy Byrne  
Sam Oliver   
Sarah Grant  
Martin Jago  
Farra Hargreaves  
Angela Henderson  
Sab Bahl  
Martin Smith  
Tushar Majithia

# Apologies

Neil Stradling

# Declarations of conflict of interest

None

# LEHN and associate medical director introduction (Farra and Deepal)

FH: Rejig of regional teams as frequently happens in NHS. We had NHS England – then last year NHS England had POD taken off and parts of med side and put into east midlands primary care team – we house the parts of commissioning contracts rel to GOS. Pharmacy and dentistry has previously had more involvement with primary care teams. Have always had LEHN chairs – Wojchiech retired earlier this year – he had 3 areas – Deepal is now LEHN chair in Lincolnshire. Farra covers Derbyshire and Northamptonshire. The east midlands area is over the five counties.

If practice wants to check coding we have member of team who looks at this who is clinical advisor for region – Sab is your clinical advisor for your area.

For East midlands looking for strategy for optometry which is in progress. Will look like the one from 2018 but better strategy for the area and the east midlands as a whole. As optometrists have evolved hugely especially since covid – we can give more to NHS and our patient and can make care more accessible.

Operational side of things Deepal will go through – the funding needs to be applied for relative to areas - £25k – enough to get the data to make an informed decision on commissioning services.

Did Doctorate in AI related to independent prescribing optometrists, also reviews CMGS – lectured and taught FB removal . Currently reading a book on therapeutics written by two Canadian optoms. Previously have written specifications and looked at contract procurement so if anything is needed feel free to get in touch.

AM: Please give contact details to Lynsey and Laura for circulation.

DB: We need to talk about what we want to try for funding for– due 13th December – we spoke about paediatric ideas.

AM: Anybody else wanting more info? – Angela, Martin, Andy declined.

Any other ideas from people?

MJ: is it the same funding discussed previously Sab?

SB: not sure

DB: LEHN funding is specifically for a pilot – something that will help to get data for commissioning – thoughts to do a paediatric one based on specification Martin has. Other idea was to do a F/F one – like a MECS but not full so we can show it is useful to have that in community – thoughts?

AB: as there is 4 or 5 areas – should not duplicate so we can get evidence from all areas so should co-ordinate – Leicester has MECS

DB: NHants and Leicester are doing MECS style – concern is that if we do full MECS then likely to be bleph / dry eye type patients – so if we do specific conditions it shows that that is useful in community – red eye could show how useful IPs are in the community.

AM: Dry eye is already part of COTATS which red eye isn’t.

DB: Because we have the FP10s which they don’t have in NHants we could show how useful it is here.

MS: My concern with bringing acute things in on a MECS style template is that they can be quite time consuming to manage – acute F/F needs to have same day / next day apt available. Red eye can be dry eye to uveitis of which some things may need to be seen by HES – can be complex to manage even by an IP in community – ultimately need to be paid appropriately. A F/F you have to take time dilating apt etc – a lot of FTP cases highlight the risk of practitioner managing them conditions.

DB: We need to consider what IPs are happy to do and what fee is appropriate.

MS: the spread will vary on qualification time – the ability to communicate and get advice form community of optoms is useful. Needs to be lines of communication with HES also – generally happy to give advice but not necessarily on an acute timescale.

DB: had this conversation with someone at a conference- optoms are usually on their own – at HES would likely have another door to knock on.

MS: with imaging can do it remotely – there will always be borderline case such as keratitis etc. What you will manage will vary but if have advice and backup – if HES is offering that then that’s good for the optom in managing the risk.

DB: deadline in 13th December – no spending time limit on the money so gives us time to consider.

AM: if we do a red eye IP pilot then there is only 6 IPs in Lincolnshire currently, whereas if we do paeds then everyone can get involved (MJ: we only have 4 IPs qualified – hopefully another 2 by April)

SB: doing it virtually with a good image – think that puts people at risk at the minute – not for F/F – ok for uveitis / keratitis maybe. Could do F/F but need a fee which is reflective – we can’t have emergency apt in practice if most of the time it won’t be filled

DB: there was an example in Gloucester / Cheltenham with a scheme – they have triage of risk – e.g. contralateral detachment or high minus would be sent to HES to save them being seen twice – the others were seen in practice which made sense

SB: Difference between MECS and CUES currently – please clarify Andy / Angela?

AH: have probably all seen new CUES spec – MECS is historic – lot of local variation as to the range of conditions seen / PEARS or MECS – there is a move to being seen within 24 hours – do need to have local arrangements in place for those patients who are seen as red flags – there is scope to put own stamp – nationally pushing for CUES more than MECS – MECS tend to be broader- MECS / PEARS in Sheffield has a lot of flexibility to conditions which can be seen. If seen px in practice with dry eye – seen under COTATS as less urgent – stand alone CUES service, less control over.

AC: is this a scheme to only get the data rather than roll it out – seem that CUES / MECS would be treading old ground – wouldn’t getting data around paeds be more useful – we obviously aren’t getting MECS / CUES in the area so why shouldn’t we get data on paeds

DB: to get local intelligence – I’m also on paeds – a lot of paeds apts are DNA – better if patient and parent do not have to travel far then it is ultimately pointing towards what NHS want

AM: locally we know there is a massive wait for paeds at HES. We have generally very good clinicians in the area. We can argue paeds are at risk in the area because of delays. If we are going to trial anything it would be better if more practitioners can offer – more paeds seen so better for everyone.

AB: we can go around the things we would like to do – need to understand the challenges locally for the commissioners of primary care – Martin?

MJ: ULHT – biggest DNA rate is paeds – we don’t have community services for paeds – disparity across whole paed pathway.

Looking at paed referrals being 52 weeks – urgent referrals are seen quicker but routines are 52 weeks which is not right for babies and children.

AH: do you have reception vision screening

MJ: no

AH: even though diverting secondary care into primary care – a lot of the px sitting on the waiting list could be managed refractively. Paediatrics would be a massive win. If have paeds service you may be able to demonstrate benefit of having reception vision screening – this has been able to be demonstrated in Bassett Law – px have become amblyopic sat on waiting lists.

SB: agree if we can do something with paeds – we are not short of orthoptists but they are busy doing glaucoma clinics – we have capacity of the orthoptists but they are elsewhere diverted – only a pilot as £25k won’t go a long way but if we can get data out of it then would be good – other thing discussed was to get more with prof cert glau. Just to go back to earlier this money has come to LOCs via Vinesh – comes from east midlands fund – is that the same pot as the LEHN stuff?

DB: The pot I’m talking of is from Vinesh – nominally on recurrent funding.

AB: tackling the most vulnerable in society would give a really good case going forward

MS: my thoughts are that a lot of the other conditions we are talking about could potentially be dealt with as a modification of the current COTATS scheme – it excludes acute thins at the moment but with small changes would be able to include acute – under 16s are excluded so this is a completely different thing so quite a good thing to investigate the viability of.

MJ: concur – we do COTATS excluding under 16s – we have issues across the county around under 16s – if we acquire the evidence would give the case more credence

AM: sounds like paeds – to go ahead

DB: application needs to come from LOC so will liaise

# Eye Casualty Referrals – Kelly and Martin

MJ: Sent out presentation in advance

Issue is getting through to HES and getting a timely response – only have one phone for GPs / optoms and they phone patients on the same phone. What the proposal is to use Cinapsis as the eye casualty portal for optical practice. Have prepped a list for true ophthalmology emergencies but need expertise to review – has been passed by various channels already

SB: Raised IOP needs to be specified

MJ: has been put on radar

DB: there is more detail around these.

MJ: also suspected emergence to be seen in 48 hours and other to be seen in 7 days – waiting for other recommendations. The difference is that between hours of 9 and 4.30 will just complete electronic referral form and not have to phone eye casualty and they will phone the patient – only ask is that the MDS is completed – most is drop down / tick box menu. If true emergency then still will phone the oncall – the second category other than weekends don’t need to be phoned through as will be picked up the following morning.

AC: can you clarify what we do between 4:30 and 5.

MJ: time given for eye casualty to clear any backlog – still ring.

AM: but some of these conditions aren’t seen in 7 days such as painful entropion will this be passed through ULHT – if its agreed then it needs to be stuck to

MJ: already passed by ULHT

AC: urgent needs clarification

SB: our terminology of urgent vs theirs is very different – suspect cancer is 2WW – if goes into HES as urgent on Cinapsis goes on RTS – if surgeon on holiday then doesn’t get looked at until back – therefore not picked up by anyone else which they have realised is an issue – rather than going to RTS then will go to secretaries so won’t get left anywhere not being looked at. A painful entropion causing an ulcer – may not be seen in 7 days but won’t be being left for 6 weeks – once we start using it once happy and using it then things will move about a bit.

MJ: ringing is still an option if having queries around the form – GP / UTC is still the highest referrer to eye casualty. If optoms are making quality referral then HES are going to trust you – Dr Kumar is leading on this – if optom referring condition in we will trust them and see them as said. Cinapsis has option for feedback too. When HES complete referral they can type in the comments box which you can see. Any concerns around the content then please let us know

AM: are we sending comms or are you sending comms.

MJ: will do all the comms before Christmas and have one month’s grace of receiving referrals via old way and via Cinapsis. Will be one work list for Boston and Lincoln – in terms of oncall don’t need to worry about who is oncall as will get same list. Have been tested in Lincoln and Boston – currently well received. All trackable and therefore no such thing as lost call. Pathways are included here.

AM: sounds really good

MJ: any questions or queries please let us know.

AC: in terms of flow charts and referrals matrix we have – is there any way they can be put on the front page of Cinapsis – can only see them if have put patient details in

DB: no other way to do it but always have to put the patient in

SO: have we got guarantee what HES aren’t going to triage and downgrade referrals?

MJ: once HES has accepted they have taken on the clinical responsibility of the patient so the risk is transferred –if they accept it as a certain urgency and if they downgrade it then it will be in the comments – they can upgrade as well and ask for more info.

SO: do we need to keep checking and chase if has not been dealt with that day

MJ: plan is same day referrals will be dealt with that day – will be different for 24 hours + as will be dealt with differently

DB: if has not been accepted can chase it by phone but shouldn’t have to

AM: concerns should be raised at eye care delivery meeting

MS: one problem with Cinapsis which is not for routine – but for acute – a lot of patients don’t go by their proper first name – if have acute referral and patient has already left than that may be a problem

AB: it’s okay secondary care accepting referral but understand where Sam is coming from as px comes back to optom asking what is happening to referral

AC: is the understanding for the 7 day one – are we telling the px that someone from the hospital will contact you?

MJ: yes – advise patient will be contacted

# Emergency referrals and Urgent referral issues – Sab

SB: already covered

# Referral Guidance Document – Deepal – (Adrian/Sab have phone numbers been updated)

DB: question regarding if phone numbers changed / checked

SB: can we have correct numbers on the emergency referral info then if they change then can be updated

DB: can be but speed of updating isn’t what it what

AM: can numbers be on comms please Martin

AP: if want to send info to medical secretaries what do we now use

DB: three things on radar are lost follow ups and other topics but there is not a direct option at the moment

# CVD pilot – Sab

SB: there is an issue with indemnity insurance with some people

AP: all a bit last minute – we are covered but no concern but now need BP specifically on indemnity – we have global policy so this is not going to happen – we can’t amend out privacy policy neither specifically for this.

AM: I raised this with Sara Starbuck – this should not be a barrier but was not brought to her attention – she said that general indemnity should apply – whatever you’ve got should be written into agreement – she is trying to make it as easy for optoms as possible, Deepal and I spoke to her last week so any other queries get in touch. One of the things we raised – they are putting the onus onto optoms – for the fee doesn’t seem worth time so that has been raised.

AP: the training video is an hour and we have lots of staff to get through so it is a lot to take on

DB: lots of practices were put off by the process

# Eyecare delivery group – Sab/Adrian

SB: covered the urgent vs non urgent, requested some slides.

Discussed was medical secretaries have no backlog – if anything is sent to them then will be seen. RTS has been stopped as was not safe as lots were being delayed. All urgents from Cinapsis are sent to the secretaries – they have just changed what they are doing internally.

UTC are the biggest referrers.

Cataract process – px being seen at ULHT for cataract then going back to optom for post op check and being referred elsewhere for second eye – being sent to ISP for the second eye – don’t think it is optoms but more the system sending them somewhere else

AP: the form is the issue – the audit forms aren’t even coming back now – if they want to pay us and make it digital then they can otherwise it is sent as a referral

DB: when booking team doing the cataracts they are not always aware of where the first eye was done – px should know

AP: px referred for spa medica or newmedica – px was refused or there was a glitch – then they are coming back to us – should be contact EACH and get them to change

DB: there is the patient referral number for EACH – that’s what they should be contacting.

# Primary Care recognition event – Deepal

DB: want to recognise everyone in primary care – pharmacy / dentistry and optometry – going to be awards in march – best team / best practitioner including innovative change – nominations come from patients and other practitioners / teams

Want someone to present at the event with 350 people to highlight the successes of optometry. There is also a long service award – how long on GOC register assuming still giving GOS services.

I am named for talking but if anyone would like to do it please volunteer.

# Dry Eye Prescribing guidelines - Martin/Annabelle

MS: Hypromellose used as first line then if doesn’t worked treated with something g else then if not worked use sodium hyaluronate – GP cannot diagnose this condition so they shouldn’t be treating it – aim was to reduce the amount GPs spend on prescribing eye drops. My advice was they shouldn’t be prescribing and should be diagnosed properly, whether they have underlying condition MGD / aqueous deficiency etc.

ULHT have already signed of guidance- contradicts talks given on dry eye – it is just current but updated and just got passed through.

My opinion is GPs should not be treating dry eye they should be referring into COTATS – Annabelle has sent them info on what COTATS is – guidance is delayed following discussion of some errors, other point is – similar to guidance for neighbouring counties so doesn’t mean we have to follow – MGD is 85% of dry eye – hoping to get them to put in a recommendation that best way to get GPs to save money is for GPs to refer to us instead.

AM: I have brought this up at optom quarterly – difficult to speak to people with the right hat on – has been raised with Sara Starbuck again – please can this be followed up at eye care delivery group.

AB: don’t think any pathway should be signed without correspondence between secondary and primary care.

SB: I think this has come about by an update in prescribing formulary

SB: pharmacist formulary has not been updated for a long time as far as I know

DB: going to struggle to get anyone to agree to a COTATS fee over an eye drops fee – only was to raise it is in the PCC meeting Sab attends

MS: it’s not an eye drop fee – it works out more than a COTATS fee every single year when it could be resolved with hot compresses and lid wipes

# PES conference – Deepal

DB: 720,000 cases, work in 29 ICBs – want to prove where the money goes 81.4% of turnover goes back through the practices – not for profit and money gets used – got better at paying people within 60 days and takes compliance work seriously – lots of membership with difference committees to get contact with right people – work on better reports – medical retina module coming through.

# Regional Conference – Deepal

DB: Discussion about possible reduction in levy fee – may mean change in service that LOCSU provides or may be getting more value for money.

LOCSU do training, PAYE service, communications, general advice and supports, templates for specifications and pathway – working on AI for meeting minutes

AB: huge turnover in knowledge in NHS England – especially in last 18 months – on subject of lowering the levy – one of sector bodies says their members are asking for lower levy – they didn’t want to see services being withdrawn in levy is going down – want to demonstrate more value for money.

Some felt sector bodies represented practitioners but LOCSU represented LOCs more so wanted reduced levy.

AM: in chat can we get some guidance for indemnity insurance guidance rel to pilots

AB: Have spoken to Zoe and sector bodies will provide separate guidance.

# Bassett Law OCT triage scheme – Chaz

AH: I’m clinical lead in Bassett Law so any questions so please come back to me

AM: bassett law rolled out an NHS funded OCT scheme – have got it commissioned – allows optom to do an NHS funded OCT – 70% of wet ARMD referrals were not wet ARMD / referral refinement for CMO etc – so px wants going for right clinic first time round. Took it to MJ and Kelly as Lincoln are very behind so directing correctly would help .

# Treasurer Update

AC: we have £46.8k, £30k to LOCSU levy. Waiting on invoice for the yellow bins. Levy is 4k per month – half to LOCSU – is this value for money.

Can people submit expenses monthly or latest the month before the next meeting please?

IP fund – Sam and Laura paid uni fees – Jason not submitted – Ryan for one module so far – need to know how much will spend on uni fees to know how much each will get for placement

AM: capped but should cover uni and placement and if not candidate to top up

DB: placement is £2k with ULHT

AC: EeRS has £8821 and there is still some work to be done with Deepal.

# AOB

AC: can all claims be put in by 31st January so can look at how we are working for next meeting please.

# Date of next meeting

February 24th proposed – if we want to debate thoughts on LOCSU then we need separate meeting for that or this gets too long.

Close: 20:57