County Durham Low Vision Services Committee

(5th) Meeting Thursday 2nd July 2009 at 9.30 a.m.

Minutes

Venue: Committee Room 1A, County Hall, Durham

Present: Andy Nuttall (Chair), Sharon Meadows, Tom Hoyle, Janet Hoyle, Jim Welch, Margaret Welch, Ann Dormer-Adcock, Linda Curtis, Derek Illingworth, Emma Keeble, Rachel Emery, Chris Steele, Phil Smith, Leigh Nicholson, Pauline Morphet, Heather Hebden, Reti Winward, Mark Forster (minutes)

Apologies

Chris Wood, Claire Rose-Innes, Adam Greatwood, Barbara Pratt, Simon Berry

Andy welcomed everyone to the meeting, and told the group that it has now been one year since the group was established.

Minutes of the last meeting – agreed as a true record.

Matters Arising

LVSC Expansion – Warren Tweed invited from Darlington Borough Council. No representative from Darlington Borough Council has attended today.

Review of LVSC Terms of Reference

Reti handed out the Aims and Objectives that the group created a year ago to review. It was felt that it was important to review the service to see how things are going.

Options were to keep, change or discard the aims and objectives, and requested feedback on whether the aims and objectives had been achieved, not achieved, or whether they were ongoing.

Groups broke into twos for a short discussion before feedback. A summary of the changes follows:

Aim:

To act together to improve low vision services for the people of County Durham. The majority felt that this was ongoing and to keep the aim.

Objectives:

To implement the recommendations and standards outlined in the 2020 UK Vision Strategy (2008) and the Low Vision Services Report (1999). The majority felt that this was ongoing and should keep this objective. The suggestion was to change to: **To use the UK Vision Strategy Implementation Plan for England 2009-2014 as a template to develop local services for low vision**

Identify and log local providers of low vision services and gaps in local provision. The majority felt that this was ongoing and should be kept.

Determine ways that services can be developed by agreeing priorities locally and action needed to meet the recommendations and standards cited above. The majority felt that this was not achieved and needed to be changed. The suggestion was to change to: **developing services in line with local need.**

Advise commissioners on priorities and budgetary implications, contributing as appropriate to local joint planning of services including the Durham County Council Health Improvement Plan 2007-2012. The majority felt that this was ongoing, but needed to be changed. The suggestion was to amend several words to: **advise commissioners on priorities, contributing as appropriate to local joint planning of services.**

Develop a user involvement strategy. The majority felt that this was not achieved and should be discarded.

Ensure local services respond to and reflect national priorities and any emerging research findings eg 2020 UK Vision Strategy. The majority felt that this should be discarded.

Ensure services are monitored and evaluated appropriately and that developments are made in light of any findings. The majority felt that this was ongoing but needed to be changed.

Ensure that information on services is easily accessible to all and consistently shared with other agencies. The majority felt that this was ongoing, not achieved, but should be kept.

Consider provision for specific groups, eg. Children and young people, people of working age and people with learning disabilities. The majority felt that this had not been achieved, but should be kept.

Link with other relevant groups. The majority felt that this should be discarded.

Develop inter-disciplinary working methods and practices. The majority felt that this should be discarded.

Raise awareness and understanding of visual impairment in County Durham. The majority felt that this had been partly achieved, was ongoing, and should be kept.

Membership

Organisations of people with low vision. The majority felt that this had been achieved, but needed to be changed to make it clearer. It was suggested to be changed to: **Voluntary and community organisations of people with low vision.**

Primary Care Trusts. The majority felt that this should be changed to: **Commissioners**.

The group said at this point that new categories should be added: **General Practitioners** and **Community Optometrists**.

Hospital Trusts. The majority felt that this should be changed to: Foundation Trusts.

Mental Health and Learning Disability Trusts. The majority felt that this should be separated into two groups.

Adult and Community Services. The majority felt that this should be changed to: **Durham County Council Adults, Wellbeing and Health**.

Appropriate professionals in health and social care working in low vision service provision (this may include Ophthalmologists, Optometrists, Nurses, Clinical and General Managers, Rehabilitation Officers, Social Workers and others). The majority felt that this should be discarded.

Children & Young People's Service. The majority felt that this should be kept.

Learning Skills Council. The majority felt that this should be discarded. Instead include **DCC Adult Learning Service and DCC Social Inclusion Service**

Department of Work and Pensions/Job Centre Plus. The majority felt that this should be kept. AN to contact DWP for attendee at future meeting.

Add Carers and Service Users

Ways of Working

Tasks identified by the LVSC will be carried out by the representative identified as the lead in that area, working with appropriate others, both within their own organisation and with other members of the LVSC. The majority felt that this had been achieved and should be kept.

The committee will develop a sub-group structure as appropriate to carry out its functions. The majority felt that this had been achieved.

Project and work groups will be established to take the lead on particular workstreams or tasks. The majority felt that this should be discarded.

As well as membership on the committee, people with low vision will be consulted at all stages of planning, implementation, monitoring and review. The group felt that this should be discarded as no person had been delegated to achieve this.

The committee will apply the following "Principles to guide Service Planning and Delivery" to its own work. The majority felt that this should be kept.

The full committee will meet on a quarterly basis with any sub-group update or report feeding into the main meeting. The majority felt that this should be kept.

The committee will review its membership and terms of reference annually. The majority felt that this should be kept.

An annual report will be produced and circulated widely. The majority felt that this should be changed to: **LVSC meetings will be minuted and circulated widely.**

Further to this item it was requested that a slot on the agenda be set aside for discussions and updates from the individual groups on the committee. AN to add to next agenda.

Due to time restraints the rest of the review is to be carried over to the next meeting in September.

Commissioner's Update

Rachel Emery informed the group that the ECLO bid had been unsuccessful earlier in the year. This was obviously a disappointment but it didn't spell the end of our work to develop services and seek funding.

Work was now starting in Derwentside and Sedgefield to provide more services for Glaucoma in the community, away from hospitals. In the first phase of the project community optometry will provide referral refinement, which will act as an assessment service closer to home. The equipment used will be aligned to that used within hospitals so that standards of care are not compromised.

The ultimate aim is to reduce waiting times by reducing the number of inappropriate referrals into hospitals, and see more people locally to save on travel time/costs and to better manage performance. By freeing up some of the space in secondary care, hospitals are able to see more complex cases.

RE agreed to bring performance data to a future group meeting. RE explained that it was also more cost effective with a potential saving of around £100 per person to the PCT for initial assessments.

The group was informed by CS that on April 22nd The National Insitute for Health and Clinical Excellence (NICE) published the new guideline on the diagnosis and management of chronic open angle glaucoma and ocular hypertension. Unusually for a NICE guideline this also included recommendations on organisation of care and service provision in primary and secondary care. In summary this document states that a definitive diagnosis of glaucoma must be made by a consultant ophthalmologist. Patients who have ocular hypertension

(raised eye pressure >21mmHg only) or people suspected of having glaucoma i.e. glaucoma suspects can be diagnosed and managed by health care professionals who have a suitable qualification in glaucoma management and relevant experience. This means optometrists for example can now diagnose and manage ocular hypertension and glaucoma suspects in the community without having to refer to a consultant ophthalmologist if they have a suitable qualification and are competent to undertake a number of additional clinical tests (e.g. gonioscopy which assess the drainage channels at the front part of the eye).

Even patients with glaucoma who have been formally diagnosed with glaucoma by a consultant ophthalmologist can be referred back to e.g. optometrists to be monitored in the community by suitably qualified healthcare professionals.

For the lowest risk group of patients who are confirmed as having ocular hypertension these people can be monitored in the community by an optometrist without any further postgraduate training or qualifications. NICE have acknowledged that it will take time (3-5 years) to get the new guideline fully implemented because of the resource implications and training/ accreditation required by health care professionals, such as community optometrists, wishing to be involved in these new roles.

Amongst other tests, to make a diagnosis of ocular hypertension this requires that the intraocular (eye) pressure is measured on two separate occasions using the reference standard (accurate) goldmann applanation tonometry (used mainly in hospitals) as opposed to non contact (air puff) tonometry techniques predominantly used by community optometrists (which are less accurate).

The community optometrists' legal defence body the Association of Optometrists (AOP) have instructed all community optometrists not do any repeat eye pressure measurements or other further clinical tests unless they are paid properly to do this. In Scotland Optometrists already do get paid enhanced fees for undertaking extra clinical tests over and above what is included in a standard (basic) NHS sight test.

So until a way forward can be agreed and all the resources and training is in place optometrists are referring EVERY patient with an eye pressure of more than 21mmHg (even based on one reading) to secondary care for the eye pressure check to be made. This has massively increased (by 20%-30%) the number of referrals to eye units across the country and PCTs are being charged a new patient tariff for every referral seen in secondary care.

Most people agree that the guideline is a very good thing and will raise the clinical standards of care for people with chronic open angle glaucoma (COAG) and ocular hypertension (OHT). Rather than restricting optometrists' involvement in glaucoma care this guideline massively increases their future role in all but making the "definitive" diagnosis for glaucoma, once the funding and resource issues can be resolved.

The Local Optical Committees Central Support Unit (LOCCSU) have published an excellent document to help PCTs set up new care pathways for glaucoma and OHT which are very closely aligned with the NICE guidelines recommended acre pathways.
The group was informed by CS that referrals into secondary services from the community was increasing significantly for Glaucoma (Ocular Hypertension) at the

present time because of the absence of funding for optometrists to undertake thorough screening and assessment within a hospital setting. A better service could be offered closer to the point of contact in community settings the proposed service development would resolve this issue.
CS explained that in Scotland, optometrists are paid extra to perform the additional tests, but those in England were not.

Training and equipment would be provided to optometrists who were interested in participating in the scheme. CS felt that it would be more of the independent optometrists than chains such as Specsavers who would provide the additional pressure tests.

PCTs will ensure that the participating optometrists have necessary competencies. RE assured the group that clinical governance arrangements would be sound and that the PCT would publicise lists of approved optometrists when identified.

The scheme is to be rolled out county-wide by April 2010.

Equality of Access to Eye Care Services – Learning Disability

AN asked the group whether they would approve representation on the committee from Learning Disability Services.

He informed the group that he was aware of positive action being undertaken by the charity SeeAbility in their work with learning disabled people and their access to eye

tests and services. The committee agreed to a discussion at the next meeting in September.

The PCT are sending out a letter to all community optometrists informing them of the information available.

Strategic Funding Programme 2009/10 bid (Equality and Human Rights Commission)

Jim and Margaret Welch spoke about the partnership bid which has recently been made for funding for information, guidance and advice services. Blind Life in Durham have fronted the bid with support from partners on the LVS Committee.
The money has been made available by the Equality & Human Rights Commission and the outline bid submitted is requesting approx £50,000 over three years to fund an ECLO role across Couny to include some rural outreach work as well.

We will know if the outline bid is successful by mid July.

Any other business

Reti W. raised the issue of LVSC accountability and suggested that this should be to people in County Durham with low vision and to LVSC members AN has met with the Older Peoples Partnership Board to create a link with them. Group approved of this.

Possibility of a representative from the committee to attend the Learning Disability Partnership Board meetings.

Discussion followed around the dates of the next meeting. It was decided that an earlier meeting should be held to

discuss the items that were deferred from this meeting due to lack of time. A meeting should be set up for the subgroup, and the group asked for an audio copy of the Implementation Plan which AN agreed to acquire.

Invite for the 2020 vision website with a picture of the LVSC group to be added to the next agenda.

Next Meeting: Thursday 10th September 2009 @ 9:30am, Committee Room 1A, County Hall