Adult Community Optical Low Vision Community Service Pathway

Issued by
Local Optical Committee Support Unit
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Foreword

The Local Optical Committee Support Unit (LOCSU) has already successfully instigated a range of community local eye services pathways, for areas of eye health such as glaucoma or cataracts. Delivered by local community based optometrists and dispensing opticians across England, LOCSU’s pathways are backed by accredited training with the Wales Optometry Postgraduate Education Centre (WOPEC) for participating eye health professionals. This ensures successful proven outcomes in terms of increasing access by the local community to an improved local eye health service which costs less.

LOCSU’s experienced Clinical Advisory Group has developed this pathway by researching established successful Low Vision Services provided by community optometrists and dispensing opticians in a number of areas across the UK, with the expertise of a multi-disciplinary team, and with advice and support from other leading eye health representative bodies and visual impairment charities through VISION 2020 UK.
Executive Summary

The UK Vision Strategy\(^1\) seeks a major transformation in the UK’s eye health, eye care and sight loss services. A determined and united cross-sector approach will make that change a reality. Three strategic outcome areas are identified:

1. Improving the eye health of the people of the UK
2. Eliminating avoidable sight loss and delivering excellent support for people with sight loss
3. Inclusion, participation and independence for people with sight loss

This pathway specifically addresses all three strategic outcome areas and particularly areas 2 and 3.

As part of actions to implement the aims of the UK Vision Strategy, a cross-sector group, led by Action for Blind People, is developing a unifying quality and outcomes framework based on what blind and partially sighted people have identified as most important to them. The achievement of this will provide the foundation for ensuring that all blind and partially sighted people have access to the same range of services, delivered to the same standard, regardless of where they live in the UK. LOCSU fully supports this approach to integrated, individualised care, and the Community Optical Adult Low Vision Service pathway has been designed to deliver the community optical elements of such a framework.

Ideally, the Community Optical Adult Low Vision Service pathway should be commissioned as part of a spectrum of care alongside hospital, social care and third sector elements of care to form a seamless network of advice, help and support for all adults with low vision. However, the pathway has been designed to allow it to be commissioned independently of the rest of the framework as a priority area for clinical improvement where necessary.

Outcomes

This Community Optical Adult Low Vision Service pathway is designed to provide all adults with sight loss with:

- a high-quality low vision assessment, information and clinical support and,
- where appropriate, low vision aids (LVAs) and daily living aids in a community setting in a convenient location for them.

This is a habilitative and rehabilitative pathway offering a specified range of services with the stated outcome of enabling people with sight loss, especially the newly diagnosed, to make maximum and best use of their remaining eyesight and visual function.

The provision of information is crucial to this outcome, and comprehensive information on the full range of local support services available for people with sight loss is made available to all patients accessing the low vision service through this pathway.

The aim is to allow people with sight loss, often elderly patients, to access services easily and nearer to home, and to release capacity within hospital eye clinics to manage other conditions such as wet AMD and glaucoma.

This pathway is designed to offer a cost-effective service with patients managed within a primary care setting closer to home.

The pathway is specifically designed to make best use of the skills of accredited community low vision practitioners (optometrists and dispensing opticians), ideally working alongside rehabilitation officers and third sector partners to provide a fully integrated service.

**Background**

It is estimated that two million people in the UK are living with sight loss. This can range from difficulties reading a newspaper, driving and recognising a friend across the room, to severe visual impairment that makes it difficult to cook, look after personal hygiene or leave the house without assistance. Even with major action on eliminating avoidable visual impairments the number of people with sight loss is likely to increase significantly for the foreseeable future, primarily because of the ageing of the population\(^2\).

Within the overall two million estimates, studies suggest that visual impairment affects about 10% of people aged 65–75 and 20% of those aged over 75. There is a strong relationship between impaired vision in older people and both reduced quality of life and increased risk of accidents, particularly falls\(^3\).


The recent report on eye care by Professor Nick Bosanquet details the substantial financial and human costs associated with sight loss, and clearly outlines why redesign of eye care services is essential to responding to the pressures of rising visual impairment⁴.

Definition of Low Vision

A person is to be considered to have low vision if they have an impairment of their visual function that cannot be corrected through the use of spectacles, contact lenses, medical or surgical intervention, and which is adversely affecting their quality of life.

The perception of what constitutes a restriction to a person’s quality of life is highly subjective to each patient and it is therefore unwise to use strict acuity-based, clinical or social criteria to define an individual’s ability or right to access such a service.

It is reported that nearly 70% of patients who benefit from LVAs and attend low vision clinics are not eligible for certification as sight impaired or severely sight impaired⁵.

Availability of services

13% of sight impaired (partially sighted) and severely sight impaired (blind) people of working age and 17% of sight impaired and severely sight impaired people of retirement age have not had access to low vision services in the year following certification. For people certified in the previous year these figures increase to 44% and 55% respectively. Thus access to services declines the further away the patient comes from certification⁶.

Some people with low vision have reported not being aware of the services offered, many assumed no help was available or that no improvement was possible. Others have cited that the difficulty of travelling long distances was the main reason for not using low vision services.

Eligibility

The LOCSU pathway for a Community Optical Adult Low Vision Service is designed to provide an alternative or complementary service to existing low vision clinics currently centred in hospitals and successful models of integrated care, where they exist.


⁵ Registration for people with sight impairment: fit for purpose? - Br J Ophthalmol 2010;94:1692-1693

⁶ Future Sight Loss UK - RNIB 2009 [Link](http://www.rnib.org.uk/aboutus/Research/reports/prevention/Pages/fsluk1.aspx)
It is of particular relevance to those areas across England where there is currently little or no access to low vision services.

A community-based service should be able to reach all individuals affected by sight loss including:

- those (predominantly but not exclusively elderly) who are eligible to be certified as sight impaired or severely sight impaired; and
- those whose vision is not yet sufficiently poor for legal classification, but who, even with their normal spectacle correction, experience difficulties with the visual aspects of everyday life.

It has been established that carrying out a full refraction, even with an amblyopic eye, can improve the visual outcome in people with low vision\(^7\).

Much visual impairment arising through untreatable age related deterioration is nevertheless amenable to improvement through the use of simple magnifiers, appropriate advice about illumination and/or the provision of simple non-optical aids.

This advice and/or provision of visual aids should have the beneficial effect of enabling independent living in a safe and secure manner.

This pathway supports close liaison between optometrists, dispensing opticians, GPs, social services rehabilitation officers, third sector support providers and patients enabling partnership working to the benefit of the patient through the expertise of those trained in rehabilitation of people with failing vision.

**Access to information**

It is important that commissioners ensure that comprehensive details of all local support services, and how to access these services, are made available to people with sight loss through healthcare professionals and other support workers providing services for people with sight loss. This pathway has been designed to ensure that this information is made available to patients during the low vision assessment. The minimum information that should be made available to patients accessing the community low vision service is specified in Appendix 3.

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Commissioning other elements of the quality and outcomes framework

Where emotional support is available early on, the patient’s journey through the low vision experience goes more smoothly. Emotional support services should normally be commissioned locally from third sector providers and should work in conjunction with the low vision pathway.

Accessing the Service

Patients may be referred in by another optical practitioner, GP, Hospital Eye Service (HES), social services, third sector etc or may self-refer.

Patients will be able to choose from a list of accredited low vision practices for their low vision assessment, including domiciliary providers where appropriate.

Commissioners should distribute copies of the accredited list to GPs, optometrists, dispensing opticians, HES, social services and the third sector.

Patients must have had a sight test within the period recommended by their optometrist or ophthalmic medical practitioner (OMP) (i.e. they must not be overdue for a sight test). This would normally be within the past two years unless the optometrist/OMP has recommended a more frequent sight test, or the patient feels that their vision has changed.

A more recent sight test will be required if the patient’s sight loss is new, unless they have been referred from the HES.

The service is available to adults suffering from poor vision or sight loss whether or not they are certified as sight impaired or severely sight impaired.

Low Vision assessment

The Low Vision Practitioner will ensure that the patient and accompanying persons are aware of the full range of local support services available and how to access them. The minimum information to be provided is listed at Appendix 3.

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8 Evaluation of Emotional Support and Counselling within an Integrated Low Vision Service - Final Report - RNIB 2010
The Low Vision Assessment will be tailored to the needs of a particular low vision patient. This will include:

- a detailed discussion and recording of the patient’s needs and expectations
- analysis of the underlying cause of sight loss
- determination of the most appropriate low vision aid(s), magnifier(s) to serve that patient’s needs and expectations
- a demonstration of how to use any low vision aid(s) prescribed
- provision of information on the full range of local support services available, as above

Each Low Vision Assessment will be bespoke, depending on the patients’ needs and expectations. By providing information alongside the Low Vision Assessment, this pathway is designed to ensure a joined-up approach such that each patient can benefit from the full range of services available.

**Magnifiers and LVAs**

Community based optometrists and dispensing opticians offering this service will have available to them an extensive and varied range of hand-held, stand, illuminated and non-illuminated magnifiers which will assist the majority of the service users in near vision tasks. For distance vision, telescopic aids will help people with seeing the TV and other tasks. Additionally, practitioners will give advice on the use of special glare control and specialist spectacle mounted devices. A full list of recommended low vision aids is available in Appendix 1.

Occasionally a patient might require more specialist assistance. Appendix 4 describes scenarios where an LVA outside the range may be needed and how this should be provided.

**Follow up**

A follow-up appointment will take place two weeks after the low vision assessment to assess the patient’s adaptation to the aids provided.

At this visit, if necessary due to a change in the patient’s emotional state and better understanding of their visual potential, the low vision practitioner will again discuss and record whether the patient might benefit from any of the other services available locally for people with sight loss.
Training and accreditation

This pathway has been designed to be delivered by registered optometrists and dispensing opticians in community practice.

A training and accreditation package has been developed by LOCSU in conjunction with WOPEC (Wales Optometric Postgraduate Education Centre).

The theoretical part is available free of charge to practitioners whose LOCs/ROCs are LOCSU members. WOPEC can support local areas to provide the practical aspects of the training and accreditation.

LOCSU recommends that accreditation is not a requirement for the following practitioner groups:

- registered dispensing opticians who hold the Association of British Dispensing Opticians Honours Diploma in Low Vision – FBDO(Hons)LVA
- registered optometrists who hold the Association of British Dispensing Opticians Honours Diploma in Low Vision – ABDO(Hons)LVA
- registered optometrists who hold the College of Optometrists Low Vision Diploma – DipRVI
- registered dispensing opticians or registered optometrists who can provide appropriate evidence of their experience in Low Vision practice

The pathway will be restricted to practices that employ these trained and accredited low vision practitioners.

Guidance for Commissioners

Implementation guidance for commissioners is available at Appendix 4.
Low Vision Pathway

Referral into low vision scheme by optom, OMP, DO, HES, GP, social services, third sector or self

Pre-assessment questionnaire sent to patient

Low vision assessment including information about the full range of local support services available

Issue LVA(s) and train in use

Two week face to face follow-up (or phone) by LV practitioner (face to face preferred)

Regular sight test as per advice from own optometrist/OMP (with own optometrist/OMP)

Low vision re-assessment as required (e.g. after sight test or ROVI* re-referral)
*Rehabilitation Officer for Visual Impairment

Rehabilitation re-assessment as required

The dotted lines in the flowchart above indicate information provision and signposting.
Pathway

1. Participating low vision practitioners will either have been accredited by the LOCSU Low Vision Training Scheme, or have another acceptable qualification, and periodic re-accreditation may be required (for details refer to page 8).

2. Participating low vision practitioners will be provided, by the commissioner, with comprehensive information on the full range of local support services available for people with sight loss. This information should be updated on a regular basis.

3. When the patient is referred in, a pre-assessment questionnaire sent to the patient.

Low Vision aid assessment

4. Patient then seen as soon as practical from point of referral into service for a low vision aid assessment; this may take place in the patient’s home if appropriate.

Emotional support and rehabilitation

5. Referral for emotional support and rehabilitation assessment will be arranged as per local protocol; this may take place in the patient’s home if appropriate.

LVAs

6. Participating low vision practitioners will be provided with an LVA kit; local commissioning bodies will need an agreed list of what is likely to be dispensed and the associated cost. (A recommended list is available at Appendix 1.)

7. All LVAs are supplied to patients on an extended loan basis.

8. LVAs should be dispensed from stock whenever possible and stock replenished as required. The kit should contain enough stock of the more commonly supplied aids in cases where a practitioner is likely to supply several patients on the same day. Alternatively, a centralised ordering system could be used, where aids from an agreed list will be supplied promptly. Patients may purchase more sophisticated aids if they wish.

9. New technology/electronic devices might have to be loaned or hired from the third sector, Access to Work, local education authorities etc or be patient-funded. Information on local arrangements should be readily available and low vision practitioners should ensure patients know how to access these services.
Information and technical support
10. LVA(s) issued with verbal and clear written or audio instructions (and communicated to accompanying persons as appropriate) which specify:
   a. Initial set of batteries supplied, further supplies are available at patient’s expense.
   b. Arrangements for ordering more complex LVA if required e.g. electronic visual aids.
   c. Arrangements for repair or replacement of broken LVAs.
   d. Supply of replacement bulbs available from the practice, LED preferred.

Records
11. A standardised record system will be used (see model at Appendix 2).

Follow up
12. Face to face or telephone follow-up after two weeks to determine how well the patient is using the LVA. Face to face follow-up is preferred. If necessary, due to a change in the patient’s emotional state and better understanding of their visual potential, revisit whether the patient would benefit from other services. Also patients will be encouraged to contact the practice whenever any advice problems associated with their sight loss is required.

Re-assessment
13. Re-assessment as required (new report form):
   a. Regular sight test with own optometrist/OMP – looking for new or changed pathology – refer to HES if necessary.
   b. Low Vision Practitioner.
   c. Third sector and/or rehabilitation officer.

Recycling LVAs
14. Unwanted or unused LVAs to be returned and recycled, if appropriate.

Audit and Patient Reported Outcome Measures (PROMs)
15. An audit will be carried out annually on overall patient experience.
Appendix 1
Recommended Low Vision Aids

Recommended Low Vision Aids Standard Kit (Magnification as labelled)

The items in blue are the minimum necessary for this pathway.

<table>
<thead>
<tr>
<th>Hand Magnifiers</th>
<th>Stand Magnifiers</th>
<th>Spectacle Magnifiers</th>
</tr>
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<tbody>
<tr>
<td>2x, 3x, 4x, 5x, 6x</td>
<td>3x, 5x, 6x, 8x, 12x</td>
<td>6x, 8x, 10x</td>
</tr>
<tr>
<td><strong>Illuminated Stand Magnifiers</strong></td>
<td><strong>Prism Half-Eye Spectacles</strong></td>
<td></td>
</tr>
<tr>
<td>2x, 3x, 5x, 7x, 10x, 15x, 22x, 30x (LED &amp; tungsten)</td>
<td>+6.00DS, + 8.00DS, (mixed eye and bridge sizes)</td>
<td></td>
</tr>
<tr>
<td>Clip-On Binocular Loupes</td>
<td>Clip-On Monocular Loupes</td>
<td>Knitting/Chest Magnifiers</td>
</tr>
<tr>
<td>2x, 3x</td>
<td>4x, 7x</td>
<td>2x/4x</td>
</tr>
<tr>
<td>Distance Telescopes</td>
<td>Near Telescopes</td>
<td>Flat Field Magnifiers</td>
</tr>
<tr>
<td>8x (binoc), 4x, 6x, 8x (monoc)</td>
<td>3x, 4x monocular &amp; binocular</td>
<td>Dome Magnifier</td>
</tr>
<tr>
<td>Pair 1.9x with near focus (inc spec clip)</td>
<td>Spectacle or headband mounted</td>
<td>Hedgehog magnifier</td>
</tr>
<tr>
<td>2.1x (binoc) e.g. MaxTV, SeeTV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pocket Magnifiers</td>
<td>Illuminated Pocket Magnifiers</td>
<td>Bar Magnifiers</td>
</tr>
<tr>
<td>3.5x, 6x</td>
<td>3x, 5x, 7x, 9x, 11x (LED &amp; tungsten)</td>
<td>2 sizes</td>
</tr>
<tr>
<td>Electronic magnifiers</td>
<td>Non-Optical Items</td>
<td>Tinted Overspecs 2 Sizes</td>
</tr>
<tr>
<td>e.g. Compactmini</td>
<td>Ocluders</td>
<td>Amber 49% LTF</td>
</tr>
<tr>
<td>Compact+</td>
<td>Reading lamp</td>
<td>Amber 16% LT</td>
</tr>
<tr>
<td>Looky</td>
<td>Reading stand</td>
<td>Brown 2% LTF</td>
</tr>
<tr>
<td>Pocket Viewer</td>
<td>Clamp</td>
<td>Grey 58% LTF</td>
</tr>
<tr>
<td></td>
<td>Typoscope</td>
<td>Grey 40% LTF</td>
</tr>
<tr>
<td></td>
<td>Large print/book/newspaper</td>
<td>Red 14% LTF</td>
</tr>
<tr>
<td></td>
<td>LogMAR DV Chart/NV Chart</td>
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<tr>
<td></td>
<td>Pelli Robson CS Chart</td>
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<tr>
<td></td>
<td>Amber 49% LTF</td>
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<tr>
<td></td>
<td>Amber 16% LT</td>
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<tr>
<td></td>
<td>Brown 2% LTF</td>
<td></td>
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<tr>
<td></td>
<td>Grey 58% LTF</td>
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<tr>
<td></td>
<td>Grey 40% LTF</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Red 14% LTF</td>
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</table>

Commissioners and providers may also wish to supplement this list with more specialist aids. As these are often more expensive, it may be necessary to seek commissioner approval on an individual basis before supply.
Appendix 2
Information to be provided as part of the low vision assessment

- ECLO – contact details (Eye Clinic Liaison Officer)
- ILCO – contact details (Independent Living Coordinator\(^9\))
- Rehabilitation Officer for Visual Impairment – contact details
- Other local social services, what they can offer and contact details
- Local Blind Society(s), what they can offer and contact details
- Local Visionary (if different), what they can offer and contact details
- Action for Blind People team (part of the RNIB group), what they can offer and contact details
- Local Citizen’s Advice Bureau - contact details
- Local tax office – contact details
- Local benefits office – contact details
- Local housing office – contact details

This information should be supplied to low vision practices by the service commissioners, CCGs and local authority social service. The information should be checked at least annually for currency and accuracy.

Appendix 3
Implementation Guidance

Funding
Funding should be per patient, per low vision assessment/dispense/follow-up, and the fee for the service should be subject to an annual uplift in line with increases in NHS expenditure. A supplementary fee should be agreed to cover the additional costs of providing the service at patients’ homes, where appropriate. In an area where no funding is available, the service might be provided privately as an accredited service with a list of low vision practices/practitioners.

LVAs
Low vision aids from an agreed list will be funded by the local commissioning body or other organisation operating the scheme. Other LVAs may be provided if prior approval is sought and agreed by the local commissioning body or other organisation operating the service. In the absence of a voucher system, there may be potential for the local commissioning body to approve – in particular cases – that the funding for a standard low vision aid might be supplemented by the patient towards the cost of a more sophisticated aid, similar to the wheelchair voucher system, if they wish. This would extend the potential LVA range whilst limiting cost to the NHS or other organisation.

Service Evaluation
It is anticipated that evaluation of the patient experience when accessing the Low Vision Service will be a major KPI for commissioners. In relation to this it should be highlighted that it is of great importance that the evaluation also refers to other services people with sight loss have accessed (not just the Community Optometry Low Vision Service) and that the results of the evaluation are shared with service users and all stakeholders.

Centralised Ordering of LVAs
The cost benefits of centralised ordering of LVAs, and direct billing to the local commissioning body should be considered. This model can also simplify VAT issues for service providers.

Patient Reported Outcome Measures (PROMs)
LOCSU will work with VISION 2020 UK and patients to develop a basket of patient reported outcome measures for this pathway. These will be piloted in late 2011.

In time it is anticipated that they will form part of a suite of user reported outcome measures across the whole of the quality and outcomes framework.
Appendix 4
Background Documents

- First report of the National Eye Care Services Steering Group (April 2004)
- UK Vision Strategy (April 2008)
- Recommended Standards for Low Vision Services – DH (January 2007)
- Right Care: Increasing Value – Improving Quality (June 2010)
- Creating a Patient-led NHS: Delivering the NHS Improvement Plan (March 2005)
- Commissioning Framework for 2007-2008
- Implement Care Closer to Home: Convenient Quality Care for Patients (April 2007)
- Commissioning Framework for Health and Well-being (March 2007)
- Trust, Assurance and Safety – The Regulation of Health Professionals (February 2007)
- Safeguarding Patients (February 2007)
- Practice Based Commissioning: Practical Implementation (November 2006)
- Health Reform in England: Update and Commissioning Framework (July 2006)
- Tackling Hospital Waiting: The 18-week Patient Pathway (May 2006)
- Standards for Better Health (April 2006)
- White Paper: Our Health, Our Care, Our Say (January 2006)
- Falls Prevention – Older People’s NSF Standards (DH)
- Reducing Falls in Older People (Improvement Foundation)
- Operating Framework 2010/11 (DH)
  - Sustainability of 18 weeks referral to treatment targets
  - The emphasis on high quality services measured across three domains
    - safety
    - effectiveness
    - patient experience
Particular thanks go to the following contributors:

**Graham Ackers**  
LOCSU Board Member, Low Vision Services Provider

**Mary Bairstow**  
Low Vision Services Implementation Officer, VISION 2020 UK

**Jane Bell**  
Community Low Vision Practitioner, LOCSU Adviser/Optical Lead, Dorset LOC Chair

**Susan Blakeney**  
Optometric Adviser, The College of Optometrists

**Jennifer Brower**  
ABDO President, ABDO Low Vision Committee Chair

**Giles Butler**  
Project Manager, National Eye Health Week, Low Vision Service User

**Bruce Gilson**  
Working Group Lead, LOCSU Advisor & Bucks LOC Chair

**David Hewlett**  
Vice Chair of Action for Blind People (part of the RNIB Group)

**Anita Lightstone**  
Programme Director, UK Vision Strategy and RNIB

**Mark Nevin**  
Head of Policy & Regulation, FODO

**Susan Parker**  
PEC Clinical Governance Lead, NHS Stockport

**Lyndon Taylor**  
IT Compatibility, LOCSU Advisor

**Kevin Thompson**  
Joint Primary Care Committee Chair

**Katrina Venerus**  
Managing Director, LOCSU

**Trevor Warburton**  
LOCSU Clinical Advisory Group Chair