Providing primary eyecare services during a global pandemic: the new normal

BY JANET POOLEY

It would be fair to say that 2020 hasn't quite turned out to be the year that anyone predicted. Living with a global pandemic has become our reality and we are having to get used to many aspects of our lives being very different. In the early part of the year many countries responded with a widespread lockdown and suspension of all but the most urgent healthcare. However, as we have locked down again in the autumn there has been a different approach; much healthcare has been able to continue, even whilst other aspects of our lives have been shut down. We are learning to live with COVID-19 whilst keeping patients and practitioners safe.

How it started for optometry

Community optometry has seen dramatic change. All routine eyecare services were suspended around the UK on 23 March, with domiciliary services in care homes and patient's own homes having already ceased as a response to limiting the spread of COVID-19. At the time it appeared to be a dramatic response, but in reality we were several weeks behind other European nations.

It became clear at an early stage that a restriction to services would be in place for some months. It was vital that an emergency service was available, but due to the length of service suspension this was deemed too limited a restriction. Essential care was almost universally interpreted as an appointment "that would not normally be considered to be an emergency, but where, in the practitioner's professional judgement, a delay in an examination may be detrimental to a patient's sight or wellbeing" [1].

Some community optometry practices closed completely, whilst many provided patients with a remote service, conducting telephone and video consultations where available. Emergency dispensing of spectacles was also maintained during the lockdown phase; a service particularly important to frontline healthcare staff and other key workers.

Face to face care in a hub

The national response tended to result in a hub style model, with those providing a remote service referring patients for face to face primary eye care in a hub. At such an early stage in the pandemic personal protective equipment (PPE) was scarce. In Scotland the service was calculated on a one hub to 100,000 population model; a calculation that ensured that travel of both practitioners and patients was kept to a minimum [2]. Similar models were seen in the other home nations.

Professional guidance

I doubt any of us has ever referred to professional guidance as much as during 2020, and this is not least because it was frequently changing and being updated. At times, the guidance was struggling to keep up with the evidence, but eyecare was not alone in that. This was a new virus, a new strain of COVID identified at the end of 2019, and the world needed to understand how it spread, its effect on people and the environment, and how to keep society safe [3].

The role of the professional bodies was key to supporting practitioners with appropriate and relevant guidance, specific to our service. Whilst the public health teams have generally done an admirable job in providing the general guidance [4], certain procedures and ways of working are unique to eyecare. It was welcome to see some joint guidance produced by the Royal College of Ophthalmologists and the College of Optometrists, thus avoiding an unnecessary opportunity for confusion, e.g. decontaminating a bowl perimeter [5].

Needs-led approach to patients' care

Key to the provision of community eyecare during the pandemic has been a needs and symptoms led approach. Whilst many patients do attend for an eye examination as the result of problems they are experiencing, most attend as the result of a routine recall. Such recall appointments have dramatically reduced during the pandemic, not least due to the large backlog driving patient demand for appointments and a reduced capacity with the infection control measures in place in practices.

We've learnt a lot since the lockdown began in March. The way we conduct an eye examination has been widely scrutinised. There is a requirement to minimise the time spent within 2m of a patient. Whilst the history and symptoms part of any examination can be conducted remotely prior to the test, or physically distanced, the examination itself cannot.

In the UK, The Opticians Act 1989 defines the 'eye test' such that a routine examination is fairly standardised across the country under this legislation. In particular, the need to "perform such examinations of the eye for the purpose of detecting injury, disease or abnormality in the eye or elsewhere as the regulations may require" demands a particular level of assessment [6].

The College of Optometrists has provided clear guidance on how to modify an examination [7]. For example, guidance supports a visual fields assessment as clinically necessary only, and to consider omitting if discs and intraocular pressures are unchanged, with no other relevant signs or symptoms. The use of a mounted, as opposed to a handheld, tonometer is advised, and streamlining of the subjective refraction and other tests that are usually considered standard is recommended.

Remote consultations

At the present time, the use of virtual consultations remains the preferred method for patient consultation in healthcare where at all possible. The item of service payments method of remuneration for General Ophthalmic Services (GOS) traditionally requires the patient to be present, but during lockdown, virtual consultations became an important method of providing care.

The General Optical Council provided high level principles for good practice remote consultation and prescribing early in the

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pandemic [8]. The principles were co-authored by a range of healthcare regulators including the General Dental Council and the General Medical Council, giving professionals reassurance about conducting such consultations.

In NHS Forth Valley Health Board in Scotland, the use of Attend Anywhere Near-Me software had begun trials last year [9]. Tele-ophthalmology had already proved to be very helpful as a remote mechanism for supporting clinical decision-making in optometry practices, with a tablet attached to the rear of a slit-lamp to enable the optometrist to gain a second opinion from a consultant ophthalmologist. During the lockdown and on-going, this health board has continued to utilise this technology to great benefit.

Infection control

Where the patient does attend for an appointment, it is vital to ensure the clinical environment is safe. Return to face to face community eyecare in many parts of the UK involved a declaration form to be provided to the NHS commissioner to support the governance around infection control and safety. NHS Wales supported this with a tool kit to provide a step-by-step guide so that practices were confident that they were doing all that was required [10].

Community practices are not hospital settings and like many other primary care settings, soft furnishings and carpets are not uncommon. Huge changes and modifications have been required, supported with clear and proportionate infection control advice to practitioners working in community practice [11].

Safe practice also requires the use of PPE. Donning and doffing PPE was a skill unfamiliar to optometry. It has had to be quickly learnt. Thankfully, despite early concerns relating to supply, the system is now well provided for and appears to be working well. Certainly, all the home nations are now provided PPE for the provision of NHS community eyecare at the very least.

Whilst some variation has been experienced across the country, it is generally accepted that disposable gloves and aprons are worn, with a fluid resistant surgical mask and eye / face protection. Splash guards on slit-lamps are now standard [12] and where at all possible, physical distancing of 2m is observed.

Physical distancing in small practice premises is a challenge. Even in larger premises pinch-points can be difficult and need to be well managed, e.g. corridors and doorways. Many practices are operating a closed door policy to ensure that too many people do not enter the premises at any one time. It is easy to see how this may be challenging to vulnerable patients. Older patients for example may be more likely to arrive early for an appointment and are less able to stand around waiting to be able to enter at an allotted time. Care needs to be taken to ensure that access to services is as easy as possible for all patients within the restrictions that the pandemic is imposing.

COVID-19 has meant that 2020 has been an incredibly hard and difficult year for so many people. New ways of working are always a challenge, but re-learning your professional role to keep yourself, your colleagues and your patients safe during a pandemic is not to be underestimated. Inevitably, new practices will be adopted to ensure safer ways of working and it would probably be fair to say that things will never be quite the same again.

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