**GUIDANCE – OPHTHALMIC SERVCIES – April 2020**

Please find attached communication for all optometrists with additional advice regarding eye care provision following further social distancing measures announced by UK and Welsh Governments on 23 March.

NHS Wales are asked to take cognisance of the speed with which change is occurring in relation to Covid-19. Health boards, Optometric Advisers, Optometry Wales and the Regional Optometric Committees, are therefore asked to develop community optometry practice ‘clusters’, to reduce the number of practices required to remain open, whilst still providing sufficient health board geographical cover of services.

At least one practice and up to three practices per ‘cluster’ would provide good coverage, however, additional services, as detailed below, may require more practices to be available to support local needs, and we encourage you to be flexible in your approach.

All health boards, working with their Eye Care Collaborative Group, Optometric Adviser, Optometry Wales and Regional Optometric Committees are to plan and deliver the local services required.

*Primary Care*

Immediate Planning

1. Develop cluster based urgent and essential eye care in primary care optometry practices as described above and in the attached letter.
2. Health boards to make full use of all the resources in primary care and wherever possible seek to utilise the premises and equipment available from both independent and national practices. Independent Prescribing qualified practitioners will be able to manage more cases and reduce the need for secondary care intervention.
3. Health boards to put arrangements in place for eye care in line with the emergency centres established for the provision of urgent dental care for patients symptomatic of Covid-19; aligning eye care services to the dental arrangements in dedicated health board centres. Arrangements to be made locally to staff the emergency centres for both professional and non-professional staff. Local optometric practices to forward a list of all staff to NWSSP and their local Optometric Adviser available to be redeployed; Optometry Wales also forward the availability of locum optometrists for this purpose.
4. Health boards and Optometric Advisors are asked to regularly communicate updates with those working in emergency centres about what is being treated, or not treated in secondary care, as this is an evolving situation. Robust communication channels are also important to access advice from ophthalmologists and/or ophthalmology departments if needed.

*Covid19 Escalation planning*

1. Health boards to urgently consider the **next step** of planning should a significant number of primary care optometric practices close. Moving to ‘cluster’ facilitated hubs, with optometrists providing sessional cover should be the next step in delivery.

**Secondary Care**

Health boards to put in place action to ensure ‘urgent’ patients are seen and reviewed as appropriate and ensure strategies are implemented that mitigate the loss of hospital based ophthalmology outpatient capacity over the next few months.

The Covid-19 outbreak and associated healthcare demands represent a significant challenge to eye care services.  It is imperative to continue to provide high quality eye care to our most at risk patients, and manage services proactively to reduce demand when the crisis is over.  The Welsh Government guidance on strategies should be employed by health boards during this period.  Changes in working practices and increased shared working between hospital and community resource is imperative.  Community resources have adjusted their working practices to support and partner hospitals safely and with appropriate oversight.

The strategy to mitigate the effect of the virus on large numbers of “at risk” members of the population is social distancing, social separation and “shielding” for up to 12 weeks. The aim is to separate this group of individuals from the circulating viral load within the healthy population, until critical care capacity improves, or herd immunity reduces the transmission of the virus. The at risk population are considered to be:

* Individuals over 70 years old
* Those with underlying medical conditions - in particular those affecting the cardio-respiratory system

There is considerable overlap between the at risk population and the majority of patients requiring continual outpatient appointments for potentially blinding disease. In particular these concern Glaucoma and Macular patients requiring intra-vitreal injection therapies. In both cases delays to review and/or treatment may result in irreversible sight loss.

Traditional models for the delivery of eye care have relied upon face to face examinations provided by appropriately trained clinicians and allied professionals within the hospital environment. Review intervals are dictated by clinical strategy and the natural history of the condition being treated.

There is abundant evidence that slit lamp examinations are a major risk factor for the transmission of Covid-19 and other aerosolised pathogens between patients and clinicians. Ophthalmic outpatient clinics have largely been cancelled across Wales to reduce the social contact between at risk patients in waiting rooms and clinical areas. Additionally it has been estimated that 20% of hospital staff may be absent through their own sickness at any one time during the pandemic.

The combination of reduced clinical activity, social distancing, infection control measures and staff absences result in a risk that surveillance and treatment of blinding eye disease will be significantly compromised during Covid-19 outbreak.

There are several mitigation strategies which may be employed to reduce the risk of unnecessary blindness whilst maintaining and enhancing protection against viral spread. By design these strategies improve the efficiency and safety of ophthalmic systems and services which can be continued in the longer term. In broad terms, these strategies fall under four main categories:

1. Risk stratification
2. Remote data gathering and review
3. Highly efficient treatment pathways
4. Continual efficiency measures

**1. Risk stratification**

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| **Concept** | Only provide face to face services to those patients for whom the risk of non-intervention within the next four months outweighs the risk of contact |
| **Purpose** | Reduce unnecessary visits to hospital to zero. |
| **Execution** | Each unit to stratify risk of adverse ophthalmic outcome by clinical group. Patients at high risk of adverse outcome with non-intervention must be contacted and appropriate intervention arranged. Patients in lower risk groups contacted and deferred. |
| **Timeframe** | Immediate. |
| **Current position** | All health boards should have completed this and patients informed.  Moorfields have produced a stratification tool that can be utilised and amended as necessary. |

**2. Remote data gathering and review**

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| **Concept** | Use community based facilities - particularly optometric practices - to gather relevant clinical data on selected patients to allow remote review of contemporaneous information with consultant led management. Pool consultant resources to provide cross cover across the region and beyond to allow for absences in each location. |
| **Purpose** | Maintain review and management pathways for medium risk patients who do not require hospital intervention, in order to reduce harm in moderate risk groups, and forestall increased demands on the service after societal restrictions are eased. |
| **Execution** | Existing models of working on glaucoma data capture pathways in health boards have proved to be effective and therefore should be used across Wales.  Based on this work, existing paperwork, payment and administration solutions have been adapted for use by NHS Wales to allow standardised paperwork. This will allow records to be sent to any available specialist in order to continue to provide reviews during period of absence of the primary consultant. |
| **Timeframe** | The existing paperwork and administrative processes can be used immediately and communication with optometric practices undertaken by the ROC groups. The proposed flow chart and pathway is attached to this correspondence |

**3. Implement efficient treatment pathways**

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| **Concept** | Services previously delivered in hospitals, may be offered in other settings where the risk of doing so is outweighed by the benefit of continuing the service. This principle will maintain pre-existing sight loss prevention strategies, and minimise waits when the service returns to normal. |
| **Purpose** | Resources should be directed towards improving the efficiency of all pathways, in order to maintain the quality of service previously offered, with reduced hospital visits and availability of clinical staff. |
| **Execution** | Sight loss pathways (mainly wAMD and glaucoma) should consider switching to community data collection, robust communication, community delivered therapies and planned hospital follow-up after 12 weeks.  wAMD pathways currently require OCT and VA before decision to treat.  In order to reduce the risk of transmission of COVID-19 to “at risk” groups (who make up a large proportion of wAMD patients), a strategy to only bring patients to injection facilities who are known to need an injection should be implemented. This can be achieved either by using fixed dosing intervals, or using community resources.   * Fixed dose intervals for injections with no OCT   + Treat every patient on pathway * PRN/T & E to continue with community gathered OCT/VA data   + Use community resources to gather data, review virtually then book injections only for patients requiring injection   Injections could be carried out using community dental facilities in the future. Rather than bringing 100 patients into the hospital for injections, they could be assigned to local dental practices and receive injections in their clean rooms. RCOphth guidance does not establish minimum requirements for injection facilities, and many intravitreal injections are carried out in office settings around the world with no increase in infective adverse events. Intravitreal injections can be carried out by all grades of ophthalmologists, as well as suitably trained allied health professionals. Injection guides and devices are available to improve the safety and repeatability of these interventions. Redundancy should be built into the injecting workforce in order to cope when staff sickness and absence occurs.  Glaucoma pathways  New and pending referrals for asymptomatic glaucoma should be returned to the referrer with a request to provide temporal data - repeat measures (IOP, field and disc image) at least four months after initial assessment before onward referral (if still required).  Asymptomatic patients not yet assessed in clinic should have repeated measures in the community.  Review patients should be stratified into “high risk of sight loss within four months” based on existing data, and “low risk”. High risk patients may have repeat measures collected in the community and virtual review undertaken, with changes in therapy directed by the consultant. Any spare community/virtual clinic capacity may be used to gather data and review lower risk cases.  Consideration should be given to placing “high risk” patients in the at risk groups (COVID-19) on maximal medical therapy without further assessment, if the risk of sight loss is thought to be outweighed by the risk of transmission of COVID-19 within data gathering environments, and ensuring prompt follow-up as soon as social distancing rules allow. |
| **Timeframe** | 2-4 weeks to full operationalisation. |

**4. Continual efficiency measures - risk stratification**

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| **Concept** | Existing follow-up lists will contain large numbers of patients who will not benefit from further follow-up. The opportunity of reduced clinical work over the next three months may allow clinicians to review the follow-up caseload and reassign patients to community based schemes, or discharge them entirely. |
| **Purpose** | To reduce the residual demand on the eye care service following resumption of normal business, and to make use of community strategies employed during the crisis for the future. |
| **Execution** | All FNUB, and follow-up patients to be virtually reviewed based on last letters and clinical information during the next three months, with resignation of follow-up status as directed by senior clinicians. |
| **Timeframe** | Within one month. |