



COVID-19 guidance consultation

This is a key piece of guidance for the sector and we congratulate the College of Optometrists for leading on it. In our brief response below we capture the main feedback from FODO members. In addition, we would be very happy to work with the College on finalising its pandemic guidance.

Summary of feedback:

Consensus

- Covid 19, other coronaviruses and highly infective respiratory illnesses, will almost certainly be with us for many years to come. Even at low levels, they will be a constant background to optometric practice for the foreseeable future. As a profession there is now an urgent need to focus on how we meet eye health and vision needs safely in such circumstances and minimise avoidable delays in care.

Feedback on the draft consolidated Covid-19 guidance

- The sector looks to the College for clinical guidance. The principles underpinning clinical care and informing clinical judgement can at times be difficult to access within detailed operational guidance - e.g. many stakeholders we spoke to reported feeling swamped with the same/similar operational guidance but wanting greater clarity on clinical guidance. It would be helpful if the College could separate out clinical and operational guidance – e.g. explaining the table but then linking to a separate College guide on handwashing etc.
- Separating out standard operational guidance will enable clinicians to access and be guided by clinical principles when faced with pandemic respiratory viruses.

Feedback on the Covid-19 pandemic guidance table

- Although the traffic light model has some limitations, at this stage the overall view is that this remains the best way to communicate important information during times of infectivity. To improve the table, it would be helpful if the College could
 - use one rather than two phases of amber
 - review its 'green' alert level. The CJB 'green' level (level 1) could be many years away. The current table does not capture the public health benefits of primary eye care and therefore needs to be reviewed
 - reconsider the guidance for contact lens practice as in reality individuals will seek contact lens fitting and advice even during periods of high infectivity and, as in other areas, the focus should be on supporting clinicians and patients to mitigate and minimise risks.

Answers to consultation questions

Is the consolidated guidance clear and easy to use?

No.

The general feedback is that the guidance is a simple compilation of guidance pulled together urgently in response to what was at the time a largely unknown threat. It is therefore reactive and written in terms of what cannot be done. This review provides an opportunity to

- simplify and streamline the guidance for future practice – including for future pandemics
- reframe it terms of what can and should be done
- reintroduce more emphasis on the clinical principles which inform professional judgement
- recognise the need to meet eye health needs and avoid visual impairment in the taking account of the informed choices and circumstances of individual patients whilst keeping clinicians safe.

We would be happy to work with the College to achieve these goals.

Is the accompanying table and terminology clear?

Yes, however the table could be further improved by merging the two amber phases and further simplifying the use of language (see feedback to other questions below).

We, along with other sector partners, would be happy to support the College in this work.

Should the phases in the table be linked directly to the Joint Biosecurity Centre levels? If not, what should they be linked to?

No, this is because

- the CJBC is not producing data as originally envisaged
- experience of local restrictions/lockdowns show no correlation with the official five CJBC alert levels at a regional level
- we have fortunately avoided level five to date and level one is potentially many years off. This makes the five levels unhelpful in managing something as important as the four nations' eye health.

The UK governments have been clear that primary eye care practices are essential healthcare premises, not shops and not non-essential retail. This means they are, rightly, considered of have population health and public health benefits and are permitted to remain open throughout the pandemic on those grounds to meet as much of the nation's eye health needs as it is safe to. This in our view should guide College guidance.

Given the above, we would suggest the College formulate its own RAG model, with three levels:

- Red would indicate a generalised or local acute lockdown – perhaps R rates above 1 and increasing – with the public instructed not to leave the house other than for daily exercise and to avoid non-essential travel or contact with other people outside the single household bubble. In this state many retail, hospitality and leisure premises would also be closed to minimise the risk of transmission (this might closely match the official level 5 and 4 alert level). Opticians however would be open, triaging patients, providing remote care and prioritising patients for clinically necessary face-to-face care based on local risk assessments working closely with local ophthalmology services and GPs supporting care home patients
- Amber would indicate that there was no strict lockdown – perhaps R rates below 1 – and/or that society was in general reopening albeit with care, face coverings etc. Within this period eye care services should generally rebuild capacity by prioritising needs while safely building back in services until the practice is able to serve as many patients as it is safe to do – e.g. in accordance with official infection, prevention and control (IPC) guidance¹
- Green could be simply marked as “post Covid” or respiratory pandemic/epidemic ‘all clear’. Although it should be made clear, this could be many years off, background levels of Covid 19 may remain and occasionally flare up, perhaps in combination with other illnesses such as winter flu, or there may be further SARS-type respiratory pandemics. This will allow the sector to better conceptualise the longevity of Covid and other pandemic respiratory risks and make decisions/investments accordingly

This, in our view, would

- Make it clear that primary and secondary eye care need to work together to meet the nation's eye health needs whilst living alongside Covid-19 (i.e. in amber)
- Delaying care until after Covid-19 (i.e. when in green) should rarely if ever be acceptable in terms of an individual's health and wellbeing
- Focus minds/resources on solutions to manage Covid-19 and similar risks rather than waiting for the ‘all clear’.

[Is there anything you disagree with and why?](#)

Unstated/unqualified risk. As the sector's scientific body, the College should always set out the rationale behind its advice if this is based on risk assessment so that it can be ‘peer reviewed’, understood and embraced. For example, there is a strong consensus that the College contact lens guidance is unrealistic – people will not wait potentially years for a fitting and may be tempted to seek higher risk options without professional advice, e.g. new patients going online without any previous examination. If the College has reasons for its guidance, these should be stated and

¹ This might be level 4 going into level 3 and through to level 2. For example, in June 2020 NHS England and NHS Improvement assessed it was safe to restart routine eye care services in primary care settings while at level 4, with the UK Chief Medical Officers confirming a level 3 alert on 19 June 2020.

then providers can assess whether there are alternative ways to mitigate risk whilst safely meeting needs.

Not separating out clinical risk and contractual issues. We agree in principle that NHS and self-funded patients should be prioritised on the basis of clinical need and therefore understand footnote two in the table document. It is important in our view however not to mix Covid-19 risk and delays in the commissioning system. For example, if practices can safely see patients but there is a delay with NHS England publishing guidance for NHS contracts, then practices should be allowed to book in self-funding patients while waiting for NHS England to clear its guidance. This approach would help practices manage capacity more effectively and ensure more appointments are available by the time NHS commissioners publish contractual documents.

Is there anything missing from the table or the guidance that you think ought to be included? If so, what?

Clinical guidance

Some members report there is too much operational detail and insufficient clinical guidance on eye health matters. In our view it might help if the guidance document was split into

- Clinical guidance, for red and amber. With the guidance document including a clearer explanation on how to use the RAG table
- Operational guidance for the pandemic. This would include more detail on IPC measures which are often available from other reliable sources but which it may be helpful to have in one place. However, the College guidance should be for clinicians who make decisions based on information not tick box formulae.

We would be happy to support the College in this process.

Review PPE guidance

It might be helpful for the College to review its PPE guidance considering Public Health England (PHE) PPE guidance published 27 July 2020 (see https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/905630/PHE_illustrative_PPE_guide_for_community_and_social_care_settings_17b.pdf)

The new PHE guidance appears to reframe “direct care” in original PPE guidance, with “touching” patients. Reading this across to primary eye care settings people doing pre-screening and other tests might only have to use a Type IIR mask and not apron and gloves (see section 3 of PHE guidance).

Domiciliary care

Domiciliary care might warrant a separate RAG table given variation across the UK. We would recommend the College works with the UK wide Optical Confederation Domiciliary Eyecare Committee on this specialist area of practice.

Exercise judgement

The need to exercise judgement should be emphasized more highly, especially as no table or guidance document can account for the vast number of scenarios that will emerge at a practice-practitioner-patient level.

Equality impact assessment

The College should consider performing an equality impact assessment to ensure individuals are not inadvertently prevented from accessing care – e.g. based on a universal approach to any protected characteristic as defined in the Equality Act 2010.

Any other comments?

We congratulate the College on its partnership approach to supporting the sector effort to meet acute eye health needs during phase one of the pandemic and its leadership role in producing evidence-based clinical guidance to inform professional judgements in the case of individual patients.

We appreciate that all sector bodies must trade off members asking for more and less guidance, and in our experience, there are two broad groups

- Clinicians and eye care providers who look to the College for high level advice and best practice. They then prefer to make their own assessments of risk and be accountable for their own clinical judgements
- More technical and process-focussed providers who prefer more detail and in some cases for College guidance to mitigate all risks

Given that during pandemic circumstances there must be a dynamic assessment of risk, we would hope the College would provide less detail and support providers manage risk locally based on professional judgement. In addition, there is a role for the College in offering further training and support on managing risk.

The College should also be focussed on clinical principles rather than any single NHS system recognising that eye care is not limited to NHS funded care. The current guidance seems very NHS England focussed at times, whereas eye care is delivered across all four UK nations and often beyond the remit of NHS systems.

We also have more detailed comments on the guidance and can share track changes if this would be helpful.