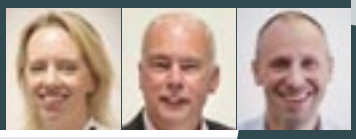

COMPETENCIES COVERED

DISPENSING OPTICIANS
Communication, Standards of Practice, Contact Lenses

CONTACT LENS OPTICIANS
Standards of Practice, Methods of Ocular Examination, Contact lenses

OPTOMETRISTS
Communication, Standards of Practice, Contact Lenses

This CET has been approved for one point by the GOC. It is open to all FBDO members, and associate member optometrists. The multiple-choice questions (MCQs) for this month's CET are available **online only** from 2 August 2021, to comply with the GOC's Good Practice Guidance for this type of CET. Insert your answers to the six MCQs online at www.abdo.org.uk. After member login, scroll down and you will find CET Online within your Personalised Dashboard. **Questions will be presented in random order**. Please ensure that your email address and GOC number are up-to-date. The pass mark is 60 per cent. The answers will appear in the December 2021 issue of *Dispensing Optics*. The closing date is 5 November 2021.

General Optical Council
Approved CET For Dispensing Opticians

General Optical Council
Approved CET For Contact Lens Opticians

General Optical Council
Approved CET For Optometrists

C-78462 Approved for one CET Point

COVID-19 and optical practice:

Where are we now?

By Alexandra Webster MSc, PGDipE, FBDO CL, FHEA, FBCLA, Max Halford FBDO CL and Dean Dunning MEd FBDO CL BA(Hons) Cert Ed FIACLE

At the time of writing, it is 14 months since the World Health Organisation made the official assessment that the CoronaVirus Disease (COVID-19) outbreak could be characterised as a pandemic[1].

According to the UK government[2], by 13 July 2021, the UK had experienced:

- 5,155,243 people had tested positive for COVID-19
- 476,161 people had been admitted to hospital with COVID-19
- 152,725 people had died with COVID-19 stated on their death certificate
- 45,923,721 first vaccine doses received and 34,872,131 second doses received

Covid-19 has had an impact on everyone and everything we do, in some way or other. In August 2020, the article 'Triage in the new normal' in *Dispensing Optics*[3] looked at the changes we had seen at that time in primary eyecare owing to the virus and considered in particular triaging patients. This article will look to inform of research and developments since then, as well as general considerations for patient care following such a lengthy and ongoing impact on optical practice and society.

COVID-19 URGENT EYECARE SERVICE (CUES)

The COVID-19 urgent eyecare services (CUES) was initially introduced in England in April 2020 as a response to the pandemic. It was developed by the Local Optical Committee Support Unit (LOCSU), NHS England, sector bodies and the Clinical Council for Eye Health Commissioning[4]. Important in its development was the endorsement it received from the Royal College of Ophthalmologists.

At this time in the initial UK lockdown, all routine eyecare ceased and practices in England were being given advice regarding 'urgent and essential eyecare' from NHS England. The NHS provision for eyecare, general ophthalmic services (GOS), is not an urgent or emergency service and, therefore, this left a gap in primary care eyecare provision for patients who needed help under the NHS. Secondary care, i.e. hospital settings were not considered appropriate to signpost patients to as they were seen as high-risk venues and their limited capacity needed

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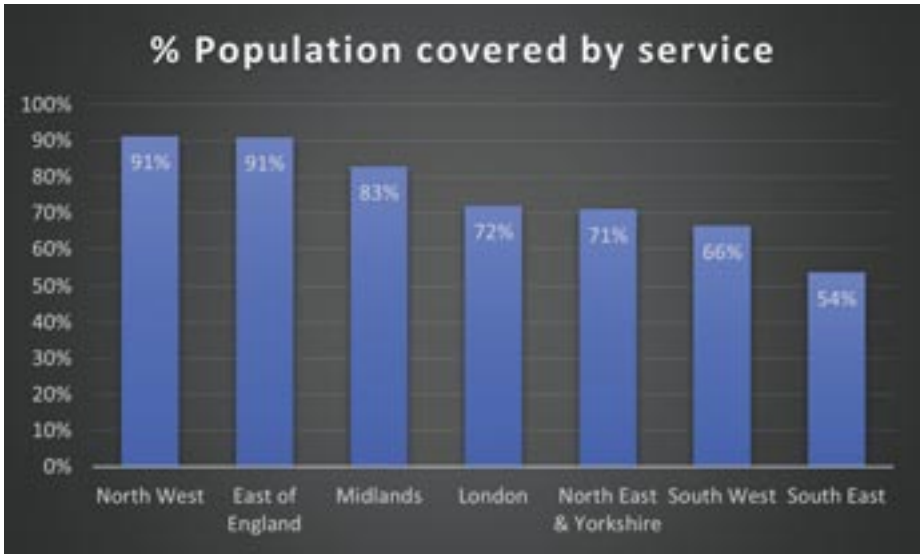

Figure 1. Percentage of the population covered by an urgent eyecare service in primary care, in each of the seven NHS England regions (March 2021)

protecting to free up space for potential Covid patients.

CUES was proposed as the solution to the gap in provision as, although minor eye condition services (MECS) were in place in many areas across England, there was concern that more urgent and emergency presentation would fall outside its service specifications. It was originally designed to be delivered from within primary care optical practices to enable patients to access a remote consultation, which could lead to:

- Advice and guidance to self-manage their condition, with access to topical medications where appropriate
- Management by an eyecare professional with advice and guidance and, if necessary, remote prescribing
- Referral to the hospital eye service

At the time of instigation, it was presumed that the majority of patient consultations would be carried out virtually, in line with the public health advice being circulated.

The CUES pathway aligned with changes to practice issued by the General Optical Council (GOC) in response to the pandemic[5], with the GOC acknowledging that "registrants are encouraged to work up to the limits of their competence" in order to support patient care during periods of lockdown. CUES allowed "optical professionals including CLOs [contact lens opticians] and those with higher qualifications" to offer a broader range of eyecare services "than is typically offered in optical practices, initiating treatment and delivering care as necessary"[4].

The service required a commissioning-decision by clinical commissioning groups (CCGs) across England and, as the service slowly rolled out, it became apparent that there were circumstances where patients and practitioners felt it appropriate for patients to be seen for face-to-face appointments, with practitioners following strict personal protection equipment (PPE) and infection control guidelines.

A CUES would typically see patients who had first undertaken a strict Covid questionnaire and completed a virtual triage, either via telephone or typically via a web-based link. Presenting symptoms might have included flashes and floaters, sudden changes in vision, suspect foreign body, or patients concerned that their eyes had become red or painful. These patients would, prior to a CUES or MECS being commissioned, have attended their local GP surgery or perhaps the accident and emergency (A&E) department at the local hospital. Therefore, the introduction of the service was designed to offer another pathway of care.

As of the end of March 2021, 78 per cent of CCGs had an urgent eyecare service in place within primary care – so, at that time, 75 per cent of the population of England had access to urgent eyecare from local practices[6].

Figure 1 shows the percentage of the population covered by service in each of the seven NHS England regions as of March 2021[6].

NHS HOSPITAL BACKLOG

It would be a near impossible task to accurately calculate the size of the backlog lists within the NHS. However, the British Medical Association has estimated that between April 2020 and March 2021 there were 21.4 million fewer out-patient attendances – and that the number of patients waiting more than 18 weeks for treatment had increased to 1.76 million[7].

The pandemic created a 'perfect storm' on many levels, however, in healthcare perhaps the real concerns are yet to come. In ophthalmology, NHS England data shows that the number of patients waiting 52 weeks or longer for treatment increased to more than 23,000 in December 2020 alone; up by a seemingly impossible 57,580 per cent on the previous year[8].

According to NHS England provisional data shared in the *Health Services Journal*, ophthalmology was the most affected in percentage terms out of all specialities, followed by ear, nose and throat at a 51,638 per cent increase[8].

The pandemic had a particularly negative impact on ophthalmology owing to the high amount of elective work in this speciality that was cancelled. Elective treatment or elective surgery means it is planned in advance, as it is does not involve a medical emergency. Therefore, it is particularly susceptible to cancellations. However, during the pandemic cancelled elective-procedures could not be rebooked due to lockdown and capacity in secondary care being targeted towards Covid patient care.

As we now move slowly down a pathway to routine clinical practice, we have more patients attending for sight tests who have been shielding or been unable to access eye health for over 12 months, many of whom may need referring. This is the 'perfect storm': a backlog of patients referred before the pandemic who were already overdue and waiting for treatment, followed by a loss of clinical capacity for 12 months during lockdown and social restrictions, followed by an upturn in referral numbers as patients access their eyecare practice for the first time in a year or more.

The actual size of the challenge ahead is unknown. However, data from NHS Digital Hospital Episode Statistics (HES) and Specsavers practices, collected by

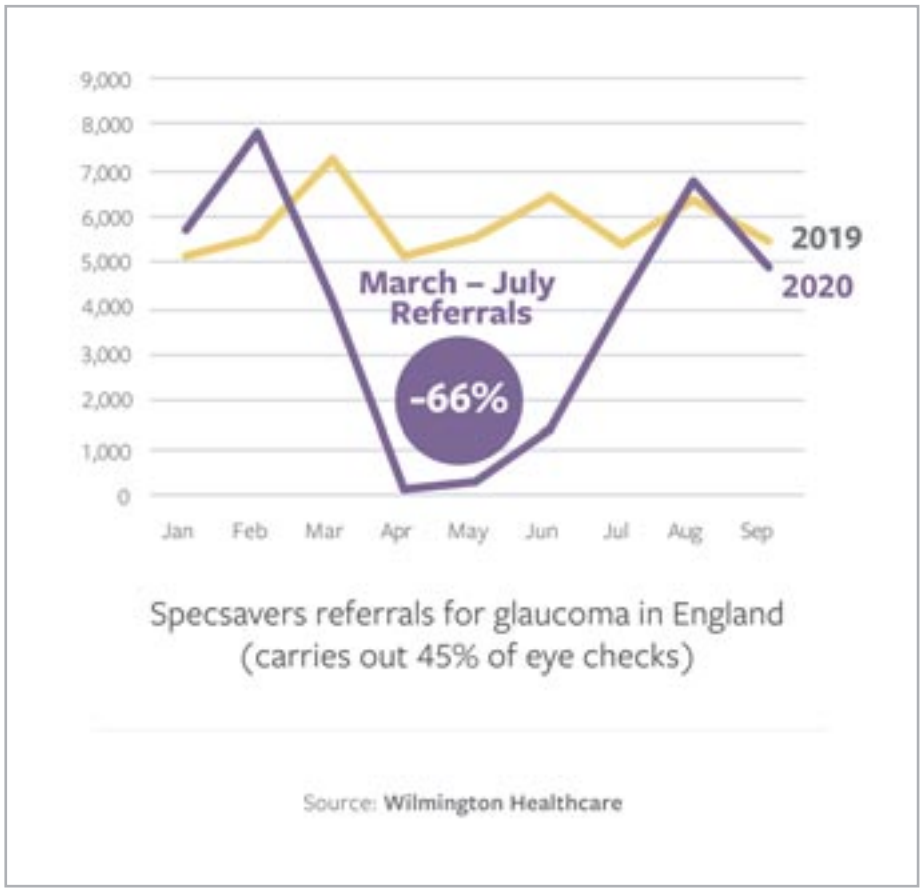

Figure 2. Specsavers referrals for glaucoma in England, 2019 and 2020 comparison. Secondary care data is taken from the English Hospital Episode Statistics database produced by NHS Digital, the new trading name for the Health and Social Care Information Centre (HSCIC) (copyright © 2020, the Health and Social Care Information Centre. Re-used with the permission of the HSCIC. All rights reserved)

Wilmington Healthcare (**Figure 2**) shows the number referrals to secondary care for glaucoma alone fell by 70 per cent in 2020 compared to 2019[9].

HOW CAN EYECARE RECOVER?

The National Eye Care Recovery and Transformation programme has been put in place by the NHS, supported by all sector and professional bodies, to focus on the recovery of services and deliver transformation of eyecare services[10].

This will include primary, secondary and community care, with the goals of: reducing out-patient appointments; developing and delivering extended services within optical practices; and introducing digital communications such as electronic eyecare referral systems (EeRS), which will facilitate routine referral and the transfer of clinical images as part of commissioned pathways between primary and secondary care. These IT systems also allow for advice and guidance from ophthalmologists to dispensing and contact lens opticians and optometrists, as well as triage pathways to be developed.

The government White Paper, 'Integration and innovation: working together to improve health and social care for all'[11], has been introduced as the next step in building a strong and effective integrated care system across England, to bring healthcare and social care together to benefit patients.

If carried forward, it will put integrated care systems (ICS) on a formal statutory footing and allow them to "plan health and care services around their patients' needs, and quickly implement innovative solutions to problems which would normally take years to fix, including moving services out of hospitals and into the community, focusing on preventative healthcare"[11].

COVID-19 AND DRY EYE

Though long-term the wearing of face masks may be mandatory in a reduced number of circumstances, the widespread use of face masks owing to the COVID-19 pandemic and the association with the misting of spectacle lenses[12] has, for many practices, led to an increase in demand for contact lens fits[13]. However, at the same time, there is the suggestion that the number of contact lens drop-outs has also increased[14]. While there could be many potential reasons for this, it is perhaps worth considering the possibility of contact lens-related discomfort connected to the pandemic.

Once such potential cause of contact lens related discomfort is mask-associated dry eye (MADE). The Centre for Ocular Research and Education (CORE) at the University of Waterloo, Canada, has suggested that the upward flow of air from ill-fitting face masks worn by contact lens wearers may accelerate tear film evaporation, leading to discomfort[14]. This could have the knock-on effect of encouraging eye rubbing to provide relief from the discomfort, and the potential for COVID-19 transmission through the hands touching the face and eyes to be increased.

While the eye is not the preferred gateway for respiratory tract infection[15] due to the inability of the virus to initiate infection of the ocular surface[16], there remains the possibility of COVID-19 infection being transmitted through contact with the eye[17] or from the flow of tears into the naso-lacrimal duct to the respiratory tract[16]. CORE has produced a downloadable infographic to support patient education about MADE (**Figure3**)[14].

Moshirfar *et al*[18] have also reported dry eye symptoms in previously symptom-free patients resulting from mask use, as well as a worsening of symptoms of those with pre-existing dry eye conditions. They too have at least partly attributed this to the upward flow of air through the top of the face mask.

CORE has stressed that the potential for dry eye-related conditions as a result of face mask wear should *not* be used to promote non-mask wearing, but rather that practitioners should advise patients of ways to manage the discomfort appropriately while reiterating the importance of mask wearing in enclosed public spaces.

One tip suggested by CORE to practitioners is to routinely ask patients how their eyes feel while wearing a mask, and to consider the role of the eye mask if previous symptoms (pre-pandemic) have become more severe.

Advice that CORE has suggested to give to patients is through the regular

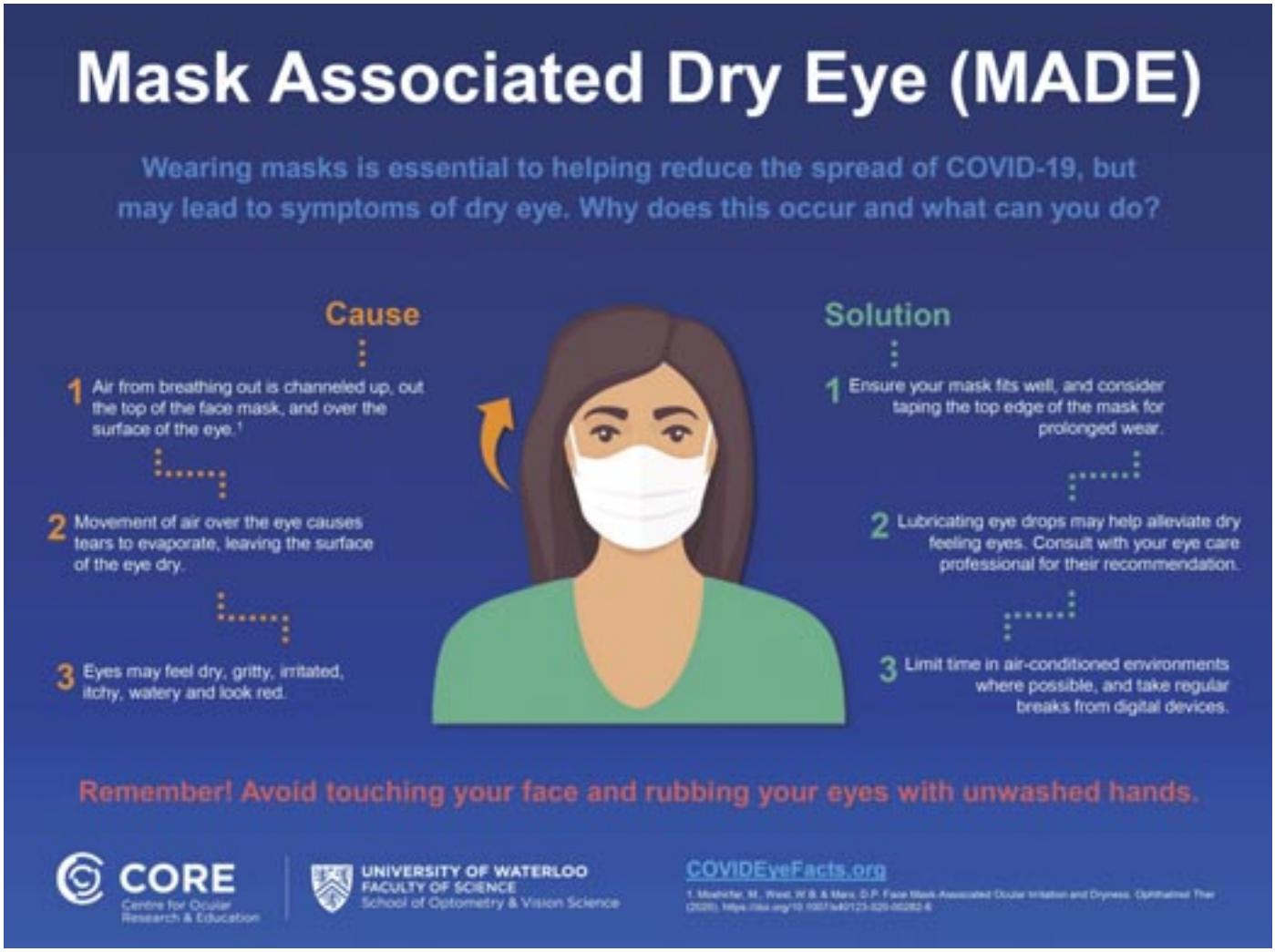

Figure 3. Mask-associated dry eye (MADE)

application of lubricating eye drops, as well as limiting the time in air-conditioned environments[14]. Patients should also ensure that the mask is well fitted, and to consider taping the top of the mask to prevent the upward flow of air; although Moshirfar *et al* have warned that the taping of the mask may potentially induce secondary ectropion and can also cause dry eye symptoms[18], especially if not taped carefully.

The British Contact Lens Association (BCLA) with Euromcontact have echoed this advice, producing a factsheet for practitioners regarding mask use with both spectacles and contact lenses[19].

COVID-19 AND CONTACT LENS WEAR

The possibility of MADE is just one potential complication of contact lens wear during the pandemic. While there is a lack of long-term studies of the effects of COVID-19 on the eye, there has still been a great amount of work done to observe the potential implications of COVID-19 on contact lens wearers.

Jones *et al* considered that while general hygiene advice to all contact lens wearers should be the same as under normal circumstances, there should be extra considerations in order to reduce the stress on stretched healthcare services[20].

The additional advice offered included the recommendation to use daily disposable contact lenses wherever possible, as there is strong evidence that daily disposable lenses reduce the risk of inflammatory complications[21]. Jones *et al* also suggest reducing or abolishing overnight use of contact lenses (if the patient has suitable knowledge of daily wear and access to care products), avoiding touching the face or eyes with unwashed hands, and ceasing all contact lens wear if there are cold or flu-like symptoms present[20].

The BCLA has also published advice regarding contact lenses and COVID-19[22]. It emphasises that there is no evidence that contact lens wear should be avoided in healthy individuals, or that there is any increased risk of coronavirus infection from contact lens wear compared to spectacle lens wear.

The Association also emphasises that there is no evidence to suggest that there is correlation between contact lens usage and the spread of coronavirus infection due to contact lens use. However, it does urge contact lens wearers to seek guidance from their eyecare professional if they have any doubts.

The College of Optometrists[23], while amending its advice to include the non-essential fitting of contact lenses (whilst in the 'amber' phase of the pandemic), still recommends a full risk assessment, together with all infection control measures being implemented before undertaking non-essential contact lens fitting.

In addition to this, for the application and removal stage of a new fitting, it is recommended that this is done in a socially distanced way using video tuition

in the practice, with the contact lens practitioner on hand in case of issues such as a stuck lens. It is also suggested that screens be used to separate the practitioner from the patient at this stage of the fitting.

In terms of contact lens aftercare, the GOC published guidance in March 2020, informing practitioners that they must exercise clinical judgement as to the level of aftercare required and how it is delivered[24].

Following consultation, from 21 June 2021, the statement was updated to state this judgement should be based upon joint regulatory and public health advice as well as the patient vulnerability; relevant clinical advice; how long it has been since the patients last contact lens check; the nature of any clinical risks and how quickly the business could see the patient after the emergency period to minimise the risks, the patient's ability to access remote care and the suitability of the technology for a remote consultation is sufficient to clearly see and hear the patient[25].

INFECTION CONTROL AND PREVENTION

ABDO has continued to provide information to members regarding infection prevention and control (IPC) measures in relation to COVID-19 throughout the pandemic. The latest advice is available in the ABDO '**Advice on COVID-19**' area of the ABDO website, which is updated regularly to reflect ongoing advice and legislation from the UK government.

Although there are constant changes through the introduction of new variants of COVID-19 into the UK, the percentages of the population being vaccinated and the easing – or restricting – of social movement, the overall advice in relation to IPC in optical practice, including the PPE guidance, remains the same and is likely to stay in place for some time.

In April 2021, the College of Optometrists and ABDO released a joint statement on maintaining high standards of infection control[26]. And, in May of this year, following its COVID-19 statement consultation, the GOC confirmed its statement on 'Infection prevention and control during COVID-19 emergency' will apply in all phases of the College of Optometrists' red-amber-green system with some amendments, including to encourage GOC registrants to check the most up-to-date guidance links[25].

CHILDREN, LOCKDOWNS AND MYOPIA

The area of myopia management has been growing exponentially in recent years in terms of available evidence, education and products to support the management of children. What we also see being published is ongoing data, gathered through long-term research programmes, showing the possible impact of lockdowns on the development of myopia in children (**Figure 4**).

Lack of time spent outdoors and increased time spent at close work[27], such as digital device use, are elements of ongoing studies and debates to better understand the implications of the onset and progression of myopia[28]. In the UK alone, nearly 10 million children were not physically attending school during lockdown[29].

For those children not able to access face-to-face education, the regular school day was replaced with remote lessons accessed which were, in the main, undertaken on digital devices. Access to time outdoors will have varied greatly for each child depending on the availability of gardens, local green spaces and the circumstances of the parents/carers with regard to their ability to provide time outside considering their personal and working circumstances.

As China was the first country to be affected by COVID-19, its population has experienced a longer time span of entering and coming out of lockdown. This has enabled data to be gathered in China that we may not be able to yet see in the UK.

Wang *et al*[30] looked at data gathered from a long-term study in China, which had five years of previous annual measurements to compare with the 2020 COVID-19 experience data. A total of 389,808 eyes were measured in 2020 and they found a substantial myopic shift (approximately -0.30D) compared with previous years. In particular, children in the aged six group showed a higher prevalence of myopia in 2020 compared to the data gathered between 2015 and 2019.

However, the study authors stated the findings should be taken with caution, particularly as the measurements are taken using photo-screenings in the school environment to measure spherical equivalent refraction, as opposed to cycloplegic refractions. Additionally, axial length is not measured as part of this study.

Another long-term myopia study in China, again looking at spherical equivalent refraction of school aged children, concluded that younger children were more susceptible to myopic progression during lockdown[31]. They also found that the accelerated myopic progression during the COVID-19 lockdown was partially reversed after lockdown, and theorised that accommodative spasm and structural changes contributed to the accelerated rate.

Again, a warning is made that the results found in this study may not directly transfer to children in other circumstances, specifically when considering the local and social environments.

Although these studies do not provide us with anything conclusive in the UK, when we consider the possible impact of lockdowns on children's refraction, we need to add in the context

FIGURE 4. RESEARCH INTO THE IMPACT OF LOCKDOWN ON CHILDREN'S VISION IS ONGOING

of the cessation of routine eyecare and the ongoing backlog we now experience. Not only may children have been put into situations that may have had the implication to accelerate the development of myopia, but they are also definitely less likely to have been seen by an optical professional, including school screening services[32].

Where practices are looking as to how they can support their patients' eye health in the continuing route to a 'new normal', children's vision needs to be well thought within this.

LONG COVID

Long Covid is a term that relates to the experiences of some people who have contracted COVID-19 and had symptoms for more than four weeks after the initial infection. It is not thought to be associated with how severe the initial infection was[33]. There are many symptoms associated with long Covid and patients may present with very different experiences. The NHS provide the following list of symptoms that can be associated with long Covid and anyone concerned is advised to contact their GP[34]:

- Extreme tiredness (fatigue)
- Shortness of breath
- Chest pain or tightness
- Problems with memory and concentration (brain fog)
- Difficulty sleeping (insomnia)
- Heart palpitations
- Dizziness
- Pins and needles
- Joint pain
- Depression and anxiety
- Tinnitus, earaches
- Feeling sick, diarrhoea, stomach aches, loss of appetite
- A high temperature, cough, headaches, sore throat, changes to sense of smell or taste
- Rashes

Although long Covid is not directly associated with ocular issues there should be an awareness of patients potentially presenting in a different general state of health than they previously did. As primary care healthcare workers, GOC registrants are in a position to pick up on patient concerns regarding their ongoing health, and identify symptoms where referral to the GP may be a suitable option.

KINDNESS AND EMPATHY

It is impossible to conceive that anyone in the UK hasn't experienced some impact of the pandemic in their personal or work lives – or both. For many, this may have been inconveniences and disruptions related to legally-imposed social restrictions. However, for others COVID-19 has caused significant unplanned life changes that can be overwhelming to consider, from the loss of a job or a business to the loss of loved ones.

As eyecare practitioners, there is a need to consider any optical implications and impacts of COVID-19 – and as people who work with people, there is a need to consider how COVID-19 may have affected our patients' overall, as well as colleagues and oneself.

It should be routine in practice to confirm and update patient information – from basic contact details to a full eye examination history and symptoms. However, there could be changes patients have experienced that may not be so easily highlighted or identified. For eyecare professionals and practice staff, there are various avenues to access wellbeing support from NHS practitioner services[35] and all ABDO members have access to support via ABDO Membership Services[36].

Understanding individual need and circumstances has always been key in providing a good service and enabling patient satisfaction. Now, more than ever, patient circumstances should not be assumed, and previous awareness of patient circumstances should not be solely relied on.

For some, the pandemic has enabled them to save money where they have not been able travel or socialise but, for others, savings have been wiped out owing to increased financial burdens and/or loss of income. Some people have experienced an up-turn in their enjoyment in life, maybe being able to spend more time with close family or taking part in activities close to home they previously didn't have the time or opportunity to do. Others have been socially isolated or trapped in unsafe domestic situations, and some have lost parents, spouses, partners, brothers, sisters or children.

There are many reasons why individuals may find themselves in significantly different situations than they anticipated before COVID-19 and this may have an impact not only on their ability to pay for their eyecare but also influence when they attend for an eye examination or other service.

Approaching all of our patient interactions with an open mind, and with kindness and empathy, is more essential than ever to enable positive patient outcomes.

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