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BIOS BRITISH AND IRISH ORTHOPTIC SOCIETY

Recovery and Restoration Guidance

Advice on the recovery and restoration of orthoptic services following the COVID-19 pandemic

The British and Irish Orthoptic Society (BIOS) have produced this guidance to support Orthoptists in planning and delivery of the recovery and restoration of Orthoptic services following the Covid 19 pandemic.

It is recognised that many services will be at different stages of recovery and restoration and have differing priorities. BIOS recognises this and therefore this document has been written as an overall guide.

During the peaks of COVID-19 many services were scaled back to deliver high risk and emergency care only or staff may have been temporarily redeployed and services halted completely. Social distancing requirements and infection control guidance has reduced capacity and increased the delay of assessment and treatment of new and follow up patients in many Trusts.

This guidance is a follow up from the BIOS guidance issued in May 2020 *"Guidance on the management of Patients During the Recovery Phase"* and *"Recovery phase guidance"* published in July 2020.

Many services adapted new ways of working during the pandemic, many of which have continued.

In the recovery and restoration planning BIOS advises heads and leads of services to consider the following:

Infection Prevention & Control guidance

It is important to refer and adhere to local infection control guidance and National guidance

- UK-wide IPC guidance is available from PHE (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control), there are some deviations from this, along with additional information available in Scotland (https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/infection-prevention-and-control-ipc-guidance-in-healthcare-settings/).

- IPC guidance for the Republic of Ireland is available from the HPSC (https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/).

There will be local variances that have been adopted from official PHE guidance, so it is advised to seek local advice in addition to national guidance.

Social distancing guidance

The IPC guidance will affect the number of patients that can be booked per clinic. The space in waiting areas may also affect the number of patients that can be safely booked per clinic. The current guidance from the UK government is still 2m distance.

A time in motion audit can be considered to determine the number of patients or clinics that can be safely undertaken at one time. This will be easier for standalone Orthoptic clinics and more complex when considering busy, multi-disciplinary Ophthalmology clinics. It is worth noting that clinics may be dealing with more complex and high- risk patients at present which will invariably require longer appointment times.

Some departments have been successful in adapting their waiting areas to make them “covid secure” with the implementation of screens or additional waiting space. Toys and other items will have been removed from paediatric waiting areas due to infection control. It is therefore important to offer alternative means of improving the experience of children whilst they are waiting which are less of an infection risk. It is important to inform parents of any reduced facilities in the appointment letter so they can come prepared with their own toys/reading material. Many organisations have adopted a 1 carer per child or vulnerable adult to reduce the risk of transmission and number of people in waiting areas, this will ensure accurate planning of clinic numbers.

Some departments have secured the use of pagers for patients to use in outside spaces/cars whilst waiting for their appointments and others have adopted online attendance apps which allows patients to wait in the car or another area until they are ready to be seen. Not all these adaptations will be available in every department, but it is useful nonetheless to be aware of different technologies which may enable clinic capacity to reach 100% of pre Covid-19 levels.

Extending the clinic day and working patterns of staff may facilitate increasing capacity but should go through a temporary or permanent organisational change consultation process if working conditions are being altered from the normal practice. It is advisable to consult your HR department and BOSTU local Rep for advice.

If social distancing measures are impacting on department capacity or the ability to tackle waiting list backlogs, ensure this is captured on a local or corporate risk register and consider practical mitigations of this risk, for example with screens or pagers or extended working days.

PPE

It is possible that the clinic appointment times have been adjusted in order to complete cleaning in between patients and changing of PPE.

The infection control current guidance should be checked regularly with local and national guidance.

It is important to report any breaches of infection control via the local incident reporting system as the clinic capacity may need adjusting.

Cleaning and decontamination of equipment and clinic rooms

Heads and leads of services should ensure that their staff are familiar with the latest local guidance for cleaning of clinic rooms and furniture. All staff should be familiar with manufacturer's guidance for decontamination of all equipment. Local audits can be undertaken to ensure compliance with these standards and guidelines.

Where appropriate services should consider the implementation of telephone/video clinics and Patient Initiated Follow ups (PIFU).

Risk register

It is important to have clear reporting processes to highlight concerns that may arise, and consideration given to mitigate these risks where possible. The use of local incident reporting systems and departmental/divisional risk registers should be used to escalate and highlight concerns and risks. There should be a clear action plan assigned to an individual to monitor progress of the action plan. All heads and leads of services should be familiar with these processes. It is worthwhile discussing any risks with the Governance Lead for your Department/Division.

Examples of risks that may be on your risk register are:

- Failure to assess, diagnose and treat patients in a clinically appropriate time, caused by the increased demand/backlog of patients resulting in potential permanent risk of sight loss.

- Failure to complete primary vision screening within the academic year caused by the delays to the service from covid19 resulting in reduced patient outcome measures/permanent risk of sight loss (This could be turned into a financial risk if it will result in reduced activity from referrals and follow ups generated from vision screening).

- Failure to reach local target of outpatient activity levels, caused by reduced clinical capacity due to IPC and social distancing requirements resulting in increased delays of new and follow up patient assessments.

Reporting Harm

The Royal College of Ophthalmology have recently published a document on reporting harm (https://www.rcophth.ac.uk/wp-content/uploads/2021/01/Measuring-levels-of-harm-in-an-ophthlamic-setting-.pdf).

It is recommended that there is an awareness of this document and leads and heads have a process in place locally on how to report suspected cases of harm due to clinical delays and that their teams are aware of this. Examples of this would be if a patient has potentially come to harm due to the delay in assessment and treatment. This would require reporting via your own local reporting system to be fully investigated.

Although this guidance is specifically in relation to adults some elements are transferable to children. It is worth considering the impact on education as well as future employment. It is also worth remembering that there may not be a loss of vision but failure to reach visual potential although it may be difficult to define this. It is worth remembering also that when initially reporting incidents of potential harm due to delay, the initial impact would be considered at least minor harm rather than no harm.

Virtual/Remote Clinics

There has been a huge increase in the number of telephone/remote/virtual clinics undertaken within a healthcare setting and Trusts are now focusing on how to convert as much clinical activity to virtual clinics where it is safe to do so. The limitations of virtual/remote clinics in Orthoptics have been well documented due to the nature of the assessments requiring diagnostic testing.

However there have been a range of services that have shared innovative ways of working during the pandemic. Many of which will remain a permanent feature.

The use of virtual and remote clinics was well documented in Scotland and other rurally remote areas for some time prior to Covid-19 and since the pandemic many other services have found new ways of working.

Examples of this include:

- The use of Attend Anywhere as a triage service for Health Visitor referrals. Jennifer Shave (Warrington and Halton NHS Teaching Hospitals) presented her experiences of this at the 2021 LOOP Conference (https://www.orthoptics.org.uk/loop-virtual-event-march-2021/).
- Special educational needs clinics
- Non-functional squints (this may stop the RTT clock whilst waiting for a surgical opinion)
- Stable IIH/headache clinics where a conversation and case history are required rather than diagnostic assessments
- Virtual paediatric and adult clinics?
- Telephone clinics for prism evaluation
- Post op squint assessment

It is important to note that with any new service implementation and change it should be well documented and have a robust audit trail. Individual departments are responsible for writing new guidance and policies that are agreed locally in an appropriate approval committee/meeting such as divisional governance meetings ensuring minutes are available. There may be further processes that Heads of service may be required to do locally such as completing Service Change/Impact forms which are monitored centrally through the governance team with CCGs. It is worth seeking advice from your clinical and governance leads before implementing these service changes.

PIFU

There is a wealth of information on the implementation of PIFU on the NHS Future platform. (FutureNHS Platform - FutureNHS Collaboration Platform). There are certain services in Ophthalmology that lend itself well to PIFU however in many areas such as diabetic ophthalmology, glaucoma, and paediatrics it is less suitable as in these areas subjective responses cannot be relied upon as a means of monitoring progression.

However, there are areas within orthoptics where PIFU can and should be explored such as cases with no amblyogenic factors, those after the critical period, monitoring IDEX, those on orthoptic exercises, stable monitoring of diplopia with prism therapy, stable IIH and non-functional strabismus are such examples where PIFU may be considered.

There are several examples of how this may be implemented in Ophthalmology clinics such as ECLO, Low vision clinics, oculoplastic and uveitis (not screening).

There will be other areas within organisations that may have implemented PIFU, therefore it is recommended to seek further guidance from areas that have implemented this successfully. It is likely that PIFU has been implemented in units for a long time but not under the guise of PIFU.

Job planning

Job planning for orthoptists guidance was launched by BIOS in March 2021 (https://www.orthoptics.org.uk/members-area/job-planning-for-orthoptists/). This guidance was based on clinic timings pre pandemic however this can still be used by heads and leads of services to highlight gaps in staffing to allow recovery plans to be implemented and to inform staffing business cases if needed.

Local recovery targets

It is advisable to understand local Trust recovery targets which may vary. Ultimately Trusts will be aiming to achieve at least 100% pre covid levels in a specified time frame. The expected targets may not be achievable for departments due a variety of factors such as, reduced staffing levels due to clinically extremely vulnerable staff, difficulty in recruitment and IPC requirements due to lack of waiting space. Reasons for the reduced clinic capacity should be documented on the risk register and monitored within the organisation.

Clinical audit and service evaluation

There have been excellent examples of service improvement and amendments to patient pathways throughout the pandemic. It is advisable to keep an accurate audit trail of all correspondence and decisions regarding the changes. Policies, SOP's, and other guidance on any new service or change to current service should be locally driven. The appropriate approval committee should be recorded, such as an orthoptic staff meeting or governance meeting. Any new service change or pathway should be

evaluated for example by undertaking an audit of the outcomes and seeking the views of the patient and any key stakeholder.

Protocols and policies

As services are varied across all countries it is advisable that policies and protocols are locally driven. The use of the BIOS website and forum are useful tools in sharing such documents to adapt to meet the needs of local departments.

It is important to note that local policies should be ratified and any decisions regarding patient care or treatment are based on the information available at the time the decision was made. To reiterate an earlier point that it is essential all service changes have a clear audit trail. Useful information can be found on the HCPC website regarding this and other information which is important to consider.

https://www.hcpc-uk.org/covid-19/advice/applying-our-standards/

Risk assessment

For any new service or pathway change any associated risks should be identified and a formal risk assessment undertaken. Examples of this can be found on the BIOS website (https://www.orthoptics.org.uk/coronavirus/member-resources/).

Peer support

There are good examples of local and regional Heads Networks which can provide excellent peer support and advice through these challenging times. It is recommended to link in with your regional BIOS trustee if you require any support or your local BOSTU rep for any union information. Contact information can be found here on the website (https://www.orthoptics.org.uk/our-team/).

Staffing

There will be departments with reduced staffing levels due to staff being advised to remain non patient facing. Specifically, those who are Clinically Extremely Vulnerable or pregnant. Again, there will be local variances and it is essential to liaise with HR and Occupational Health teams to ensure the correct process is followed.

This will undoubtedly have an impact on face-to-face clinical activity; however, Heads are encouraged to seek advice from HR and IT services to determine what help is available to enable staff to undertake certain roles or training from home.

Examples of this include:

- The use of remote clinics -Video or Telephone
- Review and update all departmental policies, guidelines, SOP’s, Patient information leaflets

- Undertaking clinical audit
- Further training
- Failsafe roles
- Other clinical administrative tasks

Finance

Payment for services moved to block contracts for all during the pandemic and finance teams are implementing new financial tariff structure post pandemic. Any shortfalls in staffing or equipment that would be required to aid recovery if the Covid 19 pandemic should be discussed with finance leads asap.