The impact of the COVID-19 pandemic on ophthalmology services across the United Kingdom: a brief report on a cross-sectional survey of clinical leads

Ther Adv Ophthalmol
2021, Vol. 13: 1–3
DOI: 10.1177/25158414211010549

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Received: 11 February 2021; revised manuscript accepted: 25 March 2021.

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Before the coronavirus (COVID-19) pandemic, ophthalmology departments accounted for more than 10% of all outpatient visits and 7% of all surgical activity across the United Kingdom. An ageing population, with increasing eye health needs, contributed to ongoing concerns regarding capacity within hospital eye services (HES), resulting in treatment delays with consequences on patients' visual outcomes.[1]

Following National Health Service (NHS) England's directive to cease all nonurgent, elective outpatient, and surgical activity at the start of the COVID-19 pandemic, the Royal College of Ophthalmologists (RCOphth) issued guidance on the provision of ophthalmology services.[2] The guidance weighed the risk of patients acquiring COVID-19 by attending hospital appointments against the risk of harm by postponing treatment.

Ting and colleagues presented important data relating to the clinical and surgical delays during the pandemic,[3] with a similar impact echoed across the world.[4,5] After the first wave of the pandemic, we conducted a cross-sectional survey to gain insight into the impact of COVID-19 on services from clinical leads of ophthalmology departments across the United Kingdom. An electronic questionnaire hosted by 'online surveys' (https://www.onlinesurveys.ac.uk/) was distributed via email to the 'Clinical Leads Forum of the Royal College of Ophthalmologists, UK' between 13 May and 13 June 2020. The questionnaire comprised 27 questions exploring the impact of elective care provision, emergency care provision and surgical activity during the pandemic. Ethical approval for this study was not sought because according to the UK legislation, the survey was a service evaluation project meaning that research ethics committee approval was not required as no patient-specific information was collected. We present a brief report on the pertinent findings of this survey. Sharing these findings is useful to the ophthalmology community as it provides solid, not anecdotal, evidence of the demands this pandemic has put on colleagues.

A total of 25 responses were received, representative of 820 doctors. One third of units had staff shielding due to government advice; 88% of units had staff members redeployed to other areas of medicine, the majority of whom were trainees. Only two units had consultants redeployed. Three quarters of units reduced their clinical activity by more than 75%, which was comparatively more than the reduction in activity highlighted by Ting and colleagues.[3]

Outpatient service provision

For face-to-face consultations, 80% of units were using surgical masks, while the remainder used FFP2 and FFP3 masks. All units were using gloves, while 96% used a disposable plastic apron or a fluid-repellent gown.

To ensure social distancing, all units surveyed implemented spaced seating within waiting rooms, allowing only carers to accompany patients where necessary. Patient staff contact episodes and duration were reduced by 88% and 72%, respectively. Further staggering of appointment times was implemented in 84% of units. All the units surveyed had consultants risk stratifying their patient

backlog, using the Moorfields tool,[6] a department-specific tool or combination of both.

In the pre-COVID era, 92% of units had already incorporated virtual clinics into their clinical practice, with 12% incorporating phone consultations or the use of telemedicine. The pandemic caused an exponential increase in phone consultations (96%), video consultations (52%) and other telemedicine platforms (28%). Despite funding by the NHS for free use, Attend Anywhere was only used by a third of units. A particularly high uptake of virtual clinics occurred in subspecialties such glaucoma and medical retina.

When looking to the future of elective services, 92% of units said they will continue to implement altered appointment scheduling, leaving an average of 18 min per clinic patient (range: 5–30); 96% will continue with phone consultations where possible and 88% plan to use virtual clinics. Furthermore, 72% of units would implement video consultations, while 36% would use another form of telemedicine.

Emergency care provision

In the prepandemic era, of those surveyed, half of the emergency departments provided a walk-in service, while the remainder had scheduled appointments, hospital telephone triage services and community optometry triage services. About 80% of units were reviewing less than 75 patients per day. More than half of the units reported that their Clinical Commissioning Groups (CCGs) provided enhanced acute optometry service provision such as the Minor Eye Conditions Scheme (MECS) or Primary Eye-care Assessment and Referral Service (PEARS).

During the pandemic, telephone triaging was increasingly utilised by eye units, with the majority assisted by nurse practitioners, consultants and non-consultant grade clinicians. A total of 12% of units implemented the COVID-19 Urgent Eyecare Service (CUES) scheme.[7]

When discussing the recovery period, while three quarters of units plan to continue with telephone triaging systems, the remainder of units would move to a scheduled appointments system. Units would also utilise referral-only systems or outsource to a community optometrist, but interestingly 20% of units reported no long-term changes.

Surgical activity

During the pandemic, the local department, at which the authors are based, saw the average number of theatre lists per week reduced from 22 to 4, with only emergency procedures performed during the first lockdown. This appears to be echoed at many units. Survey respondents considered the limiting factors for increasing surgical activity to be the availability of personal protective equipment (PPE) and preoperative COVID testing for patients, in addition to an average of 20-min (range: 5–60) change over time between surgical patients. In terms of recovery, the main solution was the use of alternative facilities, followed by increases in the number of surgical lists and sessions per day. The curtailment of surgical activity has also had an impact on training opportunities for the next generation of surgeons.[8,9]

Conclusion

The demand for ophthalmic services was predicted to rise by 25% over the next 10 years, largely driven by an ageing population; chronic eye conditions such as glaucoma and diabetes; and new therapies. The reduction in clinical and surgical activity caused by the pandemic will have a lasting impact on ophthalmic services.

With this cross-sectional survey, we have identified the challenges faced by ophthalmology departments across the United Kingdom, but also identified how services are rising to this new and challenging landscape. The pandemic has highlighted opportunities for operational improvement. There will be adaptation to new ways of working, with virtual clinics being the mainstay of the strategy to deliver care going forward, and community collaborations through improved connectivity to increase capacity for eye health provision. To prevent patients coming to harm, these solutions require urgent additional resource allocation and implementation for the timely delivery of eye care.

Conflict of interest statement

The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding

The authors received no financial support for the research, authorship and/or publication of this article.

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