



# Guidance on restarting Medical Retina Services

**This guidance has been developed by a group of medical retinal specialists as requested by the RCOphth in response to the pandemic and may be subject to change.**

## Introduction

COVID19 has resulted in a dramatic reduction in capacity within the hospital eye service (HES). The RCOphth issued guidance on prioritising patients and managing patients in the most efficient manner during the initial pandemic and Covid19 lockdown, which was necessary, but has resulted in a dramatic reduction to the number of patients seen in the HES.

The situation is likely to affect us to some degree for at least another 18 months and services need to resume more routine activity, particularly concentrating on safety and preservation of sight. Failure to do so risks compromising the independence and quality of life for tens of thousands of people for their remaining lifespan.

Moorfields Eye Hospital estimates a drop in medical retinal (MR) outpatient attendances to less than 30% of pre-COVID levels since lockdown began. Similar reductions have occurred throughout the country. In addition, with social distancing and extra infection control measures being introduced, there will be a dramatic reduction in ongoing capacity. Bristol Eye Hospital (BEH) estimates it will have up to 45 % of previous outpatient capacity and some units think it will be even less. There was already a huge backlog of medical retinal appointments due to capacity problems and this will be significantly worsened due to the COVID19 effect.. Therefore, without a radical reorganisation of MR services it will be impossible to cope with a) the backlog of appointments and b) ongoing workload. Restoration of services will require a detailed review/redesign of the whole pathway to ensure a safe environment for patients and staff. This also gives the opportunity to make changes that will have long-term benefits.

The aim of this document is to provide generic guidance on the resumption of medical retina services. Individual eye departments should tailor this guidance, taking into account their staffing, their infrastructure, the needs of their local population as well as the expectations of local commissioners and regional NHS organisations.

## Key principles/recommendations

- **Review of current patients in the Hospital Eye Service (HES):** ophthalmologists should review patients currently under HES care. It is estimated up to 10-20% of review patients could potentially be discharged. This would be after review either in clinic or by review of recent retinal imaging and then consultation with the patient either in person by telephone/video (virtual) consultation or by a letter to patient and GP.

- **Review the number of clinics required to provide care in light of reduced capacity due to social distancing/infection control measures.** Possible options include:
  - 1) Move to 3 session working and weekend clinics. This may require new contracts and increase in doctor, administrative, nursing and imaging staff to meet demand. Current staffing is unlikely to be enough to meet capacity demands on its own in many units.
  - 2) Develop off-site imaging or diagnostic hubs. This could facilitate MR and other subspecialties especially glaucoma. In addition, a collaboration with diabetic screening services may be relevant in some areas where hospital-led services were traditionally delivered from GP surgeries and this cannot now be accommodated. Possible locations could include Nightingale hospitals, community hospitals with outpatient facilities, and GP surgeries/hubs, or even converted community commercial premises or new builds. This requires significant investment in networked imaging equipment and training of appropriate staff as well as potentially estates. Or consider developing joint working with optometrists for this as described below.
  - 3) Engage with diabetic eye screening services to see an extended group of patients for virtual review e.g. hydroxychloroquine monitored patients, non-diabetic retinal conditions that require OCT and widefield retinal images. This also requires investment in additional imaging equipment and could be problematic if the screening programme also needs to use GP practice space which would be limited due to social distancing

Options 2 and 3 allow ophthalmologists or other eye care professionals to review patient data and images remotely and more efficiently. Moving to more remote working will require flexibility and changes to job plans.

- **Consider referral refinement and potential for joint working:** many optometry referrals do not need to come to the HES. There is duplication of effort where patients have OCT scans in optometry practices and again in the HES. A better option is to develop IT infrastructure to enable fundus photographs and OCT scans performed in optometry practices to be reviewed by the HES, as well as other clinical data, and a virtual opinion given or to empower optometrists to undertake more decision making on MR conditions in their practice, with links to the HES. Several such IT systems exist. It also requires a funding agreement and establishing systems for quality assurance and clinical governance. Coverage of optometric practices with OCT machines may be an issue in some areas and affect equality of access. This could be for follow-up patients currently under HES for glaucoma and medical retina, not just for the referral refinement.
- **Reduce DNA rates in the HES:** DNA rates have been as high as 50 % during the COVID19 lockdown. Telephoning patients or text reminders before their appointments can dramatically reduce DNA rates for hospital appointments.
- **Intravitreal injections**

The Royal College of Ophthalmologists has provided guidance on maintaining patients on fixed dosing anti-VEGF therapy with minimal monitoring during the COVID19 lockdown. There is no reason to swab or enforce self-isolation for 7-14 days prior to patients coming in for intravitreal injections, or steroid implants. Unless seen with the inpatient or Green pathway within the HES it is necessary to maintain adequate time between patients arriving, adequate space in all wait areas and do everything we can to speed up the patient's journey through the clinic.

The highest risk to AMD patients, in terms of their eyesight, is not having an injection when they need one. In some circumstances, to manage patient flow, it may be prudent to omit slit lamp examination, omit dilating drops and IOP checks, omit OCT particularly if on fixed regimes and even omit vision testing if patient reports no change. All patients should be asked if they have COVID symptoms on arrival and sent home if they do. Relatives should not be allowed in the waiting room unless there are exceptional circumstances. IOP checks 30 minutes after injections are not required.

- **Patient Safety:** Many patients feel unsafe to come to hospital due to COVID-19, resulting in cancelled appointments. Therefore, different pathways should be explored in terms of how treatment can be provided in an environment patients are willing to attend e.g. some Trusts have the use of mobile sites or out of hospital outpatient facilities. Potential clinical governance issues around virtual consultations need to be mitigated, when full clinical information may not be available. The lines of communications must be very clear and documented, with access to the correct information needed where possible.
  - Develop systems to allow patients to initiate follow up if required, as an alternative to absolute discharge. This could be via a dedicated email or phone line and avoids the need for a new referral. This can reduce the number of long-term review appointments.
  - Develop robust fail safe measures for patients who have had appointments postponed or have not felt it was safe to attend. It should not be forgotten that pre COVID some patients requiring retinal review will have been listed for cataract surgery. This surgery is likely to be significantly delayed so it is important to check whether these patients need a retinal review appointment whilst waiting for their cataract surgery.

#### **Diabetic eye screening.**

- It is important to note that diabetic eye screening has re-established:
- Public Health England targets for timescale from referral to assessment are still in place and have not been suspended during the pandemic
- Urgent R3a referrals should still be managed as high-risk disease as per RCOphth COVID clinical prioritisation guidance
- It is important to have a pathway for managing routine DESP referrals which are largely M1 maculopathy plus R2. The HES needs to ensure they are able to accept referrals and that these patients continue to be seen, using virtual and other methods as required to create capacity as above.

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